THE MEANING OF HOME CARE AND CARING FOR AGING RELATIVES AT HOME: THE HAITIAN CANADIAN PRIMARY CAREGIVERS' PERSPECTIVES

by

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ABSTRACT
THE MEANING OF HOME CARE AND CARING FOR AGING RELATIVES AT HOME: THE HAITIAN CANADIAN PRIMARY CAREGIVERS' PERSPECTIVES

Providing nursing care in pluralist countries such as Canada remains a challenge for nurses. Little is known about the impact of 'race,' gender, and social class in mediating Haitian Canadian caregivers' ways of caring for aging relatives at home. This critical ethnography, informed by a postcolonial feminist theoretical approach, was directed at addressing two questions: What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? and What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? The study was carried out in Eastern Canada. A sample of convenience, composed of 16 Haitian Canadian primary caregivers, nineteen aging persons, and four home care nurses, was formed. Twelve out of sixteen participants were women – mostly daughters who were caring for aging mothers. Participant observation and open-ended interviews were used to collect data from primary caregivers. Fieldwork was carried out during two periods. The first part was from November 2000 to August 2001, during which, 21 interviews and 15 sessions of participant observation at caregivers' home were conducted. The second part was from October 2001 to February 2002, during which, 3 validity interviews were conducted with some participants to map out the data analysis.

A postcolonial feminist framework guided data collection and analysis. A thematic content analysis was conducted. Results indicated that ways of caring are enmeshed in a complex nexus of social relations where power, race, gender, social class come into play to permeate each level of the caring commitment. Caring is a process of reciprocal growth. Ways of caring are structured by Haitian values, gendering of caring activities, immigration, social 'Othering,' health care reform, and cultural misunderstanding of mainstream health practitioners. These factors explain why this community tends to underutilize public home care programs.

The study points to designing culturally safe nursing interventions and revising current neocolonial home care policies. The findings underline the need to redirect nursing cultural research to address racial, gendered, and social discrimination that influence the economic accessibility to home care support programs for low-income immigrant families in Canada, creating social inequities in our health care system.

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DEDICATION

To the loving memory of my sister Nicole Racine (1947- 2002)

CHAPTER ONE
THE INTRODUCTION

Background to the Problem

At the beginning of this new millennium, the development of regional uprisings, crippling effects of wars on civilians, massive displacement of refugees, and creation of new geographical boundaries have had a significant impact in changing Canada's social and cultural mosaic. While immigration does not constitute a new demographic factor in modeling the nation's social fabric, over the last two decades, a change in the sources of immigration has been noticed. Immigration is characterized by entry of non-Western immigrants and refugees in the country (Health Canada, 1999; Mensah, 2002; Ministère de l'Immigration et des Relations avec les Citoyens, 1999a) with most new immigrants and refugees having come from Asia, Latin America, and the Caribbean (Stepick, 1998).

Before 1996, 47 percent of Canada's immigrants and refugees were coming from Europe, 31 percent from Asia, 16 percent were from the US, the Caribbean, and South and Central America. The remaining 5 percent were from Africa (Health Canada, 1999). Since 1997, the majority of new immigrants and refugees have come from non-European countries, mostly Asia and Africa (Health Canada, 1999; Ministère de l'Immigration et des Relations avec les Citoyens, 1999a). In 1995, the greater Montreal area represented 40 percent of the total population of Quebec, which was more than 7 million inhabitants. Of Quebec's total population, 83 percent were francophones[1], 10 percent were anglophones[2], and 7 percent were allophones[3] (Vaillant &

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[1] Francophone refers to the French-speaking population, regardless of ethnicity (Eller, 1999). In this document, the expressions 'French Canadians', 'Old-stock Quebecer' and 'Québécois de souche' are used interchangeably to designate the French-speaking population of European ancestry. In any case, I am aware that using the expression 'Québécois de souche' is not without its problem. This ethnic designation arises from the ideology of the settler, and only refers to Quebec-born Canadians of old French ancestry (Robin, 1996). This ideology can be used to marginalize culturally different Others along with establishing differences between 'ethnic' and 'civic' citizenships (Robin, 1996).

[2] Anglophone refers to the English-speaking population of Quebec, regardless of ethnicity (Eller, 1999).

[3] Allophone refers to Quebec's residents who speak neither French nor English as their mother tongue, regardless of ethnicity, but this category does not include Aboriginal peoples (Eller, 1999).

Dumont-Lemasson, 1995). In 1997, 13 percent of new immigrants and refugees to Canada settled in the province of Quebec, with 10 percent choosing Montreal as their city of residence (Health Canada, 1999). Statistics Canada (2001) reported that the net population of Quebec was 7,351,191 inhabitants in 1999 and that it would be 7,455,208 inhabitants by the year 2002. In 2002, the province accounted for nearly 24 percent of Canada's total population (Statistics Canada, 2001).

In contrast to other Canadian provinces like BC or Ontario, massive immigration of non-Western peoples is a relatively new phenomenon in Quebec (Health Canada, 1999; Mensah, 2002). In Montreal, the Black community represents 30 percent of the so-called visible minorities[4] whereas Arabs and Asians[5] account for 17 percent (Statistics Canada, 2001). After Toronto, Montreal has the second largest Black community in Canada. Vancouver, on the other hand, welcomes a higher proportion of South Asians and Chinese immigrants compared to Toronto or Montreal (Statistics Canada, 2001). This heterogeneous source of immigration coupled with the aging of Quebec's population must be taken into account in the delivery of home care services. I now provide a brief outline of the delivery of home care services by examining the impact of demographic aging and immigration on the accessibility to home care services. As well, the mission of the network of CLSCs[6] or Local Community Service Centres in coordinating the delivery of home care services is delineated.

Quebec's rate of population aging is stated by Roy (1998) to be exceptionally high. The population of Quebec is estimated to be the oldest among the Canadian provinces by the year

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[4] In the official Canadian and Quebec state discourse, the expression 'visible minorities' is used to describe non-White immigrants. This denomination arises, as Bannerji (2000) puts it, as a legacy of Canada's colonial past, and is reinforced in the politics of multiculturalism. The term 'visible minorities' is highly discriminative since it marks skin visibility and designates immigrants and refugees' social status as 'minorities' (Bannerji, 2000). Throughout the dissertation, I adopt the term 'people of the South' or 'non-Western' populations, to designate immigrants and refugees of Colour.

[5] The expressions 'Arabs' and 'Asians' were found in the official governmental statistics drawn from the last Canada Census of 2001.

2021 (Roy, 1998). The elderly population of Quebec is expected to be around 2 million in 2031 in comparison to 765,000 persons in 1991, regardless of ethnicity (Gauthier & Duchesne, 1991). In addition, the population of aging people will be mostly composed of older women due to men's shorter life expectancy (Gauthier & Duchesne, 1991).

The second major factor affecting families, caregivers, and home care services is associated with the new pattern of immigration where immigrants and refugees mostly come from non-Western countries. Therefore, the extent to which home care services and nursing professional interventions are culturally adapted to fulfil non-Western populations' health issues can be raised. Mensah (2002) points out:

> The Quebec government has traditionally used immigration as a means of compensating for the province's low birth rate. However, studies (e.g., Hamilton, 1990/91; Lampkin, 1985) suggest that Quebecers were not prepared for the presence of Blacks in their midst. Some felt invaded while others were afraid of, or uncomfortable with, Blacks. It was a matter of time before racial problems surfaced. Incidences of racism and racial prejudice against the Haitian population in Quebec have been reported in many studies. (p. 107-108)

Likely, in a province receiving a significant number of new citizens, health issues intersecting with race, ethnicity, gender, and social class must be addressed to shed light on social inequities within health care services. Anderson and Reimer Kirkham (1998) discuss the impact of Canadian multiculturalism in structuring racial stereotypes to categorize non-Western peoples as visible minorities or as ethnic minorities. The Eurocentric ideologies of the two founding peoples underpin the design of health care policies and programs while reinforcing racial, gendered, ethnic, and social exclusion to perpetuate systemic inequities in accessing health care services (Anderson & Reimer Kirkham, 1998). The upshot has been to gloss over the nation's cultural differences while minimizing the contributions of women caregivers' unpaid work within the Canadian health care system.

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[6] CLSC is the acronym of Quebec's community health centres, which translates into English as Local Community Service Centres.

I now describe the mission of CLSCs and illustrate how health care reforms based on neo-liberal[7] ideologies thwarted their initial mandate, increasing the contributions of women caregivers while turning a blind eye to the culturally different Others in providing public home care services.

In Quebec, the emergence of the Welfare state can be chronologically located within the Quiet Revolution[8] that unfolded from 1960 to 1966. This period marked the secularization of health, social services, and education -- sectors that were previously run by churches. In 1961, the Hospitalization Act was adopted by the provincial legislature. Later, in 1966, the Castonguay-Nepveu Commission on Health and Social Services was created with the aim to foster a development of community health programs, and implement paradigms of social medicine and health promotion. This first health care reform was driven by a political ideology based on social democratic values. The organization and delivery of health care services was completely revised and new health care facilities, such as the CLSC, were introduced. The reform was also conducted to integrate the five principles of the Canada Health Act (Bill C-6) which are: 1) public administration of the health insurance plan by a non-profit organization, 2) comprehensiveness, 3) universality, 4) portability, and 5) accessibility (Health Canada Online, 2003). These five principles must be respected, as enacted in the Canada Health Act, for the province to be eligible for federal funding. In 1971, CLSCs were created to deliver first-line health and social services across the province. The CLSC network is now composed of 148 CLSCs, which are distributed among the 18 regional health boards of the province. In the same year, the Medicare Act was adopted to lead to the creation of Quebec's Health Insurance Board

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[7] Coburn (2000) mentions "the essence of neo-liberalism, its pure form, is a more or less thoroughgoing adherence, in rhetoric if not in practice, to the virtues of a market economy, and, by extension, a market-oriented society" (p. 138).

[8] Maclure (2003) points out that "in its strictest sense, [the Quiet Revolution] refers to the period from 1960 to 1966, when the principal reforms of Jean Lesage's Liberal government were implemented. At this time, most of the education, health, and social responsibilities previously held by the Catholic Church were transferred to the government" (p. 164-165).

(RAMQ)[9] to ensure that Quebec's population has access to medical services without charge. In the no-fee service, physicians are remunerated with governmental funding.

The mission of the CLSCs is to provide a variety of primary health care and social services using a multidisciplinary approach to all of Quebec's residents, whether living in rural, semi-rural, or urban areas (Vaillant & Dumont-Lemasson, 1995). The CLSC acts as the unique point of entry for obtaining public home care services. The mission has not yet been fully achieved due to recurrent problems of under-financing and understaffing, coupled with soaring demands for services, especially in the home care sector pertaining to demographic aging (Fédération des CLSC du Québec, 1988; Roy, 1986a; Roy, 1986b).

The impact of the Côté Reform did not help CLSCs to achieve their mandate since this reform was aimed at reducing the soaring cost of health care services. Driven by a neo-liberal economic doctrine, the Côté Reform was carried out to justify the state's financial disengagement from the health care system (O'Neill & Cardinal, 1994). The upshot of this second health care reform was to increase individual responsibility and accountability while paving the way for a gradual dismantling of the Welfare state and a privatization of home support services like domestic aid. The State's disengagement marked an era of cutbacks, restrictive budgetary and staffing measures that were not without creating impacts on CLSCs' programs and services. At the same time, the large-scale deinstitutionalization movement that took place in the sectors of mental health and gerontology, contributed to increased demands for services.

Finally, the third health reform, the Rochon Reform, also called the *ambulatory shift*, occurred in 1996. The Rochon Reform accentuated the provincial government's disengagement as a means to further control the economic pressures that were put on the health care system and

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[9] RAMQ is the acronym of Régie de l'Assurance-maladie du Québec, which translates into English as Quebec's Health Insurance Board.

on public finances. Some of these measures forced health care facilities to arrive at a zero deficit and present a balanced budget to the provincial Ministry of Health. This zero tolerance budget led CLSCs to downsize or simply cut their programs and services. Reconfiguration of the health care system emerged from the merging of hospitals to form mega-hospitals, while curtailing or closing other health care facilities. The home care services sector was particularly affected since the CLSCs were given new responsibilities like assuring home care services for an early-discharged hospitalized clientele.

The ambulatory shift was aimed at reducing pressure on hospital emergency departments and surgical waiting lists, but the organizational structures were acutely missing in the CLSCs to assume this new mandate. As well, the reform promoted the early retirement of health practitioners while increasing staff displacement. The upshot of these measures, especially the early retirement, led to acute problems of understaffing, since too many people were quitting the health care system. Finally, this reform emphasized the transfer of elders' care to the community, and more specifically, to families and to the women in families (Conseil du Statut de la Femme, 2000; Ministère de la Santé et des Services Sociaux, 1992; Ministère de la Santé et des Services Sociaux, 2000).

For some authors, the Rochon Reform and the consequent lack of funding of home care services for aging persons at home occurred with the assumption that women would continue to assume their traditional roles of caring for the sick and the elderly (Conseil du Statut de la Femme, 1999; Conseil du Statut de la Femme, 2000; Shragge & Letourneau, 1987). Shragge and Letourneau (1987) mention that "community care has relied on the private sphere and on women as its primary caregivers, and therefore the current cutbacks imply more community responsibility, which means adding an increased burden onto women in their caring role" (p. 11).

The Conseil du Statut de la Femme du Québec[10] (2000) denounces the fact that health care reform was conducted at women's triple expense (e.g., women as caregivers, as health care clients, and as health care workers). Women's hidden and unpaid work as family caregivers has contributed to constrain both federal and provincial health expenditures. Nevertheless, since the Council is mainly composed of White, middle-class, francophone Quebecer women, issues may be raised about the extent to which the needs and concerns of non-Western women caregivers are adequately conveyed to Quebec's political leaders.

In summary, health care reforms have had an impact on the capacities of CLSCs to provide culturally adapted home services to meet the growing needs of an increasing population of culturally different aging persons. Despite claiming that Canada constitutes a model of social integration in its cultural diversity, Canada's politics of multiculturalism have led to disparities in the way in which cultural differences are actually acknowledged in the health care system. Bannerji (2000) points out that multiculturalism is by itself problematic since it serves the social, political, and economic interests of the English and French peoples while erasing the voices of Aboriginals and culturally different Others in shaping the nation's society. Therefore, the impact of the ideology of multiculturalism and Whiteness (Frankenberg, 1993) in modeling health care programs and services must be addressed. In other words, the extent to which cultural differences are recognized in the health care system and home care service must be examined.

Keeping in mind the colonial history of the Canadian health care system, I now turn to examine factors that have influenced the provision of home care services in the Haitian Canadian community. I draw on previous studies to explore how the demographic profile of the Haitian Canadian community in Quebec, the delivery of health care services to the Haitian Canadian community, and Haitian Canadians' relations with the health care system, have influenced the

[10] Quebec's Council on the Status of Women.

utilization of home care services in this community (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1983; Massé, 1995).

The Haitian Canadian Community Demographic Profile

The Haitian community of Montreal is one of the largest ethnic groups of the province, following closely behind the Italian Canadian community in terms of demographic weight. Haiti represented the largest source of immigration in the Montreal area, followed respectively by immigrants or refugees from China, Algeria, France, Lebanon, Morocco, Romania, Philippines, India, and Sri Lanka (Statistics Canada, 2001). According to the Statistics Canada Census of 1991, the Haitian community of Montreal included nearly 7,950 people from 45 to 65 years in age (20%) and 3,035 people aged 65 years and older, which was 8 percent of the total population of 39,410 (Ministère de la Culture du Québec, 1995). Many senior citizens came to join their adult children and their other relatives through immigration programs that were aimed at unifying families, explaining the increased proportion of aging persons in the Haitian Canadian community. The flow of immigration to Canada was based on Haiti's former relations with France and links to the former French colonies (Dougé, 1982; Stepick, 1998).

In the 1990s, an exodus of Haitians, named *boat people*, reached South Florida, fleeing from the military junta that had removed president Jean-Bertrand Aristide from office and the economic embargo that caused further deterioration of the already precarious living conditions (Stepick, 1998; Tardif, 1995). Stepick (1998) states that Haitian immigrants faced the same difficulties as those encountered by any other group of immigrants when integrating in a new country. Nevertheless, Stepick (1998) suggests that integration into US mainstream society was perhaps harder for Haitian immigrants since they struggled against, what he describes, as the *triple minorities* problem. Haitian American immigrants had to struggle with the fact that "they were foreigners, spoke Creole (a language no-one else spoke), and were Black" (Stepick, 1998, p. 4).

Haitian immigrants perceived Canada as a welcoming country in which to live, where employment, good wages, and linguistic integration were perceived to be easier than what would be expected in the US. Dejean (1980) asserts that racial discrimination was expected to be lesser in Canada than in the US, though other authors (Foster, 1996; Foster, 2002; Henry, Tator, Mattis & Rees, 2000; Li, 1990; Mensah, 2002) draw attention to the intense discrimination that was encountered by Haitian immigrants in Quebec, especially when they attempted to enter the workforce or access housing facilities. Haitian immigration was first encouraged by religious orders, predominantly composed of French Canadians, who established parishes and schools in Haiti (Dejean, 1980). Later, the province of Quebec, by way of the Gagnon-Tremblay/McDougall Agreement, signed in 1991, allowed for recruitment of French-speaking immigrants like Haitians to come to Quebec to compensate for the decline in the births among the *old-stock* Quebecers (Foster, 1996; Mensah, 2002; Ministère de l'Immigration et des Relations avec les Citoyens du Québec, 1999b).

Waves of Haitian Immigration in Canada

Four waves of immigration shaped the Haitian community of the greater Montreal area. More specifically, the first wave of immigration occurred before 1971 and represented about 7 percent of the current population. These immigrants were highly educated and the group was composed mostly of young students and professionals. They came from the elite, the upper social class, and the *bourgeoisie* of Haiti (Dougé, 1982). The second wave occurred from 1971 to 1980, when approximately 17,905 Haitians arrived to Canada. They were mainly workers who found employment in the industrial sector of Montreal. At that time, specific programs aimed at unifying families were enacted. The third wave occurred from1981 to 1991. At this time, the number of immigrants started decreasing and only 16,750 Haitians were admitted into Canada (Ministère de la Culture du Québec, 1995). According to recent provincial figures on immigration, 8,078 Haitians were admitted into Quebec during the fourth wave of immigration

that took place between 1994 and 1998 (Ministère de l'Immigration et des Relations avec les Citoyens, 1999a). From 1991 to 2001, 14,200 immigrants from Haiti settled in the Montreal and Laval areas (Statistics Canada, 2001).

A constant trend in the Haitian Canadian pattern of immigration was the over-representation of women during these four waves of immigration (Ledoyen, 1992). In 1995, the community was composed of 56 percent women of the total population of 39,410 (Ministère de la Culture du Québec, 1995). This over-representation of Haitian Canadian women, while unexplained in the data, may have been due to the effects of the civil and military dictatorship on men's survival. As well, it would be safe to argue that Haitian Canadian women's pattern of immigration followed the trend shown by the majority of Caribbean women who came to Canada to supply a labour market (Foster, 1996; Mensah, 2002; Williams, 1998).

Ninety-four percent of the Haitian Canadian population lives in three major neighbourhoods of the greater Montreal area: Rivière-des-Prairies, St-Michel, and Montréal-Nord, where they account for 36,280 inhabitants. The city of Laval accounts for 4,705 Haitian Canadian citizens. In a study of people of Colour, demography, and social mobility, Williams (1998) found that the high concentration of Haitian Canadians in these areas was explained by landlords' housing discrimination, needs to stay within the cultural community, government subsidies for housing, and the lack of social mobility. Factors such as education and economic status were positively associated with the housing conditions (Williams, 1998). Although Williams (1998) points out that highly educated people of Colour chose to stay in these neighbourhoods to avoid racial discrimination, which was subtle, but still present in more homogenous neighbourhoods of the Montreal North or South Shores. On the other hand, Bibeau (1987) claims that the need to alleviate the impact of cultural shock could explain why Haitian Canadians, as do other immigrants, choose to stay closer to their native community. For members of the last wave of Haitian immigration, the need to refer to the native community

services was imperative since they were less fluent in French than were the members of the Haitian *bourgeoisie* or the middle-class who had immigrated earlier. With an increasing Haitian Canadian population, it is time to examine their utilization of health care services and the factors that may constrain Haitian Canadian caregivers to rely on public home care services.

Delivery of Health Care Services to the Haitian Canadian Community

Several studies that focused on the dominant role played by families in caring for aging relatives were conducted in Quebec among *Québécois de souche* or the French Canadian population (Garant & Bolduc, 1990; Guberman, Maheu, & Maillé, 1993; Joubert, Laberge, Fortin, Paradis & Desbiens, 1991; Trahan, Bélanger & Bolduc, 1993). Joubert, Laberge, Fortin, Paradis and Desbiens (1991), reported that 66.7 percent of the CLSC's intensive home care program clientele, named SIMAD[11], was mostly composed of women aged 80 years and older. Of this subgroup of older women, 33 percent were living alone and 25 percent were affected by a neurological impairment, dementia, or other psychiatric problems (Joubert et al., 1991). These inquiries were carried out among the French Canadian population, though other studies (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1983; Massé, 1995) were conducted among the Haitian Canadian community of the greater Montreal area. These authors identified five major constraints in the accessing of health care services: 1) barrier of language for some immigrants or refugees; 2) misunderstanding Haitian cultural beliefs on health and illness; 3) lack of information on home care services; 4) gendering of caring; and 5) institutional racism. As well, other studies (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1995) highlighted that the relations between Haitian Canadian caregivers and mainstream's health care providers was difficult to assess due to factors that undermine the trust and credibility towards the health care system.

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[11] *Soins Intensifs de Maintien à Domicile* is translated into Intensive Home Care Service Program.

Barriers of Language

Guberman and Maheu (1997), for example, who explored the utilization of home care services, found that Haitian Canadian caregivers tended not to use public home care services. The same authors also reported that the first generation of Haitian Canadian families care for a very old population (Guberman & Maheu, 1997). Most of these caregivers arrived in Canada during the first wave of immigration that occurred from 1960 to 1969. Mensah (2002) points out that the first wave was composed of highly educated professionals who integrated into the host society due to the increased needs for educators, teachers, physicians, and nurses that was created in the midst of the Quiet Revolution. Their command of French helped them to integrate into the workforce. The second wave, in contrast, was made up of less well-educated people, most of whom only spoke Creole. Social integration was made more difficult because of the barrier of language. The second wave was composed of workers or artisans who went to work in the plastic and garment industries and in domestic services (Mensah, 2002).

Misunderstanding of Haitian Cultural Beliefs on Health and Illness

In an earlier study, Bibeau (1987) reported that the non-utilization of services could be explained by major problems of communication between Haitian Canadian caregivers and mainstream's health care providers. Problems related to the misunderstanding of the Haitian schema of interpretation of health and illness was the major complaint heard from Haitian Canadians about the mainstream health professionals (Bibeau, 1987; Massé, 1995).

Issues of language, barriers of communication, and discrepancies between the Western biomedical framework and Haitian beliefs on health and illness were found to be the major factors influencing the accessibility to health services. Health care professionals' lack of cultural competency to assess, understand, and further translate Haitian Canadian caregivers' meanings of caring for an aging relative at home into culturally safe interventions impinges on accessibility and restrains the utilization of public home care services. As well, Massé (1995) points out that

Haitian Canadians would consider illness as a family problem, valuing stoicism in facing illness and its consequences. This would explain why Haitian Canadians tend not to use public health services, even when provided in a context of gratuity (Massé, 1995).

Lack of Information on Home Care Services

Guberman and Maheu (1997) report that the lack of knowledge on home care services offered by CLSC and the barrier of language are salient features limiting Haitian Canadian caregivers' accessibility to home care services. They also found that the Haitian Canadians' distrust towards governmental agencies could explain the pattern of non-utilization of home care services. Haitian Canadians tend to distrust governmental agencies because of the torture and violation of human rights that was occurring in Haiti. Bibeau (1987) also raised this issue in an earlier study. Haitian Canadians would tend to believe that state intrusion into the private life only serves to punish people, though this tendency has been reduced among the younger generations, suggesting the effect of acculturation on Quebec-born generations (Guberman & Maheu, 1997). Although factors pertaining to Haiti's politics, history, and culture can explain the reluctance of many Haitian Canadians to use health care services, problems related to the gendering of caring and institutional racism within the health care system must not be downplayed when examining potential constraining factors.

Gendering of Caring

Guberman and Maheu's study (1997) showed that Haitian Canadian caregivers were mostly women, illustrating the cross-cultural effect of gender observed in both Western and non-Western societies (Atkin & Rollings, 1996; Climo, 2000; Doyal, 1995; Hooyman & Gonya, 1995; Neufeld & Harrison, 2000). Haitian Canadian women caregivers' everyday lives must be explored from a theoretical perspective where racial, gender, and social inequities that influence the non-utilization of public home care services can be uncovered. Despite the number of studies (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1995), that were conducted on the cultural

adaptation of health care services to ethnic communities in Quebec, including the Haitian Canadian community, problems of accessibility and non-utilization of public home care services are still observed.

Institutional Racism

Guberman and Maheu (1997) also documented issues of institutional racism that can, in some CLSCs, preclude Haitian Canadian caregivers and care receivers from receiving culturally adapted home care services. Some racist attitudes like rudeness and lack of respect have been documented in previous studies. An interview excerpt of Guberman and Maheu's (1997) study demonstrates rudeness as reported by a Haitian Canadian caregiver:

> Les infirmières, on leur enseigne les principes médicaux, les soins, la routine, mais l'éducation, ce n'est pas a l'école que ça se passe, mais bien entendu à la maison. ...On dirait que la grossièreté, elle est là, dans le ton, dans les gestes, pour tout le monde, mais lorsque vous êtes Haïtien, immigrant, je ne sais pas, vous êtes étranger, tout de suite la grossièreté augmente, pas seulement à l'hôpital mais dans tout. (p. 221)
>
> In English:
>
> Nurses learn medicine, how to provide care, how to perform routines at school, but to be polite and respectful, you can't learn that at school but for sure you can learn good manners at home [...] It looks like if rudeness, is always present, in the voice, the gestures, the behaviours, for everybody. But when you're Haitian, when you're an immigrant, I don't know, but you're a stranger, and right away rudeness increases. Not only at the hospital but everywhere. (Free English translation of the above interview excerpt)

This interview excerpt illustrates how 'race'[12] and gender intersect in shaping the relations between Haitian Canadians and the health care system. This also points to examining the notion of institutional racism. Smith (1987) uses institutional and institution as referring to "a complex of relations forming part of the ruling apparatus, organized around a distinctive function — education, health care, law, and the like" (p. 160). Raymond Williams (1976) also portrays the word 'institutional' as pertaining to the normalized social organization or to "any organized

[12] Simple quotation marks are used to draw attention to words that for this document remain contentious. For instance, 'race', 'Others', and 'Othering' are used with simple quotation marks to underline this fact.

element of a society" (p. 169). Institutional racism is thus located at the intersection of 'race', gender, and relations of ruling,[13] governing the provision of health care services and directing nursing professional practice. Anderson and Reimer Kirkham (1998) emphasize that "organizational practices in the health care system reveal institutionalized ideas and stereotypes about 'race,' gender, power relations, and the eminence of biomedicine; they are not just matters of 'cultural insensitivity' on the part of health care providers" (p. 253). When examined at the level of institution, the impact of race, gender, ethnicity, and social class on Haitian Canadian caregivers' everyday lives can be seen as being relations of ruling that structure experiences of caring and further have an impact on primary caregivers' utilization of home care resources and relations with health care providers.

Haitian Canadians' Relations with the Health Care System

The mainstream health care system is perceived as an oppressive bureaucratic body that induces distrust among some members of the Haitian Canadian community. Individuals prefer not to speak, to avoid repression. The fear of retaliation is demonstrated in this interview excerpt drawn from Guberman and Maheu's (1997) study: "La méfiance commence en Haïti, parce qu'en Haïti, tout ce que tu peux dire, peut se retourner contre toi. Alors, tu continues à être comme ça, sur la défensive" (p. 220). In other words, this participant pointed out that distrust begins in Haiti, because in Haiti, each word you say can turn back against you. Then, you continue to be like this, on your guard.

Haitian Canadian primary caregivers would prefer to care for an aging relative at home without relying on public home care services because they feel marginalized from the mainstream society. They would also choose not to allow strangers with different cultural beliefs about health and illness to enter their privacy. Haitian Canadian primary caregivers would also

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[13] Smith (1987) defines 'relations of ruling' as a set of structured social practices that organizes, directs, and regulates the social world, based on the privileged social class agenda.

prefer to manage caring activities without help because they are used to making it on their own, part of the heritage of Haiti where public help is non-existent for supporting the adult children's caring commitment (Guberman & Maheu, 1997). "On a l'habitude de s'arranger tout seuls. Ce n'est pas facile non plus d'accepter des inconnus dans votre intimité. Surtout des gens d'une mentalité tout à fait différente de la nôtre" (Guberman & Maheu, 1997, p. 216). In English, this interview excerpt can be translated as: "We're used to managing our business without help. It's not easy to accept strangers in your privacy, especially, people who hold a completely different worldview than ours." In a meeting to negotiate fieldwork for my own research, home care managers reported that visiting nurses were having difficulties to join the Haitian Canadian community. Managers mentioned that care-receivers' health assessment would be perceived as a threat, and would be viewed with suspicion, especially when disclosure of personal information was needed to initiate the delivery of home care services.

The Problem

Although a number of studies (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1983; Massé, 1995) were carried out in the Haitian Canadian community and with primary caregivers, the underutilization of home care services is still present and deserves further examination. Previous studies were focused at documenting issues of cultural ethnocentrism within the health care system or at examining caregiving and its consequences on caregivers' physical and emotional health, such as burden and strain. For instance, Guberman and Maheu (1997) explored the cultural beliefs and values pertaining to coping strategies, and sources of informal and formal support among the Haitian Canadian community of Montreal. Although Guberman and Maheu's (1997) study represents an important contribution to the development of knowledge on caregiving, few inquiries have been conducted to explore caring as a process of growth and reciprocity between caregivers and care-receivers.

In this study, I draw on Mayeroff's (1990) work to bring forward this conceptual distinction between caregiving and caring. Whereas, caring as a process involves the entire carer's resources, caregiving represents only a part of the process. For this reason, I do not address specific topics like adult children or spouses' patterns of caregiving or daughters-mothers relationships since this is not the overall goal of the research.

In assuming that Haitian Canadian caregivers' ways of caring are culturally determined, culture is defined as a static concept, impermeable to the contextual social and cultural forces within which caring activities unfold. In focusing on culture, a risk is present to gloss over the influences of the larger social world in shaping Haitian Canadian caregivers' ways of caring and the underutilization of home care services, identified in this cultural community. This points to a need to bridge the gap in knowledge by addressing the social, cultural, economic, and political context of caring. This study illustrates that Haitian Canadian primary caregivers' everyday lives are constructed in a racialized and gendered world where social and economic inequities are not without influencing caregivers' ways of caring for aging relatives at home. Moreover, the extent to which Haitian Canadian caregivers' choices about not relying on home care services is structured by the ideology of Whiteness is further examined.

Purpose of the Study

The purpose of this study is to examine the intersection between ways of caring with race, gender, and social relations. As well, the impact of social, cultural, economic, and political factors on Haitian Canadian caregivers' everyday lives is explored from the standpoint of the caregiver. A critical ethnography, informed by a postcolonial feminist approach is used to understand Haitian Canadian caregivers' ways of caring for aging relatives at home. Critical ethnography is aimed at exploring the social and cultural construction of aging and caring by illustrating how ways of caring intersect with social structural factors to influence caring and the utilization of home care services in the Haitian Canadian community of Montreal. Issues of

power relations, immigration, employment, racial, and gender inequities are explored as potential constraints that might impinge on Haitian Canadian caregivers' accessibility to home care services. Moreover, in the context of health care reform and its impact on home care services, ways of caring may vary as they are shaped by different struggles against perceived racism, sexism, and classisms.

The Research Questions

The goal of the study is to document and understand Haitian Canadian caregivers' ways of caring for aging relatives at home. The first research question was: What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? Several secondary questions are used to analyse the intersection of caring with race, gender, social class, and other social structural factors such as the cultural, political, and economic context. In using a postcolonial feminist perspective, my angle of analysis is to examine if ways of caring are related to Haitian Canadian caregivers' past encounters with perceived racism and gender discrimination in the host society, or if perceived racism and gender discrimination impinge on the utilization of mainstream home care services. In building on Guberman and Maheu's (1997) study, my objective is to elaborate on the larger social context within which caring unfolds in Haitian Canadian caregivers' everyday lives. This first aim is to uncover the influence of a racialized and gendered world on ways of caring for an aging relative at home. To this end, the social and cultural construction of aging and caring are addressed by using Haitian Canadian primary caregivers' everyday lives as a point of departure for the inquiry (Anderson 1991a; Anderson 2000a; Anderson 2002; Anderson & Reimer Kirkham, 1998; Collins, 1989; Frankenberg, 1993; hooks, 1984; Smith, 1987).

The second research question was: What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? This question is also meant to explore dominant ideologies that underpin the design of home care programs and the provision

of home care services. As well, it is aimed at unmasking the impact of the ideology of Whiteness in structuring Haitian Canadian primary caregivers' ways of caring and the utilization of home care services.

Results, due to the praxis-oriented approach of the study, are expected to be relevant to expand nursing practice by developing culturally safe[14] home care services. In this study, the notion of cultural safety was not used as an analytic tool to examine the context of caring for an aging relative at home in the Haitian Canadian community. Rather, cultural safety must be seen as a recommendation of the research. Due to its postcolonial feminist underpinnings, this research is seen as a vehicle of social activism expected to bring about social changes. This study contributes to enrich the body of knowledge on caring and nursing cultural research in Quebec. As well, findings can be used to influence policy-makers in their decisions pertaining to provincial home care policies, with particular attention to the provision of health services to non-Western immigrants and refugees in Canada.

Organization of the Thesis

Having described the key components of the problem under study in this chapter, I now turn to a review of literature that focuses on four major concepts: culture, the construction of race and racialization, caregiving, and caring. Culture, race, and racialization influence Haitian Canadian caregivers' ways of caring and decision-making, in relation to looking after aging relatives at home. A comprehensive picture of caregiving, with particular attention to major theoretical approaches used to study this concept, the methodological issues related to the measurement of this concept, and the gendering of caregiving activities, is provided. In the following chapter, I also review the concept of caring and provide a conceptual distinction

[14] The concept of cultural safety was developed in the late 1980s in New Zealand by a group of Maori nurses. Cultural safety is defined as "actions, which recognize respect, and nurture the unique cultural identity of the Tangata Whenua (Maori) and safely meets their needs, expectations, and rights" (Polaschek, 1998, p. 453). Cultural safety can also be used as an analytic framework that serves to examine health policies and programs

between caregiving and caring. In Chapter Three, I detail my postcolonial theoretical framework. In Chapter Four, I describe the methodology, methods, and methodological issues encountered during fieldwork. Chapters Five, Six, Seven, and Eight outline the key findings of this research. More specifically, Chapter Five demonstrates how gender intersects with ways of caring to shape Haitian Canadian women caregivers' everyday lives. The attempt by women caregivers to balance traditional values with the host country's economic and social context are examined. Chapter Six extends the analysis of Haitian Canadian ways of caring to illustrate the impact of the social world on caregivers' everyday lives. In the same chapter, the impact of the process of Othering on shaping ways of caring and the decision-making process, in relation to keeping an aging parent at home is presented. The findings indicate how race and social class intersect with other relations of ruling to influence ways of caring. Chapter Seven provides an analysis of Haitian Canadian ways of caring for an aging relative at home. Haitian Canadian caregivers' ways of caring in the host country are described under two overlapping themes that are treated separately for ease of understanding. Data show that caring is a pattern of cultural continuity as well as a process of reciprocity and mourning in becoming. In Chapter Eight, I discuss the Haitian Canadian caregivers' perceptions of home care services and the relationship with mainstream home care nurses. In the same chapter, it is seen that Haitian Canadians' perceptions of racial and gendered discrimination at workplaces or in the civil society influence how they perceive the mainstream health care system, and therefore, create an impact on the utilization of home care services. Chapter Five, Six, Seven, and Eight are presented separately, but overlap to construct the Haitian Canadian caregivers' ways of caring for an aging relative at home. In Chapter Nine, I present a summary of major themes of the study to locate Haitian Canadian caregivers' ways of caring in the broader social context. The thesis is concluded with a

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offered to members of minority groups by a dominant ethnic group (Polaschek, 1998). I further develop the notion of cultural safety in Chapter 9 when presenting recommendations of the study.

presentation of the key findings and recommendations, and a discussion of the implications for nursing research, practice, education, and health policy.

CHAPTER TWO
EXAMINING THE LITERATURE ON THE KEY CONCEPTS

Introduction

In the first part of the chapter, key structural elements of caring for an aging relative are discussed. The nature of the research problem directed me to explore the literature on culture, and race in Canada. In this research, culture and race are key concepts to understand Haitian Canadian caregivers' ways of caring. These concepts constitute the ideological underpinnings of colonization, racialization, and social exclusion, and are consequently examined by using a postcolonial feminist interpretive lens. I review the literature on culture, race, and racialization to provide an overview of the social and cultural construction of race and to delineate how it mediates social relations in the Canadian society and the health care system.

In the second part of the chapter, caregiving and caring are scrutinized in relation to the research problem. The impact of demographic aging and health care reform on family caregiving has been widely addressed in the literature and I will not present redundant information or demographic data on these topics. As well, it is not my intention to review adult children caregiving patterns (e.g. daughters vs. sons or daughters-in-law vs. sons-in law), spouses' caregiving, or issues related to burden or strain. Rather, I chose to examine the theoretical and empirical literature linked to the research problem. As a starting point, I focus on the major theoretical frameworks selected to study caregiving. More specifically, I address three major areas: review of the major theories used to study caregiving and their respective strengths and limitations, methodological issues pertaining to the measurement of caregiving, and the gendering of caregiving activities.

Reviewing Culture, Race, and Racialization

The Concept of Culture

Definitions of culture abound in the literature, due to the multiple and competing paradigms used to define, explore, and study culture. I do not intend to enter into the anthropological debate since it goes beyond the objectives of this study. Furthermore, I locate myself as a nurse and not as an anthropologist. My aim is to explore some conceptualizations of culture and the competing paradigms from which definitions of culture have been drawn. Culture, race, and social class are the bases upon which processes of racial, cultural, and social hegemony[14] are constructed as a means of social exclusion of non-Western peoples.

After considering these issues, I present a selective literature review on the concept of culture. I focus on culturalism and postcolonialism, defined as two influential schools of thought in cultural studies, to contrast their respective conceptualization of culture. To this end, I draw on works of anthropologists, nurse anthropologists, and postcolonial scholars to illustrate the differences between these two paradigms.

Contrasting Culturalism and Postcolonialism

Cornell and Hartmann (1998) define culture as a means of unifying people who share common understanding and interpretation about the reality and the strategic guidelines that influence actions, behaviours, and ideas. Culture is learned through social processes and shared experiences in the cultural group.

Culturalist definitions.

Cornell and Hartmann (1998) state that culture is:

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[14] Raymond Williams (1976) refers to 'hegemony' as a notion of dominance that pervades all levels of the civil society, with a large acceptance. Williams (1976) emphasizes that hegemony is "not limited to matters of direct political control but seeks to describe a more general predominance which includes, as one of its key features, a particular way of seeing the world and human nature and relationships" (p.145).

> A set of more or less shared understandings and interpretations that include ideas about what is important and what is real as well as strategic and stylistic guides to action. Such ideas and guides may be embedded in myths and stories, expressed openly in ritual activity, communicated implicitly in extended processes of socialization, learned through shared experience, or sustained in other ways. They may not only provide conceptual interpretations of the world at large and guides to action in that world, but also specify and exalt the identity of the group. What links group members to one another in such cases is the perception that to a large degree they think alike, or at least view aspects of their own lives and certain critical features of the world similarly. (p. 87)

For Geertz (1973), culture represents a set of shared symbols that gives meaning to people's social action and social world. Art, religion, ideology, science, law, morality, language, are the symbols located at the core of social action. Spector (1996) refers to culture as a complex set of symbols that influences people's beliefs, thoughts, ideas, and actions in the social world. Spector (1996) contends that culture is:

> A complex whole, in which each part is related to every other part. It is learned and the capacity to learn culture is genetic, but the subject matter is not genetic and must be learned by each person in his or her family and social community. Culture also depends on an underlying social matrix, and included in this social matrix are knowledge, belief, art, law, morals, and custom. (p. 69)

Finally, Leininger (1991) asserts that culture is transmitted and learned in a peculiar social context, which gives meaning to actions and behaviours. She states that "culture refers to the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 1991, p. 47). Culturalist definitions imply that ethnic beliefs and norms are transmitted to other generations of any particular ethnic community. Spector (1996) stresses that "many of the essential components of a given culture, however, pass from one generation to the next, unaltered. Consequently, much of what we believe, think, and do, both consciously and unconsciously, is *determined* [italics added] by our cultural background" (p. 70). It can be argued that nursing culturist theories conflate culture and ethnic diversity or ethnic beliefs. In that sense, culturalism wipes out the dialectical relations between culture and *not culture*, or put another way, between culture and the larger social world (Hall, 1994).

I will not provide more culturalist[15] definitions since the fundamental differences between culturalism and postcolonialism have been captured. I direct the reader's attention to examine some postcolonial definitions and distinguish their epistemological impact on culture.

Postcolonial definitions.

Postcolonialism not only focuses on culture *per se*, but explores it from a broader historical and social context. As a starting point, I refer to Stuart Hall (1994) who defines culture as:

> Both the meanings and values which arise amongst distinctive social groups and classes, on the basis of their given historical conditions and relationships, through which they "handle" and respond to the conditions of existence; and as the lived traditions and practices through which those "understandings" are expressed and in which they are embodied. (p. 527)

What is the distinctive conceptual feature of this definition? First, it points to one major weakness of the culturalist paradigm that tends to fix cultural differences in a rigid discourse of representation where little room is left to expand or modify culture. As Li (1990) points out:

> It is common in studies of race and ethnic relations to rely heavily on culture to explain human behaviours, since ethnic groups are often seen as primarily cultural entities. While no one would disagree that culture exists, the controversy has to do with the unrefined use of the all-embracing concept of 'culture' to account for all aspects of behaviours that are related to race and ethnicity. (p. 8)

Hall (1994) points out that the relationships between culture and historical facts tend to be overlooked to formulate a *superstructure* that does not account for the fluidity of social

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[15] In the 1970's and 1980's, the culturalist perspective like the one proposed in Leininger's Culture Care Diversity & Universality, greatly contributed to advance knowledge in transcultural nursing. Inspired by anthropology, this theory promotes the needs for Western nurses to become *culturally sensitive* or *culturally aware* by learning other ethnic groups' values and beliefs on health and illness. Nevertheless, its major limitation lays in the fact that culture is crystallized into a static system of beliefs and values pertaining to ethnic groups. *Cultural determinism* can therefore lead to generalize and stereotype non-Western peoples' beliefs (Reimer Kirkham, 2000) while obfuscating the influence of social structures and racial relations within which professional nursing unfolds (Papps & Ramsden, 1996; Polaschek, 1998). Leininger (1991) suggests three modes of nursing interventions like cultural preservation or maintenance, cultural accommodation or negotiation, and cultural repatterning or restructuring, for nurses to provide *culturally congruent* care. These modes have been criticized as a means to assimilate non-Western beliefs and values on health and illness to adapt Western worldview (Reimer Kirkham, 2000). The upshot of the assimilationist cultural perspective is to gloss over the influence of race, gender, and social class in structuring nursing professional care. The impact of social inequities on non-Western peoples' health and relations with health care practitioners and services can either be minimized or dismissed.

changes. Rather, culturalist approaches seem to essentialize people of the South[16] on the basis of some specific racial and cultural traits. For postcolonial scholars like Stuart Hall and Homi Bhabha, culture is conceptualized as a fluid and non-static entity, marked by the aftermath of colonialization. A culturalist approach tends to obfuscate the historical and material conditions within which culture operates. On the other hand, a postcolonial perspective suggests that culture cannot be dissociated from not culture due to their reciprocal influence that occur between these two entities in the social world. In other words, postcolonialism implies that culture is not only limited to explore people's subjective experiences but also to examine the historic, social, and material conditions within which subjectivities[17] are constructed. Culture is far from being an immutable concept since historical, social, political, and economic conditions that come into play with culture *per se* change over time.

Therefore, postcolonialism challenges the status quo by examining structural social factor, not culture, which interact with culture to shape people's lived experiences. Culture becomes a fluid and constantly changing entity. The goal is to contest the totalizing ideologies (e.g. colonialism) that have cast culture in a rigid interpretative discourse. As Bhabha (1994) puts it:

> An important feature of colonial discourse is its dependence on the concept of 'fixity' in the ideological construction of otherness. Fixity, as the sign of cultural/historical/racial difference in the discourse of colonialism, is a paradoxical mode of representation: it connotes rigidity and an unchanging order as well as disorder, degeneracy, and daemonic repetition. (p. 66)

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[16] Anderson (2000b) and Schutte (2000) use the words North and South to describe the countries' capital wealth. The aim is to avoid perpetuating the hegemony of Western feminism by using expressions such as *developed* or *developing* countries, while being committed to adopting an anti-imperialist feminist discourse. In the text, the expressions *people of the South, non-Western people*, and *people of Colour* are used interchangeably to designate immigrants and refugees of Colour, who have been racialized in pluralist Western countries like Canada, where discriminative immigration and labour policies were used to control the influx of non-European settlers (Anderson, 2000a).

[17] Hall (1997a) stresses that by only focusing on people's subjective experience, the risk is to overlook the collective effects of social, political, and economical forces in shaping people's identities or multiple subjectivities. Individuals are constituted through experiences of oppression, gendering, and racializing that characterize the multiplicities of locations or social positions from which people of the South speak (Lewis, 2000). People's multiple subjectivities explain why the very notion of subjective experience has to be broadened to account for the meanings attached to race, gender, and social class.

In adopting postcolonial approaches, race, gender, and social class must be taken into account to expose how these structural factors intersect with Haitian Canadian caregivers' ways of caring and perceptions of the health care system. Ways of caring can vary according to different social and economic contexts and therefore, culture must be seen as fluid and not static.

Bhabha (1990) further extends the analysis by asserting that culture is a hybrid concept that stems from the impetus of new internationalism where colonization, immigration, and economic globalization, must also be accounted for when examining culture. Bhabha (1994) in exploring cultural *hybridity* opens the doors to the notion of *third space*. For Bhabha (1994), the third space represents both a contradictory and ambivalent space where cultural differences are to be negotiated to produce hybrid cultures. The third space captures the displacement of dominant Western cultural representation toward the particularities of non-Western culture. Bhabha (1994) says:

> Interpretation is never simply an act of communication between the I and You designated in the statement. The production of meaning requires that these two places be mobilized in the passage through a Third Space, which represents both the general conditions of language and the specific implication of the utterance in a performative and institutional strategy of which it cannot 'in itself' be conscious. What this unconscious relation introduces is an ambivalence in the act of interpretation. (p. 36)

Therefore, if I refer to cultural hybridity and the notion of third space, postcolonial definitions of culture preclude any reference to cultural comparativism, strategies that had been used to stereotype, classify, and mute the culturally different Other. Bhabha (1994) asserts "the very concepts of homogenous national cultures, the consensual or contiguous transmission of historical traditions, or 'organic' ethnic communities — as the grounds of cultural comparativism — are in a profound process of redefinition" (p. 5). Moreover, Bhabha (1994) extends the definition of culture, suggesting ideas of transnational and translational cultures. This internationalization of culture illustrates the shift towards cultural hybridity, which distances us

from the fixity of Western cultural hegemony. Bhabha (1994) articulates transnational and translational in these words:

> Culture as a strategy of survival is both transnational and translational. It is transnational because contemporary postcolonial discourses are rooted in specific histories of cultural displacement, whether they are the 'middle passage' of slavery and indenture, the 'voyage out' of the civilizing mission, the fraught accommodation of Third World migration to the West after the Second World War, or the traffic of economic and political refugees within and outside the Third World. Culture is translational because such spatial histories of displacement—now accompanied by the territorial ambitions of 'global' media technologies—make the question of how culture signifies, or what is signified by culture, a rather complex issue. (p. 172)

Thus, culture cannot be seen as a static and fixed concept because of migration of populations and international exchanges that bring cultures together to develop cultural hybridity. This points to considering the importance of cultural alterity[18] when it comes to negotiating cultural meanings and understandings. Nevertheless, negotiating the third space can be problematic when individual, structural, and institutional racism pervades the social fabric of a nation (Henry, Tator, Mattis & Rees, 2000). This suggests exploring the construction of race and examining the process of racialization and how it operates in the Canadian state.

The Construction of Race

Defining Race

The concept of race is closely associated with colonialism and colonization was used to legitimize and institutionalize racialization. Race and ethnicity are often conflated, though instances occur where race and ethnicity[19] overlap (James, 1996a; Stasiulis, 1990). James (1996a) draws on Jones (1991) to illustrate that race can be defined as a biological construct.

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[18] I draw on Schutte (2000) to define cultural alterity as a process of thinking and knowing that "demands that the other be heard in her difference and that the self give itself the time, the space, and the opportunity to appreciate the stranger without and within" (p. 55).

[19] Cornell and Hartmann (1998) mention that ethnicity pertains to people's perceived common ancestry, history, and symbols, whereas race refers to the construction of social categories, which are made on the basis of physical traits. They also point out that "a human group might well meet both sets of criteria at once" (Cornell & Hartmann 1998, p. 32).

In that sense, race is defined as:

> A group of people who share biological features that come to signify group membership and the social meaning of such membership has in the society at large. Race becomes the basis for expectation regarding social roles, performance levels, values, and norms and mores of group and non-group members and in-group members alike. (Jones, cited in James, 1996a, p. 24)

Cornell and Hartmann (1998) see race as a slippery concept since many attempts were made to provide biological and sociological definitions. The genetic or biological explanations of race does not stand since it is impossible to enumerate all the possible 'races' in the world. "Consensus regarding the nature and number of human races has been elusive" (Cornell & Hartmann, 1998, p. 21). The aim was to provide spurious empirical evidence on the superiority of one racial group, mostly Caucasians, at the expense of racialized groups. In other words, biology and genetics both lack explanatory power to explain racial differences because race is a social and cultural construct (Cornell & Hartmann, 1998; James, 1996a).

Race is a social construct since it is a product of human perception and classification that is based on physical attributes such as skin colour, stature, hair type, also called 'bodily markers' (Cornell & Hartmann, 1998). Why do people categorize race? Differences between human physical traits or attributes become meaningful when race is used to organize the social world and social relations as well as individual and collective actions to give power to some racial categories over others (Cornell & Hartmann, 1998; Eller, 1999; James, 1996a; Stasiulis, 1990). Cornell and Hartmann (1998) define race as:

> A human group defined by itself or others as distinct by virtue of perceived common physical characteristics that are held to be inherent. A race is a group of human beings socially defined on the basis of physical characteristics. Determining which characteristics constitute the race—the selection of markers and therefore the construction of the racial category itself—is a choice human beings make. Neither markers nor categories are predetermined by any biological factors. (p. 24)

Racial categories are human constructions that are fluid, and subject to revisions, depending on the extent to which ethnic groups are assimilated to the dominant group. Racial

categories and the associated discrimination that goes along with it changes over time as humans construct new racial categories. For instance, these authors suggest examining the discrimination patterns towards the Irish, Italian, and Jewish Americans compared to those towards the Hispanic American and African American communities. These two communities still struggle with discrimination and racism while the three previous ethnic groups were integrated in the mainstream society that previously excluded them (Cornell & Hartmann, 1998). This instance clearly illustrates that race is socially and culturally constructed and racial categories are not stable, but change over time. Some ethnic groups escape racialization while others remain trapped in cultural essentialism and social exclusion.

Defining Racism

Racism is as an ideology based on the supposed *superiority* of one racial category over another that is judged as *inferior* to the other (Cornell & Hartmann, 1998; Eller, 1999; Lugones, 1990; Spector, 1996; Stasiulis, 1990). James (1996a) points out that three forms of racism have been identified in Canadian society, including individual, structural, and institutional racism. Individual racism is a "negative attitude that individuals hold on others. It is like an ideology—a set of ideas and related beliefs held by a person who may or may not act upon them" (James, 1996a, p. 26). Negative attitudes are generally found among dominant groups that hold social, economic, and political power to secure their political and social privileges. Structural racism refers to the ways by which mainstream society governs the exclusion of culturally different others. For instance, the non-recognition of foreign diplomas can be perceived as a form of structural racism since it may impinge on the access to better living and housing conditions. Structural racism is very subtle, though deeply rooted in people's everyday lives (James, 1996a). Finally, institutional racism is described as the means by which rules and policies produce different treatment among individuals and organizations (James, 1996a). Institutional racism

underpins the rules and policies that maintain the status quo for the benefit of the dominant social group.

Racism is constructed to maintain power relations and privileges of one ethnic group over the others (James, 1996a). The ideology of Whiteness represents the norm, and the others are just what they are—the others. On the other hand, cultural ethnocentrism is defined as the process by which individuals see things from their cultural viewpoint, assuming that their cultural point of reference is the *truth* (James, 1996a). Lugones (1990) puts it another way:

> To speak another language and another culture are not the same as being racialized. One can be ethnocentric without being racist. The existence of races as the products of racialization presupposes the presence of racism, but the existence of different ethnicities does not presuppose ethnocentrism, even if ethnocentrism is universal. So we should conclude that ethnicity is not the same as race and ethnocentrism is not the same as racism. (p. 48)

The effects of racism are more socially devastating and deleterious on health than those induced by cultural ethnocentrism (James, 1996b). Racism represents an extreme ideology of racial superiority directed at controlling culturally different 'Others' by denying their rights and freedoms as full citizens (Eller, 1999; Henry, Tator, Mattis & Rees, 2000; James, 1996a; James, 1996b; Lugones, 1990; Stasiulis, 1990). Hall (1997a) emphasizes the need to deconstruct race from its colonialist and hegemonic underpinnings. The vision is to build new ethnicities where difference and diversity[20] would displace the marginalizing, dispossessing, and forgetting construction of race from the dominant Western perspective. The idea of new ethnicities illustrates the *decentering* of fixed ideologies of race and culture towards redefinitions of a fluid culture. Moreover, a fluid culture accounts for the voices of peoples located at the margins, those who "suffered the sentence of history—subjugation, domination, diaspora, and displacement"

[20] Hall (1997a) does not refer to the Western concept of cultural diversity but argues in favour of adopting a diversity of ethnicities. This can only be achieved by rejecting racial and cultural determinism that were and are still used to promote racialization and define negative cultural stereotypes about non-Western or people of the South.

(Bhabha, 1994, p. 172). Before establishing new ethnicities, however, racialization must be addressed, since it creates and maintains social injustice in the Canadian society.

Defining Racialization

Racialization is the process by which groups and persons come to be classified as *races* or *visible minorities* by members of the dominant group. On the other hand, *ethnicization* is a process of distinguishing ethnic groups, where people come to see themselves as a distinct group linked by kinship, history, or shared cultural symbols such language, customs, or religion (Cornell & Hartmann, 1998).

Ahmad (1993) contends that racialization represents an ideological discourse of power that categorizes non-Western peoples according to "real or imagined phenotypes" (p. 18). Frankenberg (1993) points out that the ideology of Whiteness subtly structures social relations between racialized and dominant groups. Frankenberg (1993) strengthens the links between colonization, racialization, and the ideology of Whiteness. She states that Whiteness is articulated around three major dimensions: location of structural advantage, a "standpoint" from where White people look at themselves and at others in the society, and a set of cultural practices (Frankenberg, 1993). bell hooks (1984) also defines White[21] as a location and a standpoint:

> White women who dominate feminist discourse today rarely question whether or not their perspective on women's reality is true to the lived experiences of women as a collective group. Nor are they aware of the extent to which their perspectives reflect race and class biases, although there has been a greater awareness of biases in recent years. Racism abounds in the writings of white feminists, reinforcing white supremacy and negating the possibility that women will bond politically across ethnic and racial boundaries. (p. 3)

Hall (1997b) suggests that representation implies a shared system of language, signs, and mental concepts to interpret, stigmatize, or stereotype the cultural difference of 'Others', in a process that "classifies people according to a norm and constructs the excluded as Other" (p. 259). Therefore, racialization is a discourse of representation used to construct non-Western

[21] Some postcolonial feminist scholars use the expressions white and black without capitalizing the first letter of these words. This anti-racist strategy constitutes the hallmark of postcolonial feminist scholarship (Bannerji, 2000, hooks, 1984).

peoples' differences while intersecting with gender, social class, politics, and economy to create a biologically defined concept of racial and ethnic hierarchy (Bannerji, 2000).

For Spivak (1988), racialization contributes to marginalize and relegate non-Western men and women to the rank of subalterns[22] or second-order citizens. Non-Western immigrants and refugees have faced adversity in settling into the nation, regardless of the province or territory. The question to ask relates to the extent to which institutional racism pervades the nation's public and private institutions, and more specifically, the Canadian health care system. Anderson and Reimer Kirkham (1998) argue that "we need to be aware that the construction of Canada's health care system is not an entity in itself, it is enmeshed in a racialized and gendered construction of nation and capitalist worldview that organizes women's everyday lives" (p.243). This brings me to present an overview of racism in Canada and in the health care system.

Racism in Canada

Racism operates at different levels, focusing on racial, gendered, social, and ethnic differences, to exclude or silence non-Western immigrants or refugees, who do not meet the standard of Canadianness or the criterion of Whiteness. As Bannerji (2000) puts it:

> The Canadian state according to its Charter of Rights and Freedoms, claims not to discriminate on the bases of race, gender, and so on. But it is obvious that, by its very organization of social communities in "race" and ethnic terms, the state constantly creates "Canadians" and "others". This happens not only in the realm of the state constructed policy, but also in the fact of the everyday life, within what Theo Goldberg (1993) calls a 'racist culture'. (p. 72)

Behind the principle of democracy and cultural openness, Canada has an ideology of Whiteness, Europeanness, and nordicity. These intersect to define the so-called *real* Canadian citizen (Anderson & Reimer Kirkharm, 1998; Bannerji, 2000; Carty & Brand, 1993; Day, 2000; Henry, Tator, Mattis & Rees, 2000; Lee & Cardinal, 1998; Ng, 1993). According to Henry,

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[22] I draw on Spivak (1988) to use the word 'subaltern' to designate the silenced, the oppressed, the nonelite classes, the proletariat, the third-world women, the economically dispossessed, and /or any social group marked by colonization's essentialism.

Tator, Mattis and Rees (2000), racism stems from the ideology of democratic racism of the Canadian state where tensions between racist ideology[23] and democratic values occur to produce this pervasive racism. Henry, Tator, Mattis and Rees (2000) define democratic racism as:

> An ideology that permits and sustains people's ability to maintain two apparently conflicting sets of values. One set consists of a commitment to a liberal, democratic society motivated by the egalitarian values of fairness, justice, and equality. Conflicting with these values are attitudes and behaviours that include negative feelings about people of colour and that result in differential treatment of them, or discrimination against them. Democratic racism, in its simplest form, is an ideology that reduces the conflict between maintaining a commitment to both egalitarian and non-egalitarian values. (p. 15)

Can it be assumed that Canada is a racist country? The pervasive nature of individual, social, and institutional racism in Canadian society has been highlighted by several scholars (Anderson & Reimer Kirkham, 1998; Bannerji, 2000; Henry, Tator, Mattis & Rees, 2000; James, 1996a; Li, 1990). On the other hand, Lugones (1990) elaborates on the characteristics of a racist state:

> A racist state produces a classification of people that give rise to race; the classification is not a rational ordering based on any 'natural' phenomena; the classification is historically variable; the classification has a strong normative force in the form of custom or in the form of positive law; the classification is presupposed (explicitly or not) by many other legal and customary norms; the classification imposes on people a false identity and arrogates the power of self-definition; the classification is given meaning by particular organizations of social, political, and economic interaction that regulate relations among people who are differently classified; the racial state also produces ideologies that create the illusion that both the classification and the organization of life that accompany and give meaning to it are justified. (p. 49)

When examining Canada and Quebec politics of multiculturalism[24], it can be safely argued that Canada constructs its citizens on the basis of racial and gendered norms to generate

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[23] According to Henry, Tator, Mattis, and Rees (2000) ideology is defined as "a set of beliefs, perceptions, assumptions, and values that provide members of a group with an understanding and an explanation of their world" (p. 15). Inspired by Althusser, these authors contend that people are "often unaware of their ideologies" (Althusser, cited in Henry, Tator, Mattis, & Rees, 2000, p. 16). This unawareness leads people to perceive ideologies as natural and true since these ideas are not criticized. Nevertheless, ideologies are social constructs that are used to organize the social world. Henry, Tator, Mattis, and Rees (2000) point out that marginalization, exclusion, and subjugation of the culturally different Other are based on the Canadian state ideology of democratic racism.

[24] An in-depth analysis of Canada/Quebec politics of multiculturalism is provided in Chapter 6 where I present results pertaining to the 'Othering' of Haitian Canadian caregivers.

visible minority or *ethnic minority* groups. Essentially, when racial classifications are enacted in federal and provincial laws, Canada can be perceived as a subtle racist country. The extent to which racism pervades the Canadian society is not without having an impact on the health care system. I now turn to explore issues of institutional racism in the Canadian health care system.

Racism in the Canadian Health Care System

Tator (1996) points out the failure of the Canadian health care system to adapt services to the needs of immigrants and refugees. Inadequate and inappropriate services[25] are provided to immigrants. For instance, in mental health, many ethnic groups acknowledge interdependency and cooperation between family members as being more important than the individual's needs. Tator (1996) further stresses that racial stereotypes often skew assessments, and label immigrants and refugees with *personality* disorders, they do not have. She also contends that non-Western women are more at risk since racial prejudice and gender discrimination strongly operate in non-Western women's everyday lives. Tator (1996) mentions the problems of sexual and physical abuse among women of Colour who would prefer not to report assaults because of fear of losing the status of landed immigrant or of being deported to the country of origin (Stasiulis, 1990;Tator, 1996).

This illustrates the double jeopardy of women and aging people of the South. Racism and gender discrimination can reinforce the vulnerability of women and aging persons of the South to racial discrimination in the health care system. How does institutional racism operate in the health care system? Tator (1996) states:

> Racial and cultural bias is reflected in the modes of treatment and approaches to problem resolution developed by mainstream social workers, which frequently ignore the effects of systemic racism on the client or fail to take into account group values, community norms, and indigenous resources. (p. 166)

[25] Tator (1996) contends, "racial and cultural barriers continue to influence both to whom services are provided, and the quality and appropriateness of these services" (p. 166). Lewis (2000), a British sociologist, highlights how racialization impacts on professional discourses and practices when caring for people of Colour. She claims that professional knowledge intersects with race and racialization to construct the culturally different Other and perpetuates issues of dominance and subordination within the health care system (Lewis, 2000).

Patricia Hill Collins (1989), an African American feminist, asserts that "subordinate groups not only experience a different reality than a group that rules, but a subordinate group may interpret that reality differently than a dominant group" (p. 748). Cicourel (1993) argues that different schemata of interpretation or systems of beliefs impact on the processing of the information during health professional/client encounters. This means that different worldviews on caring and aging can be brought to bear on interactions with different ethnic groups.

In Quebec, the inabilities of health care practitioners to understand Haitian Canadians' schemata of interpretation about health, illness, caring, and aging, was reported as one of the major factors impinging on the utilization of the health care system (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1983; Massé, 1995). Health practitioners must acknowledge that non-Western men and women have different schema of interpretation about health, illness, caring, and aging. These different ways of conceptualizing aging, caring, and health must be acknowledged and respected, if culturally safe nursing interventions are to be implemented in the Canadian health care system.

Summary

Racism pervades all levels of Canadian society and therefore postcolonial nursing research must be directed at exploring health problems related to racism, sexism, and social class. The contributions of nursing culturalist theories in advancing knowledge on ethnic groups have been recognized, though their failure to properly address issues of racism and other discrimination affecting non-Western immigrants and refugees, must be acknowledged. The major limitation of culturalist theories is to fragment culture into a collection of statements, taxonomies, or facts on diverse ethnic groups' customs and values while opening the door to stereotyping and labelling people of the South. This theoretical limitation points to developing new paradigms of inquiry to address and document health problems stemming from social inequities in the health care system. Innovative theoretical approaches like postcolonial feminism are relevant since this

approach focuses on race, gender, and social class to examine health issues arising from social inequities.

In using a postcolonial feminist approach, the structural factors that mediate Haitian Canadian caregivers' ways of caring and influence the utilization of home care services are addressed. What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? In this thesis, the answers to these research questions are presented in Chapters Five, Six, Seven, and Eight.

In the second part of Chapter Two, I examine how caregiving has been conceptualized in the literature. As previously pointed out, I do not intend to provide an extensive review of this impressive body of literature. My aim instead is to provide a review of specific issues pertaining to caregiving as a means to further distinguish this concept from the process of caring. The process of caring is discussed in the last part of the chapter. With regard to caregiving, I examine three major issues related to this concept. The major theoretical approaches used to inform the research on caregiving and their respective strengths and limitations are discussed. I also explore some methodological issues pertaining to measurement of caregiving. Third, I present an examination of the literature on the gendering of caregiving. Finally, I review the literature on caring as a process and I draw on Mayeroff's work (1990) to contend that caring is a mutual process of growth and reciprocity between caregivers and care-receivers. This constitutes one of the major conceptual differences between caring and caregiving.

In this study, the intersection between social, cultural, economic, and political factors with race, gender, and social class was addressed to explore their impact on Haitian Canadian caregivers' ways of caring as opposed to other studies that were aimed at documenting the cultural underpinnings of caregiving or its consequences on Haitian Canadian caregivers' health like burden and strain (Guberman & Maheu, 1997).

Reviewing Literature on Caregiving

Introduction

The sector of home care services becomes increasingly relevant in Canada due to demographic aging coupled with the impact of health care reform on family caregiving[26]. In Canada, the proportion of people aged 75 years and older has not markedly increased over the last couple of years, but is expected to grow rapidly over the next few decades (Statistic Canada, 1996).

According to Statistics Canada (1996), by the year 2016, 6 million Canadians will be aged 65 and older and by 2041 an estimated 10 million of the nation's population will be senior citizens. As well, the number of people in the very oldest age groups is expected to increase rapidly over the next years in Canada. Statistics Canada (1996) projected that by 2041, 3.6 million Canadians will be aged 75 to 84, and 4.5 million people will be aged 65 to 74 years. The fastest growing segment of the overall senior population is that comprising persons aged 85 years and older (Statistics Canada, 1996; Health Canada, 1998), which also implies an increased number of Canadians living with disabilities. Since aging marks our society, we must understand how caregiving has been conceptualized. Studies over the last decades suggest a variety of theoretical angles from which this concept may be examined in future inquiries. I now turn to discuss the major theoretical conceptualizations of caregiving, the methodological issues related to the measurement of this concept, and the gendering of caregiving activities.

Examining Theoretical Approaches on Caregiving

The concept of caregiving cannot be straightforwardly defined, since many competing theoretical and operational definitions have been used to circumscribe its constitutive dimensions. Research on caregiving is affected, by what Rodgers and Knafl (1993) coined as

[26] I contend that caring encompasses the multidimensionality of caregiving while integrating the reciprocal relations between caregivers and care-receivers. In the last part of the chapter, a literature review on the process of caring is presented and the rationale supporting the choice of the term 'caring' to describe caregivers' activities is delineated.

internal and external conceptual problems. The internal conceptual problem is related to the lack of clarity on the basic dimensions of caregiving whereas the external problem is associated with the utilization of competing theories that create issues about measurement, especially when assessing caregivers' burden, strain, and coping strategies. Both internal and external conceptual problems have been identified in the literature and are discussed in this section.

Internal Conceptual Problems

Internal conceptual problems pertain to the ambiguity in defining the basic concepts or dimensions of caregiving. For instance, Biegel, Sales, and Schulz (1991) describe caregiving as an ubiquitous concept that seems to be well documented, though the boundaries between what caregiving is, and what it is not, remain unclear. These authors define caregiving as the "increment of extraordinary care that goes beyond the bounds of normal and usual care" (Biegel et al., 1991, p. 17). The extraordinary features of caregiving were mostly defined with regard to the number of tasks, and significant expenditures of time and energy spent by caregivers over long periods. Biegel et al. (1991) conceptualization is stringent since caregiving cannot be reduced to the numbers of tasks or hours spent in caregiving activities. Caregiving encompasses other dimensions that must be taken into account to provide the meanings and the context of caregiving.

Walker, Pratt and Eddy (1995) mention that "caregiving is not always easily distinguished from aid given as a part of the normal exchange in family relationships" (p. 402). Swanson, Jensen, Specht, Johnson, Maas, and Saylor (1997) contend that caregiving is a multidimensional concept that must be examined from diverse conceptualizations, including tasks, transitions, roles, and processes. In the next section, an overview of the definitions of caregiving, involving task-oriented, transition, role, and process definitions, and 'doing caregiving well,' are presented. This array of definitions illustrates the internal conceptual problem of caregiving.

Task-oriented definitions.

Some authors define caregiving as a task since they focus on activities such as hands-on care. This conceptualization of caregiving as a task is clearly caregiver-oriented because of the focus on the provision of instrumental care. For Bull (1990), caregiving is defined as "the activities or tasks that caregivers perform in responding to care-receivers' needs and demands" (p. 759). Caregivers' tasks or 'hands-on' care may be divided into two categories, regrouping the instrumental activities of daily living, and the activities of daily living. Shopping, banking, preparing meals, support, transportation, and fostering participation in social activities represent instrumental activities of daily living. On the other hand, bathing, feeding, and other hygienic care are defined as activities of daily living. Caregiving as a task is thus defined from a perspective where a hierarchy of instrumental assistance related to care-receivers' needs is defined and expanded upon to develop the concept of caregivers' burden (Biegel et al., 1991; Bull, 1990; Given & Given, 1991; Horowitz, 1985). Other studies were aimed at documenting the older person's functional status, the aging parents' or spouse's level of dependence, medical diagnosis, co-morbidities, primary caregivers' emotional dependency, or the nature of direct and indirect care. These studies contributed to expanding the dimensions of a caregiver's physical and emotional burden (Malonebeach & Zarit, 1991; Swanson et al., 1997;Walker, Pratt & Eddy, 1995).

Such task-oriented definitions tend to present caregiving as a linear and static process rather than as a holistic and dynamic process. The interaction between family and contextual factors, such as the social, economic, and cultural factors is overlooked or simply underestimated. Moreover, the task-oriented conceptualization is unclear about what exactly constitutes appropriate and indirect care (Swanson et al., 1997). This increases the lack of theoretical clarity on the dimensions of caregiving while creating some measurement problems, especially when assessing the nature of appropriate care.

Defining caregiving by referring to instrumental or hands-on activities cannot provide a holistic picture of the concept. Although these definitions illustrate the intensive commitment of caregivers, the upshot is to obfuscate the meanings of the experience of caregiving. As Abel (1990) puts it, this reductionist view of caregiving creates a theoretical vacuum in which the social and familial context are overlooked and the emotional ties between care-receivers and caregivers are glossed over. Moreover, caregiving involves a broad range of activities and roles, and caregiving can be seen as a career (Pearlin, 1992) that involves many changes of roles in the long-run. Other authors have challenged the task-oriented view of caregiving and have advocated for a more holistic picture and the expansion of theoretical definitions (Barer & Johnson, 1990; Blasinsky, 1998; Hunt, 2003; Paun, 2003; Pearlin, 1992; Penrod, Kane, Kane & Finch, 1995; Perry & Olshansky, 1996; Perry, 2002; Perry & O'Connor, 2002; Skaff, Pearlin & Mullan, 1996).

Transition, role, and process definitions.

Most of the studies on transitions have been aimed at exploring caregivers' roles, and finding out positive and negative outcomes of caregiving. These studies were also directed at delineating positive outcomes like mastery, confidence, efficacy, and self-confidence as a means of alleviating caregivers' stress and enhancing coping strategies. From this perspective, caregiving is defined as a career, a long-term process, and involving transitions closely linked to care-receivers' demands (Pearlin, 1992; Skaff, Pearlin & Mullan, 1996).

Other researchers define caregiving as a role that can explain poor caregiving and the eventual abuse of elders. For instance, Phillips and Rempusheski (1986) contend that two major roles emerge among caregivers: 1) the nurturing-supportive role where qualities such as comfort, sensitivity, insight, and acceptance are demonstrated, and 2) the monitoring-controlling role that involves patterns of intolerance and restrictions to correct the aging person's behaviour. Although controlling caregivers verbally express their love for the aging persons for whom they

care, they also seem to constantly search for the older person's inappropriate behaviour to correct it — as if the caregiver were a prison guard (Phillips & Rempusheski, 1986; Phillips, 1988). The over-reliance on this controlling and correcting role of the caregiver could, in some instances, lead to the abuse of the older person.

Caregiving is also conceptualized as a process, mixing both tasks and roles, which apply to adult children caregivers. For instance, Bowers (1987) identified five dimensions such as instrumental, anticipatory, preventive, supervisory, and protective caregiving activities. Finally, Schumacher, Stewart, and Archbold (1998) developed an instrument to measure five interrelated concepts that account for *doing caregiving well*: mastery, self-efficacy, competence, preparedness, and quality of care were the basic dimensions. The model is based upon concepts that illustrate a specific stage in the process of doing caregiving well. Mastery and perceived competence are the most global, whereas preparedness was more related to caregiving behaviours. Self-efficacy was more specific. Caregivers must be receptive to treating aging relatives with sensitivity and respect, and evaluating problems, while generating problem solving-strategies, making decisions, and maintaining a healthy environment. Caregiving outcomes would measure the care-receiver's well-being by assessing whether or not psychosocial, physical, environmental, and medical needs were being met. This conceptualization moves from caregivers to care-receivers while focusing on positive results for the persons being cared for, instead of just the caregiver's negative outcomes such as burden.

In summary, many research endeavours have been carried out to clarify theoretical definitions of caregiving, while attempting to capture the wholeness of the concept. Caregiving was defined in separate dimensions, focusing on time and energy devoted to assisting and supporting care-receivers, caregivers' tasks or hands-on activities, roles, transitions, processes, and characteristics of doing caregiving well. Although major efforts were made to achieve conceptual clarity, Barer and Johnson (1990) point out that these definitions are still

predominantly arbitrary since they are based on family relationships, care-receivers' needs for assistance, types of caregiving activities, and the kinds of assistance. For Barer and Johnson (1990), the wholeness of the concept of caregiving has not been fully captured, though the body of literature has brought new insights on the complexities and multiple dimensions of this concept.

Nevertheless, the ambiguity over the dimensions of the concept may be explained by the use of competing theoretical frameworks that focus on one dimension of caregiving such as burden, stress, tasks, roles, or transitions. As well, dimensions were mostly directed at exploring caregivers' issues while obfuscating the positive outcomes of caregiving like reciprocity, reward, and meanings of caregiving. The next section addresses theoretical issues related to external conceptual problems of caregiving.

External Conceptual Problems

External conceptual problems pertain to the use of competing theories that have expanded knowledge on caregiving, and at the same time, created a large number of contradictions. Most of the body of research on caregiving was informed by stress/coping/adaptation theories. These theoretical frameworks mostly addressed caregivers' issues like burden, fatigue, emotional distress, and strains. In other words, these approaches were used to identify the predictors of burden or emotional strain as a means to prevent or alleviate the impact of these issues on caregivers' health.

Stress/coping/adaptation theories.

One of the central external conceptual problem is related to the fact that the majority of caregiving studies have been conceptualized from Lazarus and Folkman's theory of stress and coping (Bull, 1990; Gaynor, 1990; Kramer & Kipnis, 1995; Lawton, Moss, Kleban, Glicksman & Rovine, 1991; Lindgren, 1990; Schumacher, Stewart & Archbold, 1998; Skaff, Pearlin &

Mullan, 1996). Lawton, Moss, Kleban, Glicksman, and Rovine, (1991) define Lazarus and Folkman's stress coping theory in these words:

> Stress and coping theories suggests that an "environmental situation that could potentially be harmful (the stressor) is appraised by the person in terms of whether it is in fact a threat to the person. If judged to be threatening, challenging, or harmful, a process of secondary appraisal begins whereby the person judges whether the methods available for dealing with the potential stress (coping mechanisms) are adequate. Resources are strengths that either a person draws from within or from the environment to face the stressor—resources are conceptualized as attributes that alleviate the impact of stress and could be seen as moderator or stress buffer variables. (p. 181)

Stress/coping and adaptation theories were mainly used to explore and explain negative outcomes of caregiving by relying on statistical predictors of burden. As well, these theoretical approaches were aimed at elaborating on the coping or adaptive strategies that could enhance caregivers' skills, coping abilities, and resources for assuming their roles.

The major strength of the stress/coping/adaptation approaches was based on the mechanistic view of dividing the process of caregiving, in that this body of research expanded the knowledge on the negative outcomes of caregiving on caregivers' health and well-being. In focusing on caregivers' stress and stress/coping/adaptation, however, the theories have inadequately documented the wholeness of caregiving.

Farran (1997) indicates that stress/coping/adaptation theories were mostly used in study designs, in which the phenomenon under study is taken out of the social, cultural, and economic environment that influences caregiving, caregivers, and care-receivers. The environment of caregiving has to be explored to uncover the positive dimensions of caregiving like reciprocity, reward, and development of caregivers' personal growth. Stress/coping/adaptation theories are less frequently used to document the economic impact of family caregiving, despite the fact that lack of financial resource is seen as a stressor for low-income families or individuals (Farran, Keane-Hagerty, Salloway, Kupferer & Wilken, 1991; Farran, 1997; Kramer, 1997; Langner, 1995). Moreover, some authors (Malonebeach & Zarit; 1991; Penrod, Kane, Kane & Finch,

1995) also document the roles of secondary caregivers. These authors suggested voicing care-receivers' needs and the impact of secondary caregivers on the utilization of formal care by primary caregivers of aging relatives. Earlier studies have focused on primary caregivers while acknowledging the need to study the size, scope, and composition of the secondary helper network (Penrod et al., 1995). These authors also contend that the likelihood of receiving formal assistance increases with each additional activity of daily life impairment (Penrod et al., 1995). I now turn to examine a second trend in expanding knowledge on caregiving in using theories derived from existential phenomenology, symbolic interactionism, social exchange, and role theories.

Existential phenomenology.

Some researchers have used existentialism[27] to document the meaning of the experience of caregiving for aging relatives, and also for people presenting Alzheimer's disease (Farran, Keane-Hagerty, Salloway, Kupferer & Wilken, 1991; Farran, 1997; Paun, 2003; Wood, 1991). Existentialism was one of the theoretical approaches used in two of these phenomenological studies (Farran, Keane-Hagerty, Salloway, Kupferer & Wilken, 1991; Farran, 1997). Phenomenology is the methodology of choice to explore individuals' consciousness and the meanings attributed to lived experiences (Creswell, 1998). The ontological assumptions of existentialism are congruent with the phenomenological method since reality of subjective experiences cannot be dissociated from human's consciousness[28]. Themes commonly addressed

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[27] Flew (1979) suggests that existentialism is a philosophy of being, which opposes the empiricist or positivist worldview. When using this ontological approach, researchers acknowledge that existential problems like anxiety, fear, meaning of life, freedom of choice, and responsibility for making decisions, cannot be isolated from people's unique and subjective experiences. Therefore, existential problems ontologically cannot be translated into governing or natural laws. "Being ... is revealed to the individual by reflection on his own unique concrete existence in time and space" (p. 115). Flew (1979) further mentions that the "problem of existence can have no significance if viewed impartially or in abstraction; it can only be seen in terms of the impact that experiences make on a particular existent" (p. 116).

[28] Creswell (1998) asserts that one of the major tenets of phenomenology is the recognition of the *intentionality of consciousness*. Creswell (1998) claims that "consciousness always is directed toward an object. Reality of an object, then, is inextricably related to one's consciousness of it" (p. 53). In phenomenological inquiries, the

in phenomenological studies on caregiving were directed at uncovering suffering, death, despair, hopelessness, isolation, anxiety, self-transcendence, and finding meaning (Farran et al., 1991; Wood, 1991). Basically, the major goal of phenomenological approaches was to depict the construction or the meaning of caregiving experiences.

Caregiving is linked to creative opportunities since caregivers can use innovative problem-solving approaches, to enhance relations with care-receivers, develop in-depth feelings for the person being cared for, and develop new attitudes about life, that are derived from their experiences as caregivers (Farran et al., 1991). Caregiving is also portrayed as a moral and ethical responsibility toward care-receivers, illustrating that the day-to-day tasks and experiences with aged family members can lead some caregivers to find meaning in their lives, or find existential meaning, which goes far beyond the strict fulfilment of a spousal or filial duty (Farran et al., 1991; Wood, 1991).

An interesting issue was raised in the phenomenological studies, in that, caregiving is defined as a process where feelings of powerlessness, suffering, and growth are interwoven and where the meaning of the caregivers' lives is found through experiencing these feelings. Despite caregiving being seen as a positive experience, caregiving has also been referred to as a physically and emotionally draining experience. Positive outcomes of caregiving were linked to a sense of fulfillment – in knowing that caregivers give their best to care for spouses, aging parents, or their significant others.

The major strength of existential phenomenology is in exploring and understanding the meaning of caregiving. The basic theoretical assumption is that the whole can only be understood in its context and from the perspective of the persons involved in the activities of caregiving (those experiencing the phenomenon) (Farran et al., 1991; Farran, 1997; Wood,

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'subject/object' Cartesian dichotomy cannot be applied since "reality of an object is only perceived within the meaning of the experience of an individual" (Creswell, 1998, p. 53).

1991). It can be argued, however, that the major limitation is in the lack of any statistical inferences that can be established in using a theoretical interpretative framework. Nevertheless, I do not see that the lack of generalizability is a limitation, since existential phenomenology is aimed at discovering the meanings in life's experiences and not at establishing causality.

Symbolic interactionism, social exchange, and role theories.

Some studies have been informed by symbolic interactionism and social exchange theory as frameworks to seek empirical evidence (Carruth, 1996a; Langner, 1993; Langner, 1995; Phillips & Rempusheski, 1986). More specifically, these studies explored the dynamics of poor caregiving (Phillips & Rempusheski, 1986), determining the impact of reciprocity in the caregiving process (Carruth, 1996a), delineating and understanding ways in which primary caregivers for aging relatives managed caregiving over time (Langner, 1993), and exploring dialectic relations between feelings of loss and personal growth in the caring process (Langner, 1995).

Symbolic interactionism[29] is an interpretive framework mostly developed by Blumer, which supposes that reality is shaped by the social context and social interactions. This theoretical approach is used to assess how caregiving activities are lived in the social world to uncover their underlying meanings (Gubrium & Holstein, 1997). Therefore, communication and caregivers' behaviours are studied, as well as their interactions with care-receivers, to understand caregiving experiences.

Social exchange theory is based on the assumption that exchanges have positive effects on both caregivers and care receivers. In this transactional process, or transaction, people seek to maximize rewards and minimize their cost through social exchanges. Moreover, reciprocity is a

[29] Schwandt (1994) draws on the work of G.H. Mead and Herbert Blumer who claimed that symbolic interactionism is based on three ontological premises: "First, human beings act toward the physical objects and other beings in their environment on the basis of meanings that these things have for them. Second, these meanings derive from the social interaction (communication, broadly understood) between and among individuals....Third, these meanings are established and modified through an interpretative process" (p. 124). I do not intend to provide an in-depth analysis of symbolic interactionism. This definition is presented to locate the reader.

source from which some caregivers find motives for caregiving (Carruth, 1996a; Carruth, 1996b; Noonan & Tennstedt, 1996) and the factors to evaluate the process (Phillips & Rempusheski, 1986) like poor caregiving and risks of older person abuse.

Role theory has been used to explore the motives of caregiving and describe the changes and transitions that occur during the caregivers' career. Biegel, Sales and Schulz (1991) mention that many studies, informed by role theory, were carried out to explore the motives of caregiving. Role theory has served to demonstrate that, in some cases, caregivers are motivated by the anticipated rewards (Biegel et al., 1991), which can be given under different forms such as expectations of payment, gaining social approval, receiving esteem in exchange for help provided, complying with social norms, seeing oneself as a good individual, and finally, avoiding feelings of guilt (Biegel et al., 1991; Brody, 1985). On the other hand, caregiving may also be guided by altruistic goals where empathy and understanding the other's feelings about illness and physical or cognitive losses are seen as rewards. As well, care-receivers must also gain some benefits from caregiving. In an altruistic process, caregivers seek to give rather than to receive from care-receivers. Caregivers and care-receivers' attachment, prior positive interactions, and kinship were found to be the best predictors of the degree of empathy that will be expressed by the caregiver (Biegel et al., 1991).

For Biegel et al. (1991) role theories explain motives for helping, where social norms such as reciprocity, equity, and social responsibility are considered as social and moral duties. Looking after the sick, the children, and older persons is a social role expected from spouses, adult children, and siblings. Beliefs and social norms vary greatly, depending on socialization. Consequently, the motives derived from role theory cannot be generalized to all caregivers since ethnicity, race, and culture have impacts on the process of socialization. In summary, role theories would support the fact that caregiving is a socially and culturally constructed concept, developed through experience and learning (Biegel et al. 1991).

Role theory was further used to explore how caregiver's roles could be linked to positive and negative outcomes of caregiving. The major pioneers in this area, Skaff and Pearlin (1992), contend that caregiving is a transition in the lives of caregivers where major shifts or life organization must be done to perform caring activities. The strains of modifying roles as well as the intensity of caregiving activities can lead to stressful situations such as the loss of self, or to role engulfment (Skaff & Pearlin, 1992). In the concurrent use of role and stress/coping theories, some authors have found self-mastery, briefly defined as a sense of global control over the events, as a coping mechanism to mitigate or balance stressors of caregiving, to encourage family members to redefine their roles and tasks and figure out new patterns of functioning to maintain the familial equilibrium (Pearlin, 1992; Skaff & Pearlin, 1992; Skaff, Pearlin & Mullan, 1996).

In summary, symbolic interactionism, social exchange, and role theories have been used to explore caregivers' subjective experience of caregiving and complement the epistemological weaknesses of stress/coping/adaptation theories. As mentioned earlier, stress/coping/adaptation approaches have been mostly used to delineate and measure the negative outcomes of caregiving activities on caregivers. Some researchers argue that results of studies informed by symbolic interactionism, social exchange, and role theories, cannot be generalized to other populations when referring to postpositivist criteria of external and internal validity. Some may contend that a lack of generalizability limits the usefulness of the findings, though these theories are aimed at finding the meaning of caregiving in drawing on the caregivers' subjective knowledge.

Summary

Over the past three decades, a plethora of literature on family caregiving was developed. From the 1980s to the mid-1990s, inquiries have been directed at establishing the negative impact of caregiving by focusing on caregivers' health and exploring negative outcomes like burden, strain, role fatigue, and depression. Caregiving was conceptualized as a stressful event

influencing informal caregivers' lives. Hence, studies evaluated caregivers' stress to develop coping mechanisms and adaptation strategies that would alleviate the impact of stress on informal caregivers' lives. Since the mid-1990s, theoretical approaches like existentialism, symbolic interactionism, social exchange, and role theories have greatly contributed to the advancement of knowledge on family caregiving, highlighting the positive aspects of caregiving. Many of these studies were carried out to document the meanings of caregiving and explore its positive outcomes for caregivers. At the same time, these studies also shed light on the dynamics of caregiving, and how meanings are constructed through the complex interactions between caregivers, care-receivers, families, and social networks. Caregiving was found to be a source of reward, reciprocity, self-esteem, self-mastery, and personal growth (Farran, Keane-Hagerty, Salloway, Kupferer & Wilken, 1991; Farran, 1997; Langner, 1995; Phillips & Rempusheki, 1986;Wood, 1991). I now turn to explore the methodological issues on caregiving measurement that are found in the literature.

Methodological Issues on Caregiving Measurement

Many methodological issues were identified in the literature on caregiving. These issues contribute to perpetuate both internal and external conceptual problems in caregiving (Kramer, 1997). Most of the methodological issues raised in this section are related to quantitative research designs and the exploration of negative outcomes like caregivers' burden and strain. In referring to quantitative criteria of internal and external validity, qualitative studies have been criticized for their small sample sizes and sampling strategies like the reliance on convenient samples. Thus, in assessing qualitative research, by using postposivitist criteria of rigour, the contributions of these studies in clarifying the concept of caregiving and its multiple dimensions, are undermined.

Major threats to external and internal validity are likely to produce biased and spurious correlations and causal relationships (Cook & Campbell, 1979). Therefore, a generalization of

findings to other populations is not recommended due to the lack of internal validity and the lack of reliability of certain empirical indicators (Baumgarten, 1989; Farran, 1997; Kramer, 1997; Malonebeach & Zarit, 1991). Issues like inadequate sampling strategies, inadequate sample sizes, lack of statistical power, unrepresentative study samples, uncontrolled confounding variables, inappropriate study designs, lack of comparison groups, the use of multidimensional instruments of measurement, and the lack of clarity on the psychometric properties of measurement tools, have all been reported (Abel, 1990; Barer & Johnson, 1990; Baumgarten, 1989; Farran, Keane-Hagerty, Salloway, Kupferer & Wilken, 1991; Farran, 1997; Kramer, 1997; Kuhlman, Skodol-Wilson, Hutchinson & Wallhagen, 1991; Malonebeach & Zarit, 1991; Raveis, Siegel & Sudit, 1988/1989).

To rule out these methodological flaws, other quantitative studies were carried out to clarify operational definitions of caregiving. New statistical models aimed at finding positive predictors of caregiving and at refining instruments of measurement, have been realized (Lawton, Moss, Kleban, Glicksman & Rovine, 1991; Schumacher, Stewart & Archbold, 1998; Swanson, Jensen, Specht, Johnson, Maas & Saylor, 1997).

The use of multidimensional scales is not recommended, although they are useful to provide different scores about selected dimensions. Some items are confounding, especially when stress and its impact are intertwined. Quantifying the effects of the stressor on the outcome is also difficult. Finally, efforts must be devoted to controlling confounding variables since a lack of control can lead to spurious results and overlook significant correlations between variables (Baumgarten, 1989; Malonebeach & Zarit, 1991). As well, suggestions have been made to increase sample representativeness (samples were mainly composed of women), and to increase the sample size and the statistical power, to enhance the likelihood of detecting significant effect size (Baumgarten, 1989; Kramer, 1997; Malonebeach & Zarit, 1991).

In summary, addressing methodological issues would strengthen research on caregiving when trying to measure caregiving outcomes by using unidimensional instruments aimed at assessing the process of caregiving (Lawton et al., 1991). On the other hand, Kramer (1997) underlines the need to summarize the disparate and large volume of findings. Kramer (1997) urges researchers to continue addressing the positive aspects of caregiving while further developing the area of male caregiving. Studies have been conducted on husbands (Chappell & Kuehne, 1998; Kramer & Lambert, 1999) and son caregivers (Mui, 1995; Campbell, 2000; Houde Crocker, 2002). This short review of methodological drawbacks demonstrates the current gap in the knowledge about caregiving from innovative theoretical perspectives to transcend the limitations of stress/coping/adaptation and other frameworks in addressing the issues.

I now turn to examine the gendering of caregiving, a theme that has been deeply explored from feminist theoretical perspectives. As pointed out earlier, I will not provide an in-depth review of patterns of caregiving by husbands, wives, spouses, sons, sons-in-law, daughters or daughters-in-law, since this study is aimed at examining the social and cultural context of caring and its impact on Haitian Canadian caregivers' ways of caring for aging relatives at home.

The Gendering of Caregiving

In Canada, women represent the major group of caregivers, despite the fact that most are in the workforce (Frederick & Fast, 1999):

> In 1996, women still dominated the field of senior care. Not only did they represent the majority of informal caregivers (61% or 1.3 million), but they also spent much more time than men on care-related tasks (5 hours per week compared with 3). ... Many women were caring for more than two seniors (42% versus 34% of men) and women were considerably more likely to be the primary caregiver (39% versus 27% of men). Women were also more likely to be caring for a senior who was very ill. (p. 27)

Despite some studies (Kramer, 1997; Kramer & Lambert, 1999) that claim to have recently addressed the impact of caregiving by men, empirical evidence demonstrates that women are still the major caregivers. Moreover, this assumption would be cross-culturally

supported both in non-Western and Western societies (Climo, 2000; Covan, 1997; Doyal, 1995). Shragge and Letourneau (1987) state that community-based services are mainly built on the expectations of traditional women's roles of caring. Women are expected to fulfill duties imparted to them as a result of the binary division of the social world into distinctive spheres: the private (domestic) and the public. The late Michelle Rosaldo explored this private/public dichotomy and her work represents a significant legacy to feminist research. Rosaldo (cited in Lugo & Maurer, 2000) explained this dichotomy between private and domestic spheres:

> "Domestic," as used here, refers to those minimal institutions and modes of activity that are organized immediately around one or more mothers and their children; "public" refers to activities, institutions, and forms of association that link, rank, organize or subsume particular mother – child groups…The opposition does not determine cultural stereotypes or asymmetries in the evaluation of the sexes, but rather underlies them, to support a very general (and, for women, often demeaning) identification of women with domestic life and of men with public life. These identifications, themselves neither necessary nor desirable, can all be tied to the role of women in child rearing; by examining their multiple ramifications, one can begin to understand the nature of female subordination and the ways it may be overcome. (p.18-19)

Feminist research on family caregiving demonstrates that women, particularly wives and daughters, are predominantly involved in caring activities for their aged and chronically ill relatives (O'Neill & Ross, 1991). "Women go to great lengths to care for impaired and elderly relatives, making personal sacrifices, often at great cost to their own health and well-being" (O'Neill & Ross, 1991, p. 111). Feminist authors contend that caregiving is mostly devoted to the primary female caregivers. Nevertheless, Penrod et al. (1995) assert that secondary caregivers also help the primary caregiver in caring for an aging relative at home, though contradictory findings have been documented on the lack of spousal support for women caregivers, especially middle-aged women working outside and cumulating multiple roles like raising children and looking after aging parents at home (Dautzenberg, Diederiks, Philipsen & Tan, 1999; Neufeld & Harrison, 2003).

In Canada, the UK, the US, and in other countries, the community appears to be mostly equated to women and the private domain, where activities such as caregiving and housekeeping were historically and socially devoted to women. On the other hand, public activities such as leadership, bread-winning, and political actions were presumably seen as men's prerogatives (Abel, 1990; Angus, 1994; Atkin & Rollings, 1996; Climo, 2000; Covan, 1997; Doyal, 1995; Frederick & Fast, 1999; Gaynor, 1990; Guberman, Maheu & Maillé, 1993; Hooyman & Gonya, 1995; Hooyman & Gonya, 1999; Guberman & Maheu, 1997; Guberman, 1999; Kramer & Kipnis, 1995; Lugo & Maurer, 2000; Neufeld & Harrison, 2000; Penrod, Kane, Kane, & Finch, 1995; Shragge & Letourneau, 1987).

The view of family caregiving also raises a number of controversies. Some authors dispute the view of the family as being the caregiving unit (Given & Given, 1991; Guberman, Maheu & Maillé, 1993; Guberman, 1999; Horowitz, 1985; O'Neill & Ross, 1991; Wuest, 1993; Wuest, 1998; Wuest, 2000). For Horowitz (1985), the claim that a family caregiving system exists is somewhat idealistic. She mentions that only one family member performs the role of the primary caregiver while other family members only perform secondary roles (Horowitz, 1985).

Covan (1997) suggests some ways to overcome male dominance, and urges women to get involved in the political and economic institutions to bring about changes, since demographic aging and the burden of women caregivers is likely to increase over the next few years. Covan (1997) contends that, if male social dominance over the political and social institutions persists, so too will the poor social recognition of women's caring activities.

Abel (1990) contends that women approach caregiving in ways that are different from men. Women tend to be more relational (e.g. women are more likely to demonstrate empathy and to experience emotional connectedness with the care-receiver) whereas men tend to be more instrumental. Abel (1990) urges researchers to explore the social context of caregiving by examining the labour market, income, leisure time, financial strains, and unemployment, which

influence the policies affecting families and women's caregiving. Hooyman and Gonyea (1995) underline the importance of accounting for the "structural factors and the ways public policies affect both the nature and the consequences of family caregiving" (p. 121). The assumption of women as natural caregivers needs to be deconstructed by examining the social world, to bring changes to social and health policies.

In the same line of thought, Neufeld and Harrison (2000) point out the importance of modifying the context of labour relations by encouraging part-time work and changing taxation policies to facilitate family caregiving. These measures could alleviate the economic strains related to caregiving, especially for some women who must interrupt their careers or quit the workforce altogether to assume caregiving responsibilities at home. Questions on the extent to which these issues are a part of the legislative agenda should be raised. Political activism should also be directed at ending the long history of women's unpaid work and their economic exploitation (Conseil du Statut de la Femme, 2000; Shragge & Letourneau, 1987), and the social devaluation of women's contribution to the domain of public health (Collière, 1986; Covan, 1997; Doyal, 1995; Opie, 1992).

Gendered Differences in Caregiving

A review of the literature shows the importance of women's involvement in caregiving activities. Even if women are over-represented in these studies, wives, daughters or daughters-in-law have performed most of the caregiving activities. This gendered division of caregiving may be attributed to gender theory, in which men and women must fulfill different social roles. Furthermore, it could be hypothesized that by virtue of their social role, women undertake and are expected to undertake caring activities as a conformist way to respect social expectations. Gender theory assumes that caregiving would not fit men's beliefs and social roles as breadwinners. Also, the gender effect would be expected to explain the variance in the patterns of caregiving between husbands and wives (Walker, Pratt & Eddy, 1995).

Spouses caregiving.

According to Walker, Pratt & Eddy (1995), wife caregivers find it difficult to exert control on their husbands or to exercise decision-making, whereas male caregivers are more likely to be in charge of their wives. Husbands tend to focus on caregiving tasks and projects, while continuing with outside activities. On the other hand, wife caregivers are more concerned about their husbands' needs and choices and seek activities in which they both can participate. Caregiving is more stressful for wives than for husbands since women expect to have more freedom from family and household activities once their children are raised. This study mentions that women learn to cope with caregiving stress and demands over time by becoming less emotionally involved – a strategy already used by husband caregivers (Walker, Pratt & Eddy, 1995).

Adult children caregiving.

Walker et al. (1995) report that adult daughter caregivers provide most of the personal and hygiene care or hands-on help such as transportation, performing household cleaning and other domestic chores, laundry, cooking, and personal care, compared to the son caregivers. No gender differences were observed for bureaucratic mediation (talking to health care providers, physicians and nurses, obtaining services) and for financial aid given to parents.

Daughters, rather than sons, are also more likely to be involved in decisions about the dependence of their mothers (Brody et al., as cited in Walker et al., 1995). Married daughters expect little help from their spouses but see their husbands as being supportive, as long as they do not resent or complain about their wives' caregiving activities.

Son caregivers are also more likely to receive their spouses' support and report less disruption of work activities, leisure time, and other family responsibilities than are women caregivers (both wives and daughters) (Horowitz, as cited in Walker et al., 1995). These observations reinforce the view that women must assume caregiving activities on a 24-hour basis

(Doyal, 1995), in contrast to the caregiving activities by men. As well, the impact of participating in the workforce must be examined for women caregivers since it may be contended that cumulating multiple roles decreases working-women's amount of leisure time. Walker et al. (1995) report that employed, daughter caregivers present more difficulties than those who are not in the workforce since they have fewer hours to devote to caregiving activities. Paid work and caregiving thus seem to be in conflict, and this conflict is hypothesized to be acutely felt by women caregivers who are the sole family breadwinners (Walker et al., 1995).

Although the social context is likely to change, the responsiveness of paid labour and employers is less likely to follow the same trend. Economic issues related to employment and caregiving such as low-income families and facing the obligation to quit work to care for aging and dependent relatives, needs to be addressed. Ultimately, the goal is to influence policy-makers and elaborate on the national, provincial and territorial policies for home care services.

Bunting (1992) underlines that "home became idealized as a haven where the breadwinning man could recuperate from the stresses of the competitive work environment" (p.59). The gendered division of caregiving may be considered as a social injustice because activities of caregiving are invisible, unpaid, and socially devaluated. Despite its supposed invisibility, caregiving is time- and energy-consuming. Bunting (1992) insists that women should not quit caregiving but rather, suggests that social and economic measures must be undertaken to end the impoverishment of women's future and professional careers, if they are called upon to assume the caregiver role. Bunting (1992) also points out the need to be aware of androcentric and anthropocentric biases in doing research on caregiving among ethnocultural groups.

I now turn to presenting an overview of caring as a process and delineate the differences between caregiving and caring. This review is purposely related to the research problem since the aim of the study was to uncover the intersection between Haitian Canadian caregivers' ways of caring with race, gender, and social class. The research was directed at examining through a

postcolonial lens, how race, gender, and social class intersect with Haitian Canadian caregivers' everyday lives to shape ways of caring for aging relatives at home. This study focuses on caring as a process since, for Haitian Canadian caregivers, caring represents a process of cultural continuity and an experience of reciprocity and mourning-in-becoming. This is the main conceptual difference between caring and caregiving that implies that caring goes beyond the activities of caregiving *per se*.

Reviewing Caring as a Process

In this last section, a review of literature on the process of caring is presented. The aim is to highlight the conceptual differences between caregiving and caring to provide the rationale for my choice of caring to describe Haitian Canadian caregivers' activities to look after aging relatives at home. Mayeroff (1990), inspired by the work of Carl Rogers and Viktor Frankl, portrays caring as a process in which personal growth ("being with") and self-actualization, are the core elements for developing caring attitudes. Mayeroff (1990) refers to these attitudes as 'the ingredients of caring' and the means to an end. This end consists of helping the other's intellectual and personal growth.

Mayeroff (1990) warns about the risks of confounding asymmetrical relationships, adhering to dogma, and overprotecting with caring. Moreover, these attitudes of non-caring cannot be considered as caring *per se*, or the meaning of caring may either be misunderstood or thwarted. These attitudes do not correspond to genuine caring since they are not intended to enable growth. For Mayeroff (1990), the process of caring is:

> To help another person grow is at least to help *him* [italics added] to care for something or someone apart from himself, and it involves encouraging and assisting him to find and create areas of his own in which he is able to care. Also, it is to help that other person to come to care for *himself* [italics added], and by becoming responsive to his own need to care, to become responsible for his own life. (p.13)

Caring involves knowing, trust, respect, devotion[30], consistency, and obligations towards the other for whom somebody cares, though caring may or may not be reciprocal. Mayeroff (1990) refers to parents who care for young children, but these children are too young to care for their parents in a reciprocal manner. Since caring is a process that sustains growth, the conditions of growth must be present for the process to unfold. Most importantly, caring involves knowing the other in a way that differs from a mundane acquaintance with another:

> To care for someone, I must know many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conducive to his growth; I must know how to respond to his needs, and what my own powers and limitations are. (Mayeroff, 1990, p. 19)

Caring is also a process that takes place in the present, in the 'here and now,' not in the future. Caring involves "being with" or being able to understand what is going on with the other person. It means that the carer must understand the other individual's world, his or her perspective, and his or her expectations. Mayeroff (1990) points out: "I must be able to see, as it were, with *his* [italics added] eyes what his world is like to him and how he sees himself" (p. 53). Carers (people who care for the other) can understand directly or indirectly the other's feelings or thoughts. Carers do not need to experience something to be able to understand it. For instance, one may never have been the object of racism, but one can genuinely perceive the effects of racism because of one's friendships with people who are racialized. Caring involves direct and indirect, verbal and non-verbal, affective and cognitive communications and moves beyond the mere level of verbalization.

Mayeroff (1990) states that "the process, rather than the product, is primary in caring, for it is only in the present that I can attend to the other" (p. 41). This is not meant to deny that we cannot learn from past experiences, but to underscore the view that human beings can only

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[30] Mayeroff (1990) refers to devotion in the sense of being genuinely concerned about the other person. Mayeroff (1990) contends that devotion has nothing to do with the uncritical adherence to some religious dogma.

control the present. Caring is a process, entrenched in a relationship, built on the respect of the others' differences to elicit trust and honesty. Mayeroff (1990) enumerates eight ingredients of caring; basic elements that must be found in a relationship of caring, if one really wants to care for another. He mentions: 1) knowing, 2) respect for alternative rhythms, 3) patience, 4) honesty, 5) trust, 6) humility, 7) hope and, 8) courage. These conditions or ingredients of caring are similar to Jean Watson's carative factors, developed in the theory of human caring (Watson, 1985).

Mayeroff (1990) emphasizes that, in caring for the other person, this individual becomes an extension of her/his self, but is separate. He says: "In caring as helping the other to grow, I experience what I care for (a person, an ideal, or an idea) as an extension of myself and at the same time as something separate from me that I respect in its own right" (Mayeroff, 1990, p. 7). Although Mayeroff (1990) did not refer to any religions or spiritual beliefs, one is tempted to link this last statement to a Judeo-Christian philosophy based on the love of others. On the other hand, caring is indicated to be a dedicated process, where all human resources – intellectual, physical, emotional, or spiritual, are thoroughly invested in the process.

Self-actualization is an outcome of caring, inscribed in a process of self-nurturing. It is not the process of caring *per se* that enables self-actualization, but it is the fact that the carer needs to be true to him or her, to genuinely care for the other. Mayeroff (1990) contends that, in valuing and demonstrating trust, honesty, courage, and understanding towards the other, the carer grows and actualizes through caring. Hence, caring is a general process of nurturing and self-nurturing that helps humans to find meaning in their lives (Mayeroff, 1990). I now shift the discussion to delineate some similarities between Mayeroff's process of caring and conceptualizations of caring that are found in the nursing literature.

Bishop and Scudder (1997), for instance, mention that nursing is a practice of caring. I will not enter into a debate about whether nursing is a science, an art, or a practice discipline.

Although caring cannot be the central and unifying concept of the discipline, caring is central to the art of nursing. Caring is an artful nursing practice since it is creative, sensitive, and embedded in a sense of moral imperative. Bishop and Scudder (1997) assert that, "at all times, artful practice and applied science are integrally woven into the fabric of the practice of caring called nursing" (p. 85). Gadow (1980) refers to the concept of existential advocacy to develop her argument in favour of helping clients identify their needs and to express them. Advocacy can be seen as an attribute or a dimension of the concept of caring. With reference to Walker and Avant (1995), without plunging into a concept analysis, an attribute is a defining characteristic of a concept, which may be composed of a cluster of defining attributes.

Gadow argues that advocacy is aimed at helping the client grow, which basically means helping the client make his or her own decisions. Advocacy is intended to sustain growth and, in that sense, the concept of existential advocacy is closed to Mayeroff's process of caring, since both are directed at promoting and enhancing people's growth. Values of authenticity, trust, honesty, respect, and genuine concern about another's feelings and thoughts, and the right of humans to make their own decisions, are found in conceptualizations of caring. Gadow (1980) states:

> The ideal which existential advocacy expresses is this: that individuals be assisted by nursing to authentically exercise their freedom of self-determination. By authentic, is meant a way of reaching decisions which are truly one's own – decisions that express all that one believes important about oneself and the world – the entire complexity of one's values. (p. 85)

Gadow (1980) distinguishes the right to make one's decision from paternalistic and consumerism worldviews. The latter suggests that the patient is informed of all options but does whatever he or she likes. Under paternalism, no alternative exists, since health is a paramount value and all efforts are directed to save it. Therefore, the client's opinion is merely sought and the decisions of health care professionals are imposed. Caring nurses can make a difference in these situations by supporting clients in selecting options, which are congruent with their values

and beliefs about health, illness, and recovery. In their advocating, nurses care for their clients in valuing the client's self. According to Gadow (1980), advocating refers to:

> The effort to help persons become clear about what they want to do, by helping them discern and clarify their values in the situation, and on the basis of that self-examination, to reach decisions which express their reaffirmed, perhaps recreated, complex of value. (p. 85)

In the same line of thought of Mayeroff (1990) and Gadow (1980), Benner and Wrubel (1989) mention that help and growth are the primary components of caring since caring means 'being connected' to "things that matter to people" (p. 10). Benner and Wrubel (1989) point out that "caring sets up the condition that something or someone outside the person matters and creates personal concerns. Without care, the person would be without projects and concerns" (p. 1). Still, what is non-caring? Benner and Wrubel (1989) suggest that "non-caring amounted to not being present with the patient, but rather being there only to get the job done" (p. 5).

In her theory of human caring, Watson (1985) focuses on the interpersonal process between caregivers and care-receivers. For Watson, caring represents "the highest form of commitment to self, to other, to society, to environment, and, at this point in human history, even to the universe" (Watson, as cited in Fawcett, 2000, p. 659). Human caring is a moral ideal enacted in nursing to protect, enhance, and preserve human dignity. In adopting a humanistic stance, Watson acknowledges caring as a process aimed at providing help and sustaining growth. The goal of nursing is "to help persons gain a higher degree of harmony within the mind, body, and soul which generates self-knowledge, self-reverence, self-healing, and self-care processes while increasing diversity" (Watson, as cited in Fawcett, 2000, p. 661).

Watson's carative factors are defined as nursing interventions or caring processes that fit the philosophical assumptions of the theory of human caring. These ten carative factors are: 1) formation of humanistic-altruistic system of values, 2) instillation of faith-hope, 3) cultivation of sensitivity to one's self and to others, 4) development of a helping-trusting, human care

relationship, 5) promotion and acceptance of the expression of positive and negative feelings, 6) systematic use of a creative problem-solving caring process, 7) promotion of transpersonal teaching-learning, 8) provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment, 9) assistance with gratification of human needs, and, 10) allowance for existential-phenomenological-spiritual forces (Watson, as cited in Fawcett, 1993, p. 226-227). Watson (1985) underlines that a caring nurse is preoccupied by the growth of the other person by being sensitive to the other person's concerns and distinctiveness in the world. She wrote: "The most abstract characteristics of a caring person is that she or he is somehow responsive to a person as a unique individual, perceives the other's feelings, and sets apart one person from another from the ordinary" (Watson, 1985, p. 34).

In enumerating Watson's carative factors, my intention is to draw a parallel with Mayeroff's ingredients of caring and Gadow's advocacy concept. Agreement exists between the previously cited authors and honesty, trust, respect, being present for the other, freedom to express feelings and thoughts, acceptance of other's differences, and supporting growth and self-actualization, as being identified as the main attributes of caring. Therefore, Watson's carative factors may be applied to adult children caring for their aging parents or in any other caring relations.

Differentiating Caring and Caregiving

Mayeroff (1990) mostly addresses an audience of parents and teachers but the process of caring, which he described, can be applied to all humans. The idea applies when adult children care for an aging parent since personal growth is an everlasting process of human life. The same reasoning applies to an aging spouse or partner who cares for the other – the point being that not only do children grow or learn, but older adults grow and learn, as well. Ebersole and Hess (1990) mention that aging people seek to make sense of their lives, to leave a legacy, and to learn about the process of finitude, especially when approaching the end of life. Humans must learn

how to die, and therefore the dying process becomes the last, but perhaps the most meaningful, learning experience of life. I identify the possibility of growth and learning, since adult children can help their parents to cope with illness and dying. As well, aging parents can help those who will stay behind to grow, despite the sadness of parting from their loved ones. Caring helps aging people to make sense of their lives in sharing their lived experiences, and as part of a legacy to their adult children or to other family members.

Mayeroff (1990) raises another major issue that differentiates caring from caregiving. Caring involves the whole carer's resources, as opposed to caregiving, that involves only a part of these resources. Caring is the whole and the whole is more than the sum of its parts. Caring is the whole process whereas caregiving, such as helping in performing activities of daily living, is one part of that process. In a study conducted with adult children or intergenerational caregivers, Bowers (1987) suggests re-conceptualizing caregiving according to purpose, rather than to tasks. Five categories of caregiving, among them, anticipatory, preventive, and protective caregiving, reflect the attitudes of caring such as being with, being concerned about, listening, protecting, and nurturing. Bowers's taxonomy is consistent with those offered by previous authors on caring and its attributes (Benner & Wrubel, 1989; Gadow, 1980; Mayeroff, 1990; Watson, 1985; Wuest, 1998). Additionally, Bowers (1987) distinguishes two other categories such as supervisory and instrumental caregiving, which are closely related to caregiving tasks and consist of supporting care-receivers in performing activities of daily living.

In Chapter Seven, results pertaining to Haitian Canadian caregivers' ways of caring for aging relatives at home are presented. The findings illustrate that Haitian Canadian primary caregivers' ways of caring for aging relatives at home are a process of cultural continuity and an experience of reciprocity and mourning-in-becoming. I will demonstrate that Haitian Canadian caregivers' conceptualization of caring is congruent with Mayeroff's definition of caring as being a process of personal growth and reciprocity. Caring is defined as a process of cultural

continuity to alleviate the shock of late immigration that can affect Haitian Canadian aging people. In using a postcolonial feminist perspective to explore Haitian Canadian caregivers' ways of caring, one must be aware that culture is conceptualized as being constantly changing, implying that ways of caring are socially and culturally constructed in a specific historical, social, cultural, political, and economic context.

I am not suggesting a new conceptualization of caring, but rather, want to extend the argument to include Haitian Canadian caregivers while adding distinctions with regards to mainstream caregivers. The major difference lies in the social context of the host country within which caring activities unfold since, for Haitian Canadian caregivers, issues of race, gender, and social class compile layers of complexity in the construction of caring. While the impact of culture must be taken into account when exploring caring activities, the focus must also be directed at examining the influence of the larger social world on Haitian Canadians' ways of caring, and caregivers' decision-making processes as they pertain to older person's institutionalization, and the utilization of home care services. The influence of social competing forces that come into play with culture must be addressed to understand Haitian Canadian primary caregivers' conceptualization of aging and caring.

Chapter Summary

In this chapter, concepts related to the research problem such as culture, race, racialization, caregiving, and caring have been scrutinized. The review of the literature on culture and race demonstrates how racialization has an impact on the social construction of the culturally different 'Other'. Non-Western immigrants and refugees' health care needs can be overlooked due to the influence of democratic racism in shaping health care discourses and professional practices. Haitian Canadian caregiver's ways of caring for aging relatives at home may be constructed as a means to counteract perceived individual, social, and institutional racism. As well, the impact of gender and social class needs to be assessed to understand Haitian

Canadian caregivers' ways of caring. A review of the literature on caregiving was presented to delineate its major features and illustrate how caregiving and caring represent different theoretical concepts. The review illustrates that the effects of caregiving on caregivers' physical health and emotional well-being have been documented in the literature on caregiving – using stress, coping, and adaptation theories. Caregiving has been mostly apprehended from the caregivers' perspectives where predictors for alleviating burden or stress and for enhancing the development of coping strategies were found. An individualistic perspective has been widely adopted due to the reliance on stress/coping/adaptation theories. Moreover, this individualistic conceptualization of caregiving has contributed to expanding the knowledge of caregiving while leaving a gap in the knowledge on the process of caring. I argue that caregiving represents only a part of the process of caring since caregiving is mostly task-oriented, as opposed to caring which can be seen as integrating the work and the affective dimensions of a process greater than caregiving. Far from rejecting the contributions made by previous inquiries on caregiving, I contend that researchers must extend the understanding of the process of caring by using new paradigms of inquiry to unveil the impact of the social, cultural, political, and economic context of caring and its intersection with race, gender, and social class. The larger social context varies with countries and cannot be universalized to all caregivers. In other words, contextual social factors like race, gender, social class, culture, and power intersect with caring to mediate ways of caring.

The myth that caring is a shared responsibility between the Welfare state and the community must be explored to address social inequalities related to the accessibility of home care services. The extent to which low-income families or primary caregivers can access home care services deserves careful examination. Moreover, the accessibility to home care services to low-income immigrant families and women caregivers represent a crucial issue that is poorly understood, especially in the province of Quebec. As well, it must be acknowledged that little is

known about how racialized groups care for aging relatives and their relations with the mainstream health care practitioners in Quebec. Current changes in the family structure and dynamics, especially those brought by immigration and economic liberalism, point to the need to develop this area of inquiry.

The use of postcolonial feminism to guide nursing cultural research on caring addresses racial, gendered, social, political, and economic constraints that influence non-Western men and women caregivers' everyday lives. This field of inquiry must be further developed in the discipline of nursing to sustain changes in health policies and correct social inequities in accessing home care services.

Chopoorian (1986) reminds us of the impact of the social world on health, caring, and individuals' behaviours. This research, informed by a postcolonial feminist approach, enables the muted voices of Haitian Canadian primary caregivers to be heard. This is a means to uncovering marginalized knowledge since Haitian Canadian primary caregivers speak from different historical, social, cultural, and economic locations, which have an impact on ways of caring.

This study addresses a gap in knowledge about nursing in the social context in which caring occurs, to integrate subaltern[31] knowledge in nursing theorization. The social context of caring is influenced by racism, gender discrimination, institutional racism, and other kinds of 'Othering'[32] that erase caregivers' voices in shaping and accessing home care programs.

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[31] I draw on Spivak (1988) to define *subaltern* knowledge as the *knowledges* that were muted by the epistemic violence of colonization.

[32] In Chapter Six, I provide a critical review of the process of social 'Othering' and how it operates in Haitian Canadian caregivers' everyday lives. 'Othering' impacts on caregivers' ways of caring and influences the utilization of public home care services since 'Othering' models caregivers' perceptions on the health care system and on health practitioners.

CHAPTER THREE
POSTCOLONIAL FEMINIST THEORETICAL UNDERPINNINGS OF THE STUDY

Introduction

Over the past few decades, the influence of critical and feminist theories, as alternatives to the Received View[32] philosophy of science in expanding the corpus of knowledge, especially in exploring health issues related to race, gender, and social classes, is widely acknowledged in the discipline of nursing (Anderson, 1986; Anderson, 1996; Boutain, 1999; Cheek, 1999; Cheek, 2000; Cheek & Porter, 1997; Drevdahl, Kneipp, Canales, & Dorcy Shannon, 2001; Dzurec, 1989; Jackson 1993; Tang & Anderson, 1999; Taylor 1999). Despite the social significance of these approaches in uncovering health disparities, the need to address racial inequality and its impact on health in pluralist countries prompts developing them further. The prevailing liberal[33] ideology that influences nursing science (Browne, 2001) has an impact on the fact that nursing research is still perceived as being neutral and apolitical. This liberal ideological assumption may explain why sensitive issues related to race, gender, and class must evolve. As a potential explanation, Baker, Varma, and Tanaka (2001), suggest that racism is not viewed as a domain of the discipline, which indicates the need to revisit ways to tackle health inequities related to social injustices in nursing. Critical and feminist approaches represent promising avenues for eliciting new knowledge to address health inequities by shifting the reflexive thought into transformative[34]

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[32] Jacox and Webster (1986) mention that the 'Received View' emerged in the 17th century, as a scientific worldview that conceptualized scientific reality as a mechanistic and naturalistic entity, about which only 'God' knew the foundational laws. The aims of scientists were to discover these operating laws to explain and predict natural or physical phenomena. Later, philosophers of the Vienna Circle introduced the notion of falsification, implying that scientific reality can only be approximated at best.

[33] Browne (2001) states that liberal ideology, by promoting notions of equity, freedom, and individualism undermines the structural effects of race, gender, and class in generating social and health inequities.

[34] Golding (1988) points out that Antonio Gramsci's philosophy of praxis unifies the theoretical and practical knowledge in science, as a science in action or praxis-oriented science, aimed at elaborating transformative knowledge.

interventions aimed at achieving social justice -- using research as a vehicle of social activism (Anderson 2000a; Drevdahl, Kneipp, Canales, & Dorcy Shannon, 2001).

In this chapter, the rationale underlying the choice of a postcolonial feminist theoretical approach to understand Haitian Canadian caregivers' ways of caring for an aging relative at home is discussed. A postcolonial feminist theoretical perspective explores how the larger social and cultural world has an impact on the everyday lives of Haitian Canadian caregivers. Marginalized locations represent important sites from which health problems that intersect with power, race, gender, and social classes, are addressed. Postcolonial feminism provides the analytic lens to look at the impact of these factors in shaping caring and health experiences. Moreover, postcolonial feminism is aimed at addressing health inequities stemming from social structural determinants like race, ethnicity, gender, and social class, which produce and sustain discrimination in our society and its institutions.

First, I provide an overview of feminism as a paradigm of inquiry. Feminist research, the evolution of feminist inquiries, and the tensions and controversies among feminist scholars and researchers are delineated. Second, I examine postmodern feminism and delineate its ontological, epistemological, and methodological underpinnings. Philosophical differences between postmodern feminism and postcolonialism are discussed. My rationale for choosing postcolonial feminism to inform this study is also presented. In general, postmodernism could have been used to guide this research but limitations of postmodern thought convinced me to adopt a new theoretical perspective. My aim is to focus on the impact of race, gender, and social classes in uncovering health and social inequalities in the health system. Although postmodernism and postcolonial feminism share some commonalties, especially in critiquing the impact of Enlightenment on knowledge generation and the hegemony of Western science, the limitations of postmodernism, in addressing social inequities that affect non-Western populations' health, well-being, and accessibility to health care services, motivated my choice to use a postcolonial

feminist approach to guide this study. I now sketch out feminism as a paradigm of inquiry, and further describe postmodern feminism and its philosophical underpinnings.

The Feminist Paradigm of Inquiry

Skeggs (1995) points out that the ways of conceptualizing people's oppression differ with regards to the researcher's emotional, social, and political location. As she puts it: "All knowledge is political because of its intention and effects, and because of the fact that it is produced in the interests of particular groups; although some knowledge may have more direct political implications" (Skeggs, 1995, p. 12). Accordingly, multiple strands of feminism can be used to explore, define, and understand the oppression of women and men. A distinctly feminist paradigm thus involves the co-existence of multiple ways of explaining gender discrimination and the consequences of sexism on women's everyday lives (Reinharz, 1992). Radical, liberal, socialist/Marxist, African American, postmodern, and postcolonial feminisms enrich feminist thought. Although Reinharz (1992) acknowledges the ontological and epistemological differences of feminist approaches, she underlines that feminist research must be grounded in a common struggle. Reinharz (1992) asserts that feminist studies must uncover women's oppression along with elaborating emancipatory knowledge aimed at establishing social justice. Smith (1999) states that a sociology, from women's standpoint, is not directed at objectifying women's experiences, but rather at investigating "how that society organizes and shapes the everyday world of experience. Its project is to explicate the actual social relations in which people's lives are embedded and to make these visible to them/ourselves" (p. 74). Therefore, it may be argued that feminism cannot be considered as a homogeneous theoretical corpus, but rather as a heterogeneous family of theories, into which multiple feminisms co-exist. Nevertheless, what exactly do we mean when we talk about feminist research? What constitutes the hallmarks of feminist inquiries?

What is Feminist Research?

When exploring feminist research, the major issue that comes to mind has a bearing on methodology and methods. For instance, does a unique way of doing feminist research exist? Is a unique methodology available? What criteria are used to assess whether or not a study is feminist? Reinharz (1992) suggests relying on people's self-definition to solve this problem of defining feminist research. Reinharz's working definition, however, is too inclusive since some studies can be labeled as feminist while being blatantly non-feminist, as opposed to others that can be seen as being feminist without having been acknowledged as such. Barnett and Baruch's (as cited in Reinharz, 1992) definition of feminist research is perhaps put more succinctly:

> We consider ourselves to be "feminists" in that we believe fully in the goals of the women's movement: to reject old constraints, to make women aware of the conditions that limit their life choices, and to ensure that women are no longer barred from access to high-level positions in any social institutions. (p. 7)

Feminist research must therefore be grounded in people's subjective experiences and the goal of feminist researchers is to voice the concerns of oppressed women and men. Feminist scholarship is particularly useful in cultural nursing studies since this paradigm enables the silenced voices of underserved peoples to be heard. The individual is acknowledged as an active participant and the expert of her or his own life. Participants not only represent mere objects to be observed and studied from the social world, but are also recognized as co-creators of knowledge. Subjective experiences become a legitimate source of knowledge and theorization must take place in a democratic process where asymmetric power relations between the researcher and participants is to be equalized as much as possible (Anderson, 1991a; Anderson, 1991b; Campbell & Bunting, 1991). Although Wolf (1996) points out that equalization of power relations in feminist research constitutes a methodological challenge, I discuss the issue of power relations in the section on the feminist interviewing process.

Harding (1987) contends that no hegemonic feminist theory could stand *per se* because of the historical complexities of class, gender, race, and culture. Adopting one feminist theory would be replicating the oppression of the dominant viewpoint by silencing divergent voices. Smith (1987) stresses that feminist theory is aimed at challenging the exclusion of women's voices created and perpetuated by the hegemony of men's standpoint in science. Smith's basic feminist assumption is that research must be done for women, by women, and grounded in women's everyday lives (Smith, 1987). The exclusion of men from being 'feminist' researchers, however, seems to be problematic to some feminists. Some studies conducted by men are clearly realized to help women and would then be classified as being pro-feminist, especially in domains such as pornography (Reinharz, 1992). The American sociologist Kandal (as cited in Reinharz, 1992) emphasizes the oppressive nature of men's exclusion from feminist research:

> Feminist critical discourse has raised the epistemological question of whether one must be a woman in order to contribute to an authentic sociology of or for women. Obviously, having written this book, my answer is: not necessarily. Although a man cannot experience what it means to be a woman, this does not preclude making a contribution to the sociology of women. ...Oppression seems to me to have transgender aspects, which those who have experienced it can communicate. (p. 14)

According to Michelle Fine (as cited in Reinharz, 1992) men doing pro-feminist research could be perceived as being more authoritative or credible than would women doing the same types of studies. Fine applies the same logic to studies done by Caucasian women on African American women but not the opposite:

> Those who study injustice, are often ascribed more objectivity, credibility, and respect. When men discuss feminist scholarship, it is taken more seriously than when women do. When Whites study the Black family the work may be viewed as less "biased" than when Black scholars pursue the same areas. But if a Black social scientist studies White people, one might expect the resulting analyses to be considered the "Black perspective". (p.15)

bell hooks (1989) contends that feminist researchers should be able to learn from diversity and to study ethnic groups, even if not a member of that group:

> I stressed that the ideal situation for learning is always one where there is diversity and dialogue, where there would be women and men from various groups. But I also insisted that we should be capable of learning about an ethnic/racial group and studying its literature, even if no person of that group is present. (p. 47)

bell hooks (1989) suggests that White women need to be aware of their locations and not speak from an authoritative or normative standpoint. She states "problems arise not when White women choose to write about the experiences of non-White people, but when such material is presented as 'authoritative'" (hooks, 1989, p. 48). In the same line of thought, Tuhiwai Smith (1999) contends that research that was done on Aboriginal or indigenous women was constructed around White men's "cultural views of gender and sexuality" (p. 8). This kind of research perpetuates inequalities and racial stereotypes (Tuhiwai Smith, 1999) that only serve the interests of the dominant group.

Feminist Assumptions

The methodological debate is articulated around this question: Is there a distinctive method that should be used to engage in feminist inquiry? In other words, what are the assumptions of feminist research?

Methodology is defined as the theoretically informed framework that guides the research process on the basis of epistemological assumptions (Sigsworth, 1995). For Harding (as cited in Sigsworth, 1995), methodology is "a theory and analysis of how research does or should proceed" (p. 897). Harding (1987) further argues against the idea of a distinctive feminist method of research in favour of using methods in a way that will be different from the traditional ways of doing research where women as knowers are excluded from the process of knowledge generation.

Farganis (1989) claims that feminist research must have a different methodology or set of practices to counterbalance the effects of the Cartesian model of science. She bases her argument on the premise that the world is socially gendered and that women have different social

experiences than men, and therefore, women must necessarily see the world from a different viewpoint. Farganis (1989) points out "knowledge of the world is socially constructed and, within the world in which we live, gendered; for if gender patterns who we are, it also patterns how we think, and our views on science cannot escape this" (p. 207). In other words, science must be carried out differently, from a different ontology, to generate useful knowledge for women. This claim is nevertheless reductionist since it obfuscates race as an oppressive factor.

Farganis also proposes that feminist methodology is aimed at challenging the traditional view of science, e.g. the notion of an objective, clearly discernible reality that the human mind can understand through the process of reasoning. When adopting a feminist perspective, especially one that is postmodernist, reality cannot be apprehended as purely objective and neutral. Traditional science has disregarded issues related to politics, class, gender, race, ethnicity, history, emotions, and subjectivity as non-objective truths but these issues are of paramount importance for feminist theorization (Farganis, 1989).

Another feminist methodological assumption consists of viewing the dialogic relation between researcher and participants. As Harding (1987) points out, "the researcher appears to us not as an invisible, anonymous voice of authority, but as a real, historical individual with concrete, specific desires and interests" (p. 9). Reflexivity entails that the researcher's beliefs and behaviours cannot be stripped off or bracketed from the inquiry, but constitute data as well. Finally, Harding contrasts the difference between methodology and methods. Methodology is defined as a theory and analysis that guide the inquiry and includes "how 'the general structure of theory finds its application in particular scientific disciplines'" (Harding, 1987, p. 3). Grounded theory, phenomenology, and ethnography can be viewed as methodologies. The same author defines research method as a technique for gathering evidence like participant observation and interviewing (Harding, 1987).

Feminist research assumptions challenge the androcentric biases of Western science in documenting women's issues such as the objectivity and neutrality of science, Cartesian dualism, the opposition of the mind and the body, and the Newtonian mechanistic view. Feminist methodology requires the researcher to be reflexive about representing findings in a way that will not serve to perpetuate people's oppression, but rather to empower people in struggling for emancipation and social change (Anderson, 1991b; Farganis, 1989; Harding, 1987; Lather, 1991; Opie, 1992).

In summary, contemporary feminism is a paradigm of inquiry that moves researchers beyond the classical opposition between men and women. "Being pro-woman and anti-male supremacy does not necessarily mean being anti-man" (Daly, as cited in Reinharz, 1992, p. 14). Above all, feminism and more specifically, its postmodern strand, casts doubt on the hegemony of Western science and its assumptions on universal truths, prescriptive theories, generalizability of findings, objectivity, and neutrality in research endeavours. In adopting a postmodern feminist approach, the rationale is to disrupt the discourse of dominant ideologies that govern organization of the social world. Bordo (1990) asserts "in the context of our specific history, assessing where we are now, I believe that feminism stands less in danger of the "totalizing" tendencies of feminists than of an increasingly paralyzing anxiety over falling (from what grace) into ethnocentrism or essentialism" (p. 142).

Postmodern feminism opens up alternatives to essentialism by correcting failures of Western science to properly address the complexities of health problems (Anderson, 1991a; Anderson, 1991b; Cheek, 1999; Cheek, 2000; Fraser & Nicholson, 1990; Harman, 1996; Herdman, 2001; Lather, 1991; McCormick & Roussy, 1997; Stevenson & Beech, 2001). In the next section, postmodern feminism is defined and its ontological, epistemological, and methodological underpinnings scrutinized.

Defining Postmodern Feminism

Positivism was widely recognized as being the dominant paradigm of inquiry, though its failure to properly address human complexities has been raised (Lather, 1991; Tuhiwai Smith, 1999). For Lather, the theoretical hegemony of positivism "has been disrupted and displaced by a newly hegemonic discourse of paradigm shifts. Interpretative and increasingly critical 'paradigms' are posited and articulated" (1991, p. 2). Nevertheless, what is postmodernism? According to the *Cambridge Dictionary of Philosophy* (1994), postmodernism is defined as:

> Relating to a complex set of reactions to modern philosophy and its presuppositions, rather than to any agreement on substantive doctrines or philosophical questions. Despite there being little agreement on precisely what the presuppositions of modern philosophy are, and despite the disagreement on which philosophers exemplify these presuppositions, postmodern philosophy typically opposes foundationalism, essentialism, and realism. (p. 634)

Developed in the 1960's and 1970's, postmodernism is a "reaction to the structuralist movement that began in the linguistics of Ferdinand de Saussure (1956) and the anthropology of Claude Lévi-Strauss (1963), who postulated that all philosophical inquiry is essentially a matter of language" (Miller, 1997, p. 143). Miller points out that "structuralists are concerned philosophically with how meaning is constructed through language" (Miller, 1997, p. 143). Despite the intellectual diversity of postmodern thought, all strands of postmodernism recognize the pluralism of cultures, traditions, values, theories, ideologies, and forms of life (Miller, 1997). Postmodernism questions the structures of Western scientific thought and the assumptions related to traditional research such as universal truth, subjectivity, reason, and neutrality.

Lister (1997) mentions that postmodern has a variety of contested applications. First, it is a philosophy of thought that critiques theories and grand narratives reflecting viewpoints of French philosophers such as Derrida, Foucault, and Lyotard. Postmodernism can also be applied to the fields of arts and humanities where it refers to the negation of the modern movement in painting, architecture, and literature. Finally, postmodernism is also used to describe social and

political changes that have been brought to the Western world by technology and economic liberalism (Lister, 1997).

Postmodernism is a current of thought that seeks to "develop conceptions of social criticism, which do not rely on traditional philosophical underpinnings" (Fraser & Nicholson, 1990, p. 21). Finally, Lather (1991) contends that "postmodernisms are responses across the disciplines to the contemporary crisis of representation, the profound uncertainty about what constitutes an adequate depiction of social reality"(p. 21). Cheek (2000) states:

> Postmodern thought disavows the idea that human experience can be reduced to and captured by grand or totalizing theories, the metanarratives of which Lyotard was so critical. Rather, postmodern thought emphasizes that reality is plural and that there are multiple positions from which it is possible to view any aspect of the reality. (p. 20)

Ontological and Epistemological Underpinnings of Postmodern Feminism

Postmodern philosophy challenges the Enlightenment of rationality, scientific neutrality of Western science, and hegemony of the Received View as the only means by which scientists can apprehend the so-called reality. Fraser and Nicholson (1990) point to the need to conciliate feminism and postmodernism since both entities attempt to redefine the relation between philosophy and social criticism and to develop innovative knowledge.

On one hand, postmodernists discovered the anti-foundational philosophical assumptions from which the shape and character of social criticism would be studied (Fraser & Nicholson, 1990). On the other hand, feminists developed the social and critical perspectives and from there, drew conclusions about philosophy (Fraser & Nicholson, 1990). In this process, both tendencies ended up with strengths and weaknesses, which reconciled the postmodernist critique of essentialism with the feminist critical analyses of social phenomena related to sexism, classism, and oppression. Fraser and Nicholson indicate the need to reconcile postmodernism and feminism: "Postmodernists offer sophisticated and persuasive criticisms of foundationalism and essentialism, but their conceptions of social criticism tend to be anemic. Feminists offer robust

conceptions of social criticism, but they tend at times to lapse into foundationalism and essentialism" (Fraser & Nicholson, 1990, p. 20).

Postmodernism also challenges realist ideas on linearity, causality, and neutrality of facts since facts cannot be value-free, but are rooted in a social, historical, cultural, and political context. For Dzurec (1995), postmodernism does not acknowledge universal laws sought by empiricists nor recognize attempts by phenomenologists to essentialize people based on metaphysical truths. Lather (1991) points out:

> The essence of the postmodern argument is that the dualisms, which continue to dominate Western thought, are inadequate for understanding a world of multiple causes and effects interacting in complex and non-linear ways, all of which are rooted in a limitless array of historical and cultural specificities. (p. 21)

In other words, realities are multiple and located in a social, cultural, economic, and political context. This context of pluralism precludes universalizing, which consists of drawing transhistorical and acontextual totalizing statements. This also precludes essentializing people in defining universal traits based on gender, race, skin colour, or any other experiences. As well, Miller (1997) emphasizes that the structures underlying Western scientific thought are "sociohistoric constructions serving specific political ends, and are not universal truths" (Miller, 1997, p. 143). Fraser and Nicholson (1990) contend that the focus of the postmodern critique is directed at disrupting the universalizing tendencies of metanarratives, while accepting narratives. They describe Lyotard's critique of the metanarratives:

> In Lyotard's view, a metanarrative is "meta" in a very strong sense. It purports to be a privileged discourse capable of situating, characterizing, and evaluating all other discourses but not itself to be infected by the historicity and contingency, which render first-order discourses potentially distorted, and in need of legitimation. (Fraser & Nicholson, 1990, p. 22)

This subtle distinction contradicts the classical nihilist critique raised against postmodern theorization. For instance, some philosophers, like Toulmin, perceive postmodernism as a nihilistic entity characterized by the acceptance of multiple realities and governed by no

universal laws. "Things fall apart; the center cannot hold" (Toulmin, as cited in Watson, 1995, p. 60). Fraser and Nicholson (1990) illustrate that theorization is possible in using a postmodernist feminist approach to explore problems of interest to the discipline of nursing and inform the provision of nursing professional care.

New theories or narratives can be developed while accounting for the historicity of health problems related to gender and class. These new sources of knowledge differ from ahistorical epistemologies produced by modern science since theories emerge from people's experiences. As Cheek (2000) puts it:

> Postmodernism is a way of thinking about reality just as any theoretical perspective is. Indeed, one of postmodernism's great contributions to nursing and health care analyses is to highlight how theory itself, along with the research methods and approaches associated or congruent with any particular theoretical orientation, frames our understandings of what is appropriate subject matter to study in the first place. The unsettling effect of postmodern thought on what we may have come to take for granted in health practice realms is one of its greatest contributions, offering possibilities for bringing about changes and allowing "other" voices and perspectives to surface. (p. 21)

Therefore, postmodern feminism is not the theoretical iconoclastic entity that was found to jeopardize the discipline of nursing (Kermode & Brown, 1996; Kikuchi & Simmons, 1996; Reed, 1995; Romyn, 1996). Far from rejecting theorization, postmodern approaches question the status quo that impinges on the integration of marginalized knowledge in nursing theories while sorting out dominant ideologies that underpin nursing professional practice (Allen, 1992; Anderson, 1990; Anderson, 2000a; Anderson, 2000b; Anderson, 2002; Cheek, 1999; Cheek, 2000; Cheek & Porter, 1997; Herdman, 2001; Im & Meleis, 1999; Im & Meleis, 2001; Meleis & Im, 1999; Reimer Kirkham & Anderson, 2002; Stevenson & Beech, 2001; Tang & Anderson, 1999). Before entering the discussion on postcolonialism and postcolonial feminism, I address the limitations of postmodernism. In describing the limitations of postmodern thought, the rationale underlying my paradigmatic shift to postcolonial feminism is presented.

Limitations of Postmodernism

As discussed earlier, the major ontological and epistemological assumptions of postmodernism are aimed at disrupting and eroding the scientific dogmatism of Enlightenment. This issue is located at the core of the crisis of representation where postmodernism targets universalizing representation and the prevailing concepts of truth and objective knowledge. A postmodern view of science also assumes that scientific endeavours reflect the underlying relations of power that exist in the larger society. Postmodernism further interrogates the legitimacy of the metanarratives in universalizing people's experiences into a rigid, Western scientific viewpoint (Lather, 1991). More precisely, postmodernism implodes ideas about knowledge production and legitimation by demonstrating that knowledge is historically situated and structurally located (Lather, 1991). Feminist research is aimed at producing praxis-oriented findings that must be directed at generating transformative knowledge. In other words, results must be translated into interventions that may bring about social change. Inspired by Antonio Gramci's praxis of the present, Lather (1991) defines praxis as a process by which research endeavours generate transformative knowledge to bring about social changes. Findings used to perpetuate domination contradict the feminist commitment to challenge oppression.

Nevertheless, Lather (1991) raises the question about the need to abandon Enlightenment principles or to revisit its assumptions to develop emancipatory knowledge. Lather's position is not without its problems and prompts critiques from some postcolonial scholars. This suggests examining some postcolonial scholars critiques against postmodernism to demonstrate how postcolonialism transcends postmodern limitations in guiding studies addressing social and health inequities stemming from structural determinants like race, gender, and social class.

Postcolonial critiques

Some postcolonial scholars, for instance, argue that postmodernism is just a mere extension of Western science (Bhabha, 1994; Hall, 1996; Quayson, 2000). Postmodernism

would reproduce the assumptions of Enlightenment that it is supposed to challenge and counteract. The Nigerian scholar, Denis Ekpo (as cited in Quayson, 2000) argues that postmodernism is a Western crisis that occurs as the logical consequence of the deification of reason and objectivity, which would not affect ways of conceptualizing reality of non-Western cultures:

> For cultures (such as ours) that neither absolutized, i.e. deified, human reason in the past nor saw the necessity for it in the present, the postmodern project of de-deification, de-absolutization of reason, of man, of history, etc., on the one hand, and of a return to, or a rehabilitation of, obscurity, the unknown, the non-transparent, the paralogical on the other hand, cannot at all be felt like the cultural and epistemological earthquake that it appears to be for the European man. In fact, it cannot even be seen as a problem at all. (p. 132-133)

Stuart Hall (1996) also critiques postmodernism from this stance, saying that postmodernism is a Western product, a sort of prolongation of modernity that tries to recapture or redefine concepts such as subjectivity and the local experiences that Enlightenment and Cartesian dualism obfuscated in modeling Western scientific thought. Hall (1996) mentions:

> Postmodernism is the current name we give to how these old certainties began to run into trouble from the 1900s onwards. In that sense, I don't refuse some of the new things the postmodernists point to... But the attempt to gather them all under a singular sign -- which suggests a kind of final rupture or break with the modern era -- is the point at which the operation of postmodernism becomes ideological in a very specific way. What it says is: this is the end of the world. History stops with us and there is no place to go after this. (p. 134)

Finally, for postcolonial scholars, the notion of subjective experience or subjectivity is not without its problems. Hall (1996) states that, despite the positive aspects of learning about peoples' subjective experience or subjectivity, the focus on subjective experience overlooks the collective effects of social, political, economic, and social forces in shaping identity. Lewis points out that the White feminists' notion of subjectivity erases "the sociality of experiences" (Lewis, 2000, p. 172) to universalize people's and especially women's identity without

acknowledging the multifaceted and complex differences of locations[35] in modeling people's lives.

Lewis (2000) claims that the very notion of subjective experience has to be broadened to account for the meanings attached to race, gender, and social class occurring in various historical moments. Subjects are constituted through experiences of oppression, gendering, and racializing, which characterize the multiplicities of locations or positions from which people of the South speak — creating multiple subjectivities or positionalities (Lewis, 2000). Subjectivities emerge from "the different constellation of social, cultural and economic forces. If we are in part constructed as subjects through the particular layering of historical discourses, which we inhabit, then new kinds of sensibilities begin to be clearly discernible" (McRobbie, 1997, p. 247). Hence, race, gender, and social class interlock as systems of oppression in defining the multiple identities or multiple selves of people of the South.

Quayson (2000) cogently points out "postmodernism can never fully explain the state of the contemporary world without first becoming postcolonial" (p.154). Postcolonial scholars contend that the major drawback of postmodernism is located in its ahistorical and apolitical features. Postcolonial and postmodern theoretical perspectives both question the concepts of totality and universality in representing cultural Otherness. Postmodernism is flawed, however, since it erases the historical factors like colonialism, from which totalizing and universalizing discourses were developed under Western eyes (Mohanty, 1988; Quayson, 2000; Tuhiwai Smith, 1999).

It is precisely from these critiques that a change from postmodernism to postcolonialism was the best theoretical option to examine Haitian Canadians' ways of caring as a means to counteract the effects of colonialism on the shaping of health policies and home care services. I

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[35] Inspired by the work of Adrienne Rich and Chandra Talpade Mohanty, Lewis (2000) defines location as referring to "the historical, geographical, cultural, psychic, and imaginative boundaries that provide ground for political definition and self-definition" (p. 173).

now define postcolonialism and illustrate how this theoretical approach transcends postmodern limitations to guide nursing cultural research.

Defining Postcolonialism

The impetus of postcolonialism[36] as a process of inquiry in the social sciences reflects the multidisciplinary influences of political sciences, sociology, literature, anthropology, and linguistics. Postcolonialism transcends the collective efforts of the scholars of non-Western countries to critically analyze the colonial aftermath and challenge the hegemony of Western science (Bhabha, 1994; Gandhi, 1998; Hall, 1994; Hall, 1997a; Mohanty, 1988; Quayson, 2000; Said, 1979; Spivak, 1988). Postcolonialism challenges Western science as being the unique source of knowledge production and uncovers healthcare inequities related to gender, race, and class resulting from the process of colonialization and neocolonialization.

Postcolonialism is related to the period after colonization. The word postcolonial does not mean the end of the colonizing process. In other words, the colonial process has antecedents and consequences since "all post-colonial societies are still subject in one way or another to overt or subtle forms of neo-colonial domination, and independence has not solved this problem" (Ashcroft, Griffiths & Tiffin, 1997, p. 2). Quayson (2000) explains:

> To understand this process [postcolonializing], it is necessary to disentangle the term, "postcolonial", from its implicit dimension of chronological supersession, that aspect of its prefix, which suggests that the colonial stage has been surpassed and left behind. It is important to highlight instead a notion of the term as a process of coming-into-being and of struggle *against* [italics added] colonialism and its after-effects. In this respect the prefix would be fused with the sense invoked by "anti". (p. 9)

Said (2000) draws on the work of geographer Paul Leroy-Beaulieu on French imperialism, to define colonization as "the expansive force of a people; it is its power of reproduction; it is its enlargement and its multiplication through space; it is the subjugation of

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[36] As suggested by Quayson (2000), unhyphenated versions (postcolonialism/postcolonial) are used in this thesis instead of the hyphenated versions (post-colonialism/ post-colonial). By using the unhyphenated versions, I want to underline that I am referring to a scientific process, and not to the chronological period of time after colonialism.

the universe or a vast part of it to that people's language, customs, ideas, and laws" (p. 135). Inspired by a poststructuralist framework, Said (1979) first coined the word Orientalism to describe the domination of one part of the world (the Orient) by the other (the West). Orientalism also expresses the political process of colonialism *per se,* as well as the scientific school of thought that governs how non-Western cultures were perceived and studied by Western scientists.

Said (1979) further translates the relationship between the Orient and the Occident as a relation of power and domination, from which assumptions were made to speak for and about the Orient. In fact, it is a discourse of representation where the truth was dictated by the European colonial régimes. Therefore, Orientalism is a paradigm of thought that assumes the hegemony of Western culture over non-European cultures and peoples. Cultural domination sets up binaries such as, us vs. them, objectivity vs. subjectivity, superiority vs. inferiority, rational knowledge vs. others' knowledge (Said, 1979). The issue at stake – production of knowledge derived from Newtonian thinking – is privileged and has pervasive effects on other cultures. For non-Western peoples, whose processes of knowing and discovering are not rooted in the Enlightenment values of rationality and objectivity, the empirical reality differs. Therefore, postcolonialism is directed at uncovering the exclusionary effects of dominant ideologies in Othering subjugated[37] knowledge. Bhabha (1994) further extends Said's notion of colonialism and postcolonialism:

> Postcoloniality, for its part, is a salutary reminder of the persistent "neo-colonial" relations within the "new" world order and the multinational division of labour. Such a perspective enables the authentication of histories of exploitation and the evolution of strategies of resistance. (p. 6)

Bhabha points to the failure of capitalism and class, in documenting the intersectionality of the social world with historical, political, economic, and cultural factors where racism, sexism,

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[37] I refer to Spivak (1988) in defining *subjugated* knowledge as *subaltern knowledges* that were muted by the epistemic violence of colonization.

and classisms have an impact on the health of people of the South. Quayson (2000) acknowledges the complexities of postcolonialism and suggests this definition:

> A possible working definition for postcolonialism it that it involves a studied engagement with the experience of colonialism and its past and present effects, both at the local level of ex-colonial societies as well as at the level of more general global developments thought to be the after-effects of empires. Postcolonialism often also involves the discussion of experiences of various kinds, such as those of slavery, place, and the responses to the discourses of imperial Europe. (p. 2)

For Quayson (2000), the central feature of postcolonialism is to focus on dominant discourses and ideologies that shape the social world and to look at the material effects of subjugation[38]. More succinctly, some authors argue that postcolonialism is a means to address social inequalities in a world marked by economic globalization and social structural factors that perpetuate social injustice under the forms of neocolonial ideologies (Bhabha, 1994; Quayson, 2000). Other postcolonial scholars insist on using postcolonialism to deconstruct the hegemony of Western science and redirect scientific endeavours to revisit the dehumanization of non-Western peoples. Postcolonialism deconstructs the universalizing discourses drawn from hegemonic scientific methodologies and methods by pointing to the effects of colonialism in representing people of the South as subalterns (Gandhi, 1998; Mohanty, 1988; Spivak, 1988; Tuhiwai Smith, 1999).

From these authors' perspectives, postcolonialism cannot be conceptualized as a single theoretical entity but instead as a set of ontological and epistemological assumptions used to allow the disenfranchised knowledge of people of the South to be heard. For instance, postcolonialism can be defined as a discursive practice of political resistance and identity affirmation (Bhabha, 1994; Said, 1979; Spivak, 1988) used to voice subjugated knowledge. Postcolonialism can also be seen as a strategy of deconstruction (Gandhi, 1998; Mohanty, 1988),

[38] Subjugation is the process by which imperialism and colonialism impose a condition of positional superiority over the colonized (Said, 2000).

a theoretical and methodological process (Quayson, 2000; Tuhiwai Smith, 1999) by which social inequalities perpetuated by postcolonial practices, are uncovered.

How can we bridge postcolonial theory and process? The process is to ground in the reality of our contemporary world phenomena like immigration, unemployment, or health services, to unmask the interrelations of these phenomena with new colonial ideologies. In using postcolonial theory, the aim is to "relate modern-day phenomena to their explicit, implicit, or even potential relations to this fraught heritage" [colonialism] (Quayson, 2000, p. 11). Furthermore, postcolonialism suggests revisiting the assumptions of Western science to decolonize, as Tuhiwai Smith (1999) puts it, methodologies and methods.

In the next section, I define postcolonial feminism and I present the theoretical strengths of using this framework to guide the exploration of Haitian Canadian caregivers' ways of caring for an aging relative at home, while examining the effects of colonialism on the shaping of health policies and home care services.

Defining Postcolonial Feminism

I draw on Anderson (2000a,b), Meleis and Im (1999), Quayson (2000), Schutte (2000), and Smith (1987), to define postcolonial feminism as a critical perspective aimed at addressing health problems stemming from social inequities that impact on non-Western peoples' well-being. More precisely, postcolonial feminism is aimed at disrupting the relations of ruling that silence the culturally different Other voices; at integrating subjugated knowledge in nursing theorization; at unveiling asymmetrical power relations that pervade client/professional health encounter; and at developing transformative knowledge directed at achieving social justice by correcting health inequities arising from social discrepancies affecting people of the South (Racine, 2003).

Anderson (2000b) urges nurses to hear the silenced subaltern voices as a means to generate transformative knowledge that will, in turn, call for the implementation of social actions

to democratize the health care system and improve the quality of care. Meleis and Im (1999) assert that despite the usefulness of nursing cultural theories in understanding immigrants' health beliefs and practices, the extent to which health care experiences have been "stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around" (p. 95) needs to be questioned. To this end, postcolonial feminism explores oppression from a broader theoretical platform to assess how subordination is intertwined with patriarchy, traditionalism, and modernity in affecting the everyday lives of people of the South. The key point is that postcolonial feminist epistemology not only focuses on patriarchy as a source of oppression, but also examines how social inequalities are located and constructed within a political, historical, cultural, and economic context, since facts cannot be studied out of these realities (Quayson, 2000).

In using a postcolonial feminist perspective, nurse researchers integrate the knowledge of people of the South to look at health problems differently, to "give a voice to racialized women who have been silenced, and provide the analytic lens to examine how politics and history have variously positioned us, and shaped our lives, knowledges, opportunities, and choices"(Anderson, 2000b, p. 145). The purpose is to counteract the hegemonic practices of Western science in marginalizing other forms of knowledge.

Nevertheless, Spivak (1988) cogently points out that subalterns must speak for themselves, instead of relying on Western intellectuals to speak for them. Can Western academics speak for the subalterns, without misrepresenting them? McLaren (1992) argues that if researchers engage in academic decolonization, a process described as a critical way of unlearning accepted ways of thinking and of refusing to analyze subalterns in the mode of the dominator, the concerns of the subalterns can then be conveyed. Researchers of the dominant group must recognize that Whiteness is associated with privileged social locations. Roman (1993) points out that "institutionalized whiteness confers upon Whites (both individually and

collectively) cultural, political, and economic power" (p. 72). As well, Alcoff (1991) urges researchers to examine their social location since they speak from a particular embodied position that cannot be erased in the inquiry.

To hear the subaltern voices, nurses need to question their everyday practice to see how health care programs have an impact on the health of people of the South. Nurses also need to reflect on the impact of imposing their cultural and biomedical interpretative frameworks on health and illness (Anderson, 2000a; Dyck & Kearns, 1995; Good, 1994; Papps & Ramsden, 1996). Negative racial stereotypes underlying culturally unsafe[39] nursing practices and their deleterious effects on the health of Aboriginals of New Zealand and Canada have been documented (Browne & Smye, 2002; Dyck & Kearns, 1995; Maeda Allman, 1992; Papps & Ramsden, 1996; Polaschek, 1998; Reimer et al., 2002; Smye & Browne, 2002).

Tang and Anderson (1999) suggest re-writing nursing professional practice by engaging practitioners in a reflexive process, to understand people's lived experiences from a broader social and cultural context, and to examine the effects of power in encounters between clients and health care providers. Postcolonial feminism is a means to grasp cultural differences by decentering knowledge production from the academy to the margins of the society. It is from the margins that culturally different Others' voices can be heard and understood – not from a centered position – also defined as the culturally dominant position. Decentering is a means for researchers to let groups that have been marginalized express their standpoints on the health or social issues that have an impact on their everyday lives.

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[39] The concept of cultural safety underlines the need for dominant health practitioners to examine, as Dyck and Kearns (1995) put it, "their own cultural realities and the attitudes they bring to their practices" (p. 141). For a fuller discussion of the concept of cultural safety, its methodological implications in nursing research, and its application to multicultural contexts, see for example, Papps and Ramsden (1996), Polaschek (1998), Browne and Smye (2002), Reimer Kirkham et al. (2002) Smye and Browne (2002), Anderson et al (2003).

Strengths of Postcolonial Feminism

The choice of postcolonial feminism strengthens data collection and analysis since the focus is not only directed at examining gender discrimination but at unmasking the interlocking system of oppression composed by race, gender, ethnicity, and social classes. Issues pertaining to gender and race have been debated among postcolonial feminist scholars. Postcolonial feminism addresses problems of representation created by the hegemony of Western feminism in assessing the health and social issues of women of the South. Non-Western feminist scholars point out that marginalization and ghettoization have become the outcomes of the White, middle-class Western feminist discourse. Non-Western feminists argue that subordination comes from different sources that should be explored when examining women's oppression. As Gandhi (1998) mentions:

> Some feminist postcolonial theorists have cogently argued that a blinkered focus on racial politics inevitably elides the "double colonisation" of women under imperial conditions. Such theory postulates the "third-world woman" as victim par excellence – the forgotten casualty of both imperial ideology, and native and foreign patriarchies. (p. 83)

In other words, geographical, cultural, historical, social, religious, and economic factors shape different oppressive contexts for non-Western women. Therefore, Western feminism could be seen as a reductionist, ethnocentric, and Eurocentric discourse where the dominant cultural norms on women's roles are used to derive spurious and universal comparisons on the subjugation of non-Western women. Western and non-Western women do not experience similar sources of oppression and therefore, the generalization of women's oppression must be avoided.

Spivak (1988) suggests that the universal categorization of woman is problematic, especially when oppression is based on Western criteria such as income, skin colour, and gender. "Clearly, if you are poor, Black and female you get it in three ways" (Spivak, 1988, p. 294). Basically, Spivak addresses a critique of Western feminists ways of speaking *for* or *about*

women of the South, in a way that essentializes oppression by drawing on White Western feminist cultural norms, beliefs, and values.

In the same line of thought, Mohanty (1988) argues that the major limitation of the Western feminist explanatory model is to assume that women are "an already constituted, coherent group with identical interests and desires, regardless of class, ethnic, or racial location or contradictions, implies a notion of gender or sexual difference or even patriarchy, (as male dominance—men as a correspondingly coherent group) which can be applied universally and cross-culturally" (p. 55). Thus, 'woman' as a category of analysis cannot be uncritically applied in cross-cultural studies without considering the historical, cultural, and social contexts within which subjugation unfolds. In using Western criteria, White feminists can only contribute to universalize women's experiences in a colonialist and totalizing discourse that freezes the reality of non-Western women – to the point of the inescapable subaltern location. Mohanty (1988) points out "women are constituted as women through the complex interactions between class, culture, religion, and other ideological institutions and frameworks" (p. 63).

Along the same line of thought, African American feminist scholars (Collins, 1989; hooks, 1984; hooks, 1989) emphasize that the White feminist discourse, in essentializing and objectifying experiences of women of Colour, contributed to silencing their voices. The effect was to obfuscate while missing how women of Colour "self-defined their oppression from a different political and economic status" (Collins, 1989, p. 747). Moreover, postcolonial feminism, in joining the strengths of Black feminist thought and postcolonial theory, is aimed at unmasking health and social inequalities arising from colonialism, by unveiling how these issues intersect with race, gender, ethnicity, and social classes. Anderson (2002) states:

> Post-colonialism and black feminism, taken together, shed light on the complex issues at the intersection of gender, race, class relations, and culture, and further our understanding of how material existence, shaped by history, influences health and well-being for those who, in Homi Bhabha's words have 'suffered the sentence of history…[of] diaspora, [and] displacement'. (p. 11)

Postcolonial feminism rejects the hegemony of totalizing and essentialist discourses about non-Western women's oppression. At the ontological and epistemological levels, the multiplicities of the lived experiences or subjectivities are acknowledged from a perspective where cross-cultural comparisons cannot be drawn since geographic, cultural, religious, and social contexts within which sexism, racism, and classism occur are different.

Postcolonial feminism, in studying the whole context of imperialism, colonialism, and oppression related to social inequalities, does not reject men's problems. Therefore, I argue that Haitian Canadian caregivers' ways of caring for an aging relative at home are entangled among ideas of patriarchy, traditionalism, modernism, and neocolonialism. The use of a postcolonial theoretical framework is aimed at understanding the complex interactions of these contextual factors while respecting the distinctiveness of Haitian Canadian caregivers' lived experiences, regardless of their gender. This does not preclude the need to be aware of Haitian Canadian women's conditions.

Summary

Defining postcolonial feminism as a new paradigm of inquiry highlights the inadequacy of other paradigms to properly address issues of racialization, genderization, and colonization in nursing research. Kuhn (1993) describes this tension between tradition and innovation in science as a means to overcome problems that could not be solved with older paradigms. The need to seek new explanatory models for anomalies that are left unexplained by normal science is an antecedent to paradigm shifts or scientific revolutions (Couvalis, 1997). As well, a new paradigm can be seen as a way to *de-orientalize* or deconstruct the binaries introduced in research by Western science and colonialism (Quayson, 2000; Said, 1979).

Postcolonialism is rooted in a reality where people's lived experience cannot be studied out of the historical and social world where they arise and unfold in everyday lives (Quayson, 2000). Applying postcolonialism to nursing cultural research unmasks how Western discourse

essentializes the Other as a unique, crystallized, neutral, rational, and objectivist cultural entity. As well, decolonializing methodologies and methods is directed at disrupting the power relations to voice subjugated knowledge that come from different subjectivities.

In using a postcolonial feminist framework, my intent is to acknowledge Haitian Canadian caregivers' pespective in exploring the reality of caring for aging relatives at home. At the same time, I want to take into account that caring activities unfold in a racialized and gendered world (Anderson & Reimer Kirkham, 1998). Since racism is a part of Canada's history, this points to the need to explore Haitian Canadian caregivers' relations with the health care system by examining the impact of individual, social, and institutional racism on Haitian Canadian caregivers' everyday lives (Anderson & Reimer Kirkham, 1998; Bannerji, 2000; Brown & Brown, 1996; Henry, Tator, Mattis, & Rees, 2000; James, 1996a; James, 1996b; Li, 1990).

The Haitian Canadian caregivers' ways of caring for an aging relative at home are thus historically, socially, and culturally located in the former colonial past of Haiti, the repressive political régimes inherited from the colonizers after Haiti's independence, and the neocolonial practices of the mainstream health care system that may have an impact on the provision of public home care services. Opie (1992) states, "the characteristic features of the colonizer/colonized relationship are clearly replicated in the relationships of health system/informal caregiver and researcher/researched" (p. 55). Therefore, Haitian Canadian caregivers' ways of caring must be explored by keeping in mind the impact of race, gender, social class, and relations of power that pervade the health care system. Moreover, James (1996b) points out that the failure of ethnic groups to use health and social services in Canada are constrained by the environment:

> In an economically, ethnically, and racially stratified society like ours, individuals' inability to gain access to, and receive, services that address their particular needs and expectations is not merely a result of their failure to take advantage of available services. Rather, it is in part, a consequence of the structural barriers that are inherent in society. (p. 3)

In choosing critical ethnography as a qualitative method to explore and understand the Haitian Canadian primary caregivers' ways of caring for an aging relative at home and to examine the contextual factors that might impinge on caregivers' access to home care services, the research questions were answered. The rationale underlying the choice of critical ethnography is presented in the next chapter, where the methodology and methods used to explore the problem and the research questions, are described.

CHAPTER FOUR
METHODOLOGY AND METHODS

Introduction

In this chapter, the rationale is provided for the choice of a qualitative design inspired by critical[40] ethnography. Sampling strategies and methods used to collect data such as interviewing, participant observation, and writing of fieldnotes are also delineated. Methodological issues faced during fieldwork are described and explained and finally, issues of trustworthiness, ethical concerns, the process of data analysis, and limitations of the study are discussed.

The choice of a qualitative approach is relevant when considering the exploratory nature of the research. The study was aimed at understanding the Haitian Canadian caregivers' ways of caring for an aging relative at home and at exploring how caregivers relate to public home care services. The scarcity of knowledge in nursing cultural research in Quebec also guided the choice of a qualitative inquiry. Finally, this option is congruent with the postcolonial feminist theoretical perspective used to inform this research. Postcolonial feminism provides the epistemological platform for addressing the health problems arising from social inequities in the health care system. Methodology and methods were directed at exploring issues that are located where caring, race, gender, and social classes intersect to impact on the Haitian Canadian caregivers' everyday lives. Methods were also aimed at examining how caring is embedded in multi-layered contexts where historical, economic, political, social, and cultural elements have an impact on caring activities and caregivers' utilization of home care services. Therefore,

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[40] I draw on Denzin and Lincoln (2000) to define the term critical as referring to the set of critical interpretative paradigms, like feminisms, Marxism, poststructuralism, postmodernism, and postcolonialism. These paradigms are rooted in a materialist and realist ontology, implying that "the real world makes a material difference in terms of race, class, and gender" (p. 21). I am not referring to the Frankfurt School's notion of critical social theory but locate this research within the broader set of critical theories that has flourished since World War II (Kincheloe & McLaren, 1994). The aim of the study is not to raise people's consciousness since it would represent Western cultural imposition. A cultural imposition would violate the ontological and epistemological postcolonial feminist assumptions since disenfranchised knowledge has to be voiced and incorporated in theorization endeavours.

caregivers' experiences represent legitimate sources of knowledge and nursing theorization (Anderson, 1991b; Anderson, 2000a; Anderson, 2002; Collins, 1989; Meleis & Im, 1998; Reimer Kirkham & Anderson, 2002; Smith, 1987).

Defining Qualitative Research

Morse and Field (1995) state that qualitative research is aimed at making sense of reality, to describe the social world and develop explanatory models and theories. Leininger (1985) mentions that qualitative research is directed at observing, documenting, analyzing, and interpreting attributes, characteristics, and meanings of the phenomenon under study. Qualitative inquiry documents people's lives, experiences, emotions, feelings, and behaviours, locating these events in a larger social and cultural context (Smith, 1987; Strauss & Corbin, 1998). Denzin and Lincoln (1994) point out that the complexities and tensions of qualitative research cannot be captured in a single definitive statement, and put forward an overarching definition where "qualitative research is many things to many people. Its essence is twofold: a commitment to some version of the naturalistic, interpretative approach to its subject matter and an ongoing critique of the politics and methods of postpositivism" (Denzin & Lincoln, 2000, p. 8).

Qualitative research is guided by multiple traditions of research, each of which conveys its tensions and competing views. Traditions of research are the paradigms from which ontological beliefs on the nature of scientific reality, epistemological assumptions on the kind of knowledge to be developed, and the methods used to generate this knowledge are defined (Gubrium & Holstein, 1997). "Method connotes a manner of viewing and talking about reality as much as it specifies technique and procedure" (Gubrium & Holstein, 1997, p. 5).

Paradigms are social constructions that cannot be dichotomized into being true or false, or good or bad because they are inherently human constructions; therefore, no paradigm can be said to overthrow others. Guba and Lincoln (1994) state, "no construction is, or can be, incontrovertibly right; advocates of any particular construction must rely on persuasiveness and

utility rather than proof in arguing their positions" (p.108). The choice of methods is determined by the nature of the problem, research questions, and researcher's worldview. Denzin and Lincoln (1994) assert that positionality or sociocultural locations influence the researcher's choices. They state: "the gendered, multiculturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways" (Denzin & Lincoln, 1994, p. 11).

Like Clifford, my beliefs in viewing reality as being represented in a mosaic of partial truths (Clifford, 1986), in acknowledging the legitimacy of marginalized knowledge as a source of theorization, and in recognizing people as experts of their lived experiences, explain my choice of critical ethnography. I conceptualize research as a means of social activism to challenge dominant ideologies and achieve social justice in the health care system. In this research, I am entering into what Denzin and Lincoln (2000) call the 'seventh' moment of qualitative research where "writers seek to connect their writings to the needs of a free democratic society" (p. 17).

Contrasting Positivist and Critical Ethnography

Ethnography, derived from the discipline of anthropology, is one of the oldest methodologies of research. At the beginning of the 20th century, under the influence of modern anthropologists, ethnography was recognized as a scientific method. These anthropologists were committed to raising anthropology to the rank of a scientific discipline by relying on natural or physical sciences, as a blueprint for ethnographic research. In the 1930's, John Dewey and George Herbert Mead, of the Chicago School of Sociology, challenged this modern view of anthropology (Denzin & Lincoln, 1994). Influenced by German historicism and pragmatism, anthropology and ethnography were defined as being more akin to the humanities because of their domain of inquiry. This multiparadigmatic nature of ethnography reflects the historical

evolution of anthropology over the years (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 1995). For instance, Clifford (1986) mentions the influence of critical social theories, feminism, poststructuralism, and postmodernism in expanding the scope of ethnographic research. Under the influence of postcolonial and Black feminist scholars, postcolonialism provides new impetus to ethnographic research. Postcolonial theories inform research that is aimed at uncovering the impact of colonialism and neocolonialism on people's lives and deconstructing how race, gender, and social class have been essentialized, in positivist ethnographies (Denzin & Lincoln, 2000; Hall, 1994). Denzin and Lincoln (2000) mention that "class, race, gender, and ethnicity shape the process of inquiry, making research a multicultural process" (p. 18).

For postcolonial scholars, Eurocentrist ethnography represents a colonialist methodology that only contributed to obfuscate the voices of culturally different Others. Western science, by imposing its ontological and epistemological standards, defines culturally different Others as being passive subjects – in the same way as did Western[41] colonizers, by imposing their social, cultural, and racial stereotypes on the colonized (Minh-ha, 1989; Said, 1979;Tuhiwai Smith, 1999). Tuhiwai Smith (1999), a Maori scholar, argues that research is the process by which the imperialism of Western science is legitimized and regulated through academia by scholarly disciplines and paradigms of inquiry that have been used to dehumanize non-Western cultures. She states:

> Although many indigenous writers would nominate anthropology as representative of all that is truly bad about research, it is not my intention to single out one discipline over another as representative of what research has done to indigenous peoples. I argue that, in their foundations, Western disciplines are as much implicated in the study of us into "their" science, others were employed in the practices of imperialism in less direct but far more devastating ways. (p.11)

[41] The word Western is used to describe pluralist societies including former European colonial powers and some of their former colonies, where discriminative immigration policies were used to constrain entry of settlers of Colour (Anderson & Reimer Kirkham, 1998; Grace & Helms, 1998). For a fuller discussion on Canada's immigration policy, see for example, the history of South Asian immigration on the West Coast (Grace & Helms, 1998).

In other words, Tuhiwai Smith (1999) refers to the process of *Orientalization*, first coined by Said (1979), to describe ways by which Western science established its epistemological hegemony over the non-Western world -- silencing non-Western voices in textual accounts or narratives. The epistemological imperialism contributed to essentialize the culturally different Others, in marginalized or subjugated identities.

Exploring Definitions of Ethnography

Ethnography is a method by which researchers are immersed, for a certain amount of time, in a natural setting to share participants' lives, observe social events and behaviours, ask questions, and document a research problem (Hammersley & Atkinson, 1995). Fetterman (1998) defines ethnography as the "art and science of describing a group or culture. The description may be of a small *tribal group in some exotic land* [italics added] or a classroom in middle-class suburbia" (p. 473). According to Spradley (1979), ethnography represents "the work of describing a culture. The essential core of this activity is to understand another way of life from the *native* [italics added] point of view" (p. 3). For Clifford (1986), ethnography is "actively situated between powerful systems of meaning. It poses its questions at the boundaries of civilizations, cultures, classes, races, and genders. Ethnography decodes and recodes, telling the grounds of collective order and diversity, inclusion and exclusion. It describes processes of innovation and structuration and is itself part of these processes" (p. 2). Consequently, ethnography is a discursive act of writing, inscribing, and representing cultures where power and history come into play to model the fragmented character of truth or as Clifford (1986) puts it, the partial truths. Clifford (1986) draws on Nietzsche in defining scientific truth as a social construct made of selective ontological, epistemological, and methodological premises since "all constructed truths are made possible by powerful "lies" of exclusion and rhetoric" (Clifford, 1986, p. 7). This explains why ethnographic truth can never be fully achieved but remains partial and committed. It points to examining whose truth was represented in positivist ethnographies.

Minh-ha (1989) contends that positivist ethnography represents a discourse of power, used to marginalize, stereotype, and misrepresent non-Western populations. Minh-ha (1989) underlines that "power, as unveiled by numerous contemporary writings, has always inscribed itself in language. Speaking, writing, and discoursing are not mere acts of communication; they are above all acts of compulsion" (p. 52). In the same line of thought, hooks (1990) emphasizes the double impact of whiteness and *maleness* in shaping the authorative discourse of ethnography, linking ethnography, race, gender, and ethnicity. hooks (1990) critiques Clifford and Marcus' book, *Writing Culture. The Poetics and Politics of Ethnography*. On the book's cover, a picture of Stephen Tyler doing fieldwork in India is shown. hooks (1990) comments about Tyler's photograph:

> As a script, this cover does not present any radical challenge to past constructions. It blatantly calls attention to two ideas that are quite fresh in the racist imagination: the notion of the white male as writer/authority, presented in the photograph, actively producing, and the idea of the passive brown/black man who is doing nothing, merely looking on. (p. 127)

This positivist stance has been widely used to guide ethnographic research in the discipline of nursing.

Ethnography and Nursing Research

Leininger (1985) defines ethnography as "the systematic process of observing, detailing, describing, documenting, and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment" (p. 35). Inspired from the same paradigm, Aamodt (1991) contends that ethnography is "a way of collecting, describing, and analyzing the ways in which human beings categorize the meaning of their world...within the context of their culturally constituted environment" (p. 41). Muecke (1994) asserts that ethnography is a "written description of a people that focuses on selected aspects of how they lead their routine, remarkable, and ritual lives with each other in their environment, and of the beliefs and customs that comprise their common sense about their

world" (p. 189-190). Finally, Morse and Field (1995) define ethnography as "a means of gaining access to the health beliefs and practices of a culture and allows the observer to view phenomena in the context in which they occur, thus facilitating our understanding of health and illness behavior" (p. 26).

This collection of definitions demonstrates how positivism and postpositivism has inspired the development of cultural theories, which in turn, have influenced ways of doing ethnography in nursing. Stuart Hall (1994) argues that the drawback of culturalist frameworks is to isolate culture from the larger social system, thereby stripping social facts of their contextual meanings to translate them in a transhistorical and universal way. Hall (1994) points out that "culture is not a practice nor is it simply the descriptive sum of the 'mores and folkways' of societies" (p. 523). Some ethnographers, concerned with the connections between truth, modernity, representation, and power, questioned the validity of narratives that perpetuate the hegemony of naive empiricism. Alternative or competing worldviews consist of democratizing knowledge development, to use research as a means of social activism, and are aimed at addressing social injustice arising from dominant ideological, political, and socio-cultural systems (Anderson, 2000b; Anderson 2002; Brodkey, 1996; Crehan, 2002; Denzin & Lincoln, 2000; Hoare & Nowell Smith, 1999; Lather, 1991; Rabinow, 1986; Roman & Apple, 1990).

Defining Critical Ethnography

Critical ethnography is directed at unmasking hidden political and social agendas to challenge the status quo and induce social changes (Anderson, 1989; Brodkey, 1996; Carspecken, 1996; Kincheloe & McLaren, 1994; Quantz, 1992; Thomas, 1993). Thomas (1993) defines critical ethnography as "the reflective process of choosing between conceptual alternatives and making value-laden judgments of meaning and method to challenge research, policy, and other forms of human activity" (p. 4). Although critical ethnography shares the methodological roots of other ethnographies (Quantz, 1992), its major distinction lies in the fact

that research becomes a means of developing transformative knowledge. First, critical ethnography is aimed at addressing the ways in which participants may be constructed as marginal and subordinate. Giroux (as cited in Quantz, 1992) explains:

> In the critical tradition, culture is analyzed, not simply as a way of life, but also as a form of production that always involves asymmetrical relations of power, and through which different groups in their dominant and subordinate positions struggle to both define and realize their aspirations. (p. 487)

The second goal is to unmask social structures where race, gender, and social classes come into play as an interlocking system of oppression. A third aim is for critical ethnography to be directed at inducing and sustaining social transformations (Anderson, 1989). The fourth objective consists of unmasking asymmetrical relations and social inequities, to generate transformative knowledge, and achieve social justice (Anderson, 2000a; Anderson, 2002; Brodkey, 1996). Therefore, critical ethnography addresses the relationships between history, freedom, democracy, and representation. These issues are not emphasized in conventional ethnography. Kincheloe and McLaren (1994) point out that critical ethnography's "hermeneutical task is to call into question the social and cultural conditioning of human activity and the prevailing sociopolitical structures" (p. 153). Carspecken (1996) contends that critical ethnography is directed at addressing social inequities to bring about constructive social changes. He underlines that criticalists[42] deal with "the nature of social structure, power, culture, and human agency. We use our research, in fact, to refine social theory rather than merely to describe social life" (Carspecken, 1996, p. 3).

In choosing critical ethnography for this study, fieldwork was directed at obtaining a thick description of Haitian Canadian caregivers' ways of caring for aging relatives at home

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[42] I draw on the work of Schutte (2000) to define *postcolonial feminisms* [italics added] as critical approaches directed at addressing health problems stemming from social inequities in the health care system. Health and social issues intersect with race, gender, social classes, and ethnicity, to have an impact on immigrants and refugees of the South, as well as on the utilization of health care services in Western pluralist societies like Australia, Canada, the UK, New Zealand, and the US.

along with observing interactions and communication with home care nurses. The aim was to delineate the contextual factors impinging on the utilization or non-utilization of home care services. Critical ethnography transcends the descriptive stage of conventional ethnography, to examine how Canada's two founding peoples dominate the ideologies on biomedicine, caring, and the aging model of home care services. This ideological hegemony has an impact on Haitian Canadian caregivers' perceptions of mainstream's francophone visiting nurses.

At this point, it is useful to be reminded of the research questions, since Kaufman (1994) points out that research questions delineate what was studied and how the phenomenon was examined. The research questions were: 1) What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? and, 2) What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? I now turn to examine postcolonial feminist methodological underpinnings and how they were articulated with critical ethnography to guide the study.

Articulating Critical Ethnography and Postcolonial Feminism

Moccia (1988) contends that the selection of a research design is not a technical choice but one that represents an ethical, ideological, and political activity. Fundamentally, this choice represents the researcher's values on the philosophy of science and the production of knowledge. As Moccia (1988) puts it:

> The choice between methods has meaning and implications beyond the technical. It is a choice between an open-system and a closed-system view of the world; between knowledge that is legitimately sought and developed for inclusion in nursing science and that which is not legitimate; between definitions of science as a force for change or as a defense of the status quo; and between a nursing practice that hopes to predict and control phenomena and that which attempts to understand and explain them. (p. 3)

A postcolonial feminist perspective focuses on the intersection of race, gender, social class, and the larger social system in modeling the Haitian Canadian caregivers' everyday experiences of caring for an aging relative at home. Smith (1987) reminds us that people's

everyday world is problematic since it is directed by invisible relations of ruling. Relations of ruling reflect the mainstream ethnic group ideologies, values, and beliefs that have disenfranchised minority groups by imposing the agenda of the dominant classes in shaping the health care system and home care services. Therefore, a critical ethnography informed by postcolonial feminism addresses ways of caring from the standpoint of caregivers, to unmask the disciplining discourses and practices of the health care system. A postcolonial feminist ethnography also addresses how these relations of ruling have an impact on Haitian Canadian caregivers' everyday caring activities.

Postcolonial feminism points to shifting our theoretical lens to understand how caring experiences are culturally, socially, and historically constructed in a gendered and racialized society (Anderson & Reimer Kirkham, 1998). Postcolonial feminism provides the critical[43] epistemological platform to explore health problems arising from issues of race, gender, and class inequities, that intersect with historical, economic, political, social, and cultural factors among non-Western populations. Applying postcolonial feminism to critical ethnography unpacks the reductionist Western discourse of essentializing the 'Other' as a unique, crystallized, neutral, rational, and objective cultural entity. As well, the *decolonizing* of methodologies and methods is directed at disrupting the power relations to voice subjugated knowledge. Postcolonial feminism unmasks the complexities of Haitian Canadian caregivers' multiple subjectivities enmeshed in historical and social contexts.

Therefore, postcolonial feminism can be articulated to critical ethnography to unpack these subjectivities located at the intersection of race, gender, and social classes that combine as interlocking systems of oppression on Haitian Canadian caregivers' ways of caring. Ways of

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[43] Kincheloe and McLaren (1994) mention that a critical researcher "attempts to use her or his work as a form of social or cultural criticism and who accepts certain basic assumptions: that all thought is fundamentally mediated by power relations that are socially and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription;... that certain groups in any society are

caring can be seen as experiences of marginalization that may be uncovered by using a postcolonial feminist perspective to guide critical ethnography. I now detail this postcolonial feminist approach by examining the feminist methods and methodological assumptions of this research.

Feminist Methods

The question of method is not without its problem in feminist research. Harding (1995) advocates for the pluralism of methods, where both qualitative and quantitative methods, can be used in feminist research. Although supremacy of one method does not exist, other authors (Farganis, 1986; Klein, 1983; Opie, 1992) argue that qualitative methods might better fit feminist methodological assumptions.

Guba and Lincoln (1994) mention that the question of method is secondary to the question of paradigm. The crux of the problem is the way by which methods have been used over the years by Western male researchers to seek evidence on women and how the findings were interpreted to oppress women and other underserved groups. Klein (1983) points out:

> An important goal of all feminist scholarship should be to contribute to ending the oppression of women. I think that methods which are "context-stripping", unconscious of inherent masculinist biases, and which rely on sexist "feminine/masculine" gender stereotypes are not suited for research on how women (and men!) in today's society come into being, come into holding the views they hold. (p. 93)

Harding (1995) raised the issue of the 'fetishization of method itself'. For Harding (1995), praxis and emancipation are ultimate goals of feminist research and these objectives should drive the methodology, without using androcentric ways of collecting data to increase the participants' oppression. Some authors underline the oppressive nature of feminist qualitative methods (Opie, 1992; Thorne & Varcoe, 1998).

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privileged over others; ... that oppression has many faces, and that focusing on only one at the expense of others often elides the interconnections among them" (p. 139-140).

Thorne and Varcoe (1998) state that the adherence to "absolute methodological claims" in studying women's health is not a good strategy. They argue in favour of adopting a "moderate realism that balances absolute claims in the postmodern context and a respect for individual subjective reality that balances ideological primacy within critical social theory" (p. 491). Their point is to depolarize the debate in establishing a consensus between realism and relativism. In adopting a moderate realism position in feminist cultural studies in nursing, a risk is present to maintain the status quo, obfuscate racism and classism, give primacy to universal truths over particularistic truths, and reframe problems in ways that will replicate power relations and oppression. Rather, I suggest adopting participants' standpoint to address the complexities of non-Western populations' health as a valuable alternative to 'knowing' and 'theorizing' differently, in integrating subjugated knowledge. This perspective can be articulated and implemented in cultural nursing research by using a postcolonial lens to examine health inequities stemming from social discrepancies in the health care system.

Postcolonial Feminist Assumptions

The challenge in implementing postcolonial feminism in nursing research is to avoid marginalizing people of the South by "usurping the meanings and producing ideologically disfiguring effects" (McLaren 1992, p. 78). In relying on some methodological assumptions, the pitfalls of essentialism can be avoided (Reimer Kirkham & Anderson, 2002; Reimer Kirkham et al., 2002), and the risk of re-inscribing the culturally different Other into new hegemonic discourses can be minimized.

I draw on two fundamental postcolonial feminist assumptions to underpin this study. The first assumption consists of critiquing the practices of the dominant culture by relying on marginalized knowledge. "The process of critique is turned against the domination and exploitation of culturally differentiated others" (Schutte, 2000, p. 59). This assumption is also derived from the concept of cultural safety that implies, as Polaschek (1998) puts it, the need to

move beyond cultural theories to examine structural elements by which nursing practice "diminishes, demeans, or disempowers the cultural identity and well-being of an individual" (p. 453).

On the other hand, Papps and Ramsden (1996) define cultural safety as "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on her/his own cultural identity and recognizes the impact of the nurses' culture on her/his own nursing practice" (p. 491). Cultural safety deals with racism since negative stereotypes impinge on the quality of nursing care. Notions of cultural sensitivity and cultural awareness derived from culturalist theories are not sufficient to provide culturally safe nursing care since the relationships between colonialism, neocolonialism, dominant ideologies, and nursing practice are either underestimated, overlooked, or left aside (Papps & Ramsden, 1996).

The second assumption consists of exploring dominant ideologies that underpin home care services and how these relations of ruling have an impact on the accessibility to home care services. The research process is directed at allowing Haitian Canadian primary caregivers to share experiences of the everyday world from their perspectives, located at the margins of knowledge production. The voicing of Haitian Canadian primary caregivers' knowledge on caring is aimed at unmasking dominant ideologies in the shaping of the health care system and home care programs. To this end, the researcher moves beyond the individual and family contexts, to explore and understand caring from its *micro, meso*, and *macro* levels of complexities or its multi-layered construct (Reimer Kirkham & Anderson, 2002).

I argue that caring is structured by interlocking systems of oppression or power that create inequities in the access of home care services. Therefore, postcolonial feminist epistemology represents a critical perspective from which "access to the everyday experiences of marginalization, as structured by the micropolitics of power and the macrodynamics of a structural and historical nature" (Reimer Kirkham & Anderson, 2002, p. 2) is allowed. Applying

these two assumptions to this research are the means by which Haitian Canadian caregivers' subjugated voices are to be heard and understood – otherwise, the inquiry does not influence nursing practice and fails to challenge the status quo. Keeping in mind feminist assumptions, intensive reflexivity is required when it comes to negotiating entry into the field, to equalize power differentials in interviewing and participant observation, and to understand the researcher's own racial biases.

Reflexivity

A feminist paradigm assumes a dialectical[44] epistemology that starts with data collection. The process of self-reflexivity represents a key issue in feminist methodology. Reflexivity is the means by which the researcher becomes aware that research is a power relation *per se*. In becoming conscious of this issue of power asymmetry, the researcher attempts to equalize this imbalance of power by respecting people's ways of sharing information. In this process of self-reflexivity, the feminist researcher must also be aware of her or his personal, social, economic, ethnic, gendered, and cultural background to *democratize* inquiry.

Harding (1995) defines self-reflexivity as a process by which the researcher becomes a part of the research in assessing her or his social class, gender, race, and culture assumptions, as well as beliefs and behaviours. The researcher is embodied in the process as an individual with a historical story possessing concrete desires and interests. For Lather (1991), reflexivity is a process by which the researcher develops self-critique skills to avoid theoretical imposition and to respect the dialogic exchange with participants in generating knowledge. Self-reflexivity makes the researcher visible in the process of inquiry as a real, historical individual, having her or his own interests (Harding, 1995), instead of being an anonymous figure of authority. Self-reflexivity entails that non-exploitative relations must be established between researcher and

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[44] A dialectical methodology is established, as Lather (1991) puts it, "through dialogue [with participants] and reflexivity, design, data and theory emerge, with data being recognized as generated from people in a relationship" (p. 72).

participants from the beginning of the research process (Ristock & Pennel, 1996). The discussion now turns to examine the practical steps by which the study was designed, implemented, and conducted.

Negotiating the Field

Negotiating Entry into the Field

Negotiating entry into the field was the most critical part of the research since without accessing caregivers, the research would not have been possible. I formed an entire network of CLSCs home care managers, Haitian community leaders, and key informants, to reach Haitian Canadian primary caregivers. Hammersley and Atkinson (1995) cogently mention that negotiating entry is not limited to requesting authorization, but also implies from whom the authorization must be requested. As well, negotiating entry into the field is a core issue in ethnographic research and required that I build my credibility and establish confidence in the community.

Preliminary contacts were made one year prior to starting the fieldwork. In August 1999, I contacted three CLSCs home care managers and informed them of my research project. These CLSCs were located in neighbourhoods where demographic data show a high proportion of Haitian Canadians living in these areas. I received a positive answer from one of these CLSCs and met the home managers to discuss the feasibility of the study. I could not meet with other home care managers since their availability was restricted due to summer vacations and nurses' job actions that were being held across the province. At the meeting with the home care managers, I was told that 30 participants could easily be reached by relying on the home care services list. At that time, the inclusion criteria were not straightforwardly defined but were later delineated when I defended the project. Throughout the academic year 1999-2000, I kept the home care managers informed of the progress in my coursework. In mid-November 2000, I started fieldwork at CLSC Site 1 where it soon became clear that fieldwork is not a linear

process. In January 2001, I negotiated access at CLSC Site 2 due to volunteers' recruitment problems and in May 2001, I contacted CLSC Site 3 for the same reason. At the same time, I contacted numerous Haitian Canadian organizations and developed contacts with four key informants to work out the issue of the lack of participants. In the following eight months, I established my credibility and crafted trusting relationships with the community leaders and key informants. Gaining the trust of key informants is mandatory before accessing potential participants since they will decide whether or not to recommend participating in the study. The key informants then contacted their networks to recruit people who would be interested in participating in the study. One male participant told me: "I accepted to participate in the study because she [the key informant] told me it was important to do so. Otherwise, I would have declined like I had done for a previous research study" (CG03-M).

I am not overemphasizing the importance of respecting members of the Haitian Canadian community by disclosing all the information related to the selection of Haitian Canadian caregivers, purpose of the study, and the potential benefits by participating in the study. Despite intensive recruitment efforts, issues related to lack of participants could be explained by the stringent inclusion criteria that were delineated prior to the start of the study, the lack of nurses' time for getting involved in recruitment endeavours, the effect of illegal immigration, and the lack of financial resources needed to hire a Creole interpreter.

Sampling Strategy

The goal of the sampling strategy was to select participants to get rich and detailed information. Purposeful samples are aimed to provide an understanding of the phenomenon under study by selecting people who know and preferably have experience with the research topic (Morse, 1991; Morse & Field, 1995; Patton, 1990; Sandelowski, 1995a). In this study, sampling was aimed at finding participants to help answer two research questions to understand ways of caring for an aging relative at home among Haitian Canadian primary caregivers who

were, or were not receiving home care services at the time of the study, regardless of their gender. Patton (1990) defines this sampling strategy as maximum variation sampling, where the researcher expects to grasp differences between the two groups concerning their decision on whether or not to rely on home care services. Sandelowski (1995a) also stresses that sampling is directed at increasing validity of the research findings.

Qualitative Sample Size

The hallmark of qualitative sampling is to select participants, events, and observations that will contribute to the understanding of a phenomenon. In other words, the features of qualitative inquiry do not require the researcher to have a large sample size since it is not generalizability, but the in-depth understanding of a phenomenon that is the issue. "The qualitative researcher must characteristically think purposively and conceptually about sampling" (Huberman & Miles, 1998, p. 204). Sandelowski (1995a) also underlines that qualitative sampling is theoretically driven and that sample size must be assessed with regard to the goals of the study:

> An adequate sample size in qualitative research is one that permits—by virtue of not being too large—the deep, case-oriented analysis that is the hallmark of all qualitative inquiry, and that results in—by virtue of not being too small—a new and richly textured understanding of experience. (Sandelowski, 1995a, p. 183)

In this study, the size of the sample is diversified and represents an array of experiences that helped understand the Haitian Canadian primary caregivers' stand on caring for an aging relative at home. The quality of the collected information enabled the answering of the research questions. The first research question was stated as follows: What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? Haitian Canadian primary caregivers and care-receivers were recruited to provide data for the understanding of ways of caring for aging relatives at home. The second research question was related to the contextual factors that have an impact on the utilization of public home care services. The question was thus expressed:

What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? Nurses were recruited to explore the dynamics of home care visits and the relationships between Haitian Canadian primary caregivers and home care nurses. To this end, I observed home care nurse visits to Haitian Canadian primary caregivers' homes as a means to document the contextual factors that might impinge on primary caregivers' utilization of public home care services. Neither the visiting nurses nor the Haitian Canadians' elders were interviewed in this study. On one hand, the study was directed at gaining the primary caregivers' perspectives on caring for aging relatives at home — not at collecting mainstream nurses' perspectives. On the other hand, the choice not to interview the aging persons was motivated by the fact that most of them spoke Creole only. The Haitian Canadian elders' lack of fluency in French, associated with my absolute lack of knowledge of Creole, precluded me from interviewing the aging relatives, which would have threatened data validity. Nevertheless, during the fieldwork, I had many informal talks with some aging persons at the caregivers' homes and during the CLSCs' social activities.

Recruitment Process

Twenty-eight primary caregivers were contacted to participate in the study, but four of them who did not meet the inclusion criteria, were excluded. Of the remaining twenty-four potential caregivers, sixteen primary caregivers agreed to participate in the study. Of these 16 primary caregivers, Haitian Canadian organizations, and key informants referred a total of 11 caregivers. Altogether the three CLSCs accounted for five referrals. One CLSC did not provide any referrals and the home care managers acknowledged the difficulties they encountered in trying to reach the Haitian Canadian community living in their territory. Home care managers also reported issues related to home care nurses who lacked the time to participate in caregivers' recruitment. A home care manager told me that nurses were too busy, almost all in burnout, and struggling to provide services to their clients. Another manager raised the issue of illegal

immigration, which impinges on the abilities of the CLSC to reach caregivers and the elderly, within their territory. Since CLSCs are official governmental bodies, illegal immigrants do not request health care services from these facilities, due to the fear of being deported. These issues, coupled with the fact that few Haitian Canadian primary caregivers rely on formal home care services, shed some light on the recruitment of volunteers. Other methodological issues, like the application of stringent criteria of inclusion in a community that is already acknowledged in the literature as being difficult to reach, and the lack of financial resources to hire an interpreter, also contributed to the difficult recruiting conditions. Recruitment issues and the under-utilization of home care services explained why the sample was unevenly split between five primary caregivers who were receiving home cares services, and eleven others who were not receiving home care services. In the next section, I detail the roles played by key informants in the study and provide descriptive statistics for the primary caregivers, care-receivers, and visiting nurses.

Description of the Sample

The sample was composed of 39 informants, 16 of whom were primary caregivers, 19 were care-receivers, and 4 were home care nurses. Four key informants participated in the study and were involved in all its stages, in particular, contributing to participants' recruitment. Leininger (1985) underlines that key informants are recognized as community experts since they are cognizant about the culture and domain of inquiry. All key informants were Haitian-born women aged 37 to 65 years old. To protect confidentiality, additional information will not be disclosed. Three of these women were university graduates and some spoke more than three languages fluently. As well, they knew the host society and how to deal with mainstream society. Of the four key informants, one was also included in the sample of primary caregivers. The others did not meet the inclusion criteria since they were not involved in caring activities at the time of the study. Three of the four key informants were not formally interviewed for the purpose of the study since they were not caregivers. Our discussions were informal and took

place while driving to a place, at a coffee shop, or in their homes or offices. Because they were not tape-recorded, the flow and exchange of information tended to be enhanced. All of these women knew about caring for aging relatives since they were daughters who once cared for their now-deceased parents. While in Vancouver, I kept in touch with two key informants with whom I developed committed relationships, to keep them informed about how the study was unfolding.

In this study, key informants helped to recruit participants by introducing me to their networks or by referring me to other community resources. I identified these key informants in the course of fieldwork. As well, they helped me to navigate my way in doing the fieldwork, acting as cultural brokers. They taught me the importance of being empathetic with aging people. Respecting the older generation, as I learned, is a paramount value in the Haitian culture. The key informants also suggested that I bring a small gift to the aging parent to demonstrate my respect and gratitude for the time they shared with me. Therefore, each primary caregiver and care-receiver was given a small gift such as a hand cream, etc. Caregivers and care-receivers acknowledged this symbolic gesture.

Descriptive Statistics of Caregivers and Care-Receivers Samples

A sample of convenience of 16 primary caregivers was formed, among which 12 were women caregivers. Five inclusion criteria were delineated to provide an in-depth understanding of Haitian Canadian caregivers' ways of caring. Inclusion criteria for primary caregivers were 1) agreeing to participate in the study, 2) speaking English or French fluently, 3) being committed intensively in caring for an aging relative at home, 4) born in Haiti, and 5) currently enrolled with home care services or having been in contact within the last three months. Three CLSCs, Haitian organizations, women's and Golden Age centres were contacted (see Appendixes A and B for advertisement forms). Both Haitian Canadian and French Canadian religious leaders were also contacted to boost the recruitment of volunteers. French and Creole advertisements were broadcast on two Haitian radio stations during Sunday programs. Written advertisements

(pamphlets) that explained the study, were left in CLSC waiting rooms, to reach the Haitian Canadian community and overcome difficulties in the recruitment. Prior to posting any information, I obtained authorization from the CLSC director or chief executive officer to leave the pamphlets in waiting rooms.

Eight people declined to participate in the study and their refusals were documented. Among these eight individuals, five were women who declined because of their intensive involvement in the workforce, one woman reported being too physically exhausted to participate, one woman was frightened to talk with me, and a man refused to participate due to his fears of being tape-recorded.

Table 1. Reasons given by primary caregivers to decline to participate in the study, N = 8

Reasons	**f**	Percentage
Too busy (in the workforce)	5	62.50
Tiredness (physical exhaustion)	1	12.50
Fears of the researcher	1	12.50
Fears of being tape-recorded	1	12.50
Total	8	100.00

The mean age of the caregivers was close to 53 years old and the median age was 51 years. The youngest primary caregiver was 36 years old and the oldest was 87 years old. The mean age of the care-receivers was nearly 82 years old, while the median age was 85 years old. The youngest care-receiver was 47 years old and the oldest was 97 years old. A 47-year-old woman was included as a care-receiver in the study. Although the study was aimed at understanding Haitian Canadian primary caregivers' ways of caring for an aging relative, this woman's physical condition included co-morbidities and a limited life-span, comparable, in some ways, to the lived experiences of aging. Her inclusion in the study helped in exploring conditions where chronological age does not always inform about the reality of aging. The advent of chronic illnesses can have an impact on biological age and influence an individual's

every day life so that co-morbidities coupled to a shorter life expectancy are likely to produce premature aging. The mean ages and family kinship of the caregivers and care-receivers are presented (see Appendix C for mean ages).

The gender distribution of the caregivers and care-receivers showed a similar trend of over-representation of women. Of the 16 participants who were in the primary caregivers' sample, 75 percent (12) were women. This over-representation of women was also observed in the care-receivers' gender distribution, where 84 percent (16) of the care-receivers were women. This trend could be explained by women's longer life expectancy coupled to men's premature loss of lives in Haiti (Marotte & Razafimbahamy, 1997).

In the province of Quebec, the life expectancy for men is 74.9 years, compared to 81.2 years for women (MSSS, 2000). The shorter life expectancy for men is related to the higher rate of mortality caused by cardiovascular diseases, cancer, suicide, and accidental deaths. The gender distribution for the sample in this research is consistent with those obtained in two previous studies carried out in the greater Montreal area. One was conducted among French Canadian caregivers (Guberman, Maheu & Maillé, 1993) while the other was carried out among Italian and Haitian Canadians' caregivers (Guberman & Maheu, 1997). In each of these two studies, the number of participating women outnumbered the men, in both the groups of caregivers and of care-receivers.

In the present study, a high proportion of daughters were caring for their mothers or mothers-in-law, with the exception of two husbands who were caring for their wives, a son who was caring for his parents, and a man who was caring for two female cousins of his extended family. More precisely, eleven mothers, one mother-in-law, two female cousins, two fathers, one stepfather, and two wives comprised the group of care-receivers. Although caring appears to remain as a woman's activity, a slightly higher proportion of men now seem to be looking after aging or very ill wives or aging female relatives of their extended families. The length of stay in

Canada of the caregivers and care-receivers was documented by asking participants for their year of entry into the country (see Appendix D for length of stay).

The caregivers' mean length of stay in Canada was 27 years as opposed to 22 years for the care-receivers. The distribution of the caregivers' year of entry into Canada was tri-modal with 1970, 1973, and 1976 as modal years. This corresponds to the second wave of Haitian immigration in Canada, though one caregiver entered in the first wave of immigration that occurred in the 1960's. On the other hand, the care-receivers' mean length of stay in Canada was 22 years and the modal year of entry into the country was 1981.

It would be fair to assume that the majority of adult children sponsored their aging parents' entry into Canada, except for one mother who secured her daughter's entry in 1989. This study's data is consistent with figures obtained by anthropologists Laguerre (1984) and Stepick (1998), who studied the patterns of Haitian immigration into New York City and its suburbs, and into the greater Miami area, respectively. In the 1960's, the Haitian elite and members of the middle-class were fleeing Francois 'Papa Doc' Duvalier's iron fist political regime. In the 1970's, the working class and farmers were escaping his son, Jean-Claude 'Baby Doc' Duvalier's dictatorship and the living and economic conditions that were prevailing in Haiti at that time (Laguerre, 1998). During the interviews, all caregivers first described themselves as Haitians, and secondly as Canadians, despite having a median length of stay of 26.5 years in Canada. None of them mentioned that they were economic refugees, though the year of their entry provides a likely reason for their escape from Haiti. No data pertaining to income was collected as it could have represented a sensitive topic that may have jeopardized the caregivers' further participation in the study, and raise legitimate fears about my potential association with the governmental apparatus.

Descriptive Statistics of Visiting Nurses' Sample

The nurses' sample was comprised of three women and a man, presenting an average age of 36 years. The average working experience was 12.5 years (range from 4 to 24 years) of practice in the health care system while the average working practice in CLSC is nearly 4 years. Three nurses were Canadian-born while the other was born overseas. None of them received cultural training after being hired at the CLSC. Two of them mentioned having gained cross-cultural nursing knowledge while attending the university but no continuing education on culture or cross-cultural care had been provided at the workplace since they were hired. As well, cross-cultural knowledge was not a pre-requisite for their employment. The language of work was French but one nurse spoke Creole fluently. Two nurses held baccalaureates in Nursing while the others had completed collegial courses or taken some courses in public or community health programs. Nurse recruitment was difficult since it was directly associated with the primary caregivers' utilization of home care services, in that caregivers, care-receivers, and nurses needed to obtain consent for me to observe a home visit.

Data Collection

In critical ethnography, when using a postcolonial feminist lens, data collection is not neutral but rather directed at examining the historical, social, cultural, political, and economic factors that mediate Haitian Canadians' caring experiences (Reimer Kirkham & Anderson, 2002). I also draw on the work of Smith (1987) to argue that postcolonial feminist data collection addresses "a world directly experienced from oneself as center (in the body) on the one hand and a world organized in the abstracted conceptual mode, external to the local and particular places of ones' bodily existence" (p. 84). Haitian Canadian primary caregivers' experiences of caring for aging relatives at home must be documented from both the local and material realities within which caring activities unfold. To access this centered and silenced knowledge, data collection must be performed from a reciprocal approach or with a dialectic/dialogic process. Far from

being constrained in a rigid frame of standardized questions, data collection becomes like a discussion between caregivers and the researcher. As participants described their experiences of caring, they were telling me their stories. This dialogic and dialectical process of data collection gives room for the subjugated voices to be heard. I always kept in mind the risk of imposing my views since the goal was to let the participants express their thoughts, and describe their actions. Hence, theory building becomes a subjective reciprocal process into which participants and I became fully immersed. Lather (1991) mentions that reflexivity facilitates dialectical theory building since reflexivity heightens the researcher's awareness of her or his racial, ethnic, cultural, social, and political locations and therefore, her or his speaking position.

Thus, I strived to *decenter* my *self* in a process of cultural *alterity*, which shifted my ways of knowing to hear and understand the culturally different Other. Schutte (2000) defines cultural alterity as a way of knowing that "demands that the other be heard in her difference and that the self give itself the time, the space, and the opportunity to appreciate the stranger without and within" (p. 55). Minh-ha (1990) indirectly addresses this concept of cultural alterity in her discussion on identity and difference, when she refers to the blurring insider/outsider identity that occurs during fieldwork. I strived to develop what Minh-ha (1990) calls a hybrid identity in the sense that I was not quite an outsider and not quite an insider. She states: "She who knows she cannot speak of them without speaking of herself, of history without involving her story, also knows that she cannot make a gesture without activating the to and fro movement of life" (Minh-ha, 1990, p. 375). In this postcolonial feminist study, cultural alterity and reflexivity guided the data collection as a means to deconstruct the crystallized Cartesian objective/subjective paradigm, for the researcher to experience Otherness.

The second feature is to uncover the implicit and explicit effects of race, gender, ethnicity, social classes, and neocolonialism in mediating Haitian Canadian primary caregivers' caring activities. The aim is to voice the subjugated knowledge of Haitian Canadians on caring

for aging relatives at home. The ultimate goal is to produce transformative knowledge directed at fostering possible emancipatory changes in the health care system and developing culturally safe nursing interventions (Dyck & Kearns, 1995; Golding, 1988; Quayson, 2000; Reimer Kirkham & Anderson, 2002). Reimer Kirkham and Anderson (2002) argue that postcolonial research is not driven by rigid methodological rules but emphasize the importance of documenting with scientific rigour. They state: "The postcolonial lens always take into account the context in which each life is situated, and analyzes how gender, race, class, and historical positioning intersect at any given moment to organize experience in the here and now" (Reimer Kirkham & Anderson, 2002, p.15). Therefore, fieldwork activities in this study were devoted to uncovering the social forces shaping ways of caring and caregivers' experiences in a racialized and gendered world. I will now provide a detailed account of fieldwork activities and describe the methodological issues encountered and worked out in the field.

Fieldwork

Fieldwork is composed of four activities: 1) interviewing, 2) participant observation, 3) writing and recording fieldnotes, and 4) performing other related activities. The researcher becomes the data collection instrument when doing fieldwork. C.W. Watson (1999) points out the importance of the quality of fieldwork while underlining the importance of the post-fieldwork activities to understand and theorize. Fieldwork is an intensive engagement of a limited duration, involving various techniques and strategies, of which "immersion" is the most known activity, whereby the researcher engages in different styles of learning and understanding (Watson, 1999).

The study was carried out in the large metropolitan area of Montreal and Laval (second largest city in Quebec after Montreal) from mid-November 2000 to February 2002. Open-ended interviews, participant observation, and fieldnotes were used to collect data. Fieldwork was divided into two phases. The first took place from November 2000 to August 2001, while I

resided in Montreal. The second phase occurred from October 2001 to February 2002, while I resided in my native town of Quebec City. From this location, a couple of trips were made to Montreal, about a 250 km trip. The second phase was longer than expected due to my sister's terminal illness. Although inspired from critical principles, a complete critical ethnography was not realized, since the scope of the fieldwork was aimed at documenting the two research questions. A complete critical ethnography would have meant to 'study up' an organization to unmask cultural hegemony and dominant ideologies that underpin the delivery of services (Brodkey, 1996). A complete critical ethnography was not carried out since it would have meant to uncover CLSCs' corporate ideologies. I opted not to interview CLSC directors, home care managers, or visiting nurses who were mainly coming from mainstream society, because I wanted to reach the Haitian Canadian primary caregivers' standpoint. As well, the research was focused at understanding Haitian Canadian primary caregivers' subjugated or *centred* knowledge as a means to unveil ideologies that underpin formal health care services.

Interviews

Oakley (1981) attempts to illustrate this interactive dialogical (dialogue between researcher and the researched) and dialectic process in showing that women's interviewing is more than simply asking a set of questions. The neutral and objective interview does not stand well in feminist research. Oakley (1981) found that when the relationship between interviewer and interviewee is non-hierarchical, and when the researcher invests her or his own identity in the relationship, information is shared in a productive way. Ribbens (as cited in Webb, 1993) claims that Oakley's disclosure of self was not a threat for the research endeavour since she did not make herself vulnerable in exchanging information about infant feeding and child development with women. Moreover, the act of conducting interviews, summarizing another person's life, and placing it within a context, constitutes an act of *objectification* that can be problematic when applying the epistemological and methodological assumptions of feminist

research (Acker, Barry & Esseveld, 1983). Hence, speaking for others may be viewed as a kind of imperialism.

Alcoff (1991) suggests analyzing the particular power relations and discursive effects involved in the inquiry, in that the feminist researcher must search for her or his beliefs and values in the context of the research. At the same time, the researcher is accountable for representing the words of culturally different others in a discursive practice to lessen any risks of speaking for others in a faulty manner. In this way, self-reflexivity is a powerful means to develop the researcher's consciousness of power and is a means to equalize power asymmetry as best that she or he can do during the research process.

The pitfall of domination is difficult to escape in feminist research, even with the best intentions, since the researcher must invest her or his identity to gain participants' trust. Anderson (1991b) suggests a way to invest identity when mentioning that requests for help from informants must be considered as a way for participants to know about the researcher. As Anderson (1991b) puts it, this kind of exchange is seen as a move toward a more equitable distribution of power in the relationship.

Interviewing is thus a complex process requiring that I rely and develop personal communication skills, especially when attenuating asymmetric relationships with participants, to elicit reciprocity (Fontana & Frey, 1994). Mishler (1986) underlines that research interviews are speech events. Interestingly, Kvale (1996) contends that the conversation in a research interview is not a reciprocal communication between two equal partners because of the existing asymmetry of power. In particular, I found this issue of equalizing difficult to achieve during the fieldwork. This issue is not without controversy in feminist methodology. I did my best to attenuate power relations and democratize the research process by not using scientific jargon and attempting to remain at the same level as that of the participants, by using appropriate language. Most of the interviews were conducted in Quebec's *joual*, defined as the vernacular language used in casual

conversations. I avoided using the more sophisticated French used by the elite or members of academia as I did not want to be associated with elitist groups since these positions are located at the centre of social privilege and power. I was dressed appropriately for doing fieldwork during the winter; wearing slacks, jeans, warm sweaters, blouses, and casual boots, to adopt a middle-class look. Far from assuming that all participants[45] belonged to the working class, I wanted to be considered as an average individual.

Twenty-one open-ended interviews and three data validity check interviews were conducted, all of which were tape-recorded. I asked each primary caregiver and each nurse to randomly pick a number in different envelopes to ensure confidentiality. The number of the primary caregiver was the same as the number of the care-receivers. This digit was only known by the participant and by myself and did not correspond to the rank order of the meeting. For instance, caregiver 01 or nurse 02 could have been the fifth or thirteenth individual to be met. I conducted all of the interviews and transcribed each interview into the computer.

Interviews were directed at gathering the cultural and social events that facilitate or impinge on primary caregivers' lives and on the utilization of formal home care services. Grand tour questions were meant to stimulate an experience and encourage participants to "ramble on and on" (Spradley, 1979, p. 87). Four types of grand tour questions were used (Spradley, 1979) such as those for descriptive, specific, guided, and task-related questions. At the beginning of the interview, trigger or grand tour descriptive questions were asked to get an overview of the situation or of the lived experiences (see Appendix E for trigger questions). Examples of questions included: Can you tell me about your experience of caring for your aging mother or father? Can you describe your experience of caring? These questions were also meant to elicit topics or concerns to be discussed in subsequent interviews with the same or other interviewees. These materials were also used to develop specific grand tour questions.

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[45] Some participants were members of the Haitian elite and bourgeoisie.

Specific grand tour questions were related to a topic that had been discussed in previous interviews, observed during participant observation sessions, or raised by other participants. Specific questions were recovered to get more details and achieve an in-depth understanding or 'test' working hypotheses. Examples of specific grand tour questions included: What is the impact of caring on your participation in the workforce? What is the impact of caring on your family life? What is the impact of working full-time on caring for your mother or father?

Guided grand tour questions are those to which a participant provides a picture of the situation such as: How do you define caring? What does it mean for you to care for your mother or father at home? Where do you get support? Finally, task-related grand tour questions are formulated to know how participants perform a caring activity. It provides a precise description of the task or the event (Spradley, 1979). Task-related questions were asked such as: What do you do when you care for your mother? Can you describe how you proceed? Would you give me a typical working day description? What do you do to relax? How do you cope with your mother's or father's losses? These four types of grand tour questions were aimed at exploring the cultural and social beliefs pertaining to caring activities. As well, questions were directed at understanding the impact of the social world, as Dorothy Smith (1987) puts it, on the utilization of public home care services. Interviews lasted from 45 to 150 minutes and were conducted at the homes of the primary caregivers. Four caregivers were interviewed twice or more often, while others were interviewed once, depending on participant's availability. Participants who were met on more than one occasion were either retired or key informants. Discussions with key informants were not tape-recorded, except during one interview with a key informant who was also a caregiver.

Participant Observation

Fifteen participant observation sessions were carried out in primary caregivers' homes and the length of each session varied from three to six hours. The length of the session was

negotiated with each caregiver, depending on their respective availability. Adler and Adler (1994) define observation as a process of "gathering impressions of the surrounding world through all relevant human faculties" (p. 378). They mention that observation is an unobtrusive means of collecting data that fits with the fundamental principles of naturalistic inquiry. Adler and Adler (1994) describe three membership roles depending on the degree of involvement: 1) complete-member-researcher, 2) active-member-researcher, and 3) peripheral-member-researcher. To respect feminist assumptions, the researcher must be immersed in the natural setting to grasp the depth of caregivers' lived experiences. Reciprocity, trust, and self-disclosure are mandatory for collecting data. Oakley (1981) emphasizes, "there is no intimacy without reciprocity" (p. 49). This statement clearly illustrates my experience in the field. At the beginning, I talked about my cultural background or about aspects of my personal life (i.e., my family, studies or projects) only when prompted. In this process, I was leaving behind my previous master's training in postposivisit ethnography, however, I also felt the need to re-assess or re-define my journey into this field of study, to put participants more at ease. To this end, I invested myself thoroughly by disclosing who I was – openly talking about my family origins, my social background, and my commitment in caring for my aging mother.

Men participants were prone to question my political allegiances. When participants wanted to know whether or not I was a separatist[46], I answered that I was raised in a family known for its long-standing sympathy to federalism. I explained that I was committed to the civil rights of all Canadian citizens, regardless of their ethnicity. During Quebec's most recent referendum in 1995, the Haitian Canadian community and other ethnic communities were profoundly wounded by the words of a Quebec politician. Haitian Canadians felt rejected by the White, catholic, francophone society. This event paved the way to a reciprocal process of Othering, which introduced binary oppositions like 'us' vs. 'them,' creating what seemed to be

an incommensurable distance between the two social groups. This social wound was clearly expressed in the study's results and my role, as researcher, was to voice the participant's messages to the mainstream society.

I observed that both men and women felt more at ease to express their thoughts during participant observation sessions when they were not tape-recorded. During these participant observation sessions, I always sought opportunities where I could make brief notes. Fieldnotes were tape-recorded immediately after each session and were later transcribed to the computer to ensure validity. Because of the hazardous winter road conditions, I recorded my fieldnotes before driving up to the residence where I was staying during my fieldwork. The residence was about a one-hour drive from where the participant observation activities were conducted and for the sake of validity, I did not want to forget any of the details making my journey.

Participant observation was aimed at observing the environment within which activities of caring took place. Observations focused on the nature of caring activities performed by primary caregivers or by any other person who was their family member (see Appendix F). As mentioned earlier, three to six hours of observations was initially planned to be carried out with the person who was caring for the aging relative and his or her family, but some participants were unable to participate in these sessions due to their work.

For nurses, the observation period occurred during work time at the caregivers' home. The types and units of observation, such as the services provided by home care nurses were selected for observational purposes (e.g., treatments, wound dressings, drawing of blood samples, medication assessment, vital signs, and other therapeutic interventions). The types and content of questions asked of the caregivers or care-receivers were also observed (see Appendix G).

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[46] I refer to the term used by some participants to designate members of the Parti Québécois.

Participant observation enabled my immersion in the caregivers' 'everyday lives.' In the sessions, I always offered to perform some household chores or other tasks to help the caregivers, and did not want to impinge on the caregiver's daily routine; therefore, avoiding the passive 'fly on the wall' observation style. Second, I was aware that the degree of involvement (i.e., the amount of time) required of caregivers was important and so attempted to play an active role during these sessions. Sharing domestic tasks is generally attempted in feminist research to equalize power differentials that exist between researcher and participants. I concur with Wolf (1996), who argues that in attempting to establish egalitarian relationships, the researcher does not transform nor erase her/his *positionality* in the research process, despite the blurring of the insider/outsider line. Very few participants allowed me to share in their domestic chores, except for three primary caregivers with whom I had developed significant relationships over the months. I kept in touch with one caregiver, who, because of her knowledge of the community, became a key informant. During fieldwork, she became acquainted with some of my relatives and despite the geographical distance we have remained in contact.

In these three participants' homes, I performed activities such as assisting in the preparation of meals, setting up the table, serving dishes, folding clothes, and so on. I felt like I was a member of the family. I agree with Wolf (1996) when she suggests that feminist researchers must be committed to establishing egalitarian relations with participants while remaining realistic about its attainment. In other words, it would have been unrealistic to achieve the level of trust and reciprocity that I shared with these participants, with each of the sixteen primary caregivers and their families. I agree with Cotteril (1992) when she asserts that issues of power and vulnerability cannot be avoided since caregivers had the power to accept or decline to participate in the study. On the other hand, I had to avoid Othering caregivers in analyzing and representing the data (Lather, 1991).

Participant observation sessions were also conducted at different settings like the Golden Age and CLSC daycare centres, where I attended and participated in physical activity sessions designed for the elderly. I went to a CLSC daycare center where activities were tailored for French, Italian, and Haitian elders. In the Golden Age centre, only Haitian Canadians' elders were present since activities were held in a HLM (subsidized or social housing for older persons).

Other activities, related to my close association with a key informant, led me to accompany this person in diverse social settings like the kindergarten, the hairstylist, the shopping mall, the workplace, and restaurants. These other fieldwork activities, though not related directly to caring activities *per se*, helped me understand the impact of the social context. I discovered what it meant for a Black woman to live in a gendered and racialized society (Anderson & Reimer Kirkham, 1998). For instance, one day, we went shopping and did some errands. I was struck by the disapproval of White people, expressed in the form of sidewise glances or shaking of the head. When we went to the restaurant, the waiter steered us towards a secluded area, which seemed to be hidden away from the other patrons. The waiters, whether male or female, always presented me with the menu and asked me to order. The key informant was never directly addressed.

On a few occasions, I volunteered to work in a food bank to become better acquainted with the Haitian Canadian community and perhaps meet some potential informants or caregivers. While helping out at the food bank, I felt uncomfortable being the only White woman. Some people talked with me while others ignored me. The food bank manager introduced me to newcomers and to new volunteers. Typically, I was perceived as an outsider, especially when people around me chose to speak Creole. I could not understand the conversations but later, after a care-receiver had taught me some words, I was able to catch some of their remarks. In any case, one wonders why they needed to change their customs just because one person was unable

to speak Creole? Many older ladies were at the food bank to help out and these women almost exclusively spoke Creole. Before admitting that I was being excluded, I reflected and assessed the events that prompted people to speak Creole. For instance, being addressed in Creole implied that racial and ethnic differences were no longer interfering in the relationship between participant and researcher. At the hairstylist, a key informant asked me a question in Creole and could not understand why I was taking so much time to answer. Then, realizing that she had spoken to me in Creole, said, " I forgot you did not speak Creole. I took you for a Haitian" (CG05-F).

Six caregivers declined participant observation sessions but wanted to be interviewed. All of them were women who were involved full-time in the workforce and were juggling with several tasks such as working outside, and caring for their children and for the elderly. Two of these women worked from 50 to 60 hours a week while another was in the process of moving out of town. Considering the low rate of participation, I weighed the consequences of losing participants vs. the future of the research. Thus, I chose to interview people even though it meant to sacrifice some hours of participant observation. Seibold (2000) points out that qualitative research is an ongoing process where methodological issues have to be worked out during the fieldwork. Four nurse home care visits that took place at primary caregivers houses were also observed.

Fieldnotes

Writing fieldnotes is not merely a matter of passively jotting down notes about what happened, but also involves making sense of the events as part of an active process of interpretation (Emerson, Fretz & Shaw, 1995). The authors mention:

> As inscriptions, fieldnotes are products of and reflect conventions for transforming witnessed events, persons, and places into words on paper. In part, this transformation involves inevitable processes of selection; the ethnographer writes about certain things and thereby necessarily "leaves out" others. (p. 9)

Fieldnotes reflect sensitivities, meanings, and understandings that the researcher obtains from having been close to, or after having participated in the described events (Emerson, Fretz & Shaw, 1995). Notes must provide detailed accounts of the observed event, the setting, the persons, and so on. Writing is ideally done at the same time as the event unfolds and must be as detailed as possible. Writing fieldnotes heightens the researcher's awareness to hear with greater acuteness and observe with a new lens (Emerson, Fretz & Shaw, 1995). Fieldnotes provide a 'thick description' of the phenomenon under study and their richness is expected to improve after each day spent in the field. Otherwise, the thick description, as Geertz (1973) suggests, cannot be achieved, especially when fieldnotes do not capture a large amount of detail (Carspecken, 1996).

Descriptive fieldnotes focus on sensory data, which is aimed at grounding the experience in its natural settings. Analytic fieldnotes are the products of self-reflexivity and dialogical interaction between description and reflection. Finally, personal notes are related to feelings or emotions to be reported in the reflexive process. For instance, I was deeply saddened when I witnessed racial injustice occurring at the shopping mall or at the restaurant. When confronted with racial discrimination, I was ashamed of my racial and ethnic background. I was exhausted after completing an interview or a participant observation session, during which participants described traumatic experiences involving ethnocentrism and racism, in their school, work, or the civil society. Nevertheless, these confrontations with racial discrimination helped me with my understanding of what Alcoff (2000) coins a 'White double consciousness.' She says: "For whites, double consciousness requires an everpresent acknowledgment of the historical legacy of white identity constructions in the persistent structures of inequality and exploitation" (Alcoff, 2000, p. 281).

At the beginning, I was focused on the discovery of a new culture and on the participants' recruitment issues. Fieldnotes were mostly descriptive and soon, I became overwhelmed by the amount of data to collect in a participant observation session or in other events. It became clear

that I needed to develop a rationale to manage these data and opted to select events directed at answering the two research questions and documenting critical events where racial and gendered discrimination occurred. As I became more self-reflexive, I gained a richer insight into my ways of describing events.

In this study, four types of fieldnotes were used. First, I kept a general descriptive diary in which I recorded my daily activities, emotions, and feelings pertaining to the fieldwork activities. In this general diary, I also jotted down notes about personal issues like reference to political allegiances since, if not carefully considered, they could have an impact on data collection and analysis. Second, I detailed tales or stories related to the care-receivers, such as the sorrow felt by a grandmother who had lost her eldest daughter, and other fieldwork tales pertaining to caregivers and to the environment. Third, a descriptive diary was also kept of: post-caregiver interviews, post-participant observations, and post-nurse visits. In these fieldnotes, I wrote analytic memos, theoretical hunches, or working 'hypotheses' to be explored in subsequent interviews, observed in participant observation sessions, or to be discussed with key informants. Finally, fieldnotes were used to develop self-reflexivity and also reflected on my personal biases on race and gender.

Lather (1991) points out that "the search for ways to operationalize reflexivity in critical inquiry is a journey into uncharted territory" (p. 63). For instance, I noticed I was upset by the polygamist behaviours of some Haitian Canadian men. Fortunately, my committee helped me to shift gears and sort out my preconceived ideas in a debriefing conference. Every researcher harbours preconceived ideas and I, too, did not enter the field *tabula rasa*. In any case, my committee's comments helped me in developing an awareness about these biases and how they may have been influencing my communication skills with men caregivers. I reported experiencing difficulties when interviewing men and likely, the issue of polygamy was acting somewhere in the background, during the interviews. I needed to move beyond the limitations of

my cultural framework, to understand the men's perspectives. To paraphrase Schutte (2000), I stepped out of my colonial boots and adjusted my Western feminist lens to reach the Haitian Canadian men and get their perspectives on caring and family life. I also consulted the works of Michel Laguerre (1984) while asking a key informant to help me make sense of polygamy. In adjusting my cultural frame of reference, I realized that marital and family relations took on different meanings for Haitian Canadian couples. My aim was to understand these issues without being judgmental and I had to drop the Western veil through which I had been looking at Haitian Canadian men.

I also remarked about my uneasiness to interview women who were dressed in traditional clothes such as long, vividly coloured dresses and colored hats. I was Othering these women in referring to my Western normative values. During a participant observation session, one woman reported being proud of her African ancestry, which brings me to reflect on the concept of *négritude*. Aimé Césaire, a poet born in the Caribbean, first coined the word négritude but Léopold Senghor further developed the concept of négritude as a means of self-affirmation and self-confirmation for the people of Africa. Senghor (1994) states: "Who would deny that Africans, too, have a certain way of conceiving life and living it? A certain way of speaking, singing, and dancing; of painting and sculpturing, and even laughing and crying?" (p. 27-28). One participant told me how he learned to restrain his laugh so as to not disturb co-workers (CG04-M).

My uneasiness about interviewing women who were clothed in traditional dresses showed how I was locked up in Western cultural values — being more comfortable with acculturated women. I was judging the use of traditional clothes through my Western cultural grid, and refuting the cultural differences. As Bhabha (1990) points out, the acknowledgment of cultural diversity does not imply the recognition of cultural differences:

> Although there is always an entertainment and encouragement of cultural diversity, there is always also a corresponding containment of it. A transparent norm is constituted, a norm given by the host society or dominant culture, which says that "these other cultures are fine, but we must be able to locate them within our own grid". This is what I mean by a creation of cultural diversity and a containment of cultural difference. (p. 208)

As the fieldwork unfolded, I noticed that being Haitian was allowed in very restricted areas. In other words, Haitian Canadians have to enter private areas like the home to enjoy their culture, without being subjugated to the regulations of the ruling class. Brodkey (1996) points out that social regulations translate the hegemony of the privileged group while perpetuating racial, gendered, and class inequities. The home is the cradle of Haitian culture where values, customs, and beliefs are taught to the younger generations. I also observed that, in their homes, women were free to affirm their Haitian identities, as they would have done if they were living in Haiti. When exiting the home to go to work or to school, they had to shift to the Canadian identity, though the colour of their skin was the issue that was impinging on social integration into mainstream society. As a woman caregiver once told me: "If you do something outstanding, you're Canadian. If a sad event happens in the community, you're Haitian" (CG05-F).

Doing Fieldwork Within the Haitian Canadian Community

During fieldwork, in this study that was addressing the sensitive issues of race and gender, I encountered both facilitative and obstructive relationships. I met a gatekeeper who tried to influence my understanding of the Haitian community by referring to my racial and ethnic background. For this gatekeeper, mainstream values were being jeopardized since I attempted to use a different framework to learn of the Haitian Canadian caregivers' ways of caring and their relations with home care services. This gatekeeper never found any volunteers but constantly asked to be informed about the evolution of the study. The individual told me: "Haitians must comply with our cultural norms." In doing so, this gatekeeper subtly reminded me of the privileges associated with belonging to the race of those ancestors who had founded Canada. I

did not stay in touch with this person since I recognized a pattern of obstruction. The critical event, however, helped me realize the important influence of racial issues in the research and how power is played out in the social world.

Impact of Race and Gender

Distrust is the other major issue I encountered in the field. Distrust was manifested in people's fears toward mainstream society's representatives or governmental agencies, which might explain some peoples' refusal to participate in the study. The distrust of people of Colour to participate in mainstream research has been documented in the literature. For instance, Lipson and Meleis (1989) faced this issue while doing fieldwork with Middle East immigrants. They mentioned, "immigrants tend to distrust research in general due to past bad experiences" (Lipson & Meleis, 1989, p. 105).

DeSantis (1990) also reported distrust while doing research among Haitian immigrants in Florida. Haitian immigrants were the objects of "various forms of discrimination and antagonism" because "they were Black, labeled as an at-risk group for AIDS, taking jobs and housing from other minority groups of the area, and placing additional demands on the community resources"(DeSantis, 1990, p. 360).

Patricia Hill Collins (1989) and bell hooks (1989) both describe the impact of Eurocentrist research in marginalizing and silencing African Americans' knowledge. The Tuskegee's[47] study represents an instance of Orientalization (Said, 1979) where peoples are used for so-called scientific purposes. The process of Orientalization, by reinforcing the state of subjugation, explains why African Americans and peoples of the South are reluctant to participate in mainstream studies (Adamson & Donovan, 2002; Corbie-Smith, Thomas & St.

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[47] The Tuskegee Syphilis Study was conducted in Georgia in the Macon County from 1932 to 1972. During almost 40 years, thousands of African Americans were selected to observe the natural evolution of the disease. They were denied access to proper anti-syphilitic treatments to comply with the so-called 'highly' scientific goals set by the US Department of Public Health (Reverbee, 2000). This study illustrates what Edward Said (1979) coined as the process of Orientalization to describe racism applied to science.

George, 2002; Earl & Penney, 2001). Postcolonial feminist scholars also point to the deleterious effects of positivist Eurocentric studies in representing peoples of the South as subalterns, inferiors, or second-order citizens (Minh-ha, 1989; Mohanty, 1988; Spivak, 1988).

Preliminary meetings with two Haitian Canadian key informants were particularly arduous. The first key informant told me she would not hesitate to sue me, if she learnt that I violated confidentiality. The second key informant asked me what I intended to do with the results. She asked: "Do you want to publish a book?" First, I ensured her that issues of confidentiality would be scrupulously attended, and I delineated how I intended to respect participants' confidentiality. Second, I disclosed the reasons that were underpinning this study. I was doing doctoral research and the aim of the research was not to exploit participants. I was not committed to making money at the expenses of Haitian Canadians and after setting the record straight, these two key informants became the driving-force of the study. They opened gates to access potential participants. When entering a different ethnic or cultural community, the researcher must attend to two major issues. Issues of confidentiality must be clearly stated and the means to ensure confidentiality must be explained to key informants and community leaders. As well, leaders and key informants must feel that the researcher demonstrates genuine concerns about their community and that she or he does not want to exploit participants. This leads to the issue of power, when a White researcher decides to do research with, not on or about, peoples coming from different racial and ethnic backgrounds. I refer to Patricia Hill Collins (1989) who articulates my position on this sensitive issue:

> While an oppressed group's experiences may put them in a position to see things differently, their lack of control over the apparatuses of society that sustain ideological hegemony makes the articulation of their self-defined standpoint difficult. Groups unequal in power are correspondingly unequal in their access to the resources necessary to implement their perspectives outside their particular groups. (p. 749)

For those who may remain skeptical, I ask: Did the presence of nurse Edwards, an African American nurse, help the men who were enrolled in the Tuskegee study? White

investigators silenced nurse Edward's voice and ethical concerns. She was selected because she was a Black woman, raised in the South, and the US Department of Public Health expected her to comply with male hegemony since the chief investigators were White physicians. These men represented the power of race, gender, and medicine. In 1932, it was even easier to erase nurse Edwards' race and gender, since segregation laws were still used to govern the social life in the State of Georgia (Reverbee, 2000).

Being a woman did not provide me an easier access with the women participants. Some researchers report that women of Colour are more concerned with the issue of race than they are with the issue of gender membership (Edwards, 1990; Kauffman, 1994). This contradicts Oakley (1981) and Finch (1993), who reported how easy it was to connect with and interview women. In the studies by Oakley and by Finch, however, the women of the study shared the researchers' ethnic and social backgrounds. In another study, Edwards (1990) reports that "all the Black women talked easily, after my placing of my difference rather than similarity, about their experiences, in the more public world of education, work, and so on, and in particular about racism" (p. 487). This is consistent with bell hooks's (1990) assertion that "women of color, particularly Black women, were challenging the assumption of shared oppression based on gender" (p. 53).

As well, in a study aimed at exploring the experiences of first generation Chinese-Canadian and Indo-Canadian women living with chronic illness, Dyck, Lynam, and Anderson (1995) reported similar observations. They mention that sharing the same racial background with participants does not necessarily provide a common ground between researcher and participants. They refer to research assistants, who, despite sharing the women's ethnic background, were initially perceived and associated with dominant society institutions. Just because the researcher belongs to the same gender does not mean that the recruiting of participants and collecting of

data will be easier. I concur with Edwards (1990) on the need to establish trust by recognizing racial differences when doing research with people of Colour.

The extent to which my being a woman facilitated access to men caregivers is another issue and when reflecting on my experiences in the field, I find similar circumstances as those found with Black women. The four Haitian Canadian men who participated in the study were concerned, as were their female counterparts, with issues of racial and economic injustice. Men talked about inequities they were facing in the workplace and how racial discrimination was permeating their everyday lives. They were also concerned about the future of their children who are seen as being second-order[48] citizens at school or at work. A man caregiver had said to his son, who was the object of racist jibe: "It's their country, not ours" (CG04-M).

Frankenberg (1993) addresses this issue of gender and race in demonstrating how the myths surrounding the sexuality of men of Colour were racialized. She contends that sexual behaviours were structured within the context of racial hegemony. The myth was aimed at Othering men of Colour to reinforce negative stereotypes among White women. In a study, Frankenberg (1993) mentions the impact of Whiteness, *Westerness*, racism, and colonialism, in essentializing the racially different Other, as being inferiors and subalterns. Race visibility was a factor that accounted for social injustice committed to maintaining the supposedly White racial superiority. She found that Asian American and Native American men were less likely to encounter racist comments than were African Americans (Frankenberg, 1993). Inspired by Omi and Winant (as cited in Frankenberg, 1993), she mentions:

> For the greater part of US history, as they point out, arguments for the biological inferiority of people of color represented the dominant discourse (or in their terms, paradigm) for thinking about race. Within this discourse, race was constructed as a biological category, and the assertion of white biological superiority was used to justify economic and political inequities ranging from settler colonialism to slavery. (p. 13)

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[48] Kristeva (1991) reported the same issue when referring to the social status of offspring of Maghreb immigrants in France.

Because we live north of the US border does not mean this argument does not apply to our country. Canada is not a haven for immigrants and refugees (Foster, 2002) and the flaws of Canadian multiculturalism have been largely addressed. Multiculturalism is used as an instrument of social exclusion, by categorizing immigrants and refugees, on the basis of biological attributes like gender and skin colour. This kind of politics contributes to Othering men and women of Colour by creating categories such as visible minorities or ethnic minorities. The word minority emphasizes the status of social inferiority and forces one to admit that Canadian society is structured by race and gender (Anderson & Reimer Kirkham, 1998; Bannerji, 2000; Carty & Brand, 1993; Foster, 2002; Henry, Tator, Mattis, & Rees, 2000; James, 1996a; James, 1996b; Li, 1990; Ng, 1993). The same situation was observed in the UK. Ahmad (1993) points out "the construct of 'race' has been used to support colonization of a socially constructed 'Other,' a supposedly inferior people or nation" (p. 12). This leads to reflecting on issues of race and gender prior to entering the field, and to deconstructing negative stereotypes when doing data collection and analysis, as part of being self-reflexive.

Data Analysis

The aim of data analysis was to understand Haitian Canadian caregivers' ways of caring for an aging relative at home. It was also meant to understand how the health care system and the larger social world, have an impact on ways of caring and caregivers' daily lives. Caring cannot be stripped off the social world within which it occurs. Content analysis was used to understand the influences of social and political forces in constructing caring experiences. It also pointed to examining dominant health ideologies that are the basis for home care services and CLSC nurses' practice. Dominant ideologies are the relations of ruling that are used to discipline the delivery of care as well as the practice of nursing. These ideologies have an impact on the shaping of home care programs, their accessibility, and therefore, on the utilization of these services by a population. Keeping in mind the transformative goals of postcolonial feminist

research, data analysis was directed at generating findings that respect the caregivers' standpoint and lived experiences. Data analysis also illustrated the personal effort put into the research to reach this understanding and level of conceptualization.

An analytical framework inspired by a postcolonial feminist paradigm was used to gain insight by viewing data in a dialectical and dialogical process. While doing the analysis, I posed the following questions: What is the dominant discourse about home care services? How is this dominant discourse framed from within the dominant ethnic group's cultural values about aging? What is the impact of Haitian culture in choosing to keep an aging parent at home? What societal factors were influencing Haitian Canadian caregivers' decision to look after their aging relatives at home? What were the problems encountered by Haitian Canadian caregivers in their 'everyday lives?'

Process of Analysis

Content analysis is defined as the analysis by topic, and each interview is categorized according to these topics. Codes identify the content of each interview, and category labels are used as descriptive names for each group of data. In this study, categories overlap to locate Haitian Canadian caregivers' experiences of caring for aging relatives at home in the social context that intersects with race, gender, ethnicity, and social class. Theory does not emerge from data but through the interpretative lens of the researcher. Carspecken (1996) asserts that "critical epistemology include an understanding of the relationship between power and thought, and power and truth claims." (p. 10). In other words, for critical researchers, data analysis does not occur in isolation but is guided by an ontological worldview and an epistemological approach that cannot be neutral. Critical approaches like postcolonial feminism interrogates the hegemony of mainstream and neutral inquiry to bring about social changes (Carspecken, 1996). Since "data does not stand alone" (Emerson, Fretz & Shaw, 1995, p. 144), the processes of coding and memoing were driven by my postcolonial feminist theoretical approach. Codes, categories,

themes, as well as analytic propositions reflected the Haitian Canadian caregivers' words. An intensive immersion in the data set, intellectual work, and the use of paradigmatic lenses to question data and find meanings, were required. At the beginning of the data collection, the analysis was translated into open coding, but the intense dialogical, and focused coding process, were put into effect when I exited the field.

The intensive data analysis was delayed due to personal issues related to a close relative with a terminal illness. As Seibold (2000) points out, the rules of feminist methodology sometimes cannot fit within the reality of fieldwork. Seibold (2000) mentions that "data built up and many months would elapse between periods of concentrated analysis" (p. 150). I observed a similar situation since the recruitment of volunteers was arduous and I had to perform many activities in the field before reaching a community leader in June 2001, who became thoroughly involved in recruiting. This community leader saved the research because, since November 2000, only four participants had been recruited. Data analysis is related to data collection. If participant recruitment became stalled, then efforts to work out issues would take precedence over analysis.

When in the field, I always listened to the tape of the interviews when returning to my residence. I also transcribed the recorded fieldnotes and revised them, to find elements and sort theoretical hunches that would be used in subsequent interviews with the same or other caregivers, depending on their availability. These elements were also checked during participant observation sessions. For instance, a man caregiver told me during an interview that he was helping his wife to perform household chores. Participant observation, however, demonstrated the opposite. This caregiver's wife was always cooking and performing the domestic tasks, since her husband worked full-time. She talked during the observation time and I was able to show the contrast between what was said and the facts. My intense reflective work on the data set began after my sister's death, when I returned to Vancouver. Also, doing feminist research can be difficult when the field is located 6,000 km away from the university in which I was doing my

thesis. Fortunately, after being away from the data set, I could return to it less preoccupied, more relaxed, and better able to recognize my preconceived ideas (e.g., about men and polygamy) or racial biases (e.g. women dressed in traditional clothes). The analysis may have been different if it had been completed in the field. Although I was immersed in the culture, after exiting the field, it was easier to make sense of the data and to see how oppression works in affecting ways of caring and caregivers' lives (Carspecken, 1996).

Morse and Field (1995) describe four cognitive processes involved in qualitative analysis, which supposedly start as soon as the data collection begins: 1) comprehending, 2) synthesizing, 3) theorizing, and 4) re-contextualizing. The stage of comprehending consists of making sense of the data, and occurs when the researcher is able to write a complete, detailed, coherent, and rich description of the phenomenon. Synthesizing starts when the researcher is 'getting a feeling for the setting,' and can provide a "composite" description of how people act, relating that to specific stories and being able to explain variations in the data. The third stage, theorizing, is the process of constructing alternative explanations inherent to the data. It is a process of speculation and conjecture; falsification and verification; selecting, revising, and reviewing theoretical hunches in follow-up interviews. Finally, re-contextualizing is marked by the development of the emerging theory, which may be applicable to other settings and other populations. At this stage, the literature is used to see if the results support the literature or may bring new knowledge claims.

Coding Technique

Morse (1994) points out that no magic recipe exists when it comes to describing and detailing the steps involved in qualitative data analysis. Four steps of data coding were used, inspired by the work of Carspecken (1996) and Emerson et al. (1995). The first step was to transcribe the audiotape and read the transcript to correct errors. This procedure gave me a sense of the whole interview. All interviews were conducted in French and transcribed in the same

language into the computer. Data analysis was also done in this language to stay as close as possible to the participants' original words. No qualitative data management software was used, though the idea of using such software was contemplated. The high cost and amount of time needed to become familiar with its use precluded the adoption of such data management packages. Since 24 interviews had to be managed, the data analysis was performed by hand, though an impressive amount of data, including fieldnotes, was involved.

The second step was to perform an open coding that consisted of reading the transcripts with attention while writing *in vivo* codes or questions within the margins. *In vivo* codes were then translated into English and then the third and fourth steps were completed using English. *In vivo* coding is the crucial step where the meaning of words must be respected and then translated into another language.

The third step was to create low-level codes that are descriptive in nature and correspond to categories that were formed in clustering codes. The fourth step consisted of creating what I describe as a middle-level coding, where categories were collapsed into a greater category to create a sub-theme. This middle step marked a more intensive interpretive process. Finally, the last step involved the creation of higher-level codes to construct themes that reflected the whole picture of the fieldwork, representing the Haitian Canadian caregivers ways of caring for aging relatives at home and the contextual factors that influence their daily activities.

More specifically, interviews were coded and memoed to produce a coherent account of aspects of the social life observed (Emerson, Fretz & Shaw, 1995). Coding was divided into open- and focused-coding. In open-coding, interviews were read line-by-line to identify *in vivo* codes, and to generate new and as many codes as possible. In focused-coding, data analysis was directed to answer the research questions. After coding was completed, the process of memoing began. Writing memos consisted of elaborating on ideas to get a clear sense of ideas, events, and topics and to integrate them into the larger analytic process. Memoing demonstrated the attempt

to integrate data into sub-themes and themes — as a task that aimed to reconstruct and collate the disparate pieces of analysis. Links between categories, sub-themes, and themes were established and four major themes, inspired from the *in vivo* codes, clustering of codes, and formation of categories, were constructed. These four themes do not stand alone, but each mutually influences the representation of the Haitian Canadian caregivers' ways of caring and daily life experiences in the social world.

A constant comparison approach was used to verify the categories and themes 'against the data set' and with each of the interviews. After completing the analysis of 12 interviews, a few new codes emerged and, I was able to get rich information. Data saturation is reached when no new information can add to the understanding of the phenomenon. Strauss and Corbin (1998) mention that data saturation[49] is obtained when "no new information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data" (p. 136).

Participant observation was also helpful in getting in-depth knowledge since the participants shared much of their information during these sessions. Participant observation fieldnotes were used to complement the interviews, either by describing a caring activity or by critiquing an incident. The triangulation of data collection methods helped to further develop an understanding of the ways of caring at home and how the health care system and the larger social world, create impacts on caregivers' lives and daily activities.

Creation of Categories and Themes

To begin, I present Krippendorff's (1980) conceptualization of the many ways by which content analysis may be used to analyze data:

[49] Strauss and Corbin (1996) also mention that data saturation is a matter of degree. They state: " In reality, if one looked long and hard enough, one always would find additional properties or dimensions" (p. 136).

> Data can also be looked at from numerous perspectives especially when they are symbolic in nature. In any single written message one can count letters, words or sentence. One can categorize phrases, describe the logical structure of expressions, ascertain associations, connotations, denotations, elocutionary forces, and one can also offer psychiatric, sociological, or political interpretations. All of these may be simultaneously valid. In short, a message may convey a multiple contents even to a single receiver. (p. 22)

Data management.

I did not use qualitative software to proceed to data analysis since I could not afford the cost of buying this software and did not have the time to get acquainted with how it works. I decided to manage data using word processing software. Data preparation was performed in the following steps: First, I transcribed all of the audiotapes and put the hardcopy in a file for each participant. I also filed transcribed post-interviews and participant observation fieldnotes in the corresponding caregivers' folders. Second, I read each transcript twice; the first reading was to obtain a general idea of the interview and the second reading was to begin writing down *in vivo* code in the margins. Third, when progressing with the data coding, I was able to aggregate some codes to form categories. Fourth, I created a second file for each participant where codes and categories appeared on each transcript and I underlined interview transcripts using fluorescent markers to delineate categories. This task was aimed at facilitating the work of cutting and pasting to regroup categories and themes. Finally, I cut and pasted the caregivers' interviews according to the categories and collected them in a folder to facilitate data retrieval.

Making sense of the data.

In using a postcolonial feminist theoretical approach, the concepts of culture, race, ethnicity, gender, social class, and elements of the social world (i.e., the social, cultural, political, and economic context) were explored during interviews and participant observation sessions. Caregiving and the health care system were also examined through the postcolonial lens. These concepts were the point of departure for the data collection and analysis.

The theme of Haitian Canadian primary caregivers' ways of caring as a pattern of cultural continuity and a process of reciprocity and mourning in becoming was constructed on data collected from interviews and participant observation sessions related to Haitian Canadian caregivers' construction of caring. The aim was to illustrate how caregivers make sense of the experience of caring for an aging relative at home by linking culture and caring activities. I was interested in exploring questions such as: What does it mean to care for your mother and/or father? Can you describe your experience of caring for your wife or husband? Can you describe the nature of your activities of care? How do you feel when you care for your aging parents? Can you identify your feelings? These types of questions were used as probes to understand the meanings associated with caring from caregivers' standpoint in the course of their everyday lives.

Caring as a pattern of cultural continuity is a sub-theme that addressed the process by which Haitian Canadian caregivers seek to adapt the Haitian cultural values on aging and caring in the mainstream society. How do caregivers construct aging and caring for an older parent? What is the primary caregivers' perspective on caring? This sub-theme is composed of three categories: the meaning of aging, the nature of caring, and the motives of caring. The meaning of caring is formed from excerpts from interviews where *in vivo* codes (e.g., doing, help, aid, complement, assist, maintain independence) were found in a sentence. For instance, this interview excerpt was classified in the category meaning of caring:

> "Helping somebody it is to help in doing things individuals cannot do by themselves." "We're not there to replace the individual, but just help to complete, to do things people cannot do themselves."

The nature of caring activities was formed with many *in vivo* codes referring to the kinds of care provided to care-receivers to support activities of daily living and instrumental activities of daily living. For instance, *in vivo* codes like bathing, feeding, providing hygienic care, dressing up, combing hair, alternating positions in the bed, rubbing a sore back, doing the

groceries, doing the laundry, taking the blood pressure, giving medication, preparing the meals, assisting with exercises and social activities, going out to the restaurant, listening actively, doing the banking, and driving to the doctor's office were found in the interview. An example of an interview excerpt that was classified in this category was:

> "I give her a shower once a week and I wash her hair."
> "I go to the grocery store."
> "I wake up at least two times a night to move her in her bed."
> "I listen to her. I think I'm her moral support."
> "Once in a while we bring her to dine out to the restaurant."

The category motives for caring was formed by regrouping the reasons underlying the choice of caring for an aging parent at home. For this category, *in vivo* codes like: "It's cultural," "it's a filial duty," "it's in our customs," "it's our culture," " we have been raised to care for our parent," "in Haiti, that's part of our lives as adult children," "I can never give back what they do for me," "I don't want my mother to be institutionalized," were included. Participants' comments about fears of institutionalization, love and attachment, gratefulness, and recognition, were also included in this category. The interview excerpts were:

> "We're used to that. We never part from our parents. It is like this and we've been socialized to care for our parents. And it is transmitted."
> "Caring for aging parents? It's anchored in the Haitian community."
> "It's my filial duty as a daughter to care for mummy."
> "She sacrificed herself for her family, so it's a moral duty to look after her now."

Family support and networks were formed each time that a caregiver mentioned or described the kind of support received from close family members, members of the extended family, friends, and churchgoers to support the caring commitment. For this category, *in vivo* codes like, "my aunt comes to help me," "I have cousins who come in to stay with her," "some members of my church come in to stay with her a couple of hours," "I'm alone to care for mummy," "my extended family doesn't provide any support," were included. Caregivers'

feelings of isolation were also classified in this category. Instances of interview excerpt classified in this category were:

> "Family support is very useful, because for 'us' Haitians, family is not only restricted to close family members but also to cousins, nieces, nephews, and even neighbours. When we need help, well they come in and give a helping hand."
>
> "My sisters, I mean the members of my church, help me a lot. They give me lots of support. They teach me what I need to do with mummy. They know it's not easy since they care for aging parents at home too."
>
> "I'm alone and I feel like I'm nailed down here, in that house. I receive no help from the extended family, in fact I'm the only one who cares for mummy and they [extended family] always ask me to help."

Caring as a process of reciprocity and mourning in becoming was composed of categories where caregivers reported feelings of giving something back to older parents in recognition of the past and the positive and negative outcomes of caring. As well, other caregivers mentioned starting to build memories since they felt that the mother or the father might pass away in the near future. This anticipation of losses and death illustrates the process of mourning in becoming. For this category, *in vivo* codes included: "I stare at him to print his image in my brain," "I talk with him to remember his voice," "I'm afraid to wake him up since I'm afraid to find him dead in his bed," "it's difficult to see mum forget things like that," "I can't believe she forgets to eat her breakfast," and "she helps me despite her conditions." Here is an interview excerpt classified in this category of reciprocity:

> "And I can say that mummy help me raising my kids."
> "Mummy cooks a little since she wants to help her daughter."
> "She can look after the children."
> "Since she stays with me, I learn more about her, I mean about her life as a woman."

And for the losses, which characterize the process of mourning in becoming, I classified interview excerpts where witnessing losses or anticipation of the loved ones death was mentioned:

> "It's difficult to see him now. I prefer to keep better memories of him, at a younger age."

> "I can't believe mummy is now so confused. She was so organized and so bright. And now, look at her, see what she looks like now."
> "My wife, she takes me for a stranger. She doesn't recognize me. Can you imagine how I feel?"

The gendering of caring is a second theme and was composed of ten categories: 1) impact of Haitian traditional values in defining men and women roles, 2) gendering of caring activities, 3) remodeling of the Haitian Canadian family dynamics resulting from immigration, 4) needs for women caregivers to enter the workforce, 5) patterns of negotiation on the sharing of domestic tasks with Haitian Canadian husbands or spouses, 6) impact of caring on marital life, 7) impact of caring on social life, 8) impact of caring on leisure activities, 9) impact of caring on women engaged full-time in the workforce, 10) hidden cost of caring and its impact on women caregivers.

The gendering of caring is a theme that shows how the triple-task of middle-aged women caregivers have an impact on their health and well-being. Most of the women caregivers have to raise young children or deal with teenagers, look after aging parents, work outside the home, while being accountable to perform domestic work. A sample of *in vivo* codes related to one of these ten categories include: "I must do everything in that house," "my husband doesn't want to help me," I told him to wash the dishes," "when I come back from work," "I am exhausted," "I can't do nothing," "I just want to go to sleep," "he brings his clothes to his mother and she washes them," "we are hungry can you cook something for supper?" "You must help me cleaning this house," " I can't do all the work alone."

The impact of the social world is the third theme and is formed from categories related to the process of social Othering. Interview excerpts pertain to the impact of perceived racism, cultural ethnocentrism, and sexual harassment in the workplace, in school or in the civil society (i.e., going to the shopping mall or to the restaurant). Issues related to Canada and Quebec politics, the impact of Quebec's last referendum, perceptions of social exclusion by mainstream

society due to the colour of the skin or political allegiances (which is closely associated with ethnicity in Quebec) were documented under this theme. As well, issues related to the recognition of foreign diplomas that can preclude Haitian Canadians from accessing better wages and living conditions, were included. A sample of *in vivo* codes related to these categories includes: "There's no social integration here," "racism is a lack of education," "they don't like ethnic communities," "go back home you *tonton macoute*, go back to your country, and don't tell us how to run our country," "I couldn't get the job because of my Haitian accent," or "you can't work here with me, it's not your place." This theme also refers to the social rejection of Haitian Canadians and the lack of acknowledgment of cultural differences. Here are some interview excerpts that were placed in the categories of this theme:

> "Get out of my room you dirty nigger!"
> "You won't touch me!" [A female nurse was told this]
> "Go back to your country, *tonton macoute*!"
> "Since the last referendum it's worse, it's worse!
> "I'm concerned about my kids. When will they be acknowledged as Canadians? Perhaps in 2030?"

The underutilization of health care services by the Haitian Canadian community is explored in the theme presenting results on the relations between Haitian Canadian primary caregivers with mainstream health care providers. This is the last theme to be treated and is composed of interview excerpts that pertain to caregivers' perceptions of visiting nurses, the cultural adaptation of services to Haitian culture in public health care facilities, the accessibility to home care support services (e.g., domestic aid and respite services), the expectations of Haitian Canadian caregivers in terms of needs of services. Also, interview excerpts related to the impact of health care reform in downsizing home care services to the aging persons, on nursing professional practice, on the CLSCs budget and staffing, on privatization of home support service, and the difficulties for low-income families to access privatized home support services,

were included in this theme. Instances of *in vivo* coding for the theme 'underutilization of health care services' were:

> "They give priority to the youth at the expense of the aging people who constructed Canada."
> "It's a lack of respect towards the elderly to cut programs."
> "I need some respite, otherwise I'll pass away, I'm exhausted! Do you understand?"
> "They don't invest in the aging people. And, it's a lack of dignity to treat older persons like this."
> "The nurse? Well, she rushes in and out. She doesn't have time to sit down and speak with me."
> "It's five minutes and that's it! That's over and she goes to another client."
> "Social workers and psychologists are the real sources of support for me. I never had a nurse to support me."
> "They cut seven hours of respite. It's not enough! How can I catch up sleep?"
> "I never go to the CLSC. I prefer to go to medical clinics."

These four themes overlap since their interrelations explain the context of caring for aging relatives in the Haitian Canadian community. Themes must be seen as a whole where each part intersects to mediate Haitian Canadian caregivers' experiences. Ways of caring are socially and culturally constructed depending on the social, geographical, and economic context in which caring activities unfold. These themes illustrate how race, ethnicity, gender, and social class intersect with other social structural factors to influence ways of caring. This intersection also has impacts on Haitian Canadian caregivers' choices to keep aging parents at home to protect them and the choice not to institutionalize, since care is not culturally safe to fulfill the needs of Haitian Canadian aging persons.

Language Equivalence

Interviews were conducted in French and the preliminary steps of data analysis, such as performing *in vivo* and open-coding, were also conducted in this language. After, shifting to English, I presented the logic behind the data analysis to my committee. Memoing was also performed in English and the interview excerpts were presented in both French and English. A native English-speaker, who also spoke French fluently, assessed the translations of the excerpts.

This person was born in Ontario and presently works in Quebec and checked my translations from French to English and back-translated them from English to French. A few words had to be modified. After having described issues related to data collection and analysis, I now discuss the criteria of trustworthiness and how they were applied in this research. In addition, I demonstrate the lack of relevance of postpositivist criteria when applied to assessing the scientific rigour of qualitative critical inquiries.

Issues of Trustworthiness

Lincoln and Guba (1985) define 'trustworthiness' as the criterion by which the results of an inquiry clearly reflect the 'object' or the reality of the study – in other words, if the "findings are worth being taken" (p. 290). Some qualitative researchers argue that positivist conventional criteria do not fit with the assessment of qualitative research since measurement is not the focus of such inquiry *per se* (Janesick, 1994; Leininger, 1985, Sandelowski, 1991; Sandelowski, 1995b). Sandelowski (1986) contends that the varieties of qualitative studies, with the tendency to evaluate qualitative designs against conventional criteria of rigour, and the artistic features of qualitative inquiry, can be seen as impinging on the scientific adequacy of qualitative research. On the other hand, Sandelowski (1995b) also warns against the risks of evaluating qualitative inquiry from a rigid positivist or postpositivist framework, to make it look like quantitative research. She underlines that scientific rigour, if too stringently applied, can clearly undermine the creative purpose of qualitative inquiry.

Conventional Criteria of Validity and Reliability

In qualitative research, validity is achieved by exploring and gaining knowledge and understanding about the nature, essence, meanings, attributes, and characteristics of a particular phenomenon under study (Leininger, 1985). Qualitative reliability refers to identifying and documenting "recurrent, accurate, and consistent or inconsistent features, as patterns, themes, values, worldviews, experiences, and other phenomena as confirmed in similar or different

contexts" (Leininger, 1985, p. 69). Lincoln and Guba (1985) found four naturalist[50] criteria equivalent to the criteria used to assess the scientific rigour of quantitative studies. These naturalist criteria are: credibility, transferability, dependability, and confirmability.

Credibility refers to the concept of internal validity. Credibility is defined as the extent to which the researcher adequately represents the informants' constructions or representations of the findings. The task is to demonstrate that the researcher's reconstructions are "credible to the constructors of the original multiple realities" (Lincoln & Guba, 1985, p. 296). Qualitative credibility corresponds to quantitative internal validity where causality between variables is inferred (Cook & Campbell, 1979).

Transferability refers to the generalizability of findings. Can findings be applied to a similar context or to similar populations, without relying on quantitative criteria of external validity such as randomization, random assignment, sample size, and statistical power?

Dependability is related to the quantitative notion of reliability and replication. Lincoln and Guba (1985) claim that validity cannot exist without reliability. In quantitative method, an instrument is valid only if it measures the concept it is intended to measure. Lincoln and Guba (1985) contend that demonstrating qualitative validity ensures that results are reliable.

Confirmability refers to the careful documentation of the conceptual and methodological development of the research or the Halpern's audit trail (Janesick, 1994; Lincoln & Guba, 1985; Morse & Field, 1995). It also points to the importance of neutrality since positivist and postpositivist inquiries are conceptualized as being value-free. The distance between informants and researcher must be maximized to reach that level of objectivity (Lincoln & Guba, 1985).

The Halpern's audit trail consists of six steps involving treatment of raw data, data reduction and analysis, data reconstruction and synthesis, the process used to collect data or the

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[50] Lincoln and Guba (1985) do not provide a straightforward definition of naturalistic inquiry but underline two major features of this inquiry: "First, no manipulation on the part of the inquirer is implied, and, second, the

methodological choices, the personal situation having an impact on data collection and analysis, and issues related to the development of an instrument.

Trustworthiness in this Study

It is difficult to harmonize mainstream research criteria when doing a critical ethnography since naturalist criteria violate the assumptions of critical approaches, such as the value-ladenness of facts, reciprocity, equalization of power relations, establishing trust with participants, need to democratize the research process, and the emancipatory or praxis-related goals of critical research, which cannot be assessed from conventional criteria. Lather (1994) contends that naturalist criteria represent a 'regime of truth' to discipline science according to the canons of mainstream research. Furthermore, Carspecken (1996) suggests the following rule of thumb to assess truth claims in critical inquiries: "Whenever considering a truth claim, examine the validity conditions associated with it. What procedures have to be followed to try to win the consensus of any cultural group to the claim?" (p. 57). Therefore, if consensus is obtained using force, or racial, ethnic or social privilege, the validity of the truth claim is clearly undermined. Finally, Kincheloe and McLaren (1994) point out, "claims to truth are always discursively situated and implicated in relations of power"(p. 153). Therefore, in this study, the challenge was to achieve a balance between naturalist and criticalist criteria in assessing the validity of truth claims. I now describe the strategies that were used to establish the scientific rigour of this study.

Establishing Scientific Rigour

Intensity of Fieldwork

Lincoln and Guba (1985) suggest that a prolonged engagement in the field, with persistent observation (e.g., writing thick fieldnotes), and using a triangulation of methods are the means to rule out threats to validity or credibility. Engagement in the field is one of the most

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inquirer imposes no *a priori* units on the outcome. Naturalistic investigation is what the naturalistic investigator does" (p. 8).

important things to ensure credibility since the researcher develops a network and the day-to-day experience determines a deeper integration in the setting. The researcher is thus less likely to gather distorted or superficial information (Leininger, 1985; Morse, 1994; Morse & Field, 1995; Sanjek, 1990; Spradley, 1980). The degree and intensity of participation depends on the amount of time spent in the setting and on the trust developed over time with participants. An extended period in the field and the development of a trusting network of key informants increase ethnographic validity. Dwight Heath (as cited in Sanjek, 1990) points out: "Any effective anthropologist develops *his* [sic] own social network in the process of fieldwork; the nature of this network is, at the same time, both a determinant and an outcome of the research enterprise" (p. 398). Therefore, the amount of time spent in the field and the quality of the information transmitted and shared with participants and key informants throughout fieldwork represent the key issues to establishing validity.

Participant Observation

The second means to enhance validity is by doing persistent observation by writing 'thick' fieldnotes to provide in-depth knowledge on multiple influences or contextual factors that might influence the phenomenon under study. Lincoln and Guba (1985) state:

> The purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued, and focusing on them in detail. If prolonged engagement provides scope, persistent observation provides depth. (p. 304)

Triangulation of Data Collection Methods

A triangulation of data collection methods, including interviewing, participant observation, and writing reflexive and analytic fieldnotes, was used to complement one another in grasping the phenomenon of caring for an aging relative in the Haitian Canadian community. In this study, triangulation contributed to expanding the scope of data collection since it contributed to locate Haitian Canadian caregivers' caring experiences in the broader social

context, especially when doing observation at caregivers' home. As well, participant observation was useful to verify some contradicting information gathered during interviews like the division of household tasks. Participant observation sessions at caregivers' homes helped me to contrast verbal and non-verbal information provided by participants. It was particularly useful to clarify competing information. For instance, in an interview, a man caregiver reported that he was sharing household tasks almost evenly with his wife. A participant observation session, however, demonstrated that the woman performed almost all domestic chores in that household.

I also relied on other documents like CLSC annual reports, CLSC nurses' philosophies and conceptual models, descriptions of tasks, paperwork used to access home care services, health care policy, and other official government literature to get an in-depth knowledge of the financial and human issues that intersect with the delivery of home care services.

Peer Debriefing and Member Check

Peer debriefing and member check were also used to enhance validity. Peer debriefing is done by an experienced researcher who asks questions pertaining to the substantive, methodological, legal, ethical, or other relevant matters of the study (Lincoln & Guba, 1985). Sandelowski (1991) provides some paradoxical insights on these ways of reaching validity. Basically, she claims that peer debriefing is hardly achieved since two qualitative researchers could have different analytic interpretations of a given data set. As well, one of the researchers might miss the observational content or features of the interview. Sandelowski (1991) further argues that member check can also be problematic since the informants tend to focus on their account rather than on the overall findings.

Once in the field, e-mails were regularly sent to the committee and to my supervisor, and debriefing teleconference meetings were scheduled for February 2001 and June 2001 when I was in Montreal. In addition, I went to Vancouver to meet my committee in March 2001 and two additional meetings were held in September 2001. When I was in Montreal, prior to the March

2001 visit to UBC, I translated some interviews from French into English and mailed them to my committee members, so they could understand how the interviews were going and the kind of data I was collecting. Methodological issues such as improving interviewing skills with the men caregivers, being able to formulate better open-ended questions, and enhancing my self-reflexivity to bracket my preconceived ideas were raised and applied to the research. The issue of safety was also discussed by my committee members as well as how to work out the volunteer recruitment issues.

Member check consists of presenting the results to the informants to validate the representation of the phenomenon. Due to the unavailability of some caregivers to meet with me a second or a third time, I turned to the participants whom I most often met during the fieldwork. Two men and a key informant were asked to discuss the preliminary data analysis. Although member check occurs throughout the fieldwork, a final version of the data analysis was presented to the participants for validation. The best way to achieve the goal of validity is to stay close to the participant's words (Janesick, 1994), which underlines the difficulties in doing a research study that is far from the university site. This was the major issue that complicated the research process in terms of accessing the participants once the data collection was completed. Still, I could always reach the participants by telephone to get an explanation or more details about the content of interviews.

This leads me to describe a particular problem encountered when doing member check with a participant. I was asking a participant to comment on whether I had reached the correct interpretation or reconstruction of what we shared during the interviews and participant observation sessions. I was surprised by what he said: "So, you didn't believe what I told you?" I responded that I believed what he had told me but wanted to be sure that my interpretation of the events corresponded to his. Apparently, member check can be a sensitive issue in doing cross-cultural research and it is important not to convey a feeling of disbelief among participants.

Participants must validate the researcher's interpretations, otherwise, as Carspecken (1996) points out, the truth claim must be re-negotiated. In cultural nursing research, member check can be misinterpreted and misunderstood to be a kind of distrust towards participants. C.W. Watson (1999) argues that, "understanding is only part of the task; translating is the other" (p. 7).

I suggest using this technique cautiously when doing research with peoples from different ethnocultural backgrounds, since language and interpersonal relations come into play. Participants and researchers have their own personality strengths and weaknesses that must be accounted for when doing fieldwork. Encounters with other peoples are often unpredictable – and this is the hallmark of qualitative research. Perhaps doing member check in ethnic communities, where distrust is high, was not a good idea. If this technique has to be used, however, I would emphasize the need to explain that member check is aimed at verifying the accuracy of the researcher's understanding of the participant's meanings. It is not directed at assessing the 'truth.' As a critical researcher, I should not be the only one to interpret data since I would be imposing my theoretical views on participants with whom the data set was co-constructed. Even though my most important and focused moments of data analysis occurred while I was away from Montreal, I constantly confronted the data set to be mindful of the reality of caregivers' everyday lives. As a critical researcher, my social role was in voicing the Haitian Canadian caregivers' messages without interfering in the meanings of their lived experiences, or manipulating raw data that was expressing the complexities of the larger social context.

Ethical Considerations

Informed consent is a key issue in ethnography as well as with other qualitative methods because the researcher works with human beings. Fetterman (1998) points out "ethnographers do not work in a vacuum, they work with people" (p. 499). Prior to beginning fieldwork, UBC ethics forms were submitted for approval. Letters of information were provided to Haitian primary caregivers, home care nurses, and persons cared for by the primary caregivers (see

Appendixes H, I, J, and K for letters of information). Informed consent forms were available in English and French (see Appendixes L, M, N, O, P, and Q for consent forms). The biographical forms of the Haitian primary caregivers and home care nurses were kept confidential (see Appendixes R and S for biographical forms). Interview transcripts, participant observation sessions, fieldnotes, and tapes were also kept in a locked filling cabinet.

It is highly recommended to disclose all information pertaining to the research goals and reasons for the project to be carried out. Hammersley and Atkinson (1995) state, "it is often argued that the people to be studied by social researchers should be informed about the research in a comprehensive and accurate way, and should give their unconstrained consent" (p. 264).

In this study, all information pertaining to the study was disclosed to participants, before they decided whether or not to participate in the study. Disclosure of information is the ethical basis from which to obtain informed consent. Moreover, the consent must not only be informed but also given without any constraints. I respected the desire of participants not to be recorded or observed and turned off the tape-recorder whenever asked to do so. Some aging persons had difficulties giving an informed consent due to their hearing or cognitive impairments and in these cases, the primary caregiver or a legal representative was asked to give consent on the participant's behalf. Participants were informed of their rights to withdraw from the study at any time. They were also assured that their decision to participate or withdraw from the study would not hold any consequences or prejudices for them.

This approach respects the postcolonial feminist paradigm where identification, empathy, trusting, and non-exploitive relationships are of paramount importance in the ethics of research (Punch, 1994). I was available to give information and provided my residence and cellular telephone numbers to all participants so they could reach me if need be. Doing ethnography is not "just doing it," since the consequences and potential benefits for participants must be balanced. It was unlikely that any negative effects could be induced by this ethnography and no

negative effects were reported. Although some questions triggered sadness and tears, I never left participants to manage the sadness by themselves. I always asked if the names of a Haitian Canadian community leader or CLSC health care providers were required for further help. Such offers were always declined except in the case of a care-receiver who wanted to get some help from the local food bank. I told her that by contacting the manager, I would break the confidentiality, explaining to her that others would know that she participated in the study. She did not want to call the food bank herself, however, and wanted me to intervene. I managed the issue by providing only the care-receiver's telephone number to the food bank manager and notified the care-receiver that I could not guarantee she would receive food, since the decision was in the manager's hands. In another case, I provided the name of a community leader to help a caregiver who wanted to formulate an official complaint to the CLSC in her neighbourhood. Her aging mother was asked to go to the CLSC, to provide blood samples, even when an at-home service is provided for the aging residents within the CLSC territory. I informed this caregiver of her rights to write a formal complaint about the lack of service. In hazardous winter conditions, she drove her mother to the CLSC. They walked over icy sidewalks and it was fortunate that the mother did not fall on the slippery pavement. Also, since I was a nurse, this woman asked a few questions about a health problem. I took the time to answer her questions and felt that the woman was reassured by our discussion. Another woman caregiver, who had been going through difficult events at her work with an employer, was depressed at the time of the interview. I was concerned for her and asked if I could do something for her. She replied that she was already receiving professional psychological help. Another caregiver reported having suicidal ideas but told me the feelings happened some time ago. She told me she had not sought nor needed professional help and mentioned that her religious faith precluded her from committing suicide. I found that the study acted as a method of catharsis for participants who often felt at ease to express concerns or to discuss issues of interest to them, especially during the

interviews or participant observation sessions. Some participants telephoned me while I was at my temporary residence in Montreal to share their thoughts or when they needed somebody to talk to. I also received some telephone calls later when I moved to Quebec City, after completing the first phase of the fieldwork

Limitations of the Study

Two limitations were identified in this qualitative study. First, findings cannot be generalized to the Haitian Canadian population in a statistical sense, though they might still shed light on similar situations faced by other Haitian Canadians and Canadians from other ethnic communities.

Second, the exclusion of Creole-speaking people limited access to a different social and economic group. My lack of fluency in Creole and the insufficient financial resources to hire an interpreter created this exclusion. Likely, the inclusion of Creole-speaking participants would have increased the number of participants in the study, however, the extent to which the results may have changed the final study outcome could be questioned. I suggest that the inclusion of more participants, or of additional Creolophone social classes, would not have altered the overall trends that were found in the study. A trend of non-utilization of home care services was clearly demonstrated by 11 out of 16 primary caregivers.

Reimer Kirkham and Anderson (2002) mention that postcolonial methodology must adhere to criteria of scientific adequacy and rigour. The detailed overview of the fieldwork and description of techniques used to ensure trustworthiness in this study demonstrate that criteria pertaining to scientific adequacy and rigour were respected. The goal of critical inquiry is to generate transformative knowledge, and this research would have to be assessed according to this emancipatory criterion. If grounds for social changes was generated, then the study's goals were achieved. Moreover, in critical qualitative research, participants and researchers are human persons, and as Carspecken (1996, p. 25) points out "generalization across context is always

dangerous" because social contexts, experiences, and human experiences, are holistic and contextualized.

Organization of Chapters on the Findings

After presenting the study design and methodology, I now present the findings. Presentation of results is organized to provide the reader with the background information to construct Haitian Canadian ways of caring for aging relatives at home. My aim is to demonstrate the impact of gendering and experiences of social 'Othering' on Haitian Canadian caregivers' ways of caring and utilization of health care services, and more precisely home care services. In Chapter Five, results pertaining to the gendering of caring are presented. Chapter Six illustrates the impact of 'Othering' on Haitian Canadian caregivers' perceptions on mainstream society. Issues of racial and gender discrimination in the workplace, school, and the civil society are presented. In Chapter Seven, results pertaining to Haitian Canadian caregivers' ways of caring are delineated and in Chapter Eight, the relations between caregivers and the health care system are presented. This ordering of chapters is likely to locate caregivers' experiences in the social world and to demonstrate that caring activities do not stand alone but are mediated by social, cultural, political, and economic factors, related to the mainstream society.

CHAPTER FIVE
THE GENDERING OF CARING ACTIVITIES AMONG HAITIAN CANADIAN CAREGIVERS

Introduction

In this chapter, data is presented to illustrate that Haitian traditional values pertaining to men and women's traditional roles, gendered division of domestic work, immigration, and the constraints of a free market economy, have an impact on the gendering of caring among Haitian Canadian women caregivers. These contextual factors also influence the family patterns of negotiation used by Haitian Canadian women to involve husbands or spouses in the sharing of domestic tasks, and to facilitate caring activities. Covan (1997) conceptualizes the gendering of caring in elder's care as an outcome of the sexual division of labour that imparts to women the sphere of caring and nurturing. This position can be seen as being limited to gender since it overlooks the influence of the broader social context within which caring unfolds. Covan (1997) says: "The decision-making role has been dominated by men, and household tasks have been disproportionately provided by women"(p. 329).

On the other hand, Hooyman and Gonyea (1999) argue that gender cannot be studied in isolation from structural factors like race, social class, ethnicity, and economy. A feminist model of family care uncovers the social construction of gender-based inequities in caring. This approach is directed at deconstructing preconceived ideas that model women caregivers and the lives of care-receivers, but also at understanding why men were excluded from the sphere of domesticity and caring. A postcolonial feminist perspective addresses issues in the context of caring to uncover the social, political, economic, and cultural determinants that construct experiences of caring for aging relatives at home. More precisely, social inequities that are located at the intersection of race, gender, social class, and caring are explored to expose hidden relations of ruling that influence ways of caring for Haitian Canadian aging relatives and caregivers and their utilization of the health care system.

In this chapter, the everyday struggle of Haitian Canadian women caregivers to reconcile their paid work with caring activities is described. More specifically, the extent to which women caregivers are torn between Haitian cultural traditions and the need to adapt to the Canadian market economy are examined. Traditionalism and patriarchy represent the cultural premises upon which conflicts on the sexual division of household labour arise between Haitian Canadian men and women. Second, the influence of immigration in redefining family dynamics of Haitian Canadian traditional roles is examined. The patterns of negotiation used by Haitian Canadian women caregivers to achieve this reconfiguration are described. The influence of caring on caregivers' familial and social life is scrutinized. As well, the hidden economic cost of caring on women's caregivers and their families is discussed. Finally, the impact of caring on paid work is examined and the blurring boundaries between private and public spheres in women's lives delineated.

In this study, 12 of 16 participants were women (mostly daughters, but also one daughter-in-law), caring for aging mothers or mothers-in-law. Six women were married, five were divorced, and one was single. A woman caregiver worked 20 hours a week while another was retired. The ten other women caregivers were working full-time in the paid labour force. Most of them were parenting young children, adolescents, or grandchildren, while caring for their aging parents at home. On the other hand, the four men caregivers were married (two of them were retired). The fact that women outnumbered men as caregivers and care-receivers, can be partly explained by women's longer life expectancy at birth, but demographic data alone cannot explain the gendering of caring among Haitian Canadian caregivers. Structural factors that model caring activities as well as the roles of men and women must be examined.

The Impact of Haitian Traditional Values on the Roles of Haitian Canadian Men and Women

During fieldwork, I noticed that Haitian Canadian women, like other Canadian women, juggle the triple-task issue, which consists of working in the labour force, parenting young children or adolescents, and caring for aging parents at home. Meanwhile, women remain totally accountable for performing almost all domestic duties. Haitian traditional and patriarchal values, like patriarchal values in other societies, have an impact on the gendering of caring activities. In this section, I explore how traditionalism and patriarchy influence the roles of men and women in the household, in their patterns of negotiation to share housekeeping tasks, and in the approaches to problem-solving that are used within the family to support or not support women caregivers' commitment.

The traditional authority of Haitian Canadian men, embedded in a culture of machismo, was reported in a prior study aimed at exploring the construction of Haitian ethnicity in the Montreal area (Massé, 1983). In fact, Massé (1983) documented the occurrence of asymmetrical relations of power in structuring men and women's social relations. I would be careful before asserting that asymmetrical power relations and machismo are only observed among Haitian Canadian men since I would be inscribing their identities in an essentialist cultural discourse. The point is that machismo is a social and cultural construction of colonialism. Hall (1997b) emphasizes that colonialism and slavery have had an impact on Black men's masculinity. As well, Hall (1997b) defines machismo as a means of resistance to oppose the hegemony of White men in Othering Black men's roles. Therefore, when examining some Haitian Canadian men's machismo, one must be aware that it has been aimed at resisting and counteracting the effects of negative stereotypes, that have affected Black men's identities — an effect created by colonialism and by the derived ideology of Whiteness. To avoid generalizing machismo to all Haitian Canadian men, its historical, cultural, and social constructs must be examined. These

attitudes and behaviours arise from colonial hegemony and were inscribed as normative practice aimed at disenfranchising Black men of their human rights. Machismo is deeply rooted in hegemonic discourses on race. As Hall (1997b) puts it:

> During slavery, the white slave master often exercised his authority over the black male slave, by depriving him of *all* [italics added] the attributes of responsibility, paternal and familial authority, treating him as a child. This "infantilization" of difference is a common representational strategy for both men and women. ... Infantilization can also be understood as a way of symbolically "castrating" the black man (i.e. depriving him of his "masculinity")....Treated as "childish", some blacks in reaction, adopted a "macho", aggressive-masculine style. (p. 262-263)

As a product of colonialism and imperialism, machismo must be questioned, and therefore not used uncritically to label the decisions or behaviours of Haitian Canadian men in pertaining to marital and familial roles. Keeping in mind that machismo is a colonial construct, we may understand the nuances of participants about Haitian Canadian men. In this participant observation excerpt, Margaret[51] described Haitian traditional family roles:

> Participant: In Haiti, children were the safety net, to care for their parents when they grew older. It was not uncommon to see large families of six or eight children. Education was very, very important since it's considered the key to achieving higher social ranks. In Haiti, boys were educated, they went to university, they earned graduate degrees in medicine, law, or accounting, but girls didn't get these opportunities. Boys were more valued than girls in the sense that boys were educated to assume their future functions as breadwinners and heads of family. Girls obeyed their fathers or brothers. As authority figures, boys were more protected than girls were. Girls only needed to do basic math and know to write their names because once they'd got married, they'd only need to supervise the household and the domestics' work. *Mum didn't want my brothers to enter the kitchen.* [italics added] She told them: "Kitchen isn't your place! This is not your place here. It's woman's work, not yours and stay away from the kitchen!" *Kitchen was a strictly feminine domain because parents were afraid to feminize boys by allowing them to perform domestic tasks.* [italics added] Cooking, housekeeping, cleaning, and all other domestic chores were seen as women's work. It was the same for raising the children or caring for the sick or the elderly. Domestic tasks were automatically attributed to girls since it was the custom. Caregiver 01-F
>
> Observation: Caregiver's mother sits at the table and approves the conversation by nodding her head for yes.

[51] All participants of the study were attributed various pseudonyms, to protect informants' confidentiality. As well, the identity of the number of children in some families and their gender were modified to further protect participants' confidentiality. Therefore, the reader must be aware that the number of pseudonyms exceeds the number of 16 caregivers.

She went on to explain how the women of her generation were socialized to fulfill their attributed roles in the Haitian society. These roles consisted of performing or supervising household duties, raising the children, and caring for the sick and the elderly. In a participant observation session, Margaret mentioned:

> Participant: So, people of my generation, those born and raised in Haiti, we have been used to this custom. Despite coming back home completely exhausted from work, we perform domestic tasks and supervise the kids. It's a custom and men don't participate in women's tasks. The husband just gets at the table and waits for the meal to be served. He's the breadwinner and the head of the family. Men don't attend domestic chores. A good wife must support her husband in being a good housewife. She must be a hard worker because it's the expectations, of a good wife. Basically, women care for the house, the children, and look after the aging persons. This portrayed how women of my mum's generation had to fulfill their roles as wives. In these times, they hired domestics to help them and it was easier. It's much more harder here, in Canada, since we can't afford domestic aid. It's too expensive and women must do everything, everything. Mum got it easier than I. She hired servants and only needed to supervise their work. It was a relief for her but it hasn't been my case here [in Canada]. Caregiver 01-F

This is how Margaret perceived and explained how women of her generation were socialized to perform or supervise household duties. In this interview segment, Elizabeth provided an almost identical comment:

> Participant: Mum can't speak or read French. Before, you know, parents didn't send daughters to school for a long time. Grandmother used to say that only boys need to be educated and girls needn't. Girls must know how to write their names and do basic maths. Basically, this is what mummy heard from grandmother. Caregiver 06-F

George, an 87-year-old man, described Haitian traditional men and women's roles, as they were when he was raised in his native country. George performs domestic and housekeeping tasks due to his wife's illness. It can be assumed that despite their socialization, some Haitian Canadian men adapt to the changing conditions of their lives, especially when they care for their very ill wives at home. When life circumstances clearly indicate they cannot do otherwise, men enter the kitchen, a private and restricted women's domain. Nevertheless, this

transition is difficult to figure out in the reality of everyday life, even for some adult children. For instance, George's eldest son could not understand how his father could achieve the planning of meals and do the cooking. George said:

> Participant: Oh you know I have to live with this. I've to get used to it. I cook, do the laundry, the housekeeping, and I wash her clothes as soon as possible. I told her: "Sweetie, take some rest, you've already done enough for me, it's my turn now." I'll tell you something else. Yesterday, our eldest son came in to visit and asked me: "Hey dad, from which restaurant do you order in?" I replied: "I don't order anything in. I cook everything that's on the table here, in this home. I manage your mother's diet because of her diabetes. Each day I change the menu." Caregiver 04-M

George discussed Canadian society and the bridges in the gap between Haitian and Canadian cultural values as they pertain to women's role and family dynamics. He contrasted the differences that he had noticed since his arrival in Canada:

> Participant: I'll tell you what I can't accept of Quebecers. When the husband or the wife is sick, well they [Quebecers] manage to kick them out of the house! (Claps his hands)
>
> Interviewer: They [Quebecers] put them in nursing homes?
>
> Participant: Yes. They place them and frankly speaking, I dislike it. We have a friend like this. She placed her ill husband in a nursing home and now when she sees what I'm doing with Anna, well she regrets it.
>
> Interviewer: Ok. It seems as if they [Quebecers] want to get rid of the problem. Is it what you mean? To get rid of the ill husband or wife?
>
> Participant: It's not good. I don't like this. And Quebecers divorce too easily. It's almost as if the person isn't important. Divorce is easy to get but I think it's the way of living here.
>
> Interviewer: Way of living?
>
> Participant: Yes. First of all, women weren't liberated here before. In earlier times, women weren't as powerful as they are now. But when they started claiming their rights, then everybody went their own way. And since then, women are independent and challenge men's authority. They're independent. I see it like revenge, women look like enraged animals.
>
> Interviewer: You mean women become like this [enraged animal] when they claim their rights?
>
> Participant: Yes. Exactly. When a woman claims her rights, she becomes an enraged animal.

Interviewer: Well, it was like this in Quebec, in the 30's and 40's....

Participant: *No it wasn't like this before. It was like this almost all around the world. Wives were submitted to husbands.* [italics added]

Interviewer: But what do you mean by the word submission? Do you think we must go back in this past time?

Participant: Yes. I mean an obedient wife. Wives obey their husbands. It was a submission since husbands were breadwinners and women stayed at home. Women stayed home to cook, to look after the children, to supervise housekeeping even if we had servants. These were women's duty. But Quebec's women are so different! They resist! They resist! [In the sense they oppose or challenge men's authority] Caregiver 04-M

This interview excerpt also demonstrates that patriarchy was influential across the world and also had an impact on the lives of Western women, as well. George says: "No it wasn't like this [women's freedom] before. It was like this almost all around the world. Wives were submitted to husbands." Therefore the impact of patriarchy in defining women's roles is not only restricted to Haitian Canadian women. Canadian women were also affected by patriarchy like other women around the world. Doyal (1995) mentions that "despite cultural variations between communities, it is usually women who continue to be allocated responsibility for what is regarded as 'domestic work' — the daily tasks of cooking, cleaning and caring for children and other dependant" (p. 28). This would tend to support the cross-cultural effect of gendering of caring activities among women of the South and of the North.

Subsequently, George shifted his comments back towards Haitian men and described how men were assuming their social role in his former homeland. Margaret's description of traditional Haitian women's educational and familial duties was confirmed. George explained:

> Participant: The Haitian husband is a guy who, once his studies are completed, gets involved in a certain area of work, a liberal work, as physician or lawyer, and with his family's background and education in hand, wants to get married. He seeks a wife and usually the bride's family must bring a dowry, for the girl to be accepted by the man's family. For instance, the bride's family can give a house or a piece of land as dowry. It helps the young couple to get started. The woman brings a dowry and the man brings his knowledge and good manners. They stay together and remain on the same wavelength regarding the education of their offspring. It's fundamental, the education of the children. Caregiver 04-M

This is George's perspective on how men and women ought to carry out their respective roles in Haiti. As pointed out earlier, however, George is a spouse caregiver and carries out all the domestic work previously realized by his wife Anna. This interview excerpt shows the influence of Haitian traditional values in shaping men's and women's roles in the family and illustrates how these roles can be reshaped under the influence of immigration and new social contexts. The roles of men and women are thus seen to be socially and culturally constructed in specific historical, cultural, social, and economic contexts. George's story also demonstrates that these roles may vary according to these contexts; roles are not fixed as static entities but are modelled according to the demands of the social world. As well, Haitian Canadian women's assertiveness has an impact on the traditional roles of Haitian men and women in Canada. Women request for their husbands to share in the domestic work and reconfigure the family dynamics to fulfill the caring commitment, in accordance with the needs to participate in the labour force.

The Impact of Immigration on Family Dynamics

Immigration adds a layer of complexity to the existing issue of race, gender, and class in constructing Haitian Canadian women caregivers' ways of caring. For instance, immigration heightens Haitian Canadian women's awareness of their rights, and the development of this consciousness has a direct impact on Haitian Canadian men. As well, Haitian Canadian women's participation in waged-work represents another factor that puts pressure on the men to share in domestic tasks. The integration of women into the paid labour force is a means to achieve

financial freedom and therefore, men can no longer be considered as the sole family breadwinners, as was the case in Haiti. In Canada, the higher cost of living pushes women into the workforce, though Quayson (2000) underlines that women, in accessing economic freedom, also risk becoming alienated subjects. His contention, however, must be located in a particular context that may not necessarily apply to Canada:

> Namely, this is in the peculiar condition of women taking their rightful place in modernity but having simultaneously to renounce "normality". Viewed another way, this could be described as the conundrum of attaining citizenship whilst becoming alienated subjects. This conundrum that afflicts women's lives is arguably greatly aggravated in the Third World, where women's existence is strung between traditionalism and modernity in ways that make it difficult for them to attain personal freedoms without severe sacrifices or compromises. (Quayson, 2000, p. 103)

Without implying that the Haitian Canadian women caregivers who participated in the research were alienated subjects, the data demonstrates that family dynamics can be fluid and redefined to face the demands of a different social context. Family roles are not anchored in Haitian traditional values since they may be reconfigured into a hybrid of Haitian Canadian family dynamics. Moreover, because women struggle to reconfigure family dynamics and their roles, they are not alienated but instead are challenging the status quo. Haitian Canadian women caregivers use their agency to integrate men into the private sphere of domesticity and modify a situation to provide better care for their aging parents. Women caregivers also want to have some free time to themselves, since they usually shoulder the triple-task issue, which can be draining. The major drawback is that women caregivers, in contrast to men caregivers, cannot dissociate their private from public spheres. In other words, a boundary cannot easily be drawn to delineate caring activities and the work outside the home. For Haitian Canadian women, caring has an impact on the waged work and their full-time participation in the workforce also influences their caring. Doyal (1995) points out that "whatever their cultural differences, most societies give

women ultimate responsibility for the well-being of their families, often at considerable cost to their own health" (p. 30).

At this point, interviews and participant observation excerpts are presented to illustrate how Haitian Canadian women caregivers manage the reconfiguration of family dynamics and to describe patterns of negotiation that are used to achieve this reconfiguration. The influence of immigration on Haitian traditional values is typically translated into the needs for Haitian Canadian women to enter the workforce to increase their family's wealth and meet the higher cost of living in the host society. When examining family patterns of negotiation, Haitian Canadian men's resistance to share the domestic chores is assumed to increase women's workload. Also, patterns of negotiation demonstrate the effect of immigration on Haitian Canadian men since they too need to adapt to a new way of living. While women struggle against the Haitian Canadian men's patriarchy, men must juggle the idea of equalizing or sharing power with women in the household. Men and women have different, but related, struggles that arise from the levelling of social classes and the soaring demands of a free market economy. These two issues have impacts on women caregivers, especially when assuming the competing roles as wives, daughters, daughters-in-law, and workers.

bell hooks (2000) emphasizes "consumer capitalism was the force leading more women into the workforce" (p. 50). The market economy and higher cost of living explains why Haitian Canadian husbands, like many other Canadian men, can no longer remain as the sole provider of the family's wealth. The transition from housewife to working-woman is the central issue upon which cultural clashes occur over the redistribution of domestic duties in some Haitian Canadian families. Negotiations to reconfigure the Haitian Canadian family dynamics have an important bearing on the issue.

Family Patterns of Negotiation

When referring to my fieldwork and to the literature, I perceive that Haitian Canadians do not extensively differ from Haitian American families, especially in the examination of family dynamics and functioning. In this regard, I rely on the work of Stepick (1998) who described Haitian American family dynamics and functioning. Stepick (1998) states: "Families (one's relatives) and households (with whom one lives) include not only parents and children, but also grandparents and grandchildren, uncles and aunts, cousins both near and far, and even nonrelatives from one's hometown back in Haiti" (p. 15). Despite immigration, family dynamics and functioning are maintained as much as possible to keep living arrangements close to the Haitian ways of living. The cultural shock of late immigration of aging parents may thus be alleviated, though an impact may be felt by the women caregivers who ask their partners to share in the domestic tasks to alleviate their workload. As discussed earlier, the reconfiguration of family patterns is not without problems, especially in the context of a Western society, where Haitian Canadian women must integrate into the workforce to financially support their family's subsistence. Some women caregivers are divorced and must look after a family of more than two children. In such cases, the woman is the sole family breadwinner, while acting as the single parent raising the children.

The levelling of social classes has an impact on the relations of men and women since most Haitian Canadian women participants had to join the workforce when arriving in Canada. This role transition from housewife to working-woman is the central issue for clashes over the re-distribution of domestic duties that arise in some Haitian Canadian households. Accessing the workforce is a means for women to achieve economic freedom, but paradoxically, Haitian Canadian women are often overwhelmed since they must juggle multiple roles. They must work outside, raise the children, and care for aging relatives, a triple-task that could not be worked out without asking for their husbands' participation to carry out domestic tasks. Men's involvement

in the domestic sphere is a key issue for alleviating women's workload and the negotiations focus on encouraging men to share in housekeeping tasks.

In a participant observation session, I wanted to validate the data that had been previously collected about the different roles that men and women assume in Haitian Canadian families. I asked: "Is this okay, you know, the perception I have that Haitian men exert a kind of power relation over women?" The participant said: "For sure, it's the case." Then, I asked if her husband was involved in sharing housekeeping chores. She said that she unsuccessfully tried to convince him to help her to do some tasks. For instance, she tried to teach him how to do a laundry load, but she said: "He didn't want to know about it—he even refused to push the button to start the washing machine. So now, I don't wash his clothes anymore. I sort them out and put them in a bag. I only wash my kid's, my mum's and my own clothes." I said: "So what is he doing with that?" She replied: "Well, he brings his clothes to his mother's and she washes them." In this family, Sundays are observed as strict holidays but it seems that only the husband observes the day of rest. He does not help his wife in doing household duties. As a result, she must work full-time on evening shifts while still being accountable for household duties, and looking after her aging mother and the children. Of the caregivers whom I met, Sonia was the only one to provide this amount of direct, hands-on instrumental care in supporting activities of daily living, which included bathing, showering, combing, cutting nails, and changing her mother's positions in the bed at night. When Sonia asks her husband for help, he replies: "I'm too tired." She answers: "I'm tired too," and once warned him: "I won't do everything in that house (domestic chores, cooking, laundry, dishwashing, vacuuming, dusting, shopping, doing the groceries, and the cleaning), I need your help." She has repeated her request many times in the many years of their marriage. She said: "It takes a while to change a man's ideas about the role of women and to educate a husband to share in the domestic tasks." For instance, if she asks him to sweep the floor, he gets upset, saying: "It shows we live in Quebec. It shows we live in

Quebec for you to ask me to do that. In Haiti, it would have been a different story!" She explained: "In Haiti, the man is the king and the head of the family; he's the master. When my father passed away, my older brother became the head of the family and he disciplined us. He could punish his sisters because he was a man. My brother was the king and master of the household. He did not perform any domestic tasks and he had complete authority over his younger sisters. But not on mummy, only on us." She went on to say: "Basically, Haitian men are machos." In this interview portion, Laura raised a different viewpoint in describing her perception of machismo:

> Interviewer: Do you find that men are heads of families and they make the decisions? Can it be negotiated?
>
> Participant: It depends. It's relative, since it depends on the men's and women's level of education. It's related to the level of education and to the social background. It really depends on the kind of education the man receives in his family. That's the beginning, what you get from your family. Family education is important and men are influenced by what they see in their own family. It depends on your family background, on your personal development, and mostly on what life teaches you. Some guys pick up the good things in their families but when they establish their own families, they just do the opposite of what they've been taught. The point is to show off machismo, and prove to their friends they're the masters of the household. What I can tell you for sure, I'm not the one who accepts my husband's domination. I don't have the personality, the attitude for this. My husband and I, we argue but end up fixing things up. When we started our marital life, he tried to dominate me, to subdue me. I couldn't talk back or reply since he told me he was the boss. His role was to decide for the family. I spoke to myself and said: You shall not let this man talk to you like this but I gave up and said: "Ok, ok. You're right. You're right. Drop it." Later, other arguments happened. I mean you must develop this consciousness too, it's a process, and it takes some time. Women mustn't be passive, subdued, but it's true that some men are machos and dominants. He's upset but I make many of the decisions.
>
> Interviewer: Does he accept your viewpoints?
>
> Participant: Yes, mainly ideas pertaining to the children's education. He needs my mediation when he wants to address some remarks to the kids. He wanted me to pass his messages on to the kids but I told him: "If you have something to say to your children, well do it yourself now." Caregiver 08-F

Laguerre (1984) also reports this asymmetrical power relationship among Haitian American couples but underlines the impact of immigration on changing the direction of the

power relation. Laguerre (1984) asserts that this phenomenon occurs because of the need for men to participate in household tasks and because of the fact that women are now earning money. Immigration introduces a re-definition of the roles in Haitian American families, and determines a new family economy where women's participation in the labour force gives them the right to express their ideas. If husbands were not happy, then the only choice they would have would be either to quit or get a divorce. "Life in New York has a tremendous impact on the relations between husband and wife. He [the husband] is asked to help with household duties, sometimes to cook. This is a new ingredient in Haitian household life" (Laguerre, 1984, p. 76). The same author mentions that immigration and the subsequent re-patterning of family roles leads some couples to break up. Divorce, however, is rare among Haitian American families, since it would jeopardize the entry of relatives into the US (Laguerre, 1984).

Haitian Canadian couples endure clashes over the distribution of household tasks since families may no longer be able to afford domestic services. In Haiti, many caregivers reported, for those who belong to the elite, and even for those of the middle-class, domestic aid was easier to access. Historically, some distant relatives or cousins came to the town from their villages to earn a living and were hired to work in these families. Domestic aid was affordable and the men did not need to get involved in domestic duties. Immigration, however, determines a new family dynamic and economy, which paves the way to marital conflicts, especially if the husbands are unwilling to share in the domestic tasks. As Clare reported:

> Interviewer: Did you have to negotiate with him? I mean for the sharing of domestic duties?
>
> Participant: He cleans the house, he sweeps and cleans floors, and I mean I let him do the heavy housekeeping. He also looks at the house maintenance, the big chores you know and he mows the lawn. As for dishwashing, I don't do it anymore.
>
> Interviewer: How did you do that?
>
> Participant: One day, when coming back home from work, I decided to stop doing the dishwashing. It happened that sometimes he performs the dishwashing. I told him that

when I was working, I had to get back home and prepare meals. I said: " I cook, then you wash the dishes." Basically, that's what I told him. I don't care about the dishwashing, now it's his job.

Interviewer: Do you find that immigration has changed women's affirmation?

Participant: She remains silent.

Interviewer: Or would you have done the same in Haiti?

Participant: I think I'd have done the same in Haiti because...for instance, I don't concur with my sister's attitudes toward men. My sister and I share opposite views on that matter. She says: "Don't bother. Let it go. Just spoil him." I reply: "I, too, need to be spoiled." Do you see? My sister and I, we hold very different viewpoints. Caregiver 08-F

In the excerpt, Clare demonstrates that some women, such as her sister, also collude in maintaining the rigid barriers between men's and women's work. This is the precise issue of maintaining the status quo, which Clare is addressing in developing her consciousness about social inequities pertaining to the ideological division of gendered work.

Participant observation is a useful tool to validate the content of interviews. For instance, a man caregiver told me that he was dividing his domestic tasks with his wife. They were splitting the work in the household almost evenly. When I asked him what he was doing, he mentioned that he was helping with the laundry. He also added that his aging mother helps his wife with the preparation of meals:

Interviewer: What do you do? I mean your wife and you?

Participant: But they're perfectly independent [the three aging people who stay with the family]. They need help for the food and my wife looks after that. And they need medications. Things like this but they're perfectly independent.

Interviewer: But your wife cooks the meals?

Participant: Nodded his head for yes.

Interviewer: And she does the laundry?

Participant: Nodded is head for yes.

Interviewer: She does housekeeping duties like cleaning up or vacuuming?

Participant: Yes, but when she's too busy, I help her with the laundry.

Interviewer: So you divide the domestic tasks, I mean, you and your wife....

Participant: Nodded his head for yes.

Participant: Yeah. (Begrudgingly)

Interviewer: Do you prepare breakfasts?

Participant: Yeah, but *my mother* [italics added] helps too. Caregiver 03-M

Participant observation showed that the division of domestic tasks in this household was somewhat misleading since the caregiver's wife was performing almost all of the domestic tasks. When she arrived in Canada, she worked many years in a factory. She had poor working conditions and received minimal wages. She went through hard times when working at this factory, especially during her pregnancies. Her husband was attending the university. During these times, she raised five children, with the help of her husband's parents. She reported:

> Participant: I had no choice. I had to work but when I came back from work, I was so tired. I was so tired and had to do the household duties, too. I had to cook, look after the children, do the shopping, the groceries, and so on. When I was pregnant, I had to continue working at the factory and I got so tired. I got very tired legs. My legs were so swollen at the end of the day. You can't imagine. Caregiver 15-F

In a typical day, Magdalena cooks traditional food for five people and Canadian food for her children. She is almost always at the stove. During the participant observation session, we finished cooking, eating, and clearing the dishes for the lunch at 2:00 p.m. About an hour-and-a-half later, she has to start over again to cook the dinner. She understands, but does not speak French fluently, which explains why the husband wanted to be interviewed. When I asked to interview the woman, the man appeared a bit upset and he asked: "Why? She won't tell you anything different." I responded: "But I'd very much like to have her opinion, too." I did not know before this participant observation session that she has some problems with speaking French. I came back two weeks later to conduct the interview with Magdalena. Her husband

stayed with us during the interview, translating some questions and answering some others, as well. I could not get rich data in interviewing this woman but the participant observation counterbalanced this drawback. During the interview, I felt she was uncomfortable to talk with me but was willing to discuss more during the participant observation session. The tape-recorder was not visible and we were alone in the house with the aging parents who stayed in their respective rooms.

For this participant observation, I said that I would like to help her prepare a meal. I washed the lettuce, sliced the tomatoes, and set up the table. As we were preparing the food, she kept saying that she was not born into the Port-au-Prince elite (the Haitian bourgeoisie). I told her that I was also not a bourgeoise, but she stared at me indicating that she did not believe it. In her schema of representation, I was seen as a member of the bourgeoisie, as I was a member of the dominant ethnic group -- a White Canadian woman. It makes sense, but it was not that clear during the participant observation session, which underlines the need to retire from the field periodically, for short periods, to reflect on the lived experiences and make sense of the data to avoid Othering.

The meal was comprised of roasted chicken thighs, steamed basmati rice with black beans, and boiled plantains with a red sauce, green salad, and a variety of juices. Magdalena's mother-in-law came in the kitchen and she looked at me and smiled. She was a delicate aging lady who appeared to be shy, but not distant. At first, I mistook her reserved attitude for shyness but in fact, she and I were unable to communicate. I could not speak Creole and she could not speak French. During the meal, I had an opportunity to talk with Magdalena and collect rich data in a more supple way than by using the tape-recorder. She told me that she is always Haitian and will never change. She said: "I won't change. I'll remain the same person since I haven't lost my Haitian values and customs. I live here [in Canada] the same way as I'd do in Haiti." Then, she spoke of her in-laws, and more specifically, described her relationship with her mother-in-law:

> Participant: She's 86 years old. Often, I ask her to help. She prepares the lettuce and I appreciate her work. Often, when I'm busy doing other things, I call her up and she helps me out. I ask: "Would you please do this for me?" She likes to help. She's standing besides me and gets the vegetables washed. Despite her age, she can do this. She can work and she likes giving a little helping hand. Caregiver 15-F

We ate in silence while the lady assisted her husband. Then, Magdalena started describing her life in Haiti. She said that in her native place, for lunchtime, people ate solid foods since the men were farmers. The weather is hot and the men need to eat solid, energizing, hearty foods, to be able to work hard. She said:

> Participant: The men must get hearty meals since they work hard in the fields. They are farmers you know and it is very hot outside, the sun's pounding hard. As well, men are kings and must be served first. Once the men are finished with their meals, then the children and wives can eat. They eat, but only after the men. Caregiver-15-F

She found no dissonance in telling me that children will be hungry for the rest of the day. The men must eat first and then, the children and wives can eat. If nothing is left, I wondered what happens to the children. She went on to say:

> Participant: Men must be well fed. They must be fed generously. Meals must be perfect, perfect because we don't have domestics like the bourgeois of Port-au-Prince! Women must know everything pertaining to household duties and cooking. A good housekeeper is a hard working-woman, who knows how to cook, who is thrifty and saves money. She knows how to dress up a table and properly do the table service with good manners. "Isn't that true Mrs. X?" she asked her mother-in-law. Caregiver 15-F
>
> Observation: The mother-in-law nodded her head for yes and smiled.

Suddenly, a teenager came into the kitchen, and the boy went directly to the refrigerator to pick up something, and then ran off. Magdalena explained: "Sometimes, my husband goes to the restaurant to pick up submarines, spaghetti, or other foods for the kids. Sometimes, the kids don't like traditional cuisine and my husband fetches food for them. I'm currently training my two daughters to cook, but my sons have declined. They don't want to cook. I told my sons: "You'd better get used to it! [to cook]." Then, I asked her to describe her husband's support in

doing household duties. She told me she was doing almost everything in the house: *"Haitian men don't stay in the kitchen. It's the women's place"* [Italics added] (Caregiver 15-F).

Thus, she performs almost all of the cooking and other related domestic tasks, like the laundry, dishwashing, cleaning up, and so on. The husband helps her with the laundry but she sorts the clothes and loads the washing machine. She must feed eight people, three times a day, despite her mother-in-law's help by preparing her husband's breakfast. This means that every day, Magdalena is virtually tied to the stove. When we finished eating, she described the social and economic divisions she witnessed between the working class and the bourgeoisie in her former homeland. She also talked about the precarious working conditions among domestics:

> Participant: In Haiti, there's no running water, you must go to the well to draw water. You must boil it for domestic use and drink it. After that, with the boiled water, you wash the meat. After, I spiced the chicken and added some lime. In Haiti, you cook with the products you have at hand but you can have maids to assist you with meal preparation. They can boil the water, cook the plantains, clean the chicken, wash the lettuce, and the wife doesn't have to do everything. And in the capital, Port-au-Prince, wealthy ladies of the bourgeoisie, these ladies don't cook at all. They don't even mess their hands. They have plenty of domestics to perform these jobs. The lady orders and supervises. She commands and the maids execute the lady's orders. And make no mistake! Make no mistake! The lady examines glasses, plates, utensils, and cups. She looks at everything, to see if you work well. Well if there's something not clean, you get fired right away. I know bourgeoisie, I know they can't stand any mistake. You'd be fired without any warning. I've never been like this, I've always taught domestics how to proceed. I'm not from the bourgeoisie. Caregiver 15-F

Thus far, the family is seen as a social unit where the socialization of boys and girls takes place. Family is a microcosm of the larger social world in that it reproduces the social and gender inequalities on a smaller scale. Race, gender, and class mutually construct or influence the definition of roles of men and women, as well as the family organization and functioning. As Patricia Hill Collins (2000) points out:

> Families are expected to socialize their members into an appropriate set of "family values" that simultaneously reinforce the hierarchy within the assumed unity of interests symbolized by the family and lay the foundation for many social hierarchies. In particular, hierarchies of gender, wealth, age, and sexuality within actual family units correlate with comparable hierarchies in the U.S. society. (p. 158)

This statement also applies to Canadian society, where members of families learn their respective roles constructed around race, gender, and social classes, within family units. Families may be compared to a social laboratory, where children learn social values that rule the broader social world within which the family interacts. Thus, the roles of some men or women are seen as being natural and the hierarchy is not questioned since social rules were integrated during their childhood. Children must comply with these relations of ruling in determining how men and women contribute in shaping the social world. As Patricia Hill Collins (2000) puts it:

> Individuals typically learn their assigned place in hierarchies of race, gender, ethnicity, sexuality, nation, and social class in their families of origin. At the same time, they learn to view such hierarchies as natural social arrangements, as compared to socially constructed ones. Hierarchy in this sense, becomes "naturalized" because it is associated with seemingly "natural" processes of the family. (p. 158)

Hill Collins (2000) points to understanding how social hierarchies influence the attribution of caring as women's work. As well, this difficult issue of negotiating the share of domestic duties must be also examined from Hill Collins's perspective, where the sexual division of work is aimed at maintaining a gender hierarchy. Therefore, patriarchy still influences Haitian Canadian women's roles, as wives, daughters, daughters-in-law, and mothers. Patriarchy also has an impact on the roles of other Canadian women and would not be restricted to Haitian Canadian women, only. The sexual division of work was introduced by capitalism at the time of the industrial revolution (Hooyman & Gonya, 1995). The gendered division of work, which introduces the binary division between private and public spheres, was created to satisfy the needs of a capitalist market economy, but is pervasive across the world. The gendered division of

work is not a particular characteristic of the Haitian Canadian community but affects women of the South and the North.

The findings of this study partly contradict Laguerre's (1984) assertion, who said that immigration equalized the power imbalance that influenced men's and women's traditional roles. Laguerre (1984) points out:

> Haitian women tend to become more assertive in New York, not only because of their economic independence but also because they are immersed in a more pluralistic environment. Husbands tend to be more willing to share household chores with their wives. Consequently, the imbalance in the traditional roles of husband and wife tends to diminish. (p. 86)

I would rather suggest that Haitian women may be more assertive in the North American context but the extent to which they have convinced husbands to take on domestic chores is a debatable issue. A woman caregiver told me that she would not tolerate her husband's domination, even if they would have stayed in Haiti. It deconstructs the myth of the submissive Haitian Canadian woman and shatters stereotypes of submissive so-called Third-World women. The sexual division of domestic labour is an issue that is yet to be overcome among Haitian Canadian women and it is also the case for other women, whether of the South or the North. The impact of globalization and the spreading of liberal capitalism are likely to influence women's paid and unpaid work across the world, since the ideology of the sexual division of labour, rooted in capitalism, serves corporate interests but, to some extent, men's interests as well. This leads to examining the impact of the gendering of caring on Haitian Canadian caregivers' familial and social life.

Influence of the Gendering of Caring on Caregivers' Familial and Social Life

This section begins by exploring how the gendering of caring influences caregivers' familial lives. Participant observation sessions and interview portions are presented to illustrate how gender expectations influence relationships within families and mother-daughter relations.

For instance, daughters-in-law are expected to care for their in-laws and some mothers can control their daughters' lives precluding them to marry and having their own family. This is followed by an examination of the influence of gendering of caring on caregivers' social lives. Data shows that both men and women caregivers must cut down on social activities to care for their aging relatives at home. Working women, who juggle the triple-task issue, seem to be most vulnerable to social isolation. No boundaries between the private and public spheres (e.g. between working outside, performing domestic chores, looking after the family, and caring for aging relatives) can be clearly drawn. This situation not only applies to Haitian Canadian women caregivers. The cross-cultural effect of gender on caring activities and its effects on women caregivers' family lives and economic welfare has been documented in non-Western and Western societies (Atkin & Rollings, 1996; Bunting, 1992; Doyal, 1995; Guberman, Maheu & Maillé, 1993; Guberman & Maheu, 1997; Neufeld & Harrison, 2000; Waxler-Morrison, 1990).

Atkin and Rollings (1996) report that some Asian and Caribbean women experience a general sense of isolation, resulting from the lack of support from close relatives and the increasing level of their caring commitment. Waxler-Morrison (1990) emphasizes the impact of migration on families and ways of living among Western Canadian ethnic and cultural groups. Finally, Neufeld and Harrison (2000) mention that issues located at the intersection of domestic work, labour market demands, and gender expectations related to caring activities, influence North American women caregivers' familial and social lives. I now present interview and participant observation excerpts to show how gender expectations structure relationships within Haitian Canadian families.

Influence of Gendering of Caring on Familial Life

Gender expectations influence relationships within families in the sense that sons often rely on their wives to look after their own parents. A woman who cares for both her mother and her mother-in-law illustrates that the sharing of domestic tasks coupled with caring activities

becomes a sensitive issue, for the couple. Joy has a university degree but in her roles as woman, wife, daughter, and caregiver, few differences are perceived from other women. All of the women face the same issue when it comes to the sharing of domestic duties with their spouses. She said:

> Sometimes I came back from work, sometimes I came back home very late, and I'm good for nothing. I'm very tired. I can't do anything and I just want to go to sleep. I can only look after myself but then, my husband asks me: "Can you cook something tonight? Can you cook something for the supper? We need to eat." It's always the woman who is accountable for the meals. Caregiver 08-F

Reconciling family life with caring can be difficult and especially straining for the working woman. I also observed, in some participant observation sessions, that relations could be very tense between fathers-in-law and sons-in-law. Not only did the mothers-in-law seem to be uncomfortable living with their sons-in-law, but fathers-in-law can experience the same situation, as well. I now present some interview segments to illustrate how the gendering of caring influences relationships between daughters-in-law and mothers-in-law.

Relationships between daughters-in-law and mothers-in-law.

Joy described the differences between caring for her mother as opposed to her mother-in-law:

> Participant: In general, women are held responsible for caring for the elderly. Women have a moral duty to care for the aging people. See for instance, my mother-in-law lives with us. My husband, sure, he cares for her and he thinks about her. It's sure but I've to think twice since if she needs something, she asks her son and then he passes this on me. Caregiver 08-F

Mary, who was also caring for her in-laws, expressed the same idea of feeling more committed to caring for her in-laws, than was her husband. Theresa was explicit in describing the relationships with in-laws. She reported:

Participant: Mothers feel more at ease to stay with their daughters. Adaptation is easier when living in a daughter's home than living in a daughter-in-law's home. Mothers feel like being in their home when they stay with their daughters whereas they feel like a stranger in their daughter-in-law's home. It's simply not their home. Mummy says that she's home here, because it's her daughter's home. "It's my daughter." Do you understand? It's easier to adapt. It facilitates caring.

Interviewer: And the husband, does he understand?

Participant: Remained silent.

Interviewer: I mean the husband, spouse, or partner....

Participant: They never get along very well together. Son-in-law and mother-in-law, let's put the record straight, they never get along together.

Interviewer: They never get along together....

Participant: No. There are always some problems that come up...

Interviewer: I had to turn off the tape-recorder since Theresa was talking to her daughter and it was something confidential. We did not go further to describe the problems that arise between the son-in-law and the mother-in-law.

For these caregivers, it seems the relations with mothers-in-law are more complex when it comes to affective caring. The situation is the same for sons-in-law who cannot get along with their mothers-in-law. This lends support to the results from studies on daughters (Mui, 1995; Pohl, Boyd, Liang & Given, 1995; Sheehan & Dornorfio), daughters-in-law (Globerman, 1996; Guberman, 1999), and sons' differences, in their caregiving roles (Campbell, 2000), to name a few. In the case of Laura, she asks her mother to help but does not rely on her mother-in-law. Blood ties and the affective depth of the mother-daughter relationships impact on caring activities. Daughters seem more comfortable with their mothers and the mothers seem to be less at ease with daughters or sons-in-laws. For instance, Magdalena did not speak, during the interview, of problems with her father-in-law but mentioned:

Participant: It is not because I'm not willing to do it [little tasks assigned to be performed by the mother-in-law], nor that I can't do it. I like when she's on my side but it does not happen very often. Caregiver 15-F

Mother-daughter relations.

In this next excerpt, I present the impact of caring for an aging relative on mother-daughter relationships, which is an exceptional case. In this case, the daughter has no life at all due to her controlling mother. The caregiver forgets to live for herself and in caring for her mother, the woman is like a prisoner, despite her ambivalent attachment towards her mother. The mother rejected every man who came to ask her for her daughter's hand. She did not want her daughter to get married since she did not want to stay with a son-in-law. According to the mother, no man was suitable for her daughter. The daughter, however, is upset with this uncomfortable situation. She thinks her mother has spoiled her life and when she is older, she will only have years of loneliness. She has no husband, no spouse, no child, and was forced to stay single, to please her mother. She is the only caregiver in this study, who reported living in such an extremely difficult relationship with her mother. Both of them continue to live in a perpetual state of conflict, which has already taken a toll on the daughter's health. The daughter is depressed, but despite the negative feelings, the bond with her mother is strong since during the interview, the woman burst into tears just thinking about her mother's death. She cannot imagine how she will live after her mother's death. The interview with this caregiver lasted two-and-a-half hours, and was conducted in complete darkness. The interviewee did not turn on any lights and I was unable to see her eyes or facial expressions during the dialogue. She sometimes mumbled her words and at times, I found it difficult to understand what she was saying. She said:

> Participant: Mum always manipulated me. Mother kept warning me that she didn't want me to date with this man. She said: "You can't date this man and continue your study at the same time." Then after, I started working and he came to meet my mother. Mummy said: "If you get married, I tell you I won't go to stay in the house of a son-in-law". She didn't want me to get married because she was jealous. She was so possessive that she didn't want to lose her place. She manipulated me. She manipulated me. If I could start over again, I'd challenge her. I'd not listen to her anymore. But, now it's all over, it's too late. It's too late now but she manipulated me to fulfill her needs only. She wanted me to stay with her but was only concerned with her self, her own person. Caregiver 06-F

Thus, in that situation, the mother was not caring for her daughter since, as Mayeroff (1990) puts it, caring is aimed at promoting and developing the learning process. It seems that the mother failed her daughter, and trapping her child and herself into having very lonely days. I did not speak with the mother because the caregiver told me that her mother could only speak Creole, so it would be impossible for her to communicate with me. She told me that each time, her mother suspected her of dating, the mother would wait until Victoria came back home and then reprimand her.

The interview became intense when Victoria started expressing feelings of having failed in her life, having taken a road that leads nowhere, and having contemplated suicide after getting into trouble with her mother. I was concerned about her and wanted to know if she still harboured suicidal ideas. As a nurse, I was facing an ethical dilemma and did not want to leave this woman alone in her dark apartment with suicidal ideas. I pursued with the interview:

Interviewer: Do you currently have suicidal ideas?

Participant: Oh no! (Strong voice). No. No.

Interviewer: But it's human [to have suicidal ideas]....You know....

Participant: I don't have any. I don't have any.

Interviewer: Okay.

Moreover, this woman caregiver was completely isolated in Canada since she has no siblings, no extended family, and no close friends. She can rely on her church but is basically alone to care for her mother. When she needs respite, she calls her brother and asks him to take the mother for a couple of weeks. The mother can travel, but does not enjoy living elsewhere, and every day there she asks her son to send her back to Canada. Elizabeth's lived experience points to the importance of family and social support in 'buffering' the stress that is related to caring, as well as to other life events since life is not a linear process. I now shift the discussion to explore the impact of caring on family life. This excerpt lends support to Waxler-Morrison

(1990) who states, "the disruption of life associated with migration affects many people from different cultures in similar ways. Much has been lost; family ties, familiar language, community support, the comfort that comes from the general predictability of life" (p. 6-7). Next, I examine how gendering of caring has an impact on women caregivers' social lives, and more specifically on working women, by restraining the women's and their spouse's involvement in social or leisure activities. Data also demonstrates that men caregivers appear to be socially isolated despite not having to face the triple-task issue, as do their female counterparts. For men and women caregivers, it seems that little or no time is left for them to engage in social activities. Caregivers must adapt their social lives to the needs of the cared persons.

Influence of Gendering of Caring on Social Life

The influence of caring for aging relatives at home on the caregiver's social life is apparent, especially when one is close and spends time with caregivers and their families. Nevertheless, caregivers adapt to their situations using two specific coping strategies. The first consists of bringing the aging parents with them to the restaurant or to visit relatives for religious holidays or birthday parties, etc. The second strategy is to limit social activities and cut back on leisure time to stay with the aging relatives. Both women and men caregivers' interview excerpts are presented to demonstrate how the restriction on social life affects both genders.

Alexandra reported that caring limits her social activities. On weekends, however, she has a respite since her father goes to another daughter's home, allowing to be by herself for a short time. She is a busy woman who works full-time and has to perform almost all of the domestic duties. Sometimes, the eldest daughter helps her mother to do some of the domestic tasks like loading the washing machine, dishwashing, and preparing meals:

> Interviewer: So, during weekends can you do something you like to do? I mean, doing something for you, like going out?
>
> Participant: Yes. During weekends, I don't prepare meals. We go to the restaurant almost all the time. We go for rides as well. You know just nice car rides to get out of the house

and breathe some air. I want to breathe some fresh air and most of all, being away. I don't want to see the house.

Interviewer: You don't want to see the house…

Participant: That's it!

Interviewer: Do you feel your social life is being limited, constrained?

Participant: Fortunately, I get this respite during weekends. It helps a lot you know. Otherwise, I'd feel like a prisoner in that house, I'd feel like being jailed. When mummy was staying with me, well usually, my parents came with us. I've never been somewhere without bringing mum and dad with me. Now I must always negotiate with dad since he doesn't want to go out. He wants to stay home and I feel a little guilty to go out and let him alone in the house. Caregiver 05-F

Caring also impacts on Kathleen's social life since the couple and the family must adapt their social activities to the needs of their aging mother:

Participant: When we go dining out or attending social events, we need to come back home earlier to put her in bed. Otherwise, we would feel guilty to come back at 3AM and let her moan for such a long time. We come back home as soon as possible. If we go to attend a family party, she comes with us. When she's tired, we must come back home earlier too. So this is the picture…it impacts at this level. We must always come back home earlier. For leisure time and things like that. For instance, if I go to the USA to visit some relatives, I must phone her each day and frequently. She's insecure. So I call her very often to take news since when I'm away I know it's a big deal for her. Caregiver 02-F

Clare also reported how caring activities have an impact on the couple's social life. She said:

Participant: So now both mum and my mother-in-law refuse to go to my sister's home. I felt much better when they used to go there for weekends. I could take a little break, to relax, sometimes at least for a weekend. At that time, when I was coming back from work, I was just feeling…. I was alive and able to breathe. I could breathe some air, get some spare time, and have some fun. We could attend social activities, go for a weekend getaway, just a little something like this, not a great deal, but it's…

Interviewer: Now, you don't have any respite…

Participant: That's it. And, it's a heavy load (pronounced in an almost inaudible voice). It's a heavy load. Caregiver 08-F

Martha, a 60-year-old woman who cares for her very old mother discussed her social life:

> Participant: Well, let's say I've not much time for social activities. Let's say I've no social life at all. Not at all! Not at all! My only social activity consists of attending the spiritual centre on weekends. Sometimes I'd like to have somebody to stay with mummy, to keep an eye on her. Since I must leave her alone, I can't really attend social activities. It bothers me since I don't want to leave her alone in the house. I'd feel guilty. You know I must leave her to earn my life, to earn the daily bread, and that's okay. I must go out to earn our living. However, sometimes I'd like to go to the Jazz Festival or to the theatre, but I can't let my hair loose, I cut off leisure time, since it's unfair for mummy. It's unfair since she can't come out with me in these places. So to work the issue out, I decided to come back home from work or from the centre, and that's it! I always come back home. I really don't go out very often. Anyway, caring for an aging person is demanding, you must sacrifice yourself. And if I were a woman who would need to go dancing or partying each weekend, mum would be suffering, she'd be suffering since she'd stay home alone almost days and nights. I can't stand the idea of letting mum alone in the house like this. As a matter of fact, it's a moral and ethical question too. I say to myself: "You can't do it differently." I put myself in her shoes. I say to myself: "And if it were you, perhaps you wouldn't want to be alone all day and evening long." It happens occasionally, when there's an important activity at the centre, I go. If I need to go out for my work, to meet my students' parents, I go. It pertains to my work. Do you see? I'll never let mummy alone to go to the restaurant, to go dancing or partying, or to go to the theatre. Caregiver 16-F

A young woman, who also works full-time, commented that her social life is important, too. She reported that she also must take into account her own needs, if she is to continue in her caring commitment:

> Participant: Sometimes I'm tired and I also want to breathe some air. I'd like to be free a bit, not feeling this obligation to come back home immediately after work. I'd like to go downtown, sit at a terrace, and enjoy life. I like to dine out, to stroll down the streets, to take a coffee. I also have a bunch of friends. I'd like to meet them more often. At the beginning it was a little difficult and my friends felt abandoned because we could no longer go out, as it was the case before. I was so busy with mum that my friends thought I was depressed. Now, I manage my time. When I need help [respite], I no longer wait. I ask my *sisters* [italics added] and they understand the situation and they help me. Caregiver 07-F

It seems this younger caregiver raises another issue, an issue of gendering: Is it easier for men caregivers to have a social life? The next interview excerpts show that men and women do not differ much in that regard. As mentioned earlier, men also report feelings of social isolation as a result from their caring activities.

Contrasting women's and men's perspectives.

In a first interview, John reported that caring does not have an impact on his social life but on my second visit, during his wife's interview, he mentioned that once he came back home after work, and was too tired to go out. He thought this was related to the North-American lifestyle, since in Haiti, he could go out without any problem. On the other hand, other men caregivers also reported not enjoying any social life. No differences between women and men caregivers were observed. In this interview except, John discusses his social life and mentions that caring activities do not impinge on his social activities:

> Interviewer: Have you observed some restrictions to your social activities?
>
> Participant: We never complain. It's in our culture. It's not something we're forced to do; it's natural. There's no obligation. It's cultural.
>
> Interviewer: So when you need to go out, they come with you?
>
> Participant: Of course!
>
> Interviewer: Like going to the church or the restaurant?
>
> Participant: Of course and it doesn't bother me at all!
>
> Interviewer: To visit relatives?
>
> Participant: Yes. No problems. They come with us. They always come with us.
>
> Interviewer: So, you don't find any impact on your social life?
>
> Participant: I don't find any problems with my social life. Caregiver 03-M

He suggested, however, that his work and working environment were also stressful and hindered him from enjoying a social life:

> Participant: I find life much more stressful here [in Canada]. Since I remember, when I was in Haiti, I was working from 6 AM to 7 PM and I was never tired. I came back home, took a shower, and could go to the theatre. However, here, once my day at work is over, I'm too tired to go out. It's so different. Here I work 8 hours and I'm already tired when my shift is over. I mean I'm more tired than the time when I was working 12 hours in a row. Then, after a day at work, I can't go out and I stay in. That's what I do. It's so different. It's so different.

Interviewer: Where's the difference?

Participant: It's the way of living. The way of living is stressful. Caregiver 03-M

Edward, a man in his sixties, who was caring for close relatives also reported that he had no social life:

Interviewer: So, except for meal planning, have you had other problems?

Participant: No. No.

Interviewer: I mean in the course of your personal life?

Participant: Social life? I don't have any social life now but I really don't care about it.

Interviewer: Do you mean you can't go out?

Participant: I can't get out of the house. I don't want to leave them alone here. I'd need to call somebody to keep them for a couple of hours. Most of the time, I stay here. I don't go out.

Interviewer: But would you like to go out sometimes?

Participant: No. No. I tell you, I've got plenty of significant experiences in my life so far and I can't learn more about life now. As well, going out is expensive and I can't really afford it. On the weekends, my wife and I, we go to the market (name of the market). I go to the market or the grocery store. It's my social life.

Interviewer: Don't you go to the restaurant, to enjoy a good meal with your wife?

Participant: No. Since if everybody does this here [in the house]. If I go out like this, then I need to call somebody up to come over and keep the ladies. I need to pay somebody as well. So, it's very expensive, do you see? Caregiver 09-M

Matthew spoke about his restricted social life:

Interviewer: What kind of activities do you like? For instance, do you go bowling or something like that?

Participant: Bowling…But if I go to the bowling centre, how many Haitians do you think I'll meet there?

Interviewer: Don't they [Haitian Canadians] attend bowling centre?

Participant: Very few Haitians. Indeed.

Interviewer: Do you have Canadian friends?

Participant: I've some Haitian friends and some Canadians too but I'm quiet, how can I say that, I'm like a crab. I mean the crab stays in his hole with its family, bottom line. There won't be any other crabs that will come in the hole.

Interviewer: If I understand what you're saying, you mean that your social life is restricted in a sense to your family circle, is it right?

Participant: Yes. Caregiver 12-M

The impact of caring cannot be isolated as a major cause of social isolation among both men and women caregivers. Many contextual factors pertaining to the larger social world can be associated with the lack of social activities such as work and racial relations. For instance, Matthew mentioned that he could not go to the bowling centre since very few Haitian Canadians would be present. It is like a perceived process of Othering precluded this caregiver to enjoy social life. As well, economic factors can explain why some caregivers prefer to stay home since going out means an extra cost to caring. The economic factor should be further examined since caregivers need to pay a 'keeper,' therefore increasing the cost of an evening at the restaurant or theatre. Caring for an aging relative at home implies an economic cost of caring, which is often overlooked since it is invisible.

The Gendering of Caring and Its Hidden Economic Cost

The gender expectations of caring, coupled with the unpaid and devalued nature of caring activities, can be seen as major factors explaining why the economic cost of caring remain barely noticed. It seems that the gendered nature of caring activities, and more specifically, its ideological 'naturalness' underpinnings are the basis upon which economic consequences of caring are underestimated in their effect on women caregivers and their families. Socially and culturally, women are expected to look after aging relatives at home without complaining about the social and economic inequities that arise from these activities. In her study, Archbold (1983) reports that low-income US women assume parent-caring activities with little social and

economic support. Archbold (1983) contends that expenses related to caring for aging parents are easier to afford for caregivers from higher socio-economic status, although some professional women are also found to struggle with the costs of caring. "Only a few families could afford to purchase caregiving for long periods of time. Even the professional women in the sample had little left at the end of the month after paying for housing, food, and services" (Archbold, 1983, p. 43). On the other hand, Land (as cited in Ungerson, 1983) describes the economic impact of caring on British women:

> The fact that certain values favouring the interests of men rather than women have been embodied in a variety of social policies over a long period of time, both formally in the legislation and by the way in which they are allocated or used, indicates that social policies are a very important means by which these values, and hence major inequalities between the sexes, are maintained. (p. 42)

Hooyman and Gonyea (1995) also argue that the 'natural' women's activities of caring sustain the productivity of a country's economy. They contend, "caregiving work underpins the economy, contributing to the producing sectors' overall efficiency, but remains largely invisible, isolated, misrepresented, and unrewarded by marketplace criteria" (Hooyman & Gonyea, 1995, p. 209). Some studies, carried out in Canada, the UK, and the US, assessed the economic consequences of caring, and specifically, the impact of health care reforms on caring families' wealth. It appears that health care reforms associated with globalization hardly benefit the low-income caring families. The State[52] relies on the gendered nature of caring as a means to encourage privatization of health and home care services (Atkin & Rollings, 1996; Collière, 1986; Fast, Williamson, & Keating, 1999; Hooyman & Gonyea, 1999; Martire & Stephens, 2003; Rimmer, 1983; Schroeder, 2003; Ungerson, 1983; Williams, Forbes, Mitchel, Essar & Corbett, 2003; Williamson & Fast, 1998). The upshot is to increase women caregivers' workload, especially when private home services cannot be afforded. Rimmer (1983), explored the economic cost of caring on British carers:

> What are the costs of caring to the carer? Studies of carers and their families have shown that these costs are of two types. First the direct cost of extra expenses, which handicapped or frail dependants may entail. For the frail elderly, there may be additional costs in terms of special diets, or extra heating; for the confused elderly, there may be extra costs associated with "granny sitting"; and there are of course extra costs associated with incontinence, and the extra wear and tear on clothing and furniture associated with some physical handicaps. In addition to these costs, there are also the costs to carers in terms of foregone earnings, when they give up work or reduce their hours of work to accommodate their caring responsibilities. (p. 136)

During fieldwork, I noticed that expenses related to remodelling to accommodate care in the house, paying for cleaning and housekeeping services, and for medical supplies were not taken into account. These expenses were real, however, since they were budgeted for, and deducted from a family's income. For this reason, some caregivers restrained or cut down on their leisure activities to be able to make ends meet. Some also needed support from food banks or other charity organizations. As well, any financing such as for bathroom remodelling, were not accessible to each caregiver, especially in the low-income families. Thus, the accessibility of home support services mostly depends on the caregivers' income, which introduces differences between the wealthy and the poor. Many changes may be needed to provide a quality of care, therefore, if the remodelling expenses are too costly, or if you are a tenant and your relatives present physical limitations, caregivers may ask for CLSC home services, but a minimal level of services may be available. This minimal level is restricted to hygienic care where a family auxiliary comes in to bathe the aging person once or twice a week. All other home support services like respite, meals-on-wheels, social activities, transportation, and housekeeping services are mostly only available from private agencies.

If, for example, caregivers cannot modify the bathroom or otherwise provide a 'safe' environment, then the CLSC family auxiliaries will provide a sponge bath, once or twice a week. These are norms for obtaining free hygienic care, in most provincial CLSCs. Sonia had to go to

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[52] State means all levels of government including the federal, provincial, and territorial .

the bank to renegotiate a mortgage to comply with the CLSC and Quebec Health and Security Board, saying:

> Participant: People have been hired to remodel mum's bathroom. We're doing it now. The government provides subsidies to help families with these renovations, you know, to reconfigure the bathroom. They told us that the bathroom was too small and they couldn't work safely and properly in this bathroom. Until now, they bathe her in the bed [sponge baths]. It's mandatory to remodel the bathroom. Did you know that? We'll proceed as soon as possible. Construction workers have already been hired since the bathroom is really too small. We split the expenses with the government half and half. My husband and I went to the bank to renegotiate the house's mortgage for obtaining that 50% leverage. Caregiver 02-F

Some caregivers, for example, may be able to remodel their bathroom, but many cannot afford these expenditures. Despite a 50 percent governmental financing, some caregivers cannot afford the extra costs or may be unable to ask the landlord to assume the financial responsibility to reconfigure the bathroom. Other caregivers talked about the expenses related to acquiring medical equipment to facilitate caring activities such as a hospital bed, lifter, incontinence pads, alcohol, gloves, or short bladder catheters. During a participant observation visit, a care-receiver talked about the financial expenses related to medical equipment. She said that it costs about $4,000 a year to buy pads, disinfectants, gloves, and other materials. I could not verify this information since I would have needed to ask for receipts, but in looking at the place, I saw many medical supply boxes around the room. When noticing the number of these items, I could easily estimate that the cost could have been greater than that stated by the care-receiver.

In another participant observation session, a man caregiver told me that he received a governmental subsidy of about $135 to help pay for the supply of incontinence pads. "These pads are very expensive," he said. Finally, a woman caregiver told me she pays $50 a week, to get a cleaning lady since she has no time to clean the house due to the many tasks she must perform. Other caregivers reported receiving some financial aid from their aging parents.

If the cost is allowed to go unnoticed by the government (since caring is founded on women's labour of love), are women expected to stay home and shoulder the care for the elderly, sparing the State any investment in home care services? This is far from our contemporary reality where many women work outside and are the breadwinners of the family. Caring is usually seen as a natural reality of families, and the related expenses become a means for governments to control health expenditures. This is precisely the case in the sector of home care since the State counts on women's unpaid and invisible work to maintain the health care system.

Also, despite the availability of governmental subsidies, caregivers need to know about them, and get information about these programs. Since five out of sixteen Haitian Canadian caregivers rely upon public home care services, likely, most of them do not know about these subsidies nor would they know how to access this financial support. The other question to be asked is whether or not they can access subsidies, since funding depends on the family (husband or wife) or the care-receiver's income. Families located in the middle-income bracket are not likely to qualify for the subsidies. On the other hand, they cannot afford the full price of the services. A man caregiver described the problems he encountered as a middle-class worker in accessing the CLSC program.

The Impact of Paid Work on Caring

The impact of paid work on caring cannot be isolated from the opposite, which is the influence of caring on work – as these phenomena are intertwined and mutually influence each other. bell hooks (2000) points out "when women in the home spend all their time attending to the needs of others, home is a workplace for her, not a site of relaxation, comfort, and pleasure" (p. 50). Haitian Canadian women caregivers involved in paid work and caring activities are almost always on duty. For instance, Kathleen is a professional who works full-time on evening shifts. When she comes back home around 1:00 a.m., she goes to her mother. She needs to alternate her mother's position at least twice a night to prevent bedsores. She wakes up to

prepare her children for school and then goes back to sleep. When I asked her if she encountered problems in caring for her mother, she immediately referred to her work. At the beginning of the interview, I felt her reluctance to discuss the impact of caring on her personal life and work:

> Participant: It's a bit difficult but not to the extent to say that I'm so tired and would place mummy in a nursing home.
>
> Interviewer: Does this [caring] have an impact on your life?
>
> Participant: No. No. No.
>
> Interviewer: When you're at work, do you feel that caring for your mother has an impact on your work [meaning performance at work]?
>
> Participant: No. Caregiver 02-F

She went on to describe how working outside the home has an impact on caring activities:

> Interviewer: Have you encountered some problems in caring for your mother?
>
> Participant: [She remained silent.]
>
> Interviewer: I mean, are you experiencing problems pertaining to caring?
>
> Participant: Yes. [Silence.] Sometimes. Of course, it [caring activities] does not fit with my working hours. Sometimes, I simply run out of time, I don't have the time since I'm working outside the home. I have no choice. I must work. I told you before that I'm a (name of occupation), and I'm scheduled to work on shifts. I also have children and I must look after them too. Sometimes when mummy wants something, well she wants it right away, and then we have a little argument. She's a little authoritarian (Paula laughs) but I ask her to wait since I have other priorities to attend in the house. She finds that a little difficult and that's it.
>
> Interviewer: What is difficult? The fact is that you can't satisfy or fulfill her immediate request?
>
> Participant: Yes, it's right. Moreover, she's alone in her bed for long evenings. At night, I wake up at least two times and go to see her. So it takes.... [Silence].... It takes a bit of my own comfort. It cuts my sleeping hours but I do it. The problem is having shorter hours of sleep. Caregiver 02-F

Later, in the same interview, I asked Kathleen if caring has an impact on her work outside of the home. She said:

Interviewer: As you told me earlier, you mentioned that you came back home around midnight and you go to change or alternate your mother's positions in the bed.

Participant: Huh, huh.

Interviewer: Do you feel some tiredness?

Participant: [Remained silent.]

Interviewer: Could it bring supplemental fatigue? [Conciliating her work with caring activities]

Participant: More fatigue? No. Not really. I don't feel more tired because of that. It's true that when I come back from work, after my shifts, well, I'm tired. But I'm not experiencing extreme fatigue because I look after her. Caregiver 02-F

Paula, like Kathleen, is one of the younger women caregivers who participated in the study (she was in her late 30's). The lack of sleep did not affect her health. I also cannot talk of the burden of care in this situation, since Paula's teenaged daughter sometimes assists in caring for her grandmother. Nevertheless, this interview excerpt also illustrates that caring and paid work (private and public spheres) cannot easily be separated from each other. The situation is like a continuum where caring and working outside the home mutually influence each other and neither aspect can be dealt with in isolation. Then, I shifted the conversation to present a hypothetical situation and asked Paula what she would do in such a case:

Interviewer: In the eventuality that you need to be off from work for a certain time to care for your mother, do you think it would be difficult?

Participant: If I had to take some days off?

Interviewer: Yes. Let's say that your mother became severely ill and you were absolutely needed to stay at home. I guess you'd contact a member of your extended family in that case, like you told me before, is that it?

Participant: Do you mean sick for a long time? I'd have to take days off?

Interviewer: Yes, that's the question.

Participant: You mean I must absolutely be away from my work....

Interviewer: Yes. How would you work the situation out? How would you manage this?

> Participant. [Pause.] It would be economically, a little difficult, since it would be less money in our pockets. It would surely have an impact on the family's budget. (Caregiver 02-F)

Paula's work is essential for bringing in more money for the family and supports the soaring needs from a market economy, but it also covers expenses related to caring. Paula said that her husband would find it difficult if he were the only breadwinner in the family since Paula earns higher wages. The assumption seems to be valid in that the host country's economy and home care policies affect ways of caring since women have no choice but to enter the workforce and earn a living. Also, this example supports the notion of the devaluation of the unpaid work of caring, because it is women's duty. Caring must not affect workplace efficiency, but problems at the workplace affect caring activities.

In the next interview excerpt, Barbara described a typical day of her life and the importance of her work:

> Interviewer: Can you describe a typical day in your life? I mean when you wake up in the morning and start the day?
>
> Participant: Well let me tell you that my day starts at night. I already start my daytime planning at night. I wake up at 4.30 a.m. and I know I've to get out of bed soon. I think to myself: "What am I going to do?" I repeat this question several times in my mind. It hits my mind. I always wonder if I'm not forgetting something. I say to myself: "Am I forgetting something?" I must do everything in this house, everything. I do the cooking, cleaning up, dishwashing, and the laundry. I also get the kids ready for school and drive them to school.
>
> Interviewer: Your workday really starts at night.
>
> Participant: Yes (in sadness and with a sigh)
>
> Interviewer: It looks as if you're running out of time. The day is too short…
>
> Participant: I must supervise the kids' breakfast because I want them to eat a substantial breakfast and I prepare dad's coffee. When I go to work, he's still sleeping. But I dress up the table and make things handy for him. Caregiver 05-F

During a participant observation in this caregiver's family, I noticed how busy she was parenting her young children and caring for her aging father. She works full-time and earns good

wages but has to pay for the rent, groceries, children's kindergarten, and other utilities. I went to Barbara's place and she asked me to go to the grocery store with her. We did some errands and came back home to prepare the meal. Barbara cooked a traditional dish and while preparing the food, spoke about her everyday life. I assisted her in doing some domestic chores like washing the dishes and asked her some questions.

> Interviewer: Why don't you get this dishwasher fixed?
>
> Participant: Because I must load it, empty it, and clean it. I'm alone here. They don't help me and as you can see I've enough work to do. I do the cooking, laundry, pressing clothes, folding linen, cleaning up, vacuuming, the shopping, and the banking. I look after the kids, supervise their homework, and drive them to school each morning. I must attend the school's social activities, and have to care for mummy. I must attend work meetings and enroll in continuing education courses, too.

The meal was ready to serve and I set the table. We were waiting for the children to get back from school when Barbara told me she was depressed. She said she felt overwhelmed and swamped by responsibilities, since she is accountable for doing so many tasks. The woman assists her children in doing their school assignments since she wants them to obtain good grades. She went to knock at her father's door and told him the supper was ready. He came out of his room and sat at the table. We all watched the television, which was showing an interview with a Haitian Canadian lawyer. Barbara told her husband: "See, we're not just a bunch of bums." He did not reply. Barbara's father went back to his room for the rest of the evening. After the meal, I helped her clean up the kitchen and wash the dishes. After tidying up things in the kitchen, Barbara supervised her children as they did their homework and then put them to bed. At 9:00 p.m., I left their home, feeling completely exhausted. This example of fieldwork illustrates the triple-task burden and how it unfolds in Barbara's everyday life.

Another woman, Alexandra reported the problems she was having in attempting to reconcile work outside of the home with her caring activities:

> Interviewer: When you come back home from work, you know you have to do all the things. You go directly to the stove and saucepans…

Participant: I don't have a fixed hour to come back home since I must sometimes attend three meetings at my workplace and sometimes we end up late.

Interviewer: It's a lot of work…

Participant: Yes. When I come back home, it's already dark outside. It's past 5:00 p.m. I come back and change my clothes. I never sit down when I come back from work since I won't be able to stay up and prepare the meal. I go to the kitchen to cook and sometimes I'm so exhausted that I crouch down on the kitchen counter. I cook the meal, I serve the people, and then I sit down and eat. After…

Silence.

Interviewer: After, you're done…[I mean exhausted]

Participant: Yes. And, I must help the kids with their homework. Sometimes I do that in my bed since I can barely stand up. Caregiver 05-F

Alexandra also reported being torn between her multiple roles as wife, mother, daughter, and worker. She found she was not doing enough for her father; she would like to do more for him. Working outside and performing domestic duties impact on caring by decreasing the amount of time she is able to spend with her father:

Interviewer: Can you relax a bit?

Participant: Sometimes, my husband tells me to stop doing domestic tasks. He says: "Come on, let's go out." I answer: " I must do the laundry and fold the clothes and linen. I can't go out." He says: "Drop that!" I say: If I drop the work, tell me how will this be done? Nobody helps me in this house. Tell me who will do the work?" Sometimes I let things go but I know I will do it the next day or so.

Interviewer: The next day…

Participant: I do it [finish the laundry and folding clothes] when I can do it. When I feel I can work.

Interviewer: Do you feel torn between your roles, as wife, mother, and daughter?

Participant: I'd like to do more for daddy. But mostly it's my role as a daughter.

Interviewer: And after…

Participant: It's my work. My profession.

Interviewer: Your professional duty? It's a lot of work….

Participant: I guess it's everybody's fate…to be a mother, a parent, and so on, so forth. Caregiver 05-F

So far, these women, who are both raising young children, seem extremely busy and feel they do not have much time to devote to their aging parents. They care for them, but not to the extent to which they would like. As well, they need to work and it has an impact on caring by decreasing the amount of time spent with the aging parents. Demands related to housekeeping and parenting are also high and add up to the already significant workload for these women. Likely, caring for an aging parent at home is less difficult when children are older and their upbringing is completed. Joy, mother of four grown children, talks about how paid work affects caring in the presence of teenagers and young adults. Joy's daughters do not help her in performing domestic duties and Joy's mother presents cognitive losses due to Alzheimer's disease. Nevertheless, she assists her daughter in the preparation of meals. As well, after some negotiation, Joy succeeded in getting her husband involved with performing domestic chores:

> Interviewer: Well, today I visit you to discuss about the meaning of caring for aging parents at home. I see that you care for two persons. I'd like to understand what it means for you to care for them.
>
> Participant: Remains silent.
>
> Interviewer: Let's put it another way, what does it mean for you? Can you tell me more about that?
>
> Participant: It means lots of work. It means lots of responsibilities, especially for women like me, who work outside the home on a full-time basis. I work full-time at (name of the place). Also, I can tell you that sometimes, it's scary. It's scary. Silence. Especially in these times, I'm scared about the future. It's difficult for me to figure out the coming years and the children will soon be leaving home. This is how things supposedly happen anyway. It's life. (She smiled at me sadly)
>
> Participant: Sometimes, I come back from work, sometimes I come back from work late and I can't do anything. I feel I'm completely done. I can't do anything and all I want is to sleep. I'm able to look after myself but then my husband asks me: "Will you cook something for supper? We're hungry." Women are always held accountable for the preparation of meals. Caregiver 08-F

She went on to describe the impact of work on caring activities. I asked her to describe the activities she must perform when she comes back home from work:

Interviewer: When you come back from work, what do you do first? How to you manage things?

Participant: Usually, I'm off at 4.30 p.m., but sometimes, I finish late and get back home at 6.00 p.m. If I leave at 4.30 p.m., then I come back between 5.15 or 5.30 p.m. If I do some overtime, I get back home around 6.30 p.m. and sometimes later. I must run off to get back home to cook for them. When I enter, I go directly to the stove and pick up the cauldrons. A couple of months ago, mum and my mother-in-law used to go to my sister's for the weekend. I could enjoy a small respite. So when I was working I was more relaxed. I could have a life for the weekend but now it's no longer possible. Mummy could go to my sister's home but my mother-in-law cannot climb up the stairs and she needs help. Moreover, she can't stay away from her son. She wants to stay near him. Otherwise, I think she'd feel too insecure. It's not a life for her. For this reason, I no longer send them to my sister's for the weekends.

Interviewer: So, now, you don't receive any respite?

Participant: That's it.

Interviewer: Since then, it seems like you have weight on your shoulders…

Participant: It's a huge burden. (Almost whispering) Caregiver 08-F

Laura, another woman caregiver, is busy and distressed. She is not raising young children, but cares for two aging people, and her mother presents with significant memory losses. She clearly expressed fears about bearing a huge weight on her shoulders. Hopefully, her husband has accepted to alleviate her workload by performing some light domestic tasks. She renegotiated the family dynamics and their roles but confronted her husband many times before succeeding. I asked her how she is managing during the weekends since she no longer receives respite due to her mother-in-law's physical incapacity to spend a weekend at Laura's sister house:

Interviewer: What do you do during weekends?

Participant: I'm trying to work less but let's say I'm just attempting to do it [to work less]. Before, I was doing the grocery and was cooking the meals for the whole coming week. I've stopped doing that. Now, I prepare dishes for 2 or 3 days ahead and refrigerate it. When I come back from work, I just thaw and reheat food. Cooking for a whole week in advance was exhausting. I only have a weekend off and it's short. I used to cook until 10 p.m. and then start doing the laundry. My husband cleans up the house.

Interview: Does he sweep the floors and vacuum?

Participant: Oh yes! And he cleans the kitchen up as well. I do the cooking, the laundry, and the shopping. Caregiver 08-F

Laura appears as a lonely fighter since she does not have the support of a nearby extended family. Her only sister is a single, professional woman who often travels overseas for her work. At these times, she is not always available to comfort Laura. Other events, which are directly associated with the workplace, also have an impact on women's caring commitment. In the next chapter, I discuss the impact of the social world, in particular, the impact of racial discrimination and sexism at work and at school, on caring activities and the decision made by caregivers to not utilize the health care system. Issues pertaining to the social world must not be overlooked since they account for a major part of the caregiver's subjective burden. It is not caring *per se*, or hands-on activities that induce sleeplessness, stress, fatigue, depression, and other physical and psychological manifestations. Sexual division of labour, the influence of a market economy, racial discrimination, and sexual harassment compose the larger social context within which caring activities occur.

Some of these women caregivers also went through the difficult experience of health care reform. Some saw their department being shut down and then had to be relocated to other health care centres. For some Haitian Canadian caregivers, health care reform has been another stressor piled on top of others. For instance, Laura had to relocate to another workplace where she did not feel welcomed as a Black woman. The massive displacement of health care workers had an impact on labour relations in the health care system, which was a great concern for Clare:

Interviewer: Have you always worked in this area [name of the specialty]?

Participant: Yes. I've almost always worked in this area. You see, I've worked (number of years) at (name of the centre) and we were transferred to (name of health care centre) in 1997. I've worked in operating rooms before getting this job.

Interviewer: So, you felt the impact of the health care reform?

Participant: Oh yes! (Distressed voice). We have to bite the bullet since we have no other choice

Interviewer: At (name of the centre)?

Participant: Yes. All the staff was transferred. Other changes were gradually done but it wasn't our department's case.

Interviewer: So you had to get acquainted with a new workplace?

Participant: Yes. It was very tough. It was a very tough time. My blood pressure went up during that time and I needed medications to lower it.

Interviewer: These are very stressful times aren't they? It means departmental shutdowns, reposting the staff, changing the workplace, and being acquainted with new co-workers.

Participant: It was painful for me. This was very painful.

Interviewer: Did you change your work shift?

Participant: No, but I was transferred to (name of the place) where I got into trouble with a health professional. Caregiver 08-F

The impact of health care reform can be acutely felt, especially if you are transferred to a place where racial discrimination is more prevalent than in the former workplace. As well, interview and participant observation excerpts show that it is a challenge for women to clearly separate paid work and caring activities. It seems as if caring continues at work and work continues at home, influencing caring activities, caregivers and care-receivers. As Doyal (1995) cogently points out:

> The most obvious characteristics of domestic work in *all countries* [italics added] are probably its open-endedness and its sheer volume. There is no limit to how much can be required in a given period, and no entitlement to holidays or even meal breaks. Very importantly there may be no obvious end to the working day, so that many find it difficult to separate work from rest or "leisure". Indeed those with young children may never really be "off duty" as working hours even extend to periods of snatched sleep. For many, this can lead to a punishing burden of both physical and mental labour. (p. 28)

A male caregiver reported that when he was coming back from work, he could relax. He clearly divides his paid work from his private life but does not share in the domestic tasks with his wife:

> Participant: The working place is the working place. When I work, I think about my work. When I get back home, I forget the work. (Caregiver 03-M)

Nevertheless, I assume that the more likely men are to get involved in caring activities, the more likely they are to not be able to clearly divide their private and public spheres. Matthew, for example, cares for his wife Leila and Harold looks after his cousins. In a participant observation session at Harold's home, I observed that he was at the stove in the same way as are women. Harold, who is 65 years old, is now retired and does not need to go to work outside of the home and to care for young children. The similarity of the lived experiences that men caregivers, who do not share in household tasks or who are retired, have caring for their wives or aging mothers, is not comparable to the women caregivers' experiences. In general, men do not experience women's triple-task burden. The social context and the demands on men are different, though, as in Matthew's case, exceptions to the rule exist.

Matthew clearly described the impact of caring on his work since he had decided not to apply for job promotions. Matthew said that he was already exhausted with the situation at home with his wife and his children and that he could not get any more stress in his life. He basically avoids all stressful situations, as a survival strategy, since he feels that he would reach his breaking point. He cannot do overtime work, which affects his family's finances, since Matthew is the sole breadwinner and Jane can no longer work outside of the home like she did before her illness. Furthermore, Matthew cannot stay later at his work since he must come home to look after Jane and work out any issues related to the children or to her illness.

Summary

After examining the gendering of caring activities, it may be assumed that a reconfiguration of family dynamics can only be achieved if Haitian Canadian men show a willingness to share in the domestic duties with the women. A reconfiguration of family dynamics points to the equalization of the previously asymmetrical power relationships between

men and women, in a community where domestic tasks are assigned to the private sphere, and designated as belonging to the women's domain. On the other hand, the involvement of Haitian Canadian men in accomplishing household tasks is a means to an end, and would alleviate the Haitian Canadian women's workload. Although progress has been noticed, the data demonstrates that a compromise and sharing of domestic tasks is yet to be achieved. Nevertheless, women also contribute to construct the gendering of domestic work and caring activities by keeping men away from the kitchen – a form of sexism, since aging Haitian Canadian mothers were afraid that their sons would be feminized if allowed to perform some domestic work. The situation is clearly changing and, for example, Magdalena encourages her sons to cook and to get used to it, since third-generation Haitian Canadian women are less likely to act like their mothers.

In this chapter, I have attempted to demonstrate, and refer to the term coined by the late Michelle Rosaldo (cited in Lugo & Maurer, 2000), that 'gender matters' when it comes to explaining women's struggle with issues related to the binary opposition of domestic and private spheres. For Haitian Canadian women caregivers, the gendering of caring activities is marked by a kind of 'double oppression,' in that women are torn between the native and host country's patriarchy and the process of racialization that mediates ethnic groups relations in the host society. Leela Gandhi (1998) posits that 'third-world women,' as victim *par excellence*, are "the forgotten casualties of both imperial ideology, and native and foreign patriarchies" (p. 83).

The gendering of caring activities only represents the tip of the iceberg when examining the experience of caring for aging relatives at home among the Haitian Canadian community. In the next chapter, the impact of race, gender, and class on structuring the ways of caring is discussed. Also, I describe how the process of Othering and the relations with mainstream society impact on Haitian Canadian caregivers' everyday lives, ways of caring, and perceptions about health care practitioners. The effect is to locate Haitian Canadian caregivers' experiences in a larger social perspective where caring is understood in all its layers of complexity. Without

locating Haitian Canadian caregivers' experiences of caring in a broader social perspective, the contextual factors that structure caring activities may be overlooked or silenced. What are the distinct features of women caregivers, since women, whether from the South or the North (Ahmad & Atkin, 1996; Doyal, 1995; Hooyman & Gonyea, 1995) attend to the children, the sick, and the elderly?

A postcolonial feminist perspective provides the analytical lens to unveil the impact of racism, gender discrimination, and classism on the everyday lives and ways of caring of Haitian Canadian women caregivers. It also provides the theoretical tools to uncover ideologies that drive health care reform and the provision of home care services in ways that constrain their accessibility. In addition, it examines the effects of privatization on access to home care services. Privatization seems to have contributed to the creation of a two-tiered system where only socially privileged or high-income families can afford the cost of home support services. Accessibility to home care services becomes an economic issue and a matter of social inequity for those who cannot afford these services, despite their blatant need for them.

CHAPTER SIX
THE IMPACT OF THE SOCIAL WORLD ON HAITIAN CANADIAN CAREGIVERS' EVERYDAY LIVES

Introduction

In this chapter, issues related to the larger social world are described to illustrate how perceptions of racial and gender discrimination at school or at work, influence Haitian Canadian caregivers' present or future encounters with the mainstream health care system. Data is presented to uncover how ways of caring for an aging relative at home are mediated through the process of 'Othering' and also influence Haitian Canadian caregivers' decisions to not rely on public home care services. Haitian Canadian caregiver's perceptions may have an impact on the underutilization of health care services since racism and sexism induce distrust towards mainstream institutions like the health care system.

Ways of caring cannot be studied outside of the broader social context, where cultural ethnocentrism, racial discrimination, xenophobia, non-recognition, or misrecognition of cultural differences impinge on social integration. These structural factors favour the emergence of distrust towards health care practitioners of the dominant ethnic group. Distrust towards mainstream health care facilities can be the rationale underlying their choice to care for aging relatives at home. In that sense, caring for aging relatives at home shields aging parents from the deleterious effects of individual, social, and institutional racism in the health care system.

First, I sketch out the effects of Canadian politics of multiculturalism, from which neo-colonial processes of social, political, and economic Othering are constructed. Second, I illustrate how the process of Othering arises from the ideology of Whiteness, as a vestige of Canada's colonial past, and also influences Haitian Canadian caregivers' everyday lives. Third, I describe the diverse kinds of Othering and how they take place in Haitian Canadians' everyday lives at school or at work, and how they structure ways of caring. In the following, I briefly delineate the

underpinnings of the Canadian politics of multiculturalism and its consequences on cultural representation of non-Western peoples. As well, I show that the Canadian politics of multiculturalism intersects with race, gender, and social class to model Haitian Canadian caregivers' ways of caring.

Conceptualizing Otherness: The Impact of Canadian Multiculturalism

The Canadian politics of multiculturalism constitute the underpinnings of the normative discourses and practices of Othering in our country. A brief historical review showed that the Multicultural Act was passed into law in 1988 (Multiculturalism Act, 1990) under a progressive conservative government. Nevertheless, this law is largely inspired by the late Prime Minister Trudeau's[53] philosophy of multiculturalism where the contributions of immigrants and refugees in the construction of Canada must be recognized. Trudeau argued that Canada is a multicultural country and this represents a fundamental characteristic of the nation's social fabric (Maclure, 2003). The Multiculturalism Act (1990) is also directed at proclaiming values of equality of opportunity among all Canadians while removing barriers of discrimination to enhance tolerance and social integration of culturally diverse peoples. As a result, values of equality, tolerance, and recognition were to be applied through the nation's institutions, health care system, education, social services, cultural medias, and other governmental institutions.

The Canadian politics of multiculturalism has created high expectations of social recognition among the Haitian Canadian community. Multiculturalism, however, has disguised a flawed representation that serves to reinforce both Anglo and Franco Canadian nationalisms. In focusing on racial and ethnic differences, the double discourse of multiculturalism shattered the ideals of Haitian Canadians for social recognition and enlarged the gap of cultural

[53] Trudeau was committed to a philosophy of political universalism, based on the "principles of equality, individual liberty, and undifferentiated citizenship on which liberal societies are founded" (Maclure, 2003, p. 97). Maclure (2003) mentions that Trudeau "sought to make Canada into a civic, bilingual, multicultural, uninational political community founded on a shared allegiance to values such as absolute legal equality, symmetry among the

misunderstandings. In their everyday lives, Haitian Canadians experience the neo-colonial effects of Western multiculturalism that unfolds at the workplace or at school, while being hampered in attempts to climb the social ladder or gain economic and political power. As a result, the hegemony[54] of double discourse of the politics of multiculturalism has transformed social recognition into being no more than a sheer illusion of the mind, precluding Haitian Canadians and other non-Western immigrants from fully participating in the advancement of Canada. I now turn to illustrate how multiculturalism acts to categorize non-Western men and women as second-order citizens.

Western multiculturalism, which underpins Canada's multicultural policy, is used to crystallize culturally different Others in essentialist stereotypes based on racial and ethnic[55] differences. Ng (1993) states that, by drawing on systems of domination based on race and gender, multiculturalism essentializes the culturally different Other. The drawback is to generate patterns of social exclusion based on people's skin colour, and named visible minorities, while using gender to ascribe non-Western women into categories such as women of Colour or visible minority women (Bannerji, 2000; Carty & Brand, 1993; Foster, 2002; Lee & Cardinal, 1998; Ng, 1993), fixing non-Western women and men, in positions of racial, social, political, and economic disadvantages. Anderson and Reimer Kirkham (1998) contend that the Canadian politics of multiculturalism is the fundamental premise upon which the gendering and racializing of Canada's health care system is based, and through which health care programs are elaborated. Hence, the health care system may be conceptualized as a microcosm of the larger social world.

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provinces, tolerance for religious and cultural differences expressed (only) in the private sphere, and the inalienability of individual rights (except in times of crisis)" (p. 97-98).

[54] Gramsci defines hegemony as the "spontaneous consent given by the great masses of the population to the general direction imposed on social life by the dominant fundamental group" (Gramsci, as cited in Hoare & Nowell Smith, 1999, p. 12).

[55] Ethnicity and culture must be differentiated since two groups can appear to be culturally almost identical, and yet constitute different ethnic groups due to violent interethnic relations such as Croats and Serbs in former Yugoslavia (Eriksen, 1993). Eriksen (1993) mentions: "For ethnicity to come about, the groups must have a

This ideology of multiculturalism arises from Canada's colonial past that led to the co-existence of the English and French populations -- the so-called two-founding peoples of the nation. Therefore, the politics of multiculturalism serves to ground the White Eurocentrist ideology[56] of the Canadian state and represents, as Bannerji (2000) puts it, a vehicle of racialization, dissimulated behind the principle of recognition. According to Taylor (1995), the concept of multiculturalism in a liberal democracy like the Canadian state is articulated around two notions: equality and identity. In contrasting Taylor's and Bannerji's viewpoints on multiculturalism, I demonstrate that Taylor's notions of equality and identity are flawed since Taylor's position can be translated into a politics of the status quo for Aboriginals and non-Western immigrants in Canada.

Taylor's Politics of Recognition and Critiques

In Western multicultural societies, Taylor's politics of recognition (1995) is directed at correcting the effects of nonrecognition or misrecognition of subaltern groups like the Aboriginals, ethnic minorities, and some groups of women. Taylor (1995) states:

> Our identity is partly shaped by recognition or its absence, often by the misrecognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back a confining or demeaning or contemptible picture of themselves. Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being. (p. 225)

I step back to further examine Taylor's principles of universal equality and identity, around which recognition is developed. For Taylor (1995), the principle of universal equality acknowledges that all human beings are equal and must be respected as such, for the sake of human dignity. Treating humans equally is a means to avoid determining first-class and second-

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minimum of contact with each other, and they must entertain ideas of each other as being culturally different from themselves" (p. 11-12).

[56] Ideology is defined as "the mental frameworks, the languages, the concepts, imagery of thought, and the systems of representation, which different classes and social groups deploy in order to make sense of, define, figure out, and render intelligible the way society works" (Hall, 1997a, p. 26).

class citizens. Each citizen enjoys the same citizens' rights as others including the so-called minorities like Aboriginals, women, and ethnic groups. Is it possible to create injustice in treating all human beings equally? Under this notion of equality, no differences can be acknowledged since it would violate the principle of universal equality. This notion of equality becomes problematic when it comes to acknowledging Canadians as being *all* equal citizens.

Some scholars like Bannerji (2000) have critiqued Taylor's politics of recognition and more particularly, the notion of equality. Bannerji (2000) points out that Taylor's position is aimed at maintaining the status quo, which implies a nonrecognition of cultural differences. In sustaining a view of Canada as two nations in one country, where English and French communities share a cultural essence of "Europeanness," Taylor (1995) assumes a bicultural view of the nation. In proposing this dualistic Canadian cultural identity, Taylor erases the recognition of other cultural identities, which undermines the notion of equality. Thus, Taylor's principles of equality and identity are flawed because they are used to appease Quebec's separatism and maintain Canada's unity (Bannerji, 2000). Bannerji (2000) emphasizes that Taylor's politics of recognition does not acknowledge, as equals, the whole range of Canada's cultural differences, which include First Nations peoples and non-Western immigrants or the so-called visible minorities. Therefore, Bannerji (2000) contends that Taylor's multiculturalism, in negating the "different differences," implies that the English and the French are recognized as Canadians while non-Western peoples are not considered as "real" Canadians. Hence, it can be argued that Taylor's conceptualization of multiculturalism is a means of Othering that casts the culturally different Others in essentialist categories of exclusion. Bannerji (2000) describes Taylor's political bind:

> Underneath the "two solitudes", as he knows well, Canada has "different differences", a whole range of cultural identities which cannot (and he feels should not) be given equal status with the "constituent elements" of "the nation", namely the English and the French. (p. 98)

The two founding peoples continue to govern Canada while perpetuating the hegemony of defining culturally different Others as subalterns, those who come from ethnic or visible minorities. Recognition is enmeshed in colonial relations of power, since only the two constituent elements of the nation (Taylor's "we") can grant an equal status to culturally different Others (Taylor's "them"). Bannerji (2000) points out:

> As he [Taylor] sees it, neither official multiculturalism nor the politics of representation can bring about the desired solution to the problem caused by the presence of ethnic cultural others in Canada or the West [Western societies]. Though he supports everyone's need for recognition and appeals to "us" who are in a position to grant it, he does not question why "we" have this power to grant or withhold it. He does not ask whether his discourse of recognition has moved from its universalist ground because it rests in the actuality of socio-historical relations of white settlers colonies or former colonial powers still locked in imperialist relations with the rest of the world. (p. 135-136)

In other words, Taylor recognizes the Eurocentrist history of Canada -- its former French and British colonial regimes from which the primacy of the two founding people is established. On the other hand, Taylor does not take into account the notion of cultural hegemony in silencing Aboriginals and non-Western populations. The power to recognize differences is in the hands of the social elite and Taylor obfuscates the impact of domination, colonization, and power in his efforts to bestow recognition. Bannerji (2000) thus claims that Taylor's recognition constitutes *de facto* extension of the colonial and imperialist hegemony, used to articulate the ideological discourse where cultural differences are fixed in the Canadian politics of multiculturalism. Bhabha (1994) underlines the limitations of the "consensual and collusive liberal sense of cultural community" (p. 175). I draw on Bhabha (1994) to argue that Taylor's recognition is aimed at assimilating cultural differences by using a flawed perspective of "liberal ethics of tolerance and the pluralist framework of multiculturalism" (p. 177).

Thus, Bannerji contends that Taylor's politics of recognition may bring a liberal democracy to commit social injustice. Taylor (1995) states that the principle of identity "asks that we give acknowledgment and status to something that is not universally shared" (p. 234).

Therefore, can we simultaneously promote universal equality while acknowledging cultural differences or identities? The recognition of non-Western immigrants as equal citizens in a context of cultural diversity is closely linked to the State's policy of multiculturalism. As many authors suggest, the policy may not be applied in the social institutions of the nation, which creates a context of social injustice for non-Western immigrants who seek to integrate into Canadian society (Anderson & Reimer Kirkham, 1998; Bannerji, 2000; Li, 1999; Roberts & Clifton, 1990). Taylor's politics of recognition sustains the political status quo, confirming, as Roberts and Clifton (1990) point out, Canada's preference for symbolic[57] multiculturalism and Quebec's preference for institutionalized[58] multiculturalism. For Quebec, the recognition of differences is a means to maintain its status of founding people. In the process, the status quo also encourages silencing the voices of Aboriginals and non-Western men and women.

Can a different discourse of representation be held in Quebec? Bannerji (2000) contends that no observable differences are noticed between Quebec and other Canadian provinces. Bannerji (2000) points out that multiculturalism is a turf where the two founding peoples compete to promote their social, political, and economic agendas, while glossing over the interests of Aboriginals and non-Western immigrants. Bannerji (2000) mentions that "the national project is deeply driven by the rivalry between anglophones and francophones — Canada's 'two solitudes'. Equally patriarchal and race inscribed, these two solitudes remain central cultural/political actors" (p. 73).

Cultural representation is historically, socially, and culturally constructed, and inscribed in an exclusionary discourse, around which Canada's politics of multiculturalism creates areas of racial, ethnic, gendered, social, and linguistic exclusions. This former area of social exclusion

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[57] Roberts and Clifton (1990) suggest that symbolic multiculturalism "allows members of an ethnic group to participate and benefit as members of a complex industrial society while retaining the sense that they belong to a smaller, more intimate community" (p. 134).

represents a particular feature of Canada's social and political landscape. In the following, I discuss how the politics of multiculturalism is enacted in the province of Quebec.

Quebec's Politics of Multiculturalism

In 1991, the provincial government of Quebec took control of its influx of immigrants, through the Gagnon-Tremblay/McDougall agreement[59], signed between Ottawa and Quebec City. The Quebec Ministry of Immigration's priority became the francization[60] of new immigrants and their offspring, to enhance social integration in the francophone mainstream society of the province (Denis, 1999; Germain & Rose, 2000). The Montreal area was specifically targeted by the politics of francization, since the city is acknowledged as one of Canada's major urban centres, behind Toronto and Vancouver, in attracting new citizens. Despite the federal-provincial agreement, few differences were noticed between Canada's and Quebec's politics of immigration, since both were based on the ideology of the two-founding peoples. Hidden behind the official state politics of multiculturalism and its supposedly openness to cultural differences, is the fact that ideologies of Canadianness, Quebecness, and Whiteness build the gendering and racializing of both Canadian and Quebec societies (Lee & Cardinal, 1998; Maclure, 2003).

Lee and Cardinal (1998) mention that Canadianness is "a view of the nation imagined as naturally White, male, Christian, middle- and upper-class, English-speaking, British, and more

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[58] Institutionalized multiculturalism is observed when "an ethnic group's promotion of its distinctive ideas and ideals is accomplished through a system of social arrangements with sufficient surveillance and sanctions to assure that the group's cultural orientations are put into practice" (Roberts & Clifton, 1990, p. 129).

[59] According to the Ministère des Affaires Internationales, de l'Immigration et des Communautés Culturelles, Quebec started controlling its immigration in 1978, through the Cullen/Couture agreement (Government of Quebec, 1996).

[60] In 1977, the enactment of the controversial language law (Bill 101) that stipulates French is to be the language of work for allophones (Quebec's designation of immigrants who neither speak English nor French) was aimed at imposing francization to facilitate the integration of immigrants and refugees in the mainstream society. As well, Bill 101 was directed at precluding immigrants and refugees to integrate the Anglo-Quebecer community (Denis, 1999; Germain & Rose, 2000; MRCI, 1996). On the other hand, Eller (1999) contends that Bill 101 is a means of assimilation used to promote Quebec's nationalism. I will not provide an extensive analysis of Quebec's nationalism, though multiculturalism, nationalism, and ethnicity should not be glossed over when examining the process of Othering. These factors are intrinsically linked to a misrepresentation of non-Western peoples.

recently, Northern European in [its]cultural heritage" (p. 218). These authors also contend that Canadianness is a product of a dominant Anglo Canadian nationalism, to which they ascribe the label of "hegemonic nationalism" (Lee & Cardinal, 1998, p. 218). On the other hand, Quebecness is an ideology that is believed to define a "true and authentic way to be Québécois" (Maclure, 2003, p. 137). Ideologies of Canadianness and Quebecness are associated with issues of nationalism, albeit not similar, but which nevertheless raise controversy on the notion of equal citizenship. What does nationalism mean? First, many forms of nationalism exist, with the common thread being in their close association with ethnicity, statehood, and power relations between different ethnic groups (Eriksen, 1993). Eriksen (1993) proposes this definition:

> Nationalisms are, in this view, ethnic ideologies, which hold that their group should dominate a state. A nation-state, therefore, is a state dominated by an ethnic group, whose markers of identities (such as language or religion) are frequently embedded in its official symbolism and legislation. (p. 99)

Canada's and Quebec's politics of multiculturalism, in sustaining a hidden ideology of national identities (or nationalisms), contribute to reinforce the process of Othering by defining new linguistic labels used to further divide Canadian citizens. For this reason, potential immigrants are selected on their abilities to speak one of Canada's two official languages. French-speaking immigrants are encouraged to settle in the province of Quebec, to balance its demographic deficit,[61] while English-speaking immigrants or refugees are mainly directed to other Canadian provinces (Germain & Rose, 2000). As soon as they walked upon Canadian soil, Haitian immigrants faced the paradoxical ideology of Canada/Quebec multiculturalism and the political debate over Quebec's secession or sovereignty.

Haitian Canadians are caught in a political crossfire between the two founding peoples — torn between Canada and Quebec. The upshot is to create a split and wounded identity. As Foster

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[61] Germain and Rose (2000) point out that "in 1996, only about 9 percent of Quebecers were born outside Canada, about half the Canadian average. Moreover, due to out-immigration of both native-born Quebecers and immigrants, the province has long had a migratory deficit" (p. 229).

(1996) points out, Canada is far from being a haven when it comes to integrating non-Western immigrants into the 'two solitudes' social landscape. As a consequence of the politics of multiculturalism, Haitian Canadians are confronted with a racialized society where they find that their ethnic identities are divided, wounded, stigmatized, ghettoized, and silenced.

On the other hand, some scholars provide a slightly different analysis of Quebec's multiculturalism by suggesting that Othering becomes a means to counteract Quebec's fears of marginalization in a pluralist Canada (Eller, 1999; Li, 1999; Maclure, 2003). Basically, Eller (1999) contends that Quebec lags behind Canada when it comes to acknowledging cultural differences. Eller (1999) refers to history to explain this situation:

> The Quebecois movement [Quebec's nationalism regardless of political allegiances] sees multiculturalism as a threat to its rights and status as the other Canadian society. Multiculturalism, they fear, dumps them along with every other cultural or interest group into a cultural politics in which all cats are gray, in which all groups' rights are equal and equally important, or equally unimportant. In this formulation, Quebec may be distinct, but it is not special, because everybody is distinct. This multicultural gloaming is perfectly antithetical to what the Quebecois have aspired. (p. 343)

If one follows Eller's line of argument, it would be more difficult to immigrate in the province of Quebec and integrate into the mainstream society, due to Quebec's crisis of identity. This crisis of identity, fuelled by real or imagined fears of losing a privileged status of a founding people, would impinge on the social integration of culturally different peoples. Eriksen (1993) asserts that, "ethnic identities tend to attain their greatest importance in situations of flux, change, resource competition, and threats against boundaries [ethnic boundaries]" (p. 100). This might explain the hardships of some Haitian Canadians to fully integrate into Quebec's mainstream society because immigrants can be perceived as threatening the old-stock[62] Quebecers' ethnic boundaries. In that sense, it may be assumed that Quebec's mainstream

[62] Old stock is generally used to designate the descendants of French settlers, also named Québécois de souche, Quebercers, or French Canadians living in Quebec (Eller, 1999; Robin, 1996). French Canadian is mostly used to designate French inhabitants of other Canadian provinces, excerpt Quebec (Eller, 1999).

society is struggling with major demographic[63] changes in its population. Nevertheless, Bannerji (2000) contends that other Canadian provinces also struggle with issues of immigration, but perhaps to a lesser extent than does Quebec. For instance, she reports the non-acceptance of East Indians,[64] South Asians, and Chinese immigrants in BC. Bannerji (200) points out that the status of these new immigrants cannot be compared to the hardships encountered by the first waves of South Asian and Chinese immigration on Canada's West Coast:

> As landed residents or apprentice citizens, or as actual citizens of Canada, they cannot be left in the same limbo of legal and political non-personhood as their predecessors were until the 1950's. Yet they are not authentic Canadians in the ideological sense, in their physical identity and culture. What is more, so-called authentic Canadians are unhappy with their presence, even though they enhance Canada's economic growth. Blue ribbon Hong Kong immigrants, for example, bring investments, which may be needed for the growth of British Columbia, but they themselves are not wanted. (p. 43)

It can be argued that Canadian multiculturalism sustains a process of exclusionary Othering, by introducing racial, gendered, and social hierarchical divisions among the nation's citizens. Canada remains "a liberal democracy with a colonial heart" (Bannerji, 2000, p. 75) since the nation's multicultural policy translates the fundamental notion of equality into a rhetorical discourse of social justice, that creates different levels of citizenships. The ideology of Western multiculturalism is the premise upon which the process of exclusionary Othering is socially and culturally constructed. This points to examine how the process of exclusionary Othering unfolds in Haitian Canadian caregivers' everyday lives, and consequently, on ways of caring for an aging relative at home.

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[63] In his White Paper on Immigration, published in 1966, Jean Marchand, a liberal minister, stated that "the rate of immigration to areas east of the Ottawa River is generally low" (Marchand, 1975, p. 68). He also pointed out that "some potential immigrants have felt that Quebec has provided a less favourable environment for immigrants than have most of the English-speaking provinces ...but English is the language that is most often learned" (Marchand, 1975, p. 68).

[64] For a fuller description of the history of East Indian immigration on Canada's West Coast and the Komagata Maru incident, see, for example, Grace and Helms (1998).

The Process of Exclusionary Othering

Othering has an impact on Haitian Canadian caregivers' everyday lives and on their ways of caring, since it models the caregivers' perceptions of the old stock Quebecers and the decision-making process for the use, or lack of use, of public home care services to support their caring commitment. I define Othering as an exclusionary social process by which culturally different peoples (mostly non-Western peoples) are judged against the norms, values, and behaviours of a dominant Western group. As mentioned earlier, the process of Othering arises from the ideology of Western multiculturalism. As Bhabha (1990) points out, Western multiculturalism and its underlying notion of cultural diversity, is based on competing ideologies of encouragement and containment:

> Although there is always an entertainment and encouragement of cultural diversity, there is always also a corresponding containment of it. A transparent norm is constituted, a norm given by the host society or dominant culture, which says that "these other cultures are fine, but we must be able to locate them within our own grid". This is what I meant by a creation of cultural diversity and a containment of cultural differences. (p. 208)

In other words, Bhabha (1990) emphasizes the fact that recognition of cultural diversity must not be conflated with the acknowledgement of cultural differences. Nevertheless, the consequences of Othering is to stigmatize the culturally different Others, into fixed or essentialist identities inscribed in a hegemonic discourse of representation (Canales, 2000). Hence, Othering is a socially and culturally constructed process that serves to promote and maintain the social agenda of the dominant ethnic group. It is a way of governing society where some ethnic groups are excluded from the sphere of influence, constructing a social hierarchy organized around levels of subalternity. In the next sections, interview and participant observation excerpts are presented to explore how the exclusionary effects of social, cultural, political, and economic Othering have an impact on Haitian Canadian caregivers' everyday lives and ways of caring.

Social Othering

During fieldwork, I observed that the process of social Othering seemed to occur at a very young age among Haitian Canadians. I collected the following fieldnotes during a participant observation session conducted at a caregiver's home:

> I went downstairs and we both entered her mother's apartment. During my first visit, the room had been quite dark but now it was daytime and I could see a picture of the grandmother when she was a young woman. I felt a presence next to me and I looked down and saw the toddler who was standing besides me. Suddenly, he threw his arms around my hips and hugged me. He wanted me to take him in my arms. I took him in my arms and the young boy put his head on my shoulder. He was holding me tight; his arms around my neck. I caressed his hair and stroked his back while holding him. Then, I whispered to his ear: "I'd like to have a boy like you." He replied: "Yes but I can't change my colour." It struck me so much that I was almost speechless. Then, I asked: "But who told you this?" The boy remained silent. I repeated my question: "Can you tell me who told you that?" He remained silent but started pressing his head harder against my shoulder. Afterwards when I left the caregiver's home, I was very sad. It grieved me to hear a young boy talking about his skin colour and saying that he couldn't change it. He was indirectly implying that he could not be my son since we were racially different. I was puzzled that a child could speak about racialization as a biological construct at so young an age. Many questions came to mind: Who can teach a five-year-old that his skin colour is not the right one? Had he learned this at kindergarten? Did he hear that when playing outside with the neighbour kids? Was he listening to his parents' conversations? Were his older siblings informing him about it? The formulation of these questions deserves a careful examination. For instance, what did I mean by the words 'it',' 'this' and 'that'? What was I trying to silence and for what reasons? In fact, I may have been attempting to escape some distressing facts about my own racial background.

This participant observation excerpt illustrates what Roman (1993) coined as being an instance of White defensiveness, where I saw myself as being colourness. The upshot of White defensiveness is to obfuscate and erase issues of racial privilege and unequal power relationships, which are associated with privileged locations. Lewis (2000) defines location as referring to the "historical, geographical, cultural, psychic, and imaginative boundaries that provide ground for political definition and self-definition" (p. 173).

Roman (1993) cogently points out that White defensiveness contributes to "white misrecognition of the effects of our own racially privileged locations, that is, the ways in which institutionalized whiteness confers upon whites (both individually and collectively) cultural,

political, and economic power" (p. 72). I was negating, as Roman (1993) puts it, the fact that White is a colour while trying to erase the impact of the ideology of Whiteness in inducing, among Haitian Canadians, a consciousness of racial differences pertaining to Blackness. For instance, Fanon (1967) mentions:

> As a schoolboy, I had many occasions to spend whole hours talking about the supposed customs of the savage Senegalese. In what was said, there was a lack of awareness that was at the very least paradoxical. Because the Antillean does not think of himself as a black man; he thinks of himself as an Antillean. The Negro lives in Africa. Subjectively, intellectually, the Antillean conducts himself like a white man. But he is a Negro. That he will learn once he goes to Europe; and when he hears Negroes mentioned he will recognize that the word includes himself as well as the Senegalese. (p. 148)

Fanon's point was to demonstrate that the encounter with Whiteness triggered the consciousness of Blackness among young Antilleans of his generation. Therefore, it is not surprising that the young boy told me about his skin colour since he had met with Whites and knew the binaries of Blackness/Whiteness. For others, encounters with the ideology of Whiteness take place in another social context where the structural effects of Whiteness are differently expressed, but still exclusionary. I illustrate this by examining George's lived experience, where a contrast is seen between the different contexts in which Whiteness constructs ethnic relations in Canada and in Haiti. George came to Canada at the age of 65 and his consciousness of being a Black man had already been developed since, in Haiti, he was exposed to the postcolonial hierarchical social effects of Whiteness. George described his first encounter with the Canadian ideology of Whiteness:

> Interviewer: Can you tell me what struck you when you arrived here?
>
> Participant: Well, I'll tell you. Quebecers they know very well, they have the knack to let you know that you're a Black man. As soon as the aircraft landed and hit the tarmac, as soon as you get off the plane, you know you're Haitian. I never felt like this in my country. I never think about the colour of my skin but here you're reminded that you're Haitian. For instance, I went to the bank this morning. I was the sixth person in the line up to the cashier desk and the woman before me said: " I don't like Blacks". Then, she turned around and saw me. She blushed and she said: "I was not talking of you." I replied: "Dear Madam, I don't really mind about that. I'm far beyond this since what's

important is the people and not the colour of the skin. Whether you're Black, White, Asian, or Indian, it's the same red blood running in our veins. Blood is red and the earth is black. So when we die, since all of us die, we all go back into the black earth. What is the colour of the earth? It's black. So, that's it. Do you see what I mean?

Interviewer: Yes. I see your point.

Participant: One must see beyond the colour of the skin and must search for the soul of the person. I see racism as the result of a lack of education, fear of the unknown, and fear of the strangers. And all these stereotypes saying that Blacks are dangerous criminals, it doesn't help you know. Never forget that you can find out some very nice flowers in your garden. You need to separate the wheat from the chaff. Haitians deserve to be appreciated since there are very intelligent people among them but you need to find them out.

Interviewer: I understand what you mean....

Participant: I'll tell you what I consider as real racism. For me, real racism occurs when you go to see another Haitian. You go to see a Haitian because you need some help but he doesn't want to help you.

Interviewer: Why?

Participant: Only because you're dark-skinned, your skin tone is darker than his. He's a Mulatto and I'm Black. For me, it's racism too and it hurts me much more since it's another Haitian, one of my countrymen, who did that. In Haiti, the closer you were to the Whites, the better you were economically and financially. The darker you were, the worst it was. (Caregiver 04-M)

The main idea that is extracted from George's excerpt is that: Whiteness is a means of social stratification in Haiti and in Canada. In Haiti, race was used as a means of stratification among social classes. The lighter the colour of the skin, the more likely you were associated with the wealthy Haitian elite who were mainly composed of mulattoes, and who were perceived as the colonizers' heirs. In that particular social context, Whiteness conferred social, political and economic advantages to the mulattos. In Haiti, race intersects with social classes and produces this social stratification based on the lightness of the skin. Whiteness is clearly linked to colonialism since "it is intrinsically linked to unfolding relations of domination" (Frankenberg, 1993, p. 6). Intra-ethnic racism is a vestige of Haiti's colonial past that unveils the association

between colonialism, racism, and classism. Mensah (2002) explains this skin pigmentation social taxonomy:

> Depending on a variety of factors such as the race of the native population, the imperial power involved, and the level of exploitative zeal among the settlers, those of mixed blood may, or may not, be favoured by the colonizers. In the case of most Black African and Caribbean countries, especially those in which the number of European settlers was relatively small, the mixed-bloods (i.e., the mulattos or the so-called Native Whites) were favoured on the basis of their degrees of admixture: usually, the lighter the melanin, the greater the social and economic opportunities. (p. 33)

In Canada, Whiteness represents an instrument of social stratification, officially enacted in the politics of multiculturalism, where non-White people are categorized in the visible minorities to distinguish these groups from other White Canadians. In Canada, Whiteness is also a remnant from the nation's colonial past upon which the process of Othering is based, and which sustains relations of domination of an ethnic group over culturally different Others. Whiteness is thus a means of colonization, a form of epistemic violence used to promote dominant groups' social interests and further silence the interests of culturally different Others. Frankenberg (1993) states:

> The notion of "epistemic violence" captures the idea that associated with West European colonial expansion is the production of modes of knowing that enabled and rationalized colonial domination from the standpoint of the West, and produced ways of conceiving "Other" societies and cultures whose legacies endure into the present. (p. 16)

According to George, the lack of education and fears of strangers can explain racism in the mainstream society. The process of Othering, however, has already labeled young Haitian Canadian men as being socially deviant. These negative labels inscribed to Haitian Canadian men are used to reinforce social exclusion. Even if George did not refer directly to them, the influence of the news media, in constructing negative images of Haitian Canadian men, must not be overlooked. Two key informants reported that relationships between law enforcement officers and Haitian Canadian youth must be improved. One key informant told me that she often noticed

a police cruiser parked near the schools at the end of classes, and sometimes near some of the private homes. Law enforcement officers are mainly recruited from among the dominant ethnic group as well as from older cultural communities like the Italian Canadian community. I will not provide an in-depth analysis of the relations between White police officers and Haitian Canadian youth, but the situation is reminiscent of the practice of racial profiling that is encountered in Canada. Foster (1996) reported his harsh treatment by a White policeman for an alleged traffic violation in the greater Toronto area, where he was caught just because he was a Black man driving a fancy car. He was appalled by the "condescending and demeaning tone" used by the young police officer when proceeding to examine his driver's license (Foster, 1996). As Foster (1996) points out, these tense relations with the police often lead to distrust and sometimes may degenerate into violent confrontations.

The extent to which this social stratification, based on skin colour, has been reinserted in Quebec among the Haitian Canadian community, was observed. During fieldwork, I stayed almost eight months in a women's residence. It was a monastery where room and board were provided to older ladies who could not afford the soaring cost of living in private nursing homes. I had to go to the refectory for meals and remember seeing a Haitian Canadian woman there whose skin tone was fair. I thought she was a Frenchwoman. She never sat at the table where the dark-skinned Haitian Canadian woman was usually seated for her meals. The fair-skinned Haitian Canadian woman only sat at tables in the company of White women. I observed this pattern of exclusion during the mealtimes for almost six months, noting that it occurred regardless of whether it was breakfast, lunch, or supper. The pattern was firmly set: the fair-skinned woman avoided being seated with the dark-skinned woman. As well, they did not look at each other. I ate in the company of each of these two women, but never with both of them together. To my knowledge and from my daily observations, they never greeted each other, nor engaged in any conversation. The fair-skinned woman spoke French with a Parisian accent while

the other woman spoke French fluently with a light Creole accent. One day, I was going to the first floor and decided to use the stairs since the elevator was almost always out of service. I could hear a woman talking on a telephone while I was descending the stairs. Public phones were installed on each floor close to the stairways. I could recognize a Creole accent and I was stunned to see that the fair-skinned woman was speaking. I had expected to see the other Haitian Canadian woman speaking in Creole.

From this experience, it may be hypothesized that social stratification continues to divide mulattos and dark-skinned Haitian Canadians in the host country, suggesting that some intra-ethnic tensions still pervade the relationships between Haitian Canadians. On the other hand, it can also be argued that despite sharing a Haitian ethnicity, the two women had little else in common, as it often happens in many ethnic groups. Nevertheless, in his study on emergence of Haitian ethnicity in Quebec, Massé (1983) reported that intra-ethnic tensions between fair-skinned and dark-skinned Haitian Canadians were still influencing and dividing social relations in the host country. These intra-ethnic divisions between Haitian Canadians would not have an impact on the relations with old-stock Quebecers since the degree of Whiteness would not facilitate Haitian Canadians' integration into mainstream society. I now scrutinize how the process of social Othering operates in the schools, workplaces, and the civil society. I present data to illustrate how Haitian Canadian caregivers describe their everyday encounter with the ideology of Whiteness and how Whiteness influences the caregivers' perceptions of racism.

Othering at School

During a participant observation session, Paula told me about her perceptions of racial discrimination at school and the lack of recognition of foreign diplomas. She was born in a town that is located in the northern part of Haiti. Her mother made many sacrifices for the education of her children. They all studied in private institutions, which were often directed by French, Belgians, or Canadian priests and sisters. When Paula immigrated to Canada, she encountered

some problems with her schooling. She went on to explain that the Haitian educational system is a replication of the French system — high school years are extended and college is not available. After graduating from high school, students enter directly into university. In Quebec, students need to attend college (or CEGEP) before being admitted to a university. Paula was unable to find work as a secretary in Quebec since her Haitian diploma was not recognized and so, began working in a kindergarten, soon quitting because of the poor working conditions. She decided to go back to school and enter college (a CEGEP) where she was in the program for laboratory techniques. She said that some teachers always assigned lower grades to Haitians, but was still able to complete her degree. Her perception was that Haitian Canadians were given lower grades due to racial discrimination. John seemed to share the same perception when he discussed the impact of the lack of recognition of foreign diplomas in some of the highly protected professions like medicine, law, and business:

> Interviewer: So the Americans would be more open [than the Canadians] on this subject? [Lack of recognition of foreign diplomas]
>
> Participant: Of course! Of course! When we spoke about social integration, I think we need to look at what happens in the US. I think that social integration must be realized in the recognition of the value of foreign diplomas. That's where social integration starts…you have to open the doors… [Acknowledgment of foreign diplomas]
>
> Interviewer: I understand…
>
> Participant: For instance, it's not easy for an immigrant to access medical school. It's very difficult for an immigrant to enter medical school…
>
> Interviewer: Yes. Extremely difficult…or you have a diploma and they won't accept it.
>
> Participant: That's it!
>
> Interviewer: All of this to protect…
>
> Participant: Of course! Of course! Yes, it's used to protect, to protect Quebecers [old-stock]. (Caregiver 03-M)

John revealed his perceptions on racism by describing his personal experience attending a course at the university. He also reported that he never heard his children talk about issues of racism at school (for example, being given lower marks). He said:

> Interviewer: Did your kids go through this sort of experience [racism] at school?
>
> Participant: *They must have been treated like this too but they never told it.* [Italics added]. I can speak for myself since I've been treated like this when I was attending school.
>
> Interviewer: Were you attending the university?
>
> Participant: Yes. And I had problems even with the Italians.
>
> Interviewer: Even with the Italians?
>
> Participant: (Speaks loud) Yes! The Italians! I registered in a course at the (name of university). At the beginning of the course, we were 18 people coming from the North and the Eastern part of the town [on the island]. The teacher asked us to divide up into small groups to carry out a team assignment. When it came time to form groups, suddenly I was the only guy who was coming from the Eastern part of the town. I was the only one! Nobody else was living in the East! I was left aside; all other students were divided into teams. I was left alone, no team wanted to have me in. So, I went to see the Italians. (Voice is shaking). I asked if I could join their team and they answered: "No. Our team will be meeting in (name of the town) Can you figure out? They preferred to cross the city from East to West to go to (name of the town) to get rid of me. They didn't want me to be a member of their group. So, tell me again, what is social integration?" (Hit the table with his closed fist while saying this last sentence).
>
> Interviewer: Remained silent.
>
> Interviewer: When did it happen?
>
> Participant: It happened at least five years ago. Since then, I'm quiet, very quiet. I can't do anything with that. I don't want to deal with that again. I can't change the world but I have to live within this world and bear it. (Caregiver 03-M)

In another interview excerpt, Thomas perceived racial discrimination in the labour market. He wanted to climb up the social ladder and improve his economic status by accessing higher-income jobs:

> Participant: Often, when I go to the office, I find a job posting and phone to get information on that job posting. When I called, they had already figured out that I'm, huh, that I'm Haitian [Creole accent]. So, they told me that the job was not opened since somebody had been hired for it recently. I went back to check out the board, and I saw that the job was still posted! Nobody had been hired but they simply didn't want me to get the job!
>
> Interviewer: Uh huh…[Listening]
>
> Participant: I talked to a Quebecer since I wanted to get his opinion about this situation. He told me, I don't know if it's true, but he told me I needed a mentor to get this job. At least, *I think he was honest with me* [Italics added]. He told me that if I had no mentor or somebody with some power to help me secure a job, I was wasting my time doing business and management studies. He said: "You'll never find a job in the public administration or in management if you don't have a mentor. You need to know somebody who has political or other sorts of influence to push your candidacy forward." (Caregiver 03-M)

In this last excerpt, it may be hypothesized that Thomas was racialized, even though it is true that some need a social network of influence to obtain a job. Perhaps, because he was Haitian Canadian, the odds were against him, but even for Quebecers, their chances are reduced if they do not have an influential network to push for their candidacy. Therefore, how can sense be made of the process of Othering at school? The lack of recognition of foreign diplomas affects Haitian Canadians since the immediate effect is to de-skill them further. They have no other choice except to go back to school in Canada and complete a domestic diploma that will be recognized. Some do not really have a choice, however, since they have a family to support, and must search for other kinds of employment. They are drawn to accepting low-skill, low-wage (i.e., manufacturing) jobs, which subjugates them while protecting the elite classes' social agenda. Liberal professions are closely related to political and economic power, which may explain the difficulty for immigrants to open doors to these protected areas. This phenomenon has been observed in other Canadian provinces, as well. Professional associations and licensing

bodies are reluctant to recognize foreign-trained workers or professionals. These instances represent blatant cases of protectionism,[65] affecting immigrants' social integration in the country.

The government of Quebec (1996) acknowledges some explicit and implicit instances of racism in the educational system but also emphasizes that few studies have been conducted to document the issue. The official government literature mentions that racism cannot be generalized but it occurs more often than it is reported, especially when it occurs against members of the Black community, whether they are anglophone or francophone. Nevertheless, a few cases of racism have been reported, such as that mentioned in the following quotation:

> Bien qu'il existe des cas isolés de racisme explicite chez les enseignants et entre élèves, ils s'avèrent peu documentés. Tant les études perceptives que nos répondants ont tendance à affirmer que le phénomène serait plus généralisé que les cas déclarés ne le laissent croire et toucherait principalement les Noirs francophones et anglophones, notamment au niveau du secondaire. (Ministère des Relations avec les Citoyens et de l'Immigration, 1996, p. 90)

Quebec's educational system does not provide the same opportunities to all its citizens for achieving high educational goals. Latent racism is pervasive and affects the achievement of Haitian Canadians in their education, even at the university level, where some professors have been perceived as being racists, because they attributed lower marks to Haitian Canadian students. In any case, these perceptions of racism are being influenced by social positions. Far from implying that racism does not exist in Canada and Quebec, these interview excerpts should be carefully examined. Taylor (1995) mentions that the non-recognition or misrecognition of cultural identities may lead some groups to "internalize their own inferiority" (p. 225). Perceptions of racism can be influenced by this state of inferiority. Paula constantly asked: "Is it because I'm Black?" General perceptions, therefore, are being derived from the individuals' perceptions about their racial, ethnic, and social status.

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[65] An article in the *Vancouver Sun*, states that: "The doctors from Italy, Romania, Russia, India, and the Philippines, argued as far back as 1991, that the BC College of Physicians and Surgeons had one set of rules for those from

Quebec's government must strive to develop a culturally diverse public administration since only 2.1% of the so-called visible minorities were working in Quebec's public apparatus in 2002. This proportion is as high as 9.4% in Ontario, 7.4% in BC, and 5.6% in the rest of Canada. Members of Quebec's Council on Intercultural Relations mention that very few immigrants work in Quebec's public apparatus. The Council has also said that the darker the skin tone, the less chance to be hired (*Le Soleil*, April 24 2002, p. A9). In French, the original quotation is: "Non seulement il y a peu d'immigrants dans l'administration publique québécoise, mais leur nombre diminue en plus avec la couleur de leur peau. Autrement dit, moins ils sont blancs, moins il y en a" (*Le Soleil*, p. A9). Equality in attaining educational goals remains a social priority to be addressed by the government of Quebec.

The government of Quebec also acknowledges the high toll of racial discrimination among visible minorities[66] -- young men and women, between the ages of 15 and 24-years old who are in the workforce (Ministère des Relations avec les Citoyens et de l'Immigration du Québec, 1996). For instance, official state literature mentions that the unemployment rate is higher among non-Western Quebecers than among old-stock Quebecers of the same age strata. One drawback in these observations is that the governmental data was taken from the 1986 census. In 2001, Torczyner and Springer conducted a survey in the Black[67] community of Montreal, which is scattered in different neighbourhoods on the island. They found that the rate of unemployment was two-and-a-half times higher for Blacks than for non-Blacks in the Montreal area. For Torczyner and Springer (2001), significant gaps must be addressed to correct social inequities pertaining to education, employment, and income. Lower-income families are

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predominantly White, English-speaking countries (the US, England, New Zealand, South Africa, and Australia), and another set for the rest." (*Vancouver Sun*, September 17 2002, p. A12).

[66] This refers to the official state discourse where the expression, visible minorities is still used to designate non-Western men and women belonging to a racialized group.

[67] In Torzyner and Springer's survey, members of the Black community were from the Caribbean, Bermuda, and Africa. Despite a high level of bilinguism among the young Blacks of Montreal, racial discrimination in the

affected when it comes time to pay for home support services since respite, meals-on-wheels, and housecleaning services are now mostly provided by the private sector. In precluding an access to higher education degrees, social Othering at school intersects with race to create social inequities that have a further impact on the accessibility to home care programs and that influence Haitian Canadians' ways of caring. I now turn to examine how social Othering operates in the workplace, through the prism of labour relations.

Othering in the Workforce

In this section, interview excerpts illustrate the impact of racism on health through the prism of labour relations. Whether racist remarks are subtly or ruthlessly made, they are devastating on people's health and social integration. Haitian Canadian men, compared to women, are more likely to be addressed rudely by mainstream, racist co-workers. The process of Othering in the workforce pervades the working relations between co-workers, between managers and workers, and even between customers and workers. Racist comments based on stereotypes like laziness, distrust, strategies of avoidance, sexual harassment, or from a pride of being a racist, were reported in this study. The upshot is to construct a double process of Othering where generalizations are made in both communities regarding the other ethnic group.

Othering between co-workers.

Edward is a former health care worker. He is now retired but cannot forget how rudely he was sometimes addressed by some of his mainstream co-workers. The following excerpt demonstrates how racism operated at Edward's workplace:

> Interviewer: You tell me that your religion helped you to carry on?
>
> Participant: Yes. Yes. Especially when I was working at (name of the centre) and some co-worker hurt me by doing or saying some things. Then, I was laughing.
>
> Interviewer: [Not understanding his point] You said when you were at work?

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workforce seems related to the colour of the skin. "The level of unemployment for Black university graduates was identical to that of non-Blacks who had not completed high school in 1996" (Torzyner & Springer, 2001, p. 51).

Participant: Yes. When I was at work, and somebody was doing things to hurt me, unfair things…

Interviewer: Can you give me an example? What kinds of things?

Participant: They could do anything, anything.

Interviewer: Were they addressing you rudely? Was there racism at your workplace?

Participant: Yes, there was. Yes. (Sadness in his voice)

Interviewer: They [co-workers] were treating you badly?

Participant: Of course! They were doing very wicked things. They could do anything they wanted. They didn't like me since I was doing the work they didn't want to do. Isn't that good? I should have worked like them. I should have respected their rules but I didn't know that.

Interviewer: How was racism translated at your workplace? How was it made explicit?

Participant: I was assigned to heavier workloads than all the other workers. Always. Always. Always.

Interviewer: You had to work harder and your workload was heavier. Whose people were assigning the work? Were they [old stock] Quebecers?

Participant: Yes, and this is why I decided to quit when the government made the deal with the health care workers. I was one of the first to sign up. I wanted to go.

Interviewer: You wanted to quit the workplace because you were fed up….

Participant: Yes.

Interviewer: To be treated like this?

Participant: Yes. I couldn't stand it anymore.

Interviewer: Did you think that it would be like this?

Participant: Remained silent.

Interviewer: How do you explain racism?

Participant: For me, it's a lack of education.

Interviewer: A lack of education…

Participant: Yes.

Interviewer: Or a lack of respect towards humans?

Participant: It's a lack of education. People are not educated to work with people coming from other communities.

Interviewer: Did they [the co-workers] address you rudely?

Participant: Yes. One day at work, a woman told me: "You're just a damned Negro." It doesn't matter since I know I'm a Black man, a Negro, and I don't care about it. It doesn't matter if you are Indian or Black because I didn't choose the colour of my skin. I had no choice. (Caregiver 09-M)

Othering among customers.

Charles also reported that some customers treated him badly but afterwards, they appreciated him:

Interviewer: And with the clients, how was it? Were they tough with you?

Participant: When a new resident was arriving, whether Italian or Quebecer, they're all the same. They don't greet you, even when they're with their family members.

Interviewer: Clients did not greet you?

Participant: Not at all! They didn't greet me. They were staring at me but they never said hello, or smiled, or said anything. But they were greeting the other co-workers [the Whites]. Not me, I'm just a Black. But I can tell you that after two or three weeks, then they started to greet me. Finally, they were asking for me. They wanted me to come and care for them. "Mister X come in I want to see you." (Caregiver 09-M)

Then Charles went on to describe what he considered as being the most important thing in establishing inter-ethnic relationships with mainstream society. His comments were very similar to those provided by George and which were presented earlier. Charles questioned racism in the sense that for him, all human beings were equal, regardless of the colour of their skin:

Participant: Why being a racist? You're a White woman, and I'm a Black man. Did you have the choice to be White? Did you ask to be White? You were born White weren't you?

Interviewer: Nodded my head for yes.

Participant: So then, you had no choice, hadn't you?

Interviewer: I had no choice, you're right. I was born like this [White]

> Participant: It's the same situation for me. Me too. You're a human being, before all, you're a human being. All you have, I have the same. That's the bottom line. (Caregiver 09-M)

John also reported hardships at his workplace where he met some racist co-workers and customers, as well:

> Participant: Even at my workplace, I've to endure racial slurs and discrimination. I'm humiliated. At work, some older residents shout at me 'you damned Negro!', 'dirty dog', and they say that just because I'm a Black man.
>
> Interviewer: They tell you such injurious things…
>
> Participant: Oh yes often, often. It is indeed very often, very often. Many times.
>
> Interviewer: And these people…. Are they Quebecers?
>
> Participant: Of course! They're Quebecers.
>
> Interviewer: Of a certain age?
>
> Participant: Yes, and I can tell you they aren't confused. They know what they say.
>
> Interviewer: It must be difficult to work in such a place, with such tensions…
>
> Participant: Yes it is. What do you want? Even last week, before I went on vacations…
>
> Interviewer: Uh huh…
>
> Participant: They told me such things like: you dirty nigger, dirty dog, *tonton macoute.* Some tell me to go back in my country. They say: "Hey *tonton macoute*, go back to your country!" So, how do you see integration? We [Haitian Canadians] say okay, we must integrate into the mainstream society. But how can we do that when there's always a barrier to fence us off somewhere? (Caregiver 03-M)

Othering at the worplace: The case of Haitian Canadian women.

I now illustrate how the process of Othering unfolds at work for Haitian Canadian women. Racial discrimination is perhaps less abruptly directed towards women than towards Haitian Canadian men, who were addressed with such racist slurs as nigger or dirty dog. For women, implicit sexual domination intersects with race and gender to impact on women caregivers' health and wellness. The women caregivers who encountered this problem did not report the issue to governmental authorities since they did not want to be fired. When examining

the next two interview excerpts, sexual harassment is seen to happen in highly professional workplaces and in industrial settings. Laura describes her encounter with racism at the workplace:

> Participant: In my case, it has been extremely difficult. While at work, I had some little problems with an employee. This was extremely difficult; it was almost a disaster. I was very depressed. Luckily, I was working with another person who helped me.
>
> Interviewer: That employee was not kind?
>
> Participant: He was blatantly wicked. Evil.
>
> Interviewer: A real wicked guy?
>
> Participant: Oh yes! He was very bad, very evil.
>
> Interviewer: May I ask the nature of the problems you encountered with him? Please feel free to answer or not.
>
> Participant: Nodded her head for yes.
>
> Interviewer: Were these problems related to your racial background?
>
> Participant: Yes (Without hesitation). It was related to that. I had so many problems. He told me such things that first I wanted to sue him but I didn't have enough evidence (proof) to sue him. It was his word against mine. So, I dropped the idea of suing him.
>
> Interviewer: What did he tell you?
>
> Participant: He didn't mention it directly but it was implied. He said: "People who come to this clinic are very educated, very educated. And you can't work here."
>
> Interviewer: But you have a professional degree…
>
> Participant: Yes.
>
> Interviewer: And he wasn't satisfied?
>
> Participant: Absolutely not! This employee even told me that I was chasing clients away.
>
> Interviewer: What did he say? Did he say you were not competent for the work?
>
> Participant: Not even that! It was not related to my professional competence at all. He said: "You don't need to be here." That's all. He said: "You can't do the job, you can't work with me here."
>
> Interviewer: Did he judge you like this?

Participant: Yes. And he went on to say: "You can't work here. You can't do the work. It's not just a question of being nicely dressed....You aren't.....And he said: "Do you understand what I mean?"

Interviewer: Did you ask him what he meant in saying that?

Participant: Shook her head to indicate no.

Interviewer: It's not easy to ask, is it?

Participant: Remained silent. Looked very sad and nodded her head for yes.

Silence.

Participant: He hurt me so much. He hurt me so much. I've almost (...) Just after this event, I had an accident when going back home. I almost passed away.

Interviewer: Is this situation still going on at your work now?

Participant: It's difficult but I went over this. But I had to meet a psychologist to sort things out. And my family and my friends supported me. And my faith too, my religious faith helped me. But what shocked me is that despite all the efforts I did to raise my kids...I raised them not upon the rationale that because you're Black you behave like this. No. I told my kids: "Do your best, always give the best of yourself and you'll get recognized for your achievements. You won't have troubles. And I never think about that [Being a Black woman]. It never stopped me but this situation hit me very hard." (Caregiver 08-F)

This was Laura's lived experience at work, which had an obvious impact on her health. Since then, she has been depressed and, at the time of our meeting, was under treatment. She even questioned the education that she gave to her children, fearing that, despite doing their best work, like her, they will never be accepted. The Canadian-born generation seems to be experiencing a state of limbo in citizenship, being neither Canadian nor Haitian. Kristeva (1991) reported a similar situation in the status of Maghreb immigrants in France. Haitian Canadians and their children born in Canada/Quebec are neither considered as complete strangers nor as full citizens. This incident has also had an impact on Laura's perceptions about home care services and nursing homes. She prefers to keep her aging mother at home, rather than ask for CLSC services, since she cannot see any ethnic groups in those places. Her mother is Creolophone and would not be able to communicate with the mainstream staff.

I now present Angela's story. Angela is a middle-aged woman who looks a little older than her age. When I met her, I noticed she was coughing a lot and thought that she may have been suffering with influenza or a cold. I asked her if she had consulted a doctor for her cough, and she replied: "Yes. I went to the doctor and he prescribed a medication. I've a (name of the disease) and I'm very susceptible to colds as well." I said: "Anyhow, if your condition does not improve in a couple of days, perhaps you should go back to the doctor's office. He may prescribe a chest radiography." She answered: "You know I've so much work to do, I don't have time to look after myself."

Angela is a single mother and a young grandmother. When I came in, she welcomed me, saying: "I'm so glad you're coming today. I need to vent out this anger I've against that system. I can't keep it inside anymore." I was surprised to hear her comment, but as the interview unfolded, I realized the hardships she was facing, at home and at her workplace. Moreover, Angela is caring for her aging mother who lives with one of Angela's brothers. Each weekend, Angela goes to her brother's house and looks after her mother. She went on the weekend to bathe her, do her laundry, do her hair, and the cooking. Angela added: "I love mummy and when you care for somebody it means much more that just providing basic physical care like feeding or bathing" (Caregiver 11-F).

Angela's mother receives basic hygienic care from the CLSC but does not need professional nursing services. Since her mother's illness, Angela has to make up for the services that are not provided on a free basis such as cooking, laundry, groceries, and the cleaning up. She also provides supplemental hygienic care to ensure a better physical comfort. Angela is also busy with her family — her children live in her apartment. She has to look after the house, and perform the domestic chores since her daughters do not give a helping hand. Prior to working at the factory, Angela worked as a cleaning lady for a private agency. Currently, Angela is confronted with precarious working conditions. She receives the minimum wage, as prescribed

by the government of Quebec for non-unionized workers ($7.30 per hour). Since she is not a member of a union, she does not have work benefits like participating in a retirement plan or subscribing to dental or hospitalization insurance. When earning the minimal wage, after paying for rent and groceries, little money is left. Angela described her experience at work in this interview excerpt:

> Participant: I must work twice as hard as the other workers, you know? It is not easy for me. I must devote lots of my energy, lots of efforts, and it's not easy for me. And I know there are people who don't like me.
>
> Interviewer: Can you tell me why? Why people don't like you?
>
> Participant: Because of this. [She shows her arm, designating the colour of her skin]
>
> Interviewer: It's because of the colour of your skin?
>
> Participant: Yes. So I must give more. I must work harder. The manager wants me to work harder than my co-workers.
>
> Interviewer: Because of the colour of your skin, the manager is more demanding?
>
> Participant: Oh yes! And I don't have lots of seniority, so they are tough on newcomers, too. They are very tough with me. I really feel…Sometimes I think that mummy was right when she refused to go to a nursing home. Because I, too, went through very difficult times, very tough times.
>
> Interviewer: At your work?
>
> Participant: Yes, at work, since before my divorce I was staying at home. After my divorce, I had to go back into the workforce. Oh, it's not easy to be a woman.
>
> Interviewer: It's not easy to be a woman….
>
> Participant: It's not easy to be a woman. It's not easy to be an immigrant! (Loud) No. No. No. Because the co-worker (Hits the table with her hand) He has no respect for me. Do you understand? He treats me like an animal and I think animals are better treated than I. He doesn't respect me! (Loud) Do you understand what I mean?
>
> Interviewer: He exploits you? He abuses you?
>
> Participant: Exactly! Exactly! (Very loud, upset voice tone) And he doesn't call me by my name. He shouts" "Hey you come over here!". And I can't complain, since if you talk a little, it's a piece of cake for him to fire me and hire somebody else.
>
> Interviewer: Are they Quebecers?
>
> Participant: Yes.

Interviewer: And the foreman is White?

Participant: Yes.

Interviewer: So, you don't have any safety at work. I mean nobody's there to defend workers' rights?

Participant: No. There's no union. So do you understand why the boss didn't care about threatening me? He threatens me often.

Interviewer: Can you tell me more about these threats? What kind of threats?

Participant: He threatens to fire me if I don't execute his orders, if I don't perform what he asks me to do. And you know he assigned me to men's job. Work only guys can do.

Interviewer: You must perform men's tasks?

Participant: The foreman assigned me to (name of the service). It's a tough work and if I can't do the work, then the foreman informs the boss that I can't work properly. Afterwards, the boss [owner] wants to fire me.

Interviewer: You can't perform men's work…You can't work like a man. It's more like that, isn't it?

Participant: Yes. And it's scary since I fear losing my job. I'm constantly under stress. Do you see? They don't respect workers. Other employees have to suffer these conditions, too. I'm not alone. I can't continue to work there. It's tense and too stressful. I've enough stress looking after my family and caring for mummy. I can't take it anymore. It's no good for my health nor my morale.

Interviewer: But it ends up as cheap labour…

Participant: Exactly!

Interviewer: It looks like exploitation…

Participant: That's it! Of course! It's exploitation and non-respect of human beings. I must bend my knees, crawl on the floor like a dog. Bosses trample on the workers; they crush us. I respect the authority, I know they must do their job but workers deserve being respected, too. It must be reciprocal you know?

Interviewer: This lack of respect….Have you noticed this lack of respect when you go to the hospital, to the restaurant or other places?

Participant: Just a little bit.

Interviewer: Just a little bit?

Participant: Yes, but I think there's more racism at work. I've almost reached the breaking point. I can no longer support these conditions. I'm sick and depressed.

Interviewer: It's a very tough workplace…

Participant: I'm constantly humiliated (Hits the table with her hand). They insult me with their racist comments and I can't talk back you know otherwise I'll be fired. There are some White people also who are treated like me. There are White women who are racist as well. They don't respect me either.

Interviewer: Would you say that these harsh working conditions have an impact on…how you perceive Quebecers? I mean, in general…

Participant: I can't tell you I'm not influenced, but I'm careful not to generalize. (Caregiver 11-F)

This long interview excerpt highlighting Angela's lived experience of working in a racist environment, illustrates the triple jeopardy of being a racialized immigrant woman. Angela is a blue-collar worker as opposed to Laura who is a professional. Both of these women had to face issues of racism and sexism at their work, which were both at the individual and institutional levels. Issues of racism were reported among some White women who were assuming managerial tasks – a position of social privilege. One woman was confronted by a health professional while the other had to face a foreman. Angela's situation of powerlessness may have been more acute but it does not mean that Laura felt less intimidated since she was facing a powerful man. Both situations were dangerous for the health and well-being of these women.

Racism and sexism affects culturally different women. Racialized women may come from different social classes but are confronted by the same issues where race and gender intersect with labour relations. Bannerji (2000) reports that in Canada "we [racialized women] are sexed into immigrant women, women of colour, visible minority women, black/South Asian/Chinese women, ESL (English as second language) speakers, and many others" (p. 65). In fact, some White men construct racialized women as sexual objects. Racialization is socially and culturally constructed and closely associated with gendered discrimination. For instance, Remennick (1999) reported problems that were encountered by Jewish Russian women when they immigrated to Israel. These women were racialized and sexualized by Israeli-born men who

constructed these women as sexual objects. Jewish Russian women were provided with poor living and housing conditions, were given menial tasks, and were subjected to unwanted intimacy as a means to enhance their paycheck or working conditions. Remennick (1999) reported that these women had been socialized in educated circles where blatant sexual offers were perceived as being rude and offensive:

> It can be safely argued that most Russian-Jewish immigrants were socialized in the relatively egalitarian gender culture of the Soviet intelligentsia. In Israel, these female engineers, musicians, and teachers suddenly found themselves in the middle of a Levantine male culture of the Israeli "street", which sees little point in restraining or disguising sexual interest, especially towards dependent and apparently helpless newcomers. During their first years in Israel, women with a Russian accent were often made blatant sexual offers in the markets, public gardens or buses, in apartments they rented (by the owners) and of course, in their new workplaces. (p. 450)

In presenting this quotation, I want to underline that immigrant women can be socially and culturally constructed as sexual objects. Jewish Russian women share the same ethnicity but did not share the same cultural background as Israeli-born men. Men were much more direct with Russian-born women than with Israeli-born women. Without casting Israel as a single case, my aim is to draw a parallel with the almost identical situation of women with a French Creole accent being confronted in Quebec. I personally witnessed a sexual advance being made to a Haitian Canadian woman. The woman and I were waiting for the light to change at a street intersection when a White, middle-aged man rolled down his car window, and addressed her: "Hey babe! What do you do to own such a car?" After the incident, she told me that similar episodes happened frequently. She said: "They [men] ask me this silly question just because I'm a damned Haitian woman." I knew that she could earn enough money to buy this car, but as a Haitian Canadian woman, she is being constructed as a sexual object, just as Jewish Russian women were perceived by Israeli-born men. Other issues of harassment, pertaining to the worsening of working conditions such as being attributed harder tasks, were reported during fieldwork.

Before the fieldwork, I did not see racism and sexism and these issues were unnoticed as if non-existent. I had to meet with 'Blackness' to see how 'Whiteness' mediated social relations between men and women. Haitian Canadian women helped me to develop a consciousness of what constituted White oppression. Racism and sexism act as implicit relations of ruling, unfolding in women's everyday lives. I concur with bell hooks (1984) when she mentions that Black women are located to challenge oppression, racism, sexism, classism, to bring about social justice:

> As a group, black women are in an unusual position in this society, for not only are we collectively at the bottom of the occupational ladder, but our overall social status is lower than that of any other group. Occupying such a position, we bear the brunt of sexist, racist, and classist oppression. At the same time, we are the group that has not been socialized to assume the role of exploiter/oppressor in that we are allowed no institutionalized "other" that we can exploit or oppress. (p. 14)

Despite blatant oppression, Laura and Angela sustain ideals of social justice; first, to encourage children to do their best to be recognized in the society and second, to ask managers to respect employees and stop discrimination. A woman caregiver refused sexual advances, at the price of her health, to bring about justice at the workplace. Sonia is engaged in a similar fight in her workplace as well. She challenges the sexist and racist oppression that seems to predominate at women's workplaces. In this excerpt from a participant observation session, issues of distrust towards the mainstream society pertaining to racial discrimination are delineated.

Sonia told me that when she arrived in Quebec she was "watching her guard" since she had ideas about Whites. She reported the case of a young male co-worker who was proud to proclaim himself as a racist man. He once told her: "You know I'm a racist. I don't like Haitians because they're lazy." She told him: "It's pure nonsense, what you're saying." She said that the young man always left her out of the decision-making process when a problem arose at work. As well, he harassed her by checking to see if her work was being performed.

The most striking fact is that this situation occurs in the health care system between co-workers. It would be legitimate to question how culturally different Others are treated in hospitals or community health centres where institutional racism is a part of the organization culture. Sonia understands racism from her frame of reference, her perceptions, and her experiences with Whiteness, where she was confronted with racial discrimination at the workplace. She did not seem to want to generalize negative stereotypes for all of the old stock Quebecers. Nevertheless, I would argue that being confronted on a daily basis by a racialized and gendered world might influence Haitian Canadians' perceptions about mainstream society and have additional impacts on their utilization of the health care system.

Haitian Canadians not only face the misrepresentation by old stock Quebecers, but also must deal with older cultural communities in accessing labour market and other social resources. Other ethnic communities can compete to maintain historically-obtained social privileges. As reported by some Haitian Canadian caregivers, clashes with the Italian Canadian community frequently occur. The Italian Canadian community is one of the oldest ethnic communities of the greater Montreal area, following behind the Jewish community. After Italians, immigrants from other countries such as Greece and Portugal came to Canada in quest of a better life for them and their offspring. As a consequence of racialized immigration politics, the entry of non-Western immigrants was restricted but later, the policy was lifted. Thus, immigration from Haiti has been a relatively new phenomenon, compared to European immigration. Clashes between Haitian and Italian Canadians point to how the process of cultural Othering "naturally" occurs in social events.

Cultural Othering

In a participant observation session, I noticed the social relationships between three ethnic groups: French Canadians/Quebecers, Italians, and Haitian Canadians at a social event that was held in a community health centre. In presenting these fieldnotes, my aim is to describe

the process of cultural Othering by which ethnic groups relegate others to the rank of subaltern or second-order citizens on the basis of the ideology of Whiteness. The three groups were divided according to their respective race and ethnic backgrounds. I noticed a group of Haitian Canadians, seated at a table, while other participants were seated at tables according to their ethnicity. Since I was not present when people first entered the room, I did not know if the staff had placed them in their groupings or if they had spontaneously segregated themselves naturally. The overall picture presented each ethnic group as being isolated in their cultural entities. During the event, I noticed that French Canadians and Italians exchanged jokes in French between the groups, even though they were seated at different tables. No exchanges occurred between these groups and those seated at the Haitian table. At the table where I was seated, people were speaking in Creole and I was grateful that one of the participants facilitated my integration in the conversation by translating to French. The group was comprised of senior citizens who were attending a social gathering. During the meal and afterwards, I perceived some non-verbal messages from those seated at the French Canadian tables that I was violating a silent rule. The Quebecers seemed to want me to leave the Haitian table and come over to sit with them. Apparently, I was violating the silence of relation of ruling, by which the ideology of Whiteness mediates social relations between ethnic groups. After the meal, and as the music was playing, French and Italian Canadians were mingling and soon exchanging dance partners, joking among themselves, in a relaxed atmosphere, while continuing to ignore the Haitian Canadians.

Frequently, I noticed glances of disapproval when I attended diverse activities with one key informant. Whether at a shopping mall or at a restaurant, some men and women would glance at our table and address me, not the key informant. Some of my countrymen reminded me that I was not behaving properly. The relation of ruling thus became visible as I was Othered or excluded since I was with a Haitian Canadian woman. Likely, Whiteness mediates social relations between ethnic groups more than does ethnicity *per se*. Even though Haitian Canadians

share a French culture with the Quebecers, this did not seem to influence the interactions between the two groups. Why did French and Italian Canadians exclude Haitian Canadians during the social gathering? Why did the French and Haitian Canadians not intermingle, since most of them share the same language? Moreover, these three groups are recognized as being predominantly Catholics, however, the rate of inter-cultural marriages between Italian and French Canadians is high compared to the overall rate of conjugal or marital unions between members of other Western or non-Western populations (Germain & Rose, 2000).

The answer may be found by examining how the ideology of Whiteness acts to divide people on the basis of racial determinism, where race is conceptualized as a biological attribute (Ahmad, 1993; Bannerji, 2000). In such a racial ideology, biological traits like skin colour are used to categorize people. It can be argued that Whiteness is a colonial relation of ruling from which the ideological underpinnings of the process of cultural Othering are drawn. Frankenberg (1993) states:

> The extent to which white women were "missing" or "not getting" the significance of race in either our or anyone else's experience had everything to do with standpoint: because they were race privileged, I argued, we were not in a structural position to see the effects of racism on our lives, nor the significance of race in the shaping of the US society. (p. 9)

In referring to my fieldwork experience, I cannot refute Frankenberg's argument that I was missing the picture of social inequities. As a member of a so-called founding people, I was unable to see how the structures of racism and sexism were related between cultural communities and how they intersected with the workplace. The process of blinding begins at a very young age. I was never told that slavery was sanctioned by the *Code Noir* in New France, nor perpetuated under the British regime (Mensah, 2002), to illustrate the collusion of the two founding peoples in erasing the impact of racialization on Aboriginals and non-Western immigrants in the creation of the nation. I now turn to examine issues of political and economic Othering and show its impact on Haitian Canadian caregivers' everyday lives.

Political and Economic Othering

The rise of the separatist/sovereignist movement remains an emotive and polarized issue in the Canadian political landscape. During my fieldwork, key informants and participants expressed their ideas about this issue and how they felt excluded after Quebec's most recent referendum. Issues related to the 1995 referendum came up during participant observation sessions, but less often during interviews. Haitian Canadian men were more willing to enter this political discussion than were the women — though the women also expressed their feelings of being rejected from mainstream society on the basis of political allegiances. The point is not to argue in favour of one political option over another, or to replace one nationalist discourse for another. Eriksen (1993) warns to "be critical enough to abandon the concept of ethnicity the moment it becomes a straitjacket, rather than a tool for generating new understanding" (p. 162). Nevertheless, the data illustrates that political and economic Othering intersects with ethnicity, cultural identity, politics, social class, and nationalisms to construct a discourse of social exclusion.

Political Othering is a relation of ruling aimed at promoting and imposing the political and economic interests of the dominant ethnic group while erasing other groups' interests. As a discursive practice of exclusion, political and economic Othering not only impacts on Haitian Canadians' social integration but also on health and economic welfare. As an exclusionary discursive practice, political and economic Othering influences Haitian Canadian caregivers' perceptions of mainstream institutions like the health care system and health practitioners. Many caregivers notice an increased level of racism and cultural ethnocentrism as being an outcome of the last referendum. A key informant, who immigrated to Canada 40 years ago, described how she felt hurt by the words of a politician, who attributed the defeat to money and ethnic votes. For this key informant, Quebec's secession or sovereignty represented an issue of the past. She reported that younger Haitian Canadians are less concerned about this political debate since they

are torn between the Haitian identity and the Canada/Quebec identity. She said: "It's not their reality. They feel trapped between the tree and the bark, between Haitian identity and Quebec identity. They came to Canada to live in peace, to enhance their living conditions, and for their children to get a better education, and to enjoy political freedom and safety. They are not interested. I mean they don't feel concerned about this issue of sovereignty. It belongs to the past and we must focus on the future. You are not an oppressed people, so they don't understand why you want to secede. It's your fight, not ours." Another key informant reported: "If you're not White, you're not Quebecer. If you're not Nationalist, you're not Quebecer." These excerpts illustrate the identity dilemma and the social exclusion felt by Haitian Canadians as well as by other members of cultural communities in Quebec[68]. The political issue of Quebec's secession/sovereignty seems to categorize members of ethnic communities who have chosen the federalist option, as being not "real" Quebecers.

During the fieldwork, I was often asked to discuss my political allegiance. My answer was that I still believe in Canada's future as a united country, though I cannot erase my own wounded identity – torn between Canada and Quebec. During fieldwork, I was juggling with the issue of Quebec's separation/sovereignty but felt compelled to convey the Haitian Canadians' standpoint, which provides insights that are from different historical, social, cultural, and economic locations. The participants' feelings of social rejection that was raised during the last referendum was reported as they voiced the subjugated knowledge. If I were to proceed otherwise, I would have violated my postcolonial feminist theoretical approach by imposing a colonial epistemic violence on Haitian Canadians.

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[68] During the last Quebec referendum, I was doing my master's fieldwork among the Jewish community of Montreal. When meeting participants, they expressed their hurt that was related to the issue of money and the ethnic vote. I can safely say that all members of Quebec's cultural communities felt the outrage from these words. The upshot was to emphasize the binary opposition of the us/them, which was later translated into a social wound, still to be healed.

Political and economic Othering has an impact on Haitian Canadian caregivers since it induces distrust towards mainstream society and can lead to the underutilization of the health care system and home care programs. In the following interview excerpt, Harold describes how he felt rejected by the mainstream society for political reasons:

> Interviewer: I'd like to understand. You say that it's a depressing country. Can you tell me more about that?
>
> Participant: Oh yes, it's a depressing country.
>
> Interviewer: How come? Is it related to the social issue?
>
> Participant: Sure. Social issues and this endless winter....
>
> Interviewer: And the political debate.....
>
> Participant: Laughs. I can't be a politician because I'm too honest for that! I can only speak the truth and politicians don't speak the truth, they hide what they really have in mind.
>
> Interviewer: It's difficult sometimes [not knowing the truth].
>
> Participant: Well, I'll be clear with you. For instance, Mr. Parizeau, the late Mr. Lévesque, Mr. Bouchard and Mr. Landry; when they want to be elected, what do they tell you?
>
> Interviewer: Remained silent.
>
> Participant: They talk about Quebec's independence. They want to create a nation, a state, but they know it's impossible. They talk about independence just to be elected. These guys are politicians!
>
> Interviewer: Do you see this as opportunism?
>
> Participant: They know that independence is the opium of the people, a potent drug. (He laughs) (Caregiver 09-M)

David also spoke about the referendum and its impact on his relations at work with his co-workers:

> Participant: I remember the last referendum, when the Quebecers, I mean the Parti Quebecois, lost its referendum. I was in the locker room and some co-workers were also there. They were throwing injurious things at me. They said: "They [Haitian Canadians] don't know how to run their country and they come here to tell us how to run our country?" They also said: "And they [Haitian Canadians] don't work, they're on social welfare." I said: "It's not true, it's not true. I work."

Interviewer: Uh huh....(listening)

Participant: It's true that there are people on welfare but often these people have to be on welfare. They need welfare since they can't find jobs. They have to pay for housing, they have a family, and so welfare is the last resource for them. And I know Haitians are very proud and it's tough for them just to enter the welfare office and ask for financial support (Voice is shaking)

Interviewer: Uh huh....(Listening)

Participant: Because they [Haitian Canadians] feel really diminished, they feel low. People who say these things they don't know Haitians. So when I heard their insults in the locker room, I rushed in to dress up and quit as fast as possible. Let them rant and rave. I quit because I didn't want to argue with them. It was the last thing I wanted. I said to myself: "You can't argue with them. Don't go that way." (Caregiver 03-M)

Political Othering has an impact on social integration by enlarging the division between Canadians. Political Othering is closely related to economic Othering, which happens when you cannot access higher education, when your professional diplomas may not be recognized, or when you need to drop courses because of racism and/or sexism. Economic Othering also means that you have to seek work where your competency and knowledge is not acknowledged, either socially or financially. It is the roadmap to low-wages, poor living conditions, and low-income jobs, in a context of high competition with other cultural communities in accessing the market economy.

Haitian Canadians, for example, are described as "the poorest residents of Montreal" (Germain & Rose, 2000, p. 235). It is not mentioned that many Haitian Canadians were classified as lower-skilled workers or deprived of their professional status. The impact of a racialized[69] labour market in forcing Haitian Canadians and many other non-Western immigrants to access precarious and low-wage jobs in Canada was silenced (Bannerji, 2000). Equality for a fair chance in the labour market must be developed as a means to address social inequities

[69] Mensah (2002) reports that "members of the Quebec community refused to ride taxis driven by Haitians and dispatchers also declined to send Haitian drivers to customers" (p. 108).

related to racism, sexism, and classism, and foster Haitian Canadians' social inclusion and recognition.

Summary

Racial discrimination affects both Haitian Canadian men and women since it impinges on a successful social integration. As seen in the interview excerpts, racism and sexism have an impact on women caregivers' health and indirectly, on ways of caring. How can these women manage to look after children and the caring for aging parents at home when they come home from work? How do these women feel? How can they carry on with the caring commitment without becoming exhausted? Will they have to quit the workforce if sexual harassment and the other forms of threats increase?

The common thread of Othering is based on its colonialist ideology and hegemony. Political and economic Othering leads to low-income jobs and since the caregivers' income is an important factor for accessing home care support services, some Haitian Canadian caregivers and their families are unlikely to be able to afford such expenses. They will not rely on the health care system because the resources they need have been either privatized or simply dropped from the public health care system. The impact of health care reform in the privatization of home care support services and the downsizing of respite programs will be addressed further. As well, the extent to which mainstream nurses and other health practitioners are part of the oppressive system as exercised in the workplace where institutionalized racism is a relation of ruling must also be scrutinized, if culturally safe nursing interventions are to be designed.

In the next chapter, I describe the Haitian Canadian caregivers' ways of caring for aging relatives at home. Caring is seen as a process of cultural continuity where the respect of aging persons is a paramount value explaining why Haitian Canadians tend to keep aging parents at home to shield them against individual, social, and institutional racism. Ways of caring are socially and culturally constructed as a means to protect aging parents' dignity, as Anderson and

Reimer Kirkham (1998) put it, in a racialized and gendered society. It points to examine the meaning of aging and caring, the nature and motives of caring, and the family support and networks that support Haitian Canadian caregivers' caring commitment. The gendering of caring and the impact of the social world is the background information needed to understand Haitian Canadian caregivers' ways of caring and the pattern of underutilization of the health care system or home care programs among this cultural community.

CHAPTER SEVEN
CARING: A PROCESS OF CULTURAL CONTINUITY, RECIPROCITY, AND MOURNING IN BECOMING

Introduction

In this chapter, the individual and family contexts, which comprise the third component of the phenomenon under study, represents the layer to which other layers (i.e., the gendering of caring and the impact of the social world) were previously added. This multi-layered construction of Haitian Canadian primary caregivers' ways of caring demonstrates that caring is also embedded in a nexus of power relations, where structural social factors come into play and mediate ways of caring and Haitian Canadian caregivers' relations with the civil society[70], the health care system, and home care programs. In the first part of this chapter, results pertaining to caring as a pattern of cultural continuity are presented. The second part of the chapter is devoted to describing caring as a reciprocal and mourning-in-becoming process.

Caring: Process of Cultural Continuity

The results indicate that Haitian Canadians remain close to the Haitian cultural values pertaining to aging and caring. In some ways, the process resembles a re-implantation of Haiti's ways of living in the host country, especially when it comes to caring for aging persons who were socialized in a different country and accustomed to different values for aging people, women's roles, family dynamics, and the social world. The process of cultural continuity is defined as a set of strategies by which caregivers, at both individual and family levels, adapt Haitian values on caring for aging relatives at home in the host country's cultural and social context.

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[70] I use the term civil society, as developed by Antonio Gramsci in his Prison Notebooks. Hoare and Nowell-Smith (1999) define civil society as "the ensemble of organisms commonly called private" (p. 12), which differs in the political society, the judicial system, and other institutions of the State. It is acknowledged that dominant groups direct both civil and political societies to impose social, cultural, political, and economic hegemony (Hoare & Nowell-Smith, 1999).

The sub-theme of caring as a process of cultural continuity is divided into five categories: 1) the meaning of aging, 2) the meaning of caring, 3) nature of caring activities, 4) motives of caring, and 5) family support and networks. Excerpts from interviews and participant observation sessions are presented to illustrate each of these categories. Caring, however, cannot be reduced to its individual or family dimensions, because caring unfolds in a social context that shapes and defines ways of caring. Also, Haitian Canadian caregivers' everyday encounters with racial and gendered discrimination in school, work, and the civil society have an impact on ways of caring in determining perceptions about mainstream society, and indirectly, have an impact on mainstream health care providers. I now turn to present results that describe the meaning of aging among the Haitian Canadian participants. Since aging and caring are related in this study, the conceptualization of aging must be examined in representing the rationale upon which caring is socially and culturally constructed.

The Meaning of Aging

The meaning of aging helps to make sense of the attitudes one has towards aging Haitian Canadian persons and how older people play important family and social roles in Haitian Canadian families. As John pointed out, aging people must be respected since they act as counsellors for their adult children. According to Haitian traditional values, children and young people must respect their elders' wisdom and experience. John said: "They gave me pieces of advice and supported us morally. They can provide advice to the kids, too. It's already a lot. It's already a lot" (Caregiver 03-M). Issues related to ageism, negative stereotypes of aging, and devaluation of the elders' contributions to society, were not mentioned during interviews with Haitian Canadian caregivers. Respect of aging persons is a paramount value among the community. Problems arise, however, when aging parents immigrate to Canada and integrate into a society where youthfulness and productivity are highly valued. It may be contended that in North-American countries, aging is conceptualized as a devaluing process, where aging persons

are virtually excluded socially since they no longer are productive for the society. Far from implying that a loss of youthfulness is unnoticed in Haiti, aging seems to be interpreted and lived differently in non-Western societies. Some caregivers freely admit that they would prefer to return to Haiti for their older days, since care, while being less technologically advanced, is still more humanized. In Haiti, caregivers agreed, aging people are respected. Edward compared aging in Western and non-Western societies:

> Interviewer: What does it mean for you to grow older?
>
> Silence.
>
> Participant: I remember that De Gaulle once said that an aging person is a human wreck. Aging is wreckage.
>
> Interviewer: Wreckage?
>
> Participant: He meant it's a difficult experience, a very difficult experience. It's an image.
>
> Interviewer: Yes, it's a metaphor but do you share De Gaulle's opinion? The image he used of the wreckage?
>
> Participant: Aging is a process that must be considered or seen as an opportunity, a chance. You're lucky. Many people did not get this chance...No. No. They didn't get the chance to know what it was to grow older. There were many people. You're very lucky to have a long life. Life and death are very close. Where there's life, there's also death. These are the extremes, the two opposites. A man lives and a man dies.
>
> Interviewer: And the wreckage, what does it mean for you?
>
> Participant: Well, it was De Gaulle's idea, not mine. I'd say we're survivors.
>
> Interviewer: In your opinion, growing older is an opportunity?
>
> Participant: Of course! Of course! It's a chance. When you can reach 60, 70 or 80, then you're lucky. It's a blessing.
>
> Interviewer: Don't you consider aging as a loss?
>
> Participant: Not at all, in fact, it's gaining wisdom. Caregiver 09-M

In fact, I found myself agreeing with De Gaulle's idea since it reflects Western values on aging persons. This metaphor of wreckage portrays how aging is not considered or valued to the same degree as being young. It seems as if all the good times have past and you are becoming a

human wreck. When Edward said that aging was an opportunity and a chance, I became aware that aging is culturally, socially, and economically constructed. I realized how different it was to grow older in a country where the life expectancy at birth is about 50 years old, and where brutal political repression ended young lives prematurely. He considered himself as a survivor, who had successfully passed through the hardships in Haiti and in Canada, as well.

George acutely feels the devaluation of aging people in Canada and Quebec. He came to Canada when he was 64 years old and was disappointed that he could not find work, despite his attempt to do so:

> Interviewer: You told me that when you came here in Canada, you were 64 years old and it was too late to find out work, despite your graduate education?
>
> Participant: Yes, it's true. I couldn't find work. No work. Nothing. When I went to the employment centres to search for a job or trying to be interviewed for one, the staff laughed at me. They told me: "It's a modern and advanced country here! It's an organized country here!" If I'd go back home, in Haiti, if I'd go back now at 87 years old, well, I can still find work over there. Caregiver 04-M

George went on to share his views on aging in a Western society like Canada:

> Participant: Here [in Canada], we don't have any expectations, we're hopeless, this society like others, don't count on aging people's input. Here, aged persons are trampled on; we don't like them. We don't protect them or advocate their interests. Even the government don't protect the elderly. Because those who are in office now, they forget they'll get older too. Indeed, they're very close [to old age]. When I say that aging people are trampled on, I'm talking about money. Elders have to pay more, always pay more, to contribute more. It's not good. They are your fathers and mothers. Caregiver 04-M

In an interview, David and Mary, caregivers in their early-50's, shared their views on aging, and contrasted the differences between Haiti and Canada while underlining the lack of respect of Canadians towards aging persons, regardless of ethnicity:

> Interviewer: What does it mean for you to grow older?
>
> Participant: Growing older, well, it's losing physical strength. It's starting losing strengths. OK? (Glanced at David)
>
> Interviewer: Huh huh (Listening)

Participant: You're not the person you were before and we all go there anyway. Growing older, it's when the losses…How do we say that? And to her husband: "Tell her for me!"

Participant: For her, growing older it's when a person becomes less strong, physically weaker than when she was younger.

Participant: No more vigour.

Participant: She means that the person can no longer work as hard as she used to work before.

Interviewer: Can you tell me more about what it means for you to grown older? What's the meaning of aging?

Participant: First of all, aging does not mean the same here that it means in Haiti. In *our country* [italics added], there are no programs to support aging people. In Haiti, there are no programs for the youth, neither for the elderly. There's no discrimination based on age. We don't dissociate youth from aging since aging is seen as a normal process of life. It's a natural process it's just natural.

Interviewer: Something natural…..

Participant: Of course! We deal with it. It's life and you become an old person one day or another. It's a part of life. But, aging persons help us since they provide precious advice. And even at fifty years old, we're still their children. In Haiti, aging persons are respected; we respect the aged for their wisdom, their lived experiences they gained over the years. They're considered as sage people, we called them "les sages". We always refer to them as the 'sages' since when I need an advice in the family or elsewhere.

Interviewer: They, the aging persons, are source of knowledge….

Participant: Yes both for the youth and less younger persons like me.

Interviewer: There's a lot of, a lot of…

Participant: Respect. Respect. We owe lots of respect to aging persons. And they are not well treated in the health care system.

Participant: Aging persons deserve being treated with respect and dignity. They're not respected. And I speak in general, not only for Haitians but for aging Quebecers and Italians, too. Caregiver15-F & Caregiver 03-M

I asked Eva what would be the first advice she would give to me as a nurse who is visiting Haitian Canadian aging persons. Again, the issue of respect and politeness came up in this interview excerpt:

Interviewer: Let's say that I'm a visiting nurse and I come in today to see your mother. What would you recommend me to do to respect her cultural background and satisfy her needs?

Participant: I'd say that first you must have a good idea of the Haitian values and customs towards the elderly.

Interviewer: What's important for them?

Participant: First, I'd say respect them. Show that you respect them and you must approach them very gently since some of them can be scared. Some can fear you. Some don't speak much like my aunt and she doesn't appreciate people who shout at her. She's scared when she hears somebody screaming. Caregiver 08-F

Kathleen reports the importance of aging persons in the Haitian society and described them as blessed or sacred persons that deserve all our respect:

Interviewer: Can you tell me how you see aging from a Haitian perspective?

Participant: We must respect aging persons. They're blessed I mean they're sacred. Somebody with a head full of white hair deserves respect. When I was living in Haiti, even if I didn't know the person, I greeted her. When encountering aging people on the streets, you must greet them. It's our culture. We must be polite and there are some words, like swearing or cursing that should not be pronounced in front of aging people. It's displaced, not convenient, and very rude. You must be polite and kind. Some aging persons don't like to hear about intimacy too. You must know that.

Interviewer: Do you find that Quebecers respect their aging persons?

Participant: No! Quebecers have no respect for the elderly. Caregiver 02-F

The respect of aging persons is a paramount value among Haitian Canadians, who find that aging persons, regardless of their ethnicity are devalued in Canada and Quebec societies. Aging is seen as a natural process of life and people must not be demeaned or despised because of growing older. For Haitian Canadians, aging is a natural process of life by which people gain wisdom and can help others face the hardships of life by providing advice. Aged persons stand by their adult children and support them. Adult children respect their aging parents, as do other aged persons who consider these people sources of knowledge. The importance of the oral

tradition in transmitting knowledge to younger generations was noticed among the participants of the study. Aging persons are a source of knowledge since they are experienced.

Patricia Hill Collins (1989) underlines the importance of the lived experience and the oral tradition, as invaluable sources of knowledge among African Americans. Haitian Canadian caregivers notice the lack of dignity and respect shown towards aging persons in the host society. This lack of respect is not without influencing Haitian Canadians' ways of caring, such as in keeping aging parents at home and avoiding as much as possible institutionalization in a mainstream health facility. Mainstream society lacks the show of respect towards elders and has raised doubts about the treatment that Haitian Canadian elders could receive in these institutions. Moreover, the lack of respect manifested among the dominant ethnic group, has an impact on the Haitian Canadian caregivers' decision-making, when choosing to not rely on home care services. Basically, caregivers want aging people to be shown respect and to be treated with civility. In the Haitian cultural framework, shouting at a person, such as an aging person, is perceived as being a very rude attitude, as explained by David, Mary, Eva, and Kathleen. Many other caregivers also told about the need to respect aging persons, corroborating the points made in previous excerpts.

In summary, I argue that the nature and motives of caring cannot be studied outside of the social, cultural, and economic construction of aging and caring found among Haitian Canadian caregivers. Ways of caring are defined as a pattern of cultural continuity since every effort is made to facilitate the adaptation of aging relatives in the Canadian society in re-arranging ways of caring as if aging parents were still living in Haiti. Laguerre (1984), who studied the Haitian immigration on the US East Coast mentions:

> The family provides a niche within which cultural continuity can be adapted to the exigencies of the new environment. Through the medium of the family, which influences the behaviors of its members through the mechanism of socialization, immigrants are able to retain some of their cultural heritage and develop an awareness of their ethnic legacy. (p. 66)

I now turn to present interview excerpts on the meaning of caring since the meaning attributed to caring activities underlies the nature of Haitian Canadian caregivers' activities.

The Meaning of Caring

Margaret defines caring as a helping relation, where she attempts to understand her mother's needs, and is attentive to both psychological and physical needs. Helping consists of being with the other:

> Participant: And helping somebody means to understand the other, trying to understand the other's needs. How can I say this? To understand mum's psychological and physical needs too, all this. It also means being present and available when she needs me. Caregiver 01-F

Barbara also defines caring as a set of activities designed at complementing the elder's loss of autonomy. Nevertheless, she also points out the affective component of caring:

> Participant: Caring is a kind of support, you know, it's like walking with crutches. Helping consists at doing things the person can no longer perform. You help fulfilling the needs but keep in mind not to cross that line. For instance, I won't do things I know he can do. I think that helping consists at compensating for the things they can no longer do for themselves. You fulfill the needs while trying to maintain the person's autonomy. The goal is to maintain independence as long as possible. But, I always cross this line. Sure I won't perform the things he can do by himself. Do you understand? Caregiver 05-F

Edward defines help as a mechanism of compensation, a means to compensate people's loss of autonomy:

> Participant: I must compensate the deficits. It means that I must do what she'd otherwise be able to do by herself, if she wasn't ill. Do you understand? It's my way of providing help. Caregiver 09-M

Nature of Caring

Paula is a middle-aged woman who works full-time in the labour force while raising young children and caring for her aging mother at home. She defines the nature of her activities of caring:

> Interviewer: Can you describe your activities? I mean what do you do when you look after your mum?
>
> Participant: Well, since she's sick, I do the grocery, the laundry, and I cook for the kids and for her as well. I do some housekeeping and other small tasks on an everyday basis.

As well, Mathilda is a woman caregiver, and a health care professional who is now retired. She describes her caring activities:

> Participant: Each morning, I check if she's passed a good night. I want to know if she's slept well and I ask her if she'll take her breakfast in her bedroom or in the kitchen. And, it's almost all since she's independent. She's very active and can look after her, I mean, for her hygiene and body care. Basically, I supervise and provide safety. I do the cooking but sometimes she cooks a little too, when she wants to eat a special dish. I do the laundry and the housekeeping. I drive her to the doctor or to the dentist, I book her appointments to the medical clinic, and I do the banking. I give her medication and I check out her blood pressure since she's under treatment for high blood pressure. Caregiver 01-F

I asked Victoria, who is caring for her mother, to describe her experience of caring, since she is also a very busy full-time working woman:

> Interviewer: I'd like to learn about your caring experience with your mother. You told me that you woke up very early each morning. Perhaps would you like to tell me more about that?
>
> Participant: I wake up at 4:00 a.m. to prepare mummy's breakfast. I prepare some sandwiches; I give her medication. *I must do everything. I must tell her everything.* [Italics added] "Mum you ought to take a bath. Mum you must take a bath today." Sometimes, she starts eating her breakfast, her medication is on the table, easy to reach but she forgets to take it. I check if the medication has been taken, if not then I give her the pills. Then after, she dresses up but often she puts on mismatched clothes. Whatever pieces of clothes come to her hand, she grabs it and puts it on. I check up when she's dressed to see if it's appropriate or not. Anyhow, there are many little problems like this that occur. Many problems like this. *She's almost like a child.* [Italics added].

Thomas, a man caregiver, also defines caring as a task-oriented process where the aging parents' level of functional autonomy plays a major role in determining the amount of time devoted to caring activities. His definition underlines the work aspect of caring that he translates into supporting the activities of daily life and hygienic care. Physical help becomes a

complement – a support to aging parents. Thomas seems to mainly refer to caring as an instrumental task, in other words, as a work. On the meaning of caring, he mentions:

> Interviewer: How would you describe your experience? How do you define caring, I mean, what's your personal definition?
>
> Participant: Well, it depends. It depends on the kind of care you have to provide. Sometimes, people are less independent and they need more attention, then you have to give a hundred percent. You know, those who have lost autonomy, we have to take them in charge completely. We bathe, dress, feed, and help them walk around. For those who are independent, it's quite different. They can look after themselves, bathing, dressing up without supervision, and we just do what is left to do. The remainder, what has to be done…
>
> Interviewer: Can you tell me what sorts of things are left?
>
> Participant: Well, cooking, shopping, doing the laundry and driving them to the physician. But, mostly, it's about preparing the meals and feeding them. We help. There are certain things they can perform, so we let them do these things. There are certain things people cannot do, so we do these things on their behalf. It is just a complement. Caregiver 03-M

Caring also means to realize some other tasks such as health management and support socialization:

> Participant: I book appointments and I drive them to the doctor's office. I go to the medical clinic. And, I drive mum to the church. I always drive mum to the church. Caregiver 03-M

Motives of Caring

Filial Duty and Recognition

During a participant observation session, a woman caregiver explained why adult children have to care for their aging parents. She referred to the ways of living in Haiti and mentioned the fact that grown children are expected to care for their aging parents. Caring is translated into a filial duty to acknowledge the parents' contributions in raising their offspring. Caring becomes accepted as a filial duty during childhood and is like being indebted to one's parents for their good deeds, underlining the reciprocal process upon which caring is constructed. Interestingly, Kathleen mostly refers to a daughter's role as carers of aging parents:

> Participant: In Haiti, when you have children, well it's for life. It's your duty to support your children, to feed them, raise them, and buy clothes. In short, it's a parental duty to look after your children. For instance, in Haiti, if your married daughter got into conjugal problems, it's a mother's duty to support her daughter. Caregiver 02-F

In a second interview, Kathleen delineated the importance of caring for her mother. The cultural element of caring is more clearly shown in her words to introduce a dichotomy of us/them, to differentiate Haitian ways of caring from those of mainstream society's ways of caring:

> Participant: It's paramount to look after mummy. This is a part of my task, as a daughter. It's rooted in the Haitian culture. Parents must care for the kids, and later daughters...well... children must look after their aging parents. Parents gave us everything, they did everything they could do for us and we're responsible to care for them. It's something we must give them back. Mummy sacrificed herself for her family, to raise us without a husband, you know. When dad passed away, I was very young. Mummy assumed a double role, being both the mother and the father.
>
> Interviewer: Is it a sort of recognition?
>
> Participant: Yes, it's recognition. Caregiver-02-F

In the same way, Victoria expressed her recognition for her mother's sacrifices, as part of a moral debt, too. The mother had given herself for her children and, for example, had paid for their education in college or university.

> Participant: She raised her family alone since daddy was almost practically never at home. She raised us by herself. All of us, I mean my brothers and sisters attended higher education schools and I too was well educated. I know she sacrificed herself for me, so it's my turn to do something for her. What I'm doing for her now, she did it for me. When I was young, she raised me. When I try to remember some positive points, I try to remember the good things she did for us, to educate and raise us properly. Caregiver 06-F

This sense of recognition is a common feature found among the majority of caregivers, regardless of gender. In the following excerpts, a son illustrates the pattern or idea of reciprocity and social exchange, as identified earlier with other caregivers. This son caregiver, in particular, brings new insights to the gendered difference in defining caring. For men, caring appears to be

more task-oriented, as opposed to women, where the two components of caring (love and labour) seem to be more strongly associated. The following excerpt illustrates how Thomas links together culture, reciprocity, and filial duty:

> Participant: We're used to that. We never part from our parents. We've been raised like this. And, we don't complain. It's *our* [italics added] culture. So we cannot...Even if we were in Haiti, it would be the same. It would be a chore if we were constrained to do it but in our culture, it's natural, it's automatic. There's no obligation at all. It's cultural. When we needed our parents, they stood besides us and helped us. When we were young, they looked after us. Now it's our turn to do the same for them... In addition, I wouldn't let them alone. Because of all the things they did for us. Whatever we do for them, we'll never be able to give them back... I mean we'll never be able to give them back all. So the little we can do for them now, we do it.
>
> Interviewer: Is it like a sort of filial duty?
>
> Participant: Yeah (weak voice), yeah but it doesn't bother me since it's a part of my filial duty as their son. It doesn't bother me at all. Caregiver 03-M

While caring can be conceptualized as a filial duty and as a form of recognition, caring is not perceived as a burden or as an exhausting task. Theresa, who is also a busy working-woman, explained:

> Participant: I don't consider it as a burden. It's not a burden. Yes. Perhaps it's a bit of more work but caring for mummy is really not a burden for me. Each week, on my day off, I manage to do my work. If I can't do it all, well no problem, we'll see next week. Caregiver 13-F

Caring: It is in 'Our' Culture

Iris points out that Haitian Canadians are used to manage things on their own. It is related to the Haitian culture. They manage caring as a private business, which is dealt in the family. They do not count on the State's support to look after aging parents. Iris mentions:

> *We, Haitians* [Italics added] are used to manage things on our own. We don't need the State to care for the elderly. We figure out things alone. We are resourceful and manage caring activities in our families. Moreover, when you do things out of love for the person, it's far from being a burden, and I know that God helps me. Our parents denied themselves for us. They worked hard for our education and now it's just fair to care for them in their old days. Parents deserve it very much in recognition of the sacrifices they did when they raised us. Caregiver 10-F

Eva also manages her caring commitment because the ladies for whom she cares are relatively independent. She wondered, however, what will happen when they will start losing autonomy or if they fell ill, since she works full-time:

> Participant: As I told you before, actually it's not a problem to care for my aging relatives. They're both relatively independent. And it's in our customs to care for aging parents. It's natural but when you're in the workforce, it becomes more and more difficult. It's a part of our lives to care for our parents.
>
> Interviewer: Is it cultural?
>
> Participant: Yes. That's it! We try to pass these values on to our children but we know it won't work (she laughs). It won't work!
>
> Interviewer: So when you were a young woman, you knew you'd have to care for your mother?
>
> Participant: You know, mummy looked after her mother at home and we were used to live with our grandparents. It works like this in Haiti. It's always like this. Caregiver 08-F

For Mathilda, caring for her aging mother is a normative process, embedded in the traditional Haitian culture:

> Participant: It's purely natural to care for mummy. It's only normal and natural. In Haiti, our parents spoiled us; we'll never be able to give them back what they gave us. They gave us so much. I find it very natural to care for mummy and all of this. It's almost like, well even if it's not one, I'd say a duty but it's a part of myself. Caring is a part of myself and it's natural to care for her. Caregiver 01-F

Harold is a man in his late-60's, who is now retired from the workforce. He agreed to look after relatives at home with his spouse. On reciprocity, filial duty, and sacrifice, the man caregiver mentioned:

> Participant: *Haitians* [Italics added] plan their old days. It's our culture to do such planning. Parents plan their old days by encouraging their children's education. They want their children to climb up the social ladder. And when parents grow older, they know their children will take on the caring responsibilities. It's because parents have invested in their children. So when the father and the mother grow older, it's the turn of the children to assume household responsibilities. Caregiver 09-M

Caring: Protecting Care-Receivers' Dignity

Caring also consists of preserving the aging parents dignity, especially when adult children caregivers are confronted with their parents' cognitive losses. This kind of caring behaviour, described as protective caregiving, is directed at protecting the parents from becoming aware of their cognitive losses. Bowers (1987) asserts, "the purpose of protective caregiving is to protect the parent from the consequences of that which was not or could not be prevented" (p. 421). I provide two instances of protective caregiving that were aimed at preserving parents' self-esteem and feelings of competency. In each instance, the daughters' needs to maintain the child-parent relationship are clearly illustrated. Barbara mentions that her father used to perform light domestic tasks such as dishwashing:

> Participant: Dad used to wash the dishes after each meal. He really wanted to help me this way. He liked washing the dishes. Despite it was not always well done, I let him do it. I rewashed it after, when he retired in his room. I preferred to rewash it than insulting him. I couldn't tell him the work was not well done. It happened that some plates or utensils weren't completely clean. Kids laughed at daddy. When I heard these words, see my children being so hard with him, I was sick to my stomach. Then, I asked him to stop washing the dishes. I said: "The water is too cold and it's not good for your blood circulation to get cold hands." He answered: "I'm not doing a good job?" I replied: "Not at all, not at all. You're doing a great job but it's not good for you to soak your hands in cold water. It's dangerous for you. I prefer you to stop washing the dishes." Since then I regret, I preferred when we was doing it. It was a good exercise for him but I couldn't stand hearing the kids insulting him. I couldn't take it anymore. Caregiver 05-F

Eva is a middle-aged woman caregiver who works full-time and who cares for her aging mother at home. Eva's mother had been diagnosed with Alzheimer's disease and presents memory losses. She described how she protects her mother from self-depreciation:

> Participant: Sometimes, I ask mummy to start preparing the meal. Yesterday, I asked mummy to pick up the frozen meat in the cooler and thaw it for dinner. She cooked the dish but it was a little too salty but it doesn't matter. She forgets and she always put more salt in the recipe. Since I want to keep her busy, I assigned her other little tasks like this. When I first noticed she forgot about the salt, I was very concerned. I became anxious but I tried to calm down. I said to myself: " Don't get upset, it doesn't matter. It doesn't matter anyway." So I let her cook even if I know it'll be too salty. If I want mummy to remain active, I really don't have the choice. I know she wants to help me. She wants to help her daughter. Caregiver 08-F

These two excerpts demonstrate the need for daughters to protect aging parents from being aware of the cognitive losses that may impact on their morale. One stopped her father from washing the dishes because the grandchildren despised him. Nevertheless, Barbara never told her father that the work was not well done. She told him that cold water was not good for blood circulation. As for Eva, she let her mother cook, even if the meal was too salty, because she wants to preserve her mother's dignity. She prefers to eat a salty and sometimes unpalatable meal rather than insulting her mother. Since Eva is extremely busy at work and at home, her mother wants to help her daughter. For Eva, the mother is still the mother. It is a kind of reversal of role but the mother or the father remain the authority figures, they cannot be treated as children, even if sometimes, adult children caregivers feel they are now assuming the parental role.

I now shift to discuss the lived experiences of husbands who care for their wives at home. Preserving the spouse's dignity seems a caring priority among spouses. A pattern of protection was found among these husbands. It can be hypothesized that maintaining spousal and family roles represents a mechanism of coping with a wife's illness. This mechanism is aimed at preserving the family dynamics and can facilitate young children's adaptation to a parent's illness. Children are less disturbed when they see that the family dynamics remain unchanged despite their mother's or father's illness. A man caregiver emphasized the importance for the children to communicate with their mother, the way it was before she fell ill. For instance, James talks about the limitations of his middle-age wife and how he wants to preserve her dignity as a wife and her role as a mother:

> Participant: I don't want to pass for the breadwinner only. Sometimes when we have problems with the kids, I send the kid to his mum first, even if I know that ultimately I'll deal with the problem. I want her to play a role, the mother's role. This is why I do this. I want her to feel valuable in the family, despite her illness. Even if I could fix the problem faster, I prefer my kids to go to their mother first, and after she asks me. It's a kind of dynamic…I don't want to hurt her. I prefer to see her alive, despite her limitations, than being a widower. She's very important to me, otherwise it would be the chaos in this house too! And it's important for the kids to have their mum. It doesn't mean, because a person is sick, that this person is not useful to her family or the society. Do you see?

> She's not diminished. I love my wife. I really love my wife despite her illness and I don't treat her as a diminished person. I'll never do that! Caregiver 12-M

Love and Attachment

During participant observation sessions, I observed an attitude of preserving dignity with the spousal role. I also noticed the need to enlighten parents or spouses' lives by bringing joy and happiness. Henry's and Rosa's story is presented to illustrate this need for the carer to preserve the significant other's dignity and to lighten up the days. I went to Henry's home to conduct participant observation. He is an aging husband who is looking after Rosa, his 87-year old wife who has Alzheimer's disease. Rosa merely recognizes her husband and most of the time takes him for a complete stranger. She asked Henry to bring her back to her mother's home. It grieves Henry a lot when he hears Rosa asking to go back to her mother's home. Henry performs all hygienic activities such as bathing, dressing, washing, and combing her hair. He gives her medication since she forgets to take her pills. Henry also performs domestic tasks such as cooking, cleaning, dusting, vacuuming, and so on. When I went to visit them, he told me he would like to cook one of his wife's favourite dishes. He asked me if I would mind to help him and I said I was glad to help him.

Rosa was seated at the dining room table watching her husband prepare the meal in their small kitchen. He showed me the filtering device he bought to purify the running water. He went on to explain that he secured the environment to prevent his wife from harm or accidents. He always unplugs the stove in case she might turn on the electric burners. Also, he secures the entry door since she could get up at night, go to the door, unlock it, and get lost in the building. Caring involves providing a safe environment, foreseeing hazards, and protecting the person from getting hurt. He refused to place her in a nursing home, despite his children's advice to the contrary. He wants to live with her as long as it is possible, which means as long as he is healthy. He is very fond of his wife and pats her shoulders or her hair. He kisses her on the forehead and

smiles at her. She answers non-verbally by returning his smile. To care is to learn about the other's feelings and convey affection through non-verbal communication. He told me: "She looks younger than her age, don't you think?" I said: "She has a very nice complexion." The lady, seated at the kitchen table, waiting for her dinner, was indeed beautiful. He replied: "Do you know why? She has that nice peachy skin, it's because I love her. It's because I love her. Do you know that everything is based on love? I love her and this is why she looks so nice. It's love." I also noticed that he often talked to the little kitten they kept as a pet. The kitten jumped up on Rosa's lap while she was sitting in the rocking chair. Henry said that the cat was a blessing for them and the cat was often the only companion in whom he confided. He spoke to the cat as if it were a child and the kitten behaves properly, as if the animal could perceive the couple's loneliness.

Then, Henry went on to explain that he was used to caring since he looked after his ill mother in Haiti. He described how this experience helped him to deal with his wife's illness. His cherished mother was the most important figure of his boyhood and later, of his young adult years. He showed me pictures of his parents, and of his wife and himself when they were young. Looking years younger than his age, the man appeared to be in very good shape, too. He described his past experience of caring for his mother and how this experience served him now:

> Participant: You know I did it before. I did it before since my mother was very sick. In Haiti, when I was living with my parents, I looked after mummy. She had been ill for more than 33 years but she never complained. Mum kept her feelings inside and nobody could notice she was in such pain. Despite her illness she always smiled, even when we were receiving visitors or family members. But, when she retired in her bedroom, she was so ill and so suffering. I tried to alleviate her pain (...) So with Rosa, it's like a continuum. In Haiti, I looked after mummy and now I care for Rosa. She kept me awake all night long. She wakes up about 15 times during a night. I ask: "What's going on?" She answers: "It's nothing. Nothing." We say our prayers and fall asleep. Then a couple of times later, she wakes up again and we start over again.

He defined help as a gift of self since it is motivated by love. He cannot imagine living without his wife and cannot stand the idea of placing her in a nursing home, after all the good

and bad times they have gone through, and after all the years they have lived together. At the time of my visit, they were celebrating their 60th year of marriage. Henry pointed out that caring is based on mutual love:

> Participant: Helping my wife is to give myself to her. It's being totally available. I'm doing this out of love. If I weren't so in love with her, I'd place her in a nursing home right away. Some people suggested me to place her, you know, to place her in a nursing home. I got upset and very angry. I said how could I do this? This woman gave her life to me, she gave her life to her children, she almost lost her life at childbirth, and I'd throw her away? I say I die with her. I want to die with her. I won't let her go to a nursing home. She's a part of myself, if not to say, she's all myself now. We're a whole, we're two in one. Do you see? We're united as in a single entity. Ah! I love my wife. I love her very dearly. Caregiver 04-M

Since his wife's illness, life has become very difficult for James. He is in his early-50's and the couple still have children living at home. Despite her ailments, Jane is a tough worker. She cooks and performs almost all the housekeeping work, except heavy domestic chores. She is a middle-aged woman who can no longer be the wife and the mother that she was before her illness. When I went to interview the husband and later conduct a participant session, I could not help but look at the smiling couple whose pictures were hanging on the living-room wall. I could not help but think of their fate and how illness was interfering in their marital and family life. Their lives were completely changed when the woman became sick five years ago. Again, for James, love is the basis on which caring is articulated and enacted in his daily life:

> Participant: I'm always present for her, to bring a physical help. Helping her also consists of listening to her, attending her needs. I must detect her mood, you know, when she's experiencing a psychological down. And after, I adapt consequently and do my best to help her. This is a kind of process that works for me either. So, I try to find out the problem and work it out. I'm there to provide moral support, when I can. Sometimes I said nothing. I can't say anything because I can't do anything to help her. I have my downs as well. Caregiver 12-M

For this man, caring means to actively listen to the other's concerns and doing his best to help. Sometimes, the best he can do is to do nothing. He feels powerless, and since some situations cannot be dealt with immediately, James prefers to collect himself, before discussing a

problem with his wife. According to this husband, caring is to provide physical comfort since he moves her, changes positions, and assists in doing some domestic chores that she can no longer perform due to physical limitations.

In examining Henry's and James' ways of caring, caring seems to be a role that is learned through lived experiences. Almost like a trial and error process, caring attitudes and behaviours are learned and become a part of the carer's role. Also, the carer's role is a sort of transition where husbands modify their relationships with their spouses by performing domestic chores, and develop new problem-solving strategies in working out spousal and family issues. All of these learning experiences are related to caring and would not have happened if their wives had not become ill.

The intensity of the caring commitment also varies with the care-receivers' level of autonomy or the individual's degree of independence. The greater the loss of autonomy, the greater the caregiver's involvement, in performing hygienic tasks like bathing, combing hair, clothing, and carrying on household activities. Independent parents need to be supported in instrumental activities of their daily lives such as cooking, shopping, laundry, transportation, banking and support for socialization. Most caregivers' activities were related to the area of the domestic sphere, though health care management, banking, and support for socialization were also mentioned as caring activities. Therefore, it can be hypothesized that the closer the emotive connection between caregivers and care-receivers, the greater is the intensity of the affective component of caring. For instance, the two husbands demonstrated protective and preventive caring behaviours towards their wives. Therefore, caring not only consists of compensating for the care-receivers' physical limitations or cognitive losses, but to attend the psychological needs of care-receivers and preserving the spouse's dignity. In the two husbands' excerpts, love, attachment, caring, and respect for human dignity underpinned their motives and the nature of the caring activities. The younger husband listened to his wife's concerns since he acknowledged

the importance of seeing her fulfilling her spousal and maternal roles in the family. James did his best to preserve his wife's dignity by sending the children to her first when they had problems. He wanted her to play her mother's role since he felt, as a father, that the family functioning should be maintained for their children's well-being. When family functioning was almost at the level it was before the mother became ill, it was easier for the children to cope with the mother's illness. They did not feel that their mother was different since they did not perceive any change in their father's attitudes or behaviours towards the mother. James, thus, was a role model for his children, teaching them to respect their mother despite her illness.

Perry and O'Connor (2002) described this need to "preserve the personhood" when caring for a partner with dementia. They identified four stratagies aimed at preserving personhood of care-receivers affected with dementia: 1) maintaining continuity, 2) sustaining existing competencies, 3) protecting the partner from incompetence, and 4) strategizing public encounters (Perry & O'Connor, 2002). Even if my aim was not to extend these categories to care-receivers who were not affected by dementia, James was preserving Jane's personhood in sustaining and preserving his wife's competency as a mother.

On the other hand, Henry protected his cognitively impaired wife by modifying the environment to lessen the occurrence of accidents and provide Rosa with a safe apartment in which to live. Home environmental modification strategies have been described in previous studies (Messecar, Archbold, Stewart, & Kirschling, 2002), where the authors identified seven home environment strategies used by caregivers to protect frail elders and adapt the environment to the needs of the frail care-receivers. For instance, Henry used the strategy of organizing the home to protect his wife Rosa from possible physical injuries. Also, the husband took actions to preserve his wife's dignity by protecting her from becoming aware of the extent of her losses. Henry did not infantilise Rosa when communicating with her, but spoke to her as if she was not affected by memory losses. Henry would describe to Rosa what he was doing like preparing the

meal, and consult with Rosa even though he knew that she would not be able to comment, given her advanced stage of Alzheimer's.

On the other hand, the greater the emotional distance, the more likely is caring to be perceived differently from its work component. For instance, Charles looks after members of his wife's extended family. When examining his interview excerpts, I noticed that caring was mostly equated to providing instrumental aid as a complement to the loss of autonomy. Thus, caring is mainly defined from its work component, leaving aside love or affection. The affective component between the man and his mother was evident since he told me how much he was attached to his mother. He was very fond of her and cared for her at his home, though the process of caring may be different when it is for in-laws, cousins, or members of the extended family. The affective bond is a major factor explaining the intensity of the affective component of caring.

Charles also linked caring with the geographical, social, and economic context within which caring activities occur:

> Participant: Canada is a well-structured country. At 65 years old, you're eligible for your senior allocation. Here, aging people get money. In Haiti, when you're 65 years old, you don't get a penny. Do you understand? When you're 65 years old, you don't get a penny but the children are accountable to care for you. It's not the government who cares for you. The Haitian government doesn't support aging people. We don't rely on the government but we rely on our children. Do you understand now? In this country, everybody counts on the government [the State] to work out health or education issues. In Canada, people rely on the government to solve their problems but in Haiti, it's not the case. Caregiver 09-M

This caregiver highlights the different situation encountered in caring for an aging relative in a non-Western country, where support for the elderly is not provided by the State. In Haiti, the socio-economic net is under-developed, which points to the importance for parents to raise children to care for them. In fact, children become the social and economic security net for their aging parents. Despite the availability of financial resources for elders in Canada, the

Haitian social life and the family living arrangement is transplanted in the host society. As discussed later, this re-patterning of Haitian ways of caring is also directed at facilitating the elders' transition in a new country and to counteract the impact of late immigration. This cultural component can also explain why caregivers, both adult children and spouses, do not favour institutionalization. Maintaining the cultural component of caring plays a pivotal role in the host country since it alleviates elders' culture shock and enables a continuity of life. Alexandra confirms the cultural component of caring:

> Interviewer: Is it a duty for Haitian children to look after their aging parents?
>
> Silence.
>
> Participant: I don't see it like this. I don't see caring like a duty. It's life. It's life.
>
> Interviewer: Is it life's continuity?
>
> Participant: Yes. In Haiti, nobody asks you questions on duty or such things. There are three or four generations living in the same house. It's a cultural custom. That's it, that's all! Caregiver 05-F

Ways of caring are socially, culturally, and economically constructed and therefore vary according to different contexts and countries. In Haiti, the government does not support caring activities and the looking after of aging parents remains a family and private business. During fieldwork, a Haitian Canadian priest told me: "Caring for aging relatives is a family matter. People don't like to discuss about private things. It remains in the family and it's private. And in general, women care for the elderly. It's a woman's duty to raise children and care for the elderly." In presenting this excerpt, my aim is to illustrate the influence of Haitian traditional customs in caring and to show that culture can be one of the factors explaining why caregivers are reluctant to institutionalize aging parents or spouses.

Fear of Institutionalization

Like the majority of caregivers, Edward fears institutionalization and explained why a daughter's choice was to place her mother for a couple of weeks, in a private nursing home.

Fears of institutionalization are related to issues of institutional racism that pervade the mainstream health care system. Therefore, even if caring is a Haitian cultural custom, factors pertaining to the host society, like racism can also explain why caring for aging relatives at home becomes a motive to delay or avoid institutionalization:

> Participant: Since 1970, the mother had been living with her daughter but when the daughter became ill, very depressed, the mother was maltreated. Sometimes, the daughter beat her mother up because she was very depressed. The daughter was very sick. Then, the mother was hospitalized in a long-term care facility. But, her daughter didn't want to place her mum in a nursing home like that. Caregiver 09-M

As well, Victoria could not make a decision to send her mother to a nursing home. She answered:

> Interviewer: How do you feel about institutionalization?
>
> Participant: Mummy is very sensitive and doesn't have the same lucidity she previously had. I mean mummy no longer has the clear-mind she usually had. She'd be lost with strangers around her. She won't know any people there. I think mummy eavesdropped and heard my siblings telling me to place her. Then she said: "When you'll be dead, they can place me in a nursing home. Until then, I know you won't let me go there. You won't let me down. You won't place me there." But, mummy is so sensitive and she can't figure out...She won't get out of there. A friend of mine placed her mother in a nursing home because she was completely exhausted. She placed her mother and three months later, her mother passed away. She was very attached to her mother but she has no other choice to place her mother. But when her mother passed away she told me: "If you only knew." So, I don't want to say: "If you only knew." And, mummy doesn't want to go in a nursing home. She's absolutely against the idea. When mummy hears about that, she starts crying. Caregiver 06-F

A key informant reported that gossip influences the ways of caring among the Haitian Canadian community. She mentioned that some people might say: "Look what this woman did for her children and see how they treat her now." Institutionalization[71] is not culturally accepted in the Haitian Canadian community since it is perceived as an abandonment of the aging parents into the hands of strangers. Public and semi-privatized nursing homes are integrated into the

[71] Institutionalization is not well perceived among the Hispanic American community. It is seen as a violation of cultural norms and values pertaining to family. Hispanic Americans, mostly Mexican Americans as reported in

health care system where most of the staff is from mainstream society or the dominant ethnic group. Also, in mainstream nursing homes, Haitian Canadian elders cannot express their needs since most of them speak Creole while most of the staff speak French. First, an issue of communication and language must be worked out. Second, Haitian traditional foods are not in these places, which are generally preferred by the Haitian Canadian elders. Laguerre (1984) points out that a typical Haitian meal is often composed of "fried plantains, fried pork or goat, chicken or beef marinated in Creole sauce, red beans, rice, corn, avocado, watercress, fish, bananas, orange and papaya juices" (p. 83). During participant observation sessions, I observed that these foods were the main elements of Haitian traditional cuisine. Nevertheless, grandchildren seemed to prefer Canadian food but also ate some traditional meals as a way to stay in touch with their parents' country. It is argued that the quality of care provided by adult children caregivers, with regard to the respect for Haitian cultural differences, cannot be compared to the care provided in nursing homes. Respecting Haitian cultural customs is a paramount value for adult children caregivers. As a result, adult children caregivers postpone institutionalization because they do not find health care services to be adapted to the cultural needs of Haitian Canadian elders. Eva explained:

> Participant: Anyway, nursing homes aren't prepared. I've visited some nursing homes and I found that 'ethnic groups' have no place there. I don't see them [ethnic groups] in these places. Perhaps, I've visited the wrong ones but the quality is just not the same [as in the home]. As well, there are ways of doing things; it's just not the same. I find that if a person is unconscious, it's fine since we have no choice. Caregiver 08-F

Pressure of Extended Family and Community

Edward also refers to the influence of the extended family on caring as a motive of caring. If, for instance, some caregivers decline to look after family members, they are exposed to the reactions of the extended family and to gossip. Some caregivers fear the reactions of the

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the study, proceed to a placement, only if, there's no other choice (Gorek, Martin, White, Peters & Hummel,

extended family if they decline to care for cousins. Likewise, if a daughter or a son places an aging parent, people talk about the child's ungratefulness. A woman caregiver told me she was ashamed the day her father came back from the shopping mall with plenty of items. She told me: "He was on the bus with all these things. Can you imagine what people will be talking about?" I said: "What can they say?" She replied: "They'll say his daughter don't care for him, she doesn't give a damn and that I'm not a good daughter." Family is not restricted to the sole nuclear family but is extended to cousins, nieces, nephews, aunts, uncles, and other relatives. Edward describes the kinship and the extended family:

> Participant: In Haiti, cousins are closely related, they're like brothers or sisters. Do you understand? It's very close. Cousins are members of the family. I must phone them regularly, to give some news. It's a kind of solidarity. There's solidarity between cousins and we must help each other. You can't really do without the extended family and we stick together to face any problem that may occur.
>
> Interviewer: So, the extended family is the main source of support?
>
> Participant: That's it. You have to get used to this. If you don't help cousins or members of the extended family, you're blamed. You're condemned.
>
> Interviewer: Ostracized?
>
> Participant: No. You're condemned. They'll talk in your back, they'll gossip. They say you're a family member and you don't care! You do nothing to help.
>
> Interviewer: Can it go this far?
>
> Participant: Sure. Of course! You must expect that [to help the extended family or to face the consequences of your refusal] and it's everyone turns. Caregiver 09-M

The extended family can thus be seen as both a source of support and of tension. For some Haitian Canadian primary caregivers, the extended family is perceived as being an important source of support. Members of the extended family support the primary caregivers' caring commitment by bringing punctual secondary help, as needed. This illustration presents an example of a negative case, where the extended family represents a stressor, rather than a stress

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(2002).

buffer, for the primary caregiver and his or her family. Finally, I complete the presentation of caring as a process of cultural continuity by examining Haitian Canadian primary caregivers' family support and networks. The aim is to understand the impact of these factors on shaping ways of caring and influencing Haitian Canadian primary caregivers' everyday experiences.

Family Support and Network

In this section, interview excerpts are presented to illustrate the importance of religion and the churches' support for Haitian Canadian caregivers. The active role played by Haitian Canadian protestant churches is highlighted, as well as the way in which churches help new caregivers to adapt to their roles. On the other hand, the results deconstruct the myth of the extended family support since immigration has a great impact on the availability of family members' support. Many family members were left behind in Haiti and the support of these relatives is greatly missed by Haitian Canadian caregivers. When entering the field, I expected to see a much more intensive support of extended families but the Canadian context differs from what is described in Haiti. The results of this study demonstrate that although family is not restricted to the nuclear family, extended family support can be limited.

Support of Haitian Churches

Religion is an important means to cope with caring and to support the caring commitment. Pierce and Elisme (1997) mention the importance of religion and the churches' support among the Haitian American community. During a participant observation visit, a man caregiver told me he was a good Catholic. He said he was a member of a spiritual group and informed me about the masses' hours. He told me that he can no longer attended masses but his wife went to Saturday services. "I can no longer go to the church with my wife but I pray here, at home. God knows I've work to do here. God gave me that work and He knows that I cannot attend the Mass" (Caregiver 09-M).

I was also informed about the influence of the Canadian missionaries in Haiti. Many caregivers told me about these Canadians, who described a wonderful country, where pristine snow covered the land during winter, and the colours of autumn were astonishing and vivid. A woman caregiver told me that a sister brought some maple leaves just to show her students the vivid colours. Canadian missionaries may have encouraged Haitian Canadian caregivers to construct an image of Canada and indirectly nurture dreams of immigration. Almost all Haitian Canadian caregivers told me about Canadian missionaries and reported having read religious journals, which were published in Canada and had been sent to the parishes in Haiti.

The most salient finding was that the church is an important source of support for both caregivers and care-receivers when the contribution of the extended family is minimized. Immigration has an impact on caregivers' lives since some had left their family members behind in Haiti, making this family support and network unavailable to caregivers who are often alone in their caring process. Doland and Sims (1996) described family caregiving as a solitary journey, presenting the loneliness of home caregivers.

The importance of churches has been also found among the African American community, where religion is perceived as being a source of help and support (Porter, Ganong & Armer, 2000). This reliance on religion as an individual and a community source of support was also reported among the Haitian American community of New York City (Laguerre, 1984) and in the Miami area (Stepick, 1998).

Magdalena, for example, finds the meaning of life in helping others. She is a member of a Haitian church, which is very supportive of their members. Massé (1983) reported that the head of the church is a Haitian Canadian clergyman and the majority of churchgoers are Haitian Canadians. Churchgoers formed a unified extended family by sharing religious and social values aimed at supporting each other in times of difficulties and hardships.

The Haitian American anthropologist Michel Laguerre (1984) points out "Haitian Protestants get much economic, spiritual, and emotional support from their brethren. Protestants are active in helping each other, especially in times of crisis. They care for the old and the needy, make home visits, and pray for the sick" (p. 59). The same observation can be made with the caregivers and care-receivers, whom I met. I observed the dedication of Haitian Canadians in their protestant faith to look after the sick, the aging people, and to organize transportation and church support and religious activities. Most of the caregivers in this study were Protestants. They openly talked about their faith and how religion helps them in their caring commitment. They were very committed to their church's activities though it would be wrong to assume that Haitian Catholics are not dedicated to supporting their community, as well. Commitment can be translated into other activities such at offering money or clothes to charity organizations like the St.Vincent de Paul.

In this interview excerpt, church support groups can be shown to help new caregivers in adapting to their new roles. Sylvia reports:

> Participant: Caring is a learning experience. I think that we manage to learn it and I've been supported. At my church, a group of women helped me a lot. They know about the situation, I mean, they know what it is to look after an aging person at home. My sisters (churchgoers) taught me and guided me on the pathway. They warned me that it wouldn't be easy. They helped me figure out caring from their lived experiences, from what they went through with their aging parents. Caregiver 07-F

Knowledge is transmitted through oral tradition, and not written on leaflets or pamphlets, transmitted by most experienced caregivers who talked about their lived experiences. This kind of knowledge production and transmission was described among African Americans. Patricia Hill Collins (1989) refers to this knowledge as Black feminist thought. In this current of thought, concrete experiences bear meanings and dialogues are used to validate knowledge claims in presenting information to other members of the group.

Caring is not understood from a Western feminist viewpoint but in Haitian churches, caring is constructed from an Afrocentrist feminist viewpoint. Caregivers' subjective experiences of caring are discussed and help younger women caregivers to know about caring and how to deal with issues pertaining to caring. Hill Collins (1989) points out:

> For ordinary African American women, those individuals who have lived through the experiences about which they claim to be experts are more believable and credible than those who have merely read or thought about such experiences. Thus, concrete experience as a criterion for credibility frequently is invoked by Black women when making knowledge claims. (p. 759)

Sylvia, a young caregiver, described how the church also supports her mother:

Participant: We attend a community, we attend an Anglican Haitian church, but it's a Haitian parish.

Interviewer: So people of your church, they help you?

Participant: When mummy was hospitalized, members of our religious community visited her every day at the hospital. Some are young retired people, aged of 66 or 67 years old, and they were coming in to visit her at the hospital. Volunteers are members of our religious community. They offer support and it's really on a daily basis, you know.

Interviewer: Just to know we can get support somewhere must be very comforting…

Participant: Absolutely, and since she must stay alone for about two or three hours during the day, there is always somebody, my sisters or members of the community, who called home to speak with her. There are some people of her age too. They call and pray over the phone. They say their prayers and during this time, when I'm at work, I don't worry. I call and the line is busy, I know that either one of my sister or members of the church are talking with her. Members of the church, they always call between 3 and 4 PM since they know I'm at work and she's alone in the house. They pick this time to call her and pray with her. Aging people are a bit lonely and when they call her, they pray together on the phone to break this loneliness. They form a network support and it helps, it's like listening to each other since some of them cannot walk around, some of them have mobility problems, so they communicate over the phone to break up loneliness. Caregiver 07-F

She also described her involvement as a volunteer in the Haitian Canadian community:

Participant: I'm involved in many organizations such as you know the (community organization name). Yes. I worked as (name of the work) to reach families over the phone. I also worked at the centre of family support but now I'm much more busy at home with mummy. I'm less involved now that I was earlier. I had to take some

> decisions. I can't do everything. Since two years, at home, it's a full-time job now [caring for the mother]. Caregiver 07-F

Iris was involved almost each evening in her church's activities. She is a member of a prayer group for the sick and visits people at the hospital, as well. Members of the church also helped her with her mother. Since she worked full-time and her mother must get particular treatments at the outpatient clinic, members of the church come by to pick up her mother and then stay with her during the treatment. She does not need to take a day off to stay with her mother since the church members provide support to her mother. Most of the caregivers and care-receivers I met were devout and dedicated to the needs of their community. There is an important amount of support provided by churches, and especially, the Haitian Canadian Protestant churches. I now examine the other source of support that an extended family represents for some primary caregivers.

Kin and Extended Family Support

For some Haitian Canadian caregivers, the extended family represents a valuable source of support, mainly offered as respite services. It would be wrong, however, to assume that each Haitian Canadian primary caregiver or caring family benefits from the support of extended families. Some caregivers immigrated to Canada, leaving a large number of kin behind in Haiti, or the close family has joined the caregiver, but caring still remains the work of one designated person, often a daughter. That individual is normally chosen by the aging mother or father for many reasons, but mostly because of a profound affective relationship with that child. In other cases, members of the extended family pressured some of their members to look after relatives, so that caring resembles a wage-earning job. Nevertheless, when meeting a Haitian Canadian family, an assessment should be made as to whether close relatives or extended family members are present or absent, and an evaluation should be done of the kinds of support available to caregivers and families. Some caregivers are socially isolated and lack social support that might

have an impact on caregivers' health and on the care-receivers, as well. The support of the extended family must not be taken for granted when examining caring among the Haitian Canadian community. For instance, Laguerre (1984) states, "not all members of the extended family interact equally. There are subsets or clusters of members who interact continually with each other. Some are constantly helping others whereas others are active only when they are called upon" (p. 79).

Paula reported that she appreciated the support of the extended family to bring some respite or help to her when she needed it. She also contrasted the differences between Haitian and Canadian families, focusing on the 'us/them' dichotomy and pointing to the fact that Haitian Canadian families are not restricted to nuclear families. She also emphasized that female members of the extended family provide support or respite, as she spoke about her aunts and cousins:

> Interviewer: Let's say you'd need to go out of town for a couple of weeks, who would you call to look after your mother?
>
> Participant: My cousin would come over. My cousin is coming over often to give a helping hand. She cares for grandma at her home. My cousin comes in and we have family. Family provides support. Family support is very extended because *us* [Italics added] as opposed to *you* [Italics], family isn't restricted to the father and mother. We have aunts and cousins, [She used the word 'cousines' that means female cousins]. When we need help, they all come over to help out and support me.
>
> Interviewer: Are you talking about your extended family?
>
> Participant: Yes. Yes.
>
> Interviewer: In your case, the extended family is an important source of support?
>
> Participant: Yes. Of course, for instance, if I want to go out of town for the weekend, I call up my cousin [female cousin]. She brings her kids over here, in my house. She stays with mummy, she cooks, and they have fun. We have a very large extended family, lots of relatives.
>
> Interviewer: And you support each other?
>
> Participant: Yes. It's different from Canadians. Here, it's very extended, cousins, aunts, and even friends [female friends—she used the word 'amies' indicating friends' gender]

Interviewer: So if you need respite…

Participant: The extended family is the one we rely upon for respite. Caregiver 02-F

On the other hand, Martha, despite the presence of an extended family, is almost left without support. She felt like a prisoner in her caregiver situation and is the only person who provides care to her aging mother. She is not enjoying life since she is overwhelmed by work and the responsibilities. She is always the one who is required to help but receives no help from the grown children, her siblings, or members of the extended family:

> Participant: Can't you see that I'm almost a prisoner here? I can't go out and can't accept meetings in advance because I don't know if I can get somebody to stay with her. Each day is a new day and I live each day at once, even at the minute. Do you understand?
>
> Interviewer: Yes…
>
> Participant: Do you see? I'm nailed down in that place. I feel like being trapped, locked up.
>
> Interviewer: Locked up in your situation? [Primary caregiver left without family support].
>
> Participant: Of course! I have no respite since I'm alone I'm the only one to see the work in that house. I tidy up the apartment, clean it up, wash the carpets, vacuum, cook meals, wash the dishes, undress the table, do the laundry, wash and change beds linen. Do you see? Have you seen the big laundry? I must do it now. Did you see the bathroom?
>
> Interviewer: Yes I did.
>
> Participant. I'm always working and working. I'm never finished with work, there's always work to do. So when I can no longer stay up, my body collapses, I crumble and must go to bed. I can no longer stay up and I wonder if I'll get up of my bed. Tell me how can I carry this on? When I crumble, I've no other choice than go to sleep. I take the horizontal position. I've to let things go since I can't do everything. I can't do everything, alone. I'm not enjoying life. I'm not enjoying life, as others seem to enjoy it.
>
> Interviewer: I see…
>
> Participant: There's too much work to do and I'm alone, I'm alone to do it.
>
> Interviewer: It's seems like a heavy load.
>
> Participant: Yes, it is. Of course! It's too heavy, too heavy. I'm always the one who is asked to help.

Interviewer: Can't you refuse sometimes?

Participant: I can't, I can't decline, or it has to be impossible. Caregiver 16-F

On the other hand, Natalia does not receive any support from kin or members of the extended family since she lives alone with her mother. Her siblings live abroad and Natalia does not want to receive any help. She wants to manage things by herself. In this interview excerpt, she explained her situation and how she liked to look after her business alone, without help or support:

Interviewer: Do you seek some help? I mean from relatives?

Participant: I have no relatives here. I'm alone.

Interviewer: You're alone…

Participant: Yes. Exactly. I'm alone, all alone, and absolutely alone.

Interviewer: So, where do you find some support? At the (name of organization) Can they help you?

Participant: She shakes her head negatively.

Interviewer: No…

Participant: I don't ask any help. I don't want to bother people. Therefore, I ask nobody to help me.

Interviewer: You don't ask any help?

Participant: I don't want to be bothered. I don't want to be bothered. I ask nobody and I do it myself. I manage things alone (She laughs). I never complain, I never complain. I don't speak and keep all inside me.

Interviewer: You keep things inside you….

Participant: Yes. I take it all and I mind my business. Caregiver 06-F

Social Support in Haiti vs. Canada

Other primary caregivers reported that they thought of sending back the aging mother or father to Haiti where members of extended families and friends are closer and could look after

aging relatives. For instance, Theresa told me that in Haiti caring for aging relatives is much easier because of the solidarity existing in the community. In Canada, she felt that people mind their own business and they do not care about neighbours. She has not noticed such commitment from her neighbours, even if they were Haitian Canadians. She perceives the Canadian society as an individualistic society where values like solidarity and community support cannot be found:

> Participant: Mummy goes back to Haiti each winter. She leaves in December and she comes back here for summer.
>
> Interviewer: So you have some family in Haiti who looks after your mother?
>
> Participant: Mum has relatives in Haiti. There are plenty of people there who want to care for her. It's very different in Haiti, you can't compare to Canada. It's very different.
>
> Interviewer: Can you tell me what are the differences?
>
> Participant: Well, when you grow older, everybody is at mother's beck and call. It's the privilege of aging. An aging woman like mummy, she's respected in Haiti. In Haiti, people respect aging persons. Everybody wants to help you.
>
> Interviewer: There's lots of support and your mother is surrounded?
>
> Participant: Most of her family lives over there; she has many nephews, nieces, and grandchildren. They all want to help her and look after her. They do almost everything on her behalf. She doesn't have any problem and frankly speaking she prefers to live in Haiti.
>
> Interviewer: She prefers Haiti…
>
> Participant: Of course! She's surrounded and relatives spoil her. She's never left alone in the house like it's the case here. Since I have to work, mummy stays alone in the house. In Haiti, it never happens, she has plenty of people around her.
>
> Interviewer: It is more difficult since you're far from this family network here….
>
> Participant: She remains silent. No answer.
>
> Interviewer: Let's say if you'd have a sister, a brother, a sister-in-law here, do you think it would be different? I mean for you?
>
> Participant: It would be the same since aging people want to live with a child; they usually and most often live with that child. Therefore, mummy would probably stay with me. In general, parents stay with the child with whom they feel more comfortable. They pick up a place where it's good to live. They must feel as if they were in their home.

Interviewer: They need some affective relationships with that child…

Participant: That's it. That's it. Really, what I can tell you is that parents are likely to stay in a place where they feel comfortable. Caregiver 13-F

It can be hypothesized that Theresa's perceptions are related to the fact that she is left alone in caring for her aging mother. The family network was left behind in Haiti, which has an impact on Theresa's everyday life. She perceives the Canadian society as being individualistic because she is isolated and cut off from her family network. Immigration has an impact on caregivers' lives, as the caregivers miss the support of family members who stayed in Haiti. For this reason, most of the primary caregivers I met cannot rely on extended family to support their caring commitment. Primary caregivers are left almost alone to navigate caring and find themselves isolated. As well, most working women caregivers face the responsibilities of caring for the aging mother and father without intensive involvement by the spouse or the children, except for rare exceptions. During participant observation sessions and interviews, women caregivers reported the weak involvement of their own daughters in supporting the caring commitment. They would like their daughters to care for the grandmother or the grandfather. On the other hand, mothers also want their daughters to have their own life. Second-generation Haitian Canadian women caregivers do not want their daughters to replicate their lives. A mother told me that she did not want her 16-year-old daughter to enter the 'Haitian mould.' She did not expect her daughter to care for her when she grows older and will not ask her daughter to do it. Like many other woman and men caregivers, this woman told me: "I'll look after myself. I won't ask my daughter to keep me with her when she will get married." The impact of acculturation of Haitian Canadian third-generation family ways of caring need to be further developed since a pattern of independence appears to mark this generation. Parents do not expect their daughters or sons to look after them, saying that their children are Canadians and not Haitians. The third-generation family members are being socialized in the Canadian context where Edward

perceived that his children "have been taught to live their lives and don't bother for the parents. That's life here" (Caregiver 09-M).

In a context where kin or members of extended families cannot be present to support primary caregivers' caring commitment, other resources like Haitian Canadian churches can support caregivers in providing respite hours, home keepers, transportation, and prayer groups. Many organizations also provide resources for aging people and caregivers. For instance, the House of Haiti, the Haitian Christian Organization of Montreal, to name a few, offer social activities and support to members of the Haitian Canadian community of Montreal. These organizations are secular and are not related to any particular religious faith, but volunteers and employees, are dedicated to the community's well-being to play a crucial role in providing resources for references and support.

It is challenging to summarize, in a few pages, this extensive topic of caring for an aging relative at home. Future studies would have to be conducted to address specific areas. For instance, the topic of Haitian Canadian mother-daughter relationships or in-law relationships could be further explored. In this chapter, I have attempted to provide a general picture of Haitian Canadian caregivers' ways of caring and to describe the major factors related to the individual and the family context that may facilitate or impinge on caring activities. This is the first layer of the problem that has to be linked to the larger social world and the health care system to see how caring is embedded in multi-layers of complexities intersecting with racial, ethnic, social, cultural, economical, and political factors. The aim of the study is to delineate how this multi-layered experience of caring has impacts on the lives of Haitian Canadian caregivers. Many factors must be accounted for in understanding Haitian Canadian' ways of caring activities, so that caring cannot be reduced to an atomistic perspective since caring experiences unfold in a social world.

I have described the meaning of aging, the meaning of caring, the nature and the motives of caring activities, and the family support and networks (i.e. Haitian churches and community organizations). Other factors like the family dynamics and networks of support come into play in shaping the landscape of caring. I now turn to discuss the second theme that emerged from data analysis, the description of caring as a process of reciprocity and mourning in becoming.

Caring: A Process of Reciprocity and Mourning in Becoming

The process of caring is described as an experience of reciprocity, where looking after aging parents becomes a means to recognize the sacrifices made by older parents, and to give something back to them. At the same time, caregivers may witness physical or cognitive losses of their loved ones. The co-existence of reciprocity and sadness indicates that caring is also an experience of anticipation and a witnessing of loved ones' losses. Caring is a process where caregivers experience a transitional state, unveiling the concurrent process of mourning-in-becoming, characterized by waiting for the significant others' losses. Haitian Canadian caregivers witness aging parents' losses and anticipate the finality of the life of the person for whom they care, as a sort of mourning process that has begun but is not yet completed.

At the same time, caring involves negative outcomes that can be seen as a sort of mourning process in becoming since adult children caregivers or caregiving spouses witness their loved ones' losses. For instance, they may witness a mother's loss of cognitive acuteness, a father's increased forgetfulness, or a wife's indifference. These losses create sadness and some fears, related to the sense of the incoming process of the end of life. As well, caring can bring some negative outcomes to the primary caregivers' health and well-being, even though caregivers feel the importance of caring for their aging parents at home. Caring also brings positive outcomes for the aging persons and especially in delaying and sometimes avoiding institutionalization.

In the last part of this chapter, I describe how Haitian Canadian caregivers move through this process of reciprocity and mourning in becoming by experiencing growth and losses, rewards and griefs, and also by transforming caring into a meaningful experience of life. Aging parents' positive and negative outcomes are delineated in this last section as a part of the mourning in becoming process.

Process of Reciprocity

In a study aimed at exploring the existential experience of being a caregiver for an elderly relative, Langner (1995) found that caring is a dialectic process where growth and losses cohabit in the lives of caregivers, for them to find meaning in caring. The caregiver's role is not linear but rather transitory, in the sense that caring is a journey through territories of positive and negative events, that shape the experience of caring. Positive events foster personal growth and satisfaction whereas negative events can be experienced through pain, sadness, or physical and psychological symptoms. Moreover, the negative events also stimulate the development of adaptive or coping strategies to confront stressful events while facilitating the discovery of self and inner qualities. In his conceptualization of caring, Mayeroff (1990) underlines that caring is directed at enhancing people's growth. Langner (1995) mentions, "it is through the dialectic between loss and personal growth that family members are able to redefine and frame their experiences in ways that are meaningful and facilitate coping with their situations" (p. 76).

The majority of caregivers described caring as a rich experience. Despite the fact that culture influences caregivers' decision to care for an aging mother or father at home, Haitian Canadian caregivers also benefit from the presence of their parents. Grandchildren also felt some of these positive outcomes during their youth since grandparents, notably grandmothers, played an important support role in their upbringing. Richness of the lived experience, joy and happiness, learning, having the time to build memories, preventing institutionalization and social isolation, delaying the losses of cognitive functions, providing a warm and affective environment

of life where the aging parent still has an important familial role to play, respecting the cultural customs pertaining to aging, and protecting the aging parents from attitudes of ageism and racial discrimination found in the mainstream society, were the main positive outcomes of caring that were found in analyzing the data. Sonia describes how she conceives caring for her aging mother at home:

> Participant: It's a rich and meaningful experience to care for mummy. Mummy gives a helping hand. It's comforting to know that mummy is present since I've to go to work, and she stays with the kids. I know there's a mature adult in the home to look after the kids when I'm out to work. And mummy also cooks for the kids. Oh not large meals but she prepares macaroni or things like that. Caregiver 02-F

As well, Audrey reports that she's always learning from her mother:

> Participant: It's not always easy, I can't say otherwise. I must be true but it's also a rich experience too. She told me about her past and I learn lots of things I didn't know. She talks about her life as a woman and it's interesting. She talked about her lived experiences and all the events she went through. She's very resilient and often she's the one who peps me up. She boosts me when I'm down, so you see, in fact she helps me a lot. Caregiver 07-F

Sabina also describes this reciprocity when she reported how her father helped her during difficult times of her life:

> Participant: I went though very hard times, a divorce and so on. Dad always stands by me and supports me. Caregiver 05-F

Many caregivers found the presence of grandparents at home comforting since they have helped their adult children to raise their families. They were the 'babysitters' and grandparents never complained about contributing to the raising of their grandchildren. Parents could direct their energies at work or to complete collegial or university studies without sending their children to kindergartens. As well, parents could invest the money to buy a house or get better living conditions, rather than paying for babysitting services. It must be remembered that when Haitian Canadian primary caregivers were raising families, low cost public kindergartens were

not available. David, a son caregiver, describes how his parents helped him and his wife to raise their children:

> Participant: My father walked my first two children to school and he also helped them with homework. At that time, I was working at (name of the place) and could not supervise kids' work but dad was there. He assisted the kids with homework. Do you see? Therefore, I wasn't too concerned when I was at work since I knew dad and mum were there with the kids. My children never needed keys. They don't need keys. You know keys around the neck? There is always somebody home to receive them. When the parents are gone to work, it's good to have the presence of mature adults at home. Often children whose parents work all the time, they wander in the streets. Well, I never had this problem since my parents were living here and the door was always opened. The kids enjoyed being with their grandparents, too. Now, they give advice, to my wife and I, and to the kids as well. They support us but also they support their grandchildren. It's already a lot. Caregiver 03-M

Process of Mourning in Becoming

This sub-category, which consists of three stages, addressed the losses caregivers witness and bear when caring for aging parents or ill and/or aging spouses. These stages describe a process of mourning in becoming, already started but not completed, of witnessing these losses, with some doubting of the reality of their parents' physical or cognitive losses, but finally accepting the finitude of human life and the fact that aging parents or the ill wife will not stay with the family forever. Witnessing loved ones' losses induces or pushes adult children to reflect on the finality of life but caring is also a trial and error process through which children assess their parents' losses. Accepting the losses is the most difficult part of the process, since it means that a process of mourning has already been engaged in, about the end of life.

Stages of the Process of Mourning in Becoming

Doubting is the first stage of the mourning process, which is basically haunted by doubts; adult children do not believe what they are seeing, thinking that parents are faking, and that the losses are imaginary, constructed, and not real. In this first stage, caregivers test their parents and try to get evidence about whether their parents' losses are real or not. Caregivers still cannot accept the losses they are witnessing since at the same time they are discovering a new mother, a

person who had lost the personal traits of her youth. When they believe that parents present real losses, the next step is to accept this situation, which requires caregivers to accept and integrate the fact of living with a changing parent. At this time, caregivers' behaviours also change and they accept their parents as they are.

The second stage of acceptance and integration occurs when caregivers no longer attempt to test their parents or try to correct their parents' forgetfulness. Adult children accept the new parental identity and caregivers focus on anticipatory and preventive caregiving to protect their parents' self-integrity. In other words, daughters do not want their mothers to be their child, though they recognize a different mother. Parents' losses are no longer challenged though parents are never considered as diminished. Daughter or son caregivers do their best to preserve their parents' role, for example, in maintaining the mother-daughter or the mother-son relationships.

The third stage of the mourning in becoming process consists of letting the parents go. In this 'letting go' stage, adult children accept that their parents will not live forever, and that parting may soon arrive. They reflect on the dying process and start building memories or enjoy the time being spent with aging parents as precious moments. Adult children caregivers realize that the time for the ultimate separation will soon be coming and they also reflect on their own aging. I will now present interview excerpts to illustrate how these three stages unfold in caregivers' everyday lives. Data also show how parents' physical or cognitive losses influence caregivers' health.

Stage 1: Doubting.

Two adult daughters doubted their mothers' physical and cognitive losses. Each of them reported having tested the mother, to finally determine that these losses, in fact, were true and not imaginary. These two daughters could not believe their mothers' transition from being resilient and strong women to being frail and forgetful women, as their mother grew older. In this

interview excerpt, Sylvia illustrated how she makes sense of her mother's health deterioration and how she probes the losses:

> Participant: She moved in two years ago. Before she was coming over only for the weekends and it last a couple of years. She just came in to stay for weekends. Mummy is 80 years old and she was very strong for her age. She could manage her business despite her asthma. Sometimes, she can't get up in the morning and she has to rest. She can't take it, she can't take it, she can't figure out being immobilized like this. She hasn't been used to that. It has been a couple of times, well, when she had asthma crisis, I was wondering whether she was faking or not. Since I've tested her to see if it was real crisis or not. I thought she was manipulating me. So I said I will try an experiment with an empty pump. I gave her the medication and it worked! It is the placebo effect. She was breathing perfectly well, but sometimes she has real crises. She can't breathe normally, she's wheezing. This is the problem. I find it hard since she's almost like a child now. I know she's not a child but she's like one. Do you understand? Since she's a mature adult and my mother, I can't treat her like a child. Sometimes I tell her [about her asthma]: "You did it on purpose! You don't want to go to the activities, that's why you did it!" She replies back: "One day you'll be old, you'll be old like me, and you'll know what it's like. I'm old but nobody understands me. You think I'm faking but I'm not faking. You'll see later, your turn will come." Caregiver 07-F

Sylvia went on to describe how she dealt with her mother's losses and how it draws on her to start thinking about her own aging:

> Participant: Sometimes, when she's cooking, I closely observe. I looked at her tasting the dish for about ten hundred times. Did she forget the salt? Is it salty enough? Let's put some more salt. She can't properly taste. Foods are never salty enough. She tastes the food since she forgets that she salted it before and she can't remember which day we are. She simply forgets. She doesn't know if it's a weekday or if it's the weekend. When she cooks, we must always watch since she can put fire to herself. When she's not around, in the kitchen, we unplug the stove. However, money is always a problem. She moves her cash every day and God knows where she puts it. She can't remember where she put it. When she can't find it out, then she accuses me. I've stolen it. In these moments, I stay calm and I start searching for the money. Last time, she put it under the mattress. I can't figure out, how a frail lady like her, could be strong enough to lift a heavy mattress like this. Anyway, the cash was under it and we found it. She hides her belongings; her jewels and it's almost like a habit. She can't retrieve her cash or jewels, since she doesn't remember the last place she put them. In these times, she is nervous and it triggers an asthma crisis. Caregiver 07-F

Victoria, another caring daughter was also doubtful when she noticed her mother's increasing cognitive losses. She could not figure out if these losses were real. As time went by,

she observed more and more losses or weird behaviours, and could not help but to accept her mother's losses and to deal with them:

> Participant: I must do everything, I must tell her what to do. "Mum you have to take a bath." or "Mum please take your medications". I must always check out if she's properly dressed since she mixes up her clothes. She can put on a dress that was in the laundry room. It happens like that. This makes me (silence), makes me (silence). It makes me think the mother I had used to be so clean, so meticulous, so ordered. She was giving great care to her clothes and her physical appearance. Now, she's a totally different person. I don't recognize her anymore. She's completely the opposite person I once knew. Now, she's like a child (sadness in her voice). I must tell her everything. Even sometimes, I tell her "Mum, I can't understand why you're like this!" Then after, I am sincere enough with myself to see that she's changing. She's not the same person she was before. She changed a lot and it's so painful for me. It's so painful for me, it makes me think, and it makes me ponder a lot. Sometimes, I'm saying to myself, she's growing older, perhaps you take it hard because you live in a new country, but at the same time I tell her: "I know you don't do it on purpose. I know you don't exaggerate." I try to keep her busy, I ask her to do some little things, and when I go to check on if it's done, then it's not, and she answered she forgot. Now I see she's not faking and I tell her: " I know you don't fake mummy". At these times, I felt as if I'm coming up against a wall, I hit the wall when I see that she didn't fake. She forgets and she said: "Victoria, I don't want to forget things like that. I have no intention of doing that. It's unintended. I can't help and you'll stop saying that I'm doing it on purpose!" Now I've accepted, she's in my hands now. Caregiver 06-F

Natalia's mother cannot sleep alone and often asked her daughter if she could sleep with her. The daughter's nights are short and she must wake up before dawn to prepare her mother's breakfast and to run off to work. Caring has an impact on health and can elicit sleeplessness, fatigue, and tiredness. A daughter reported:

> Interviewer: You told me when we started talking that your mother often wakes you up, during the nights.
>
> Participant: Yes. Yes. She does that.
>
> Interviewer: What does she want? Does she want to go to the bathroom?
>
> Participant: No. She comes to my bedroom and she wakes me up to tell me she has a back sore and would need a rub. She complained about other things either. "I've heartburn." Sometimes she forgets where it hurts. She says her back hurt and I rub her. Then she comes back later and she said it still hurts. I said: "Where does it hurt now?" She replied: I've a headache. Do you understand? Then she tells me: I'll sleep with you tonight".

Interviewer: She feels safe…

Participant: Absolutely. Absolutely.

Furthermore, Harold reported that he couldn't take care of himself. He looks after two relatives, but his wife and his daughter support him. Harold's wife works full-time but she cooks on the weekend. Therefore, Harold reheats foods but prepares fresh vegetables and fresh fruits each day for meals and snacks. He manages the dishwashing and other household tasks. Each morning, he bathes the ladies and dresses them up. He closely monitors their food intake and changes them if needed. He puts them to bed at 9 PM and he goes to bed and starts over the same routine each day. On the weekends, his wife prepares the meals, washes the ladies' hair and gives her husband a little break or respite. His daughter cleans up her part of the house while he tidies up the other part. Harold cannot care for himself as he would like to, and as physicians required him to do:

> Participant: Doctors told me I'd better go to the gym to exercise but I can't go, I've to look after my cousins. I must care for them.
>
> Interviewer: Do you take some time to care for yourself?
>
> Participant : Remained silent.
>
> Participant: I try, but frankly speaking, I've no time to care for myself. I must exercise but I can't since I must stay in for the ladies. I can't go out and do jogging. I must stay in to look after them.

Caring activities, as well as the mourning in becoming process, influence the primary caregiver's physical, psychological, and social wellness.

Stage 2: Acceptance and integration.

Barbara and Eva, both adult daughters, also witness parents' loss of cognitive functions but come to accept these changes. Eva talked about her mother's forgetfulness and loss of memory:

> Participant: The other day, mummy came to me, holding a pair of shoes. She told me: "These aren't mine and I found them under my bed." I replied: "Mummy, but these are your shoes. They are brand new and I bought them for you last week. Didn't you remember?" Mummy did not remember and moreover she didn't believe a word of what I was saying. I said: "Mum please come with me". We went downstairs and I showed mummy that the bed under which she found the shoes was in fact her bed. It was her bedroom. She finally agreed and put the shoes on. Caregiver 08-F

Witnessing aging parents' losses has impacts on caregivers' well-being, since it is a stressor and a source of worries. It mobilizes caregivers' forces and strengths, when the work begins – not the physical, but the work of testing, accepting and letting go — the mourning in becoming process. It is a time when caregivers try diverse adaptive strategies to cope with the stress since strategies are used as 'buffers' to counteract the effect of stress and to maintain balance or homeostasis.

Stage 3: 'Letting go'.

For instance, Alexandra reported how she manages seeing her father's daily losses by recalling the good times she shared with him. At the same time, she started to build memories to prepare for the reality of the parting. She anticipates her father's death and wanted to build memories that she could retrieve when he is gone. When Barbara talked about her father's losses, I recalled her emotions and the sadness of her voice. I perceived the cost of the anticipated loss, in her voice. In this interview excerpt, she illustrated the paradox of caring or the dialectic of caring, that involved a mix of opposite emotions:

> Participant: It makes me happy to care for him and to be with him for this last period of his life. These are his last and very precious moments. I enjoy every minute I'm with him. Often, I look at him and stare at him. I stare at him when he writes, when he talks. It's compelling I know but I need to look at him like this if I want to recall him later. I need to print his image in my mind to sort out later. I want to recall his voice too and this is why I ask questions, just to hear his voice, the sound of his voice, just to enjoy hearing him talking with me. I want to start building memories. As well, I think of the good times, when he was younger. I try my best to accept the image of him, the image I have in front of me but accepting this image is very hard. I always think of him when he was young and strong. I know the day will come when he won't be with me. He won't be there when I need him. I won't be able to speak with him. Therefore, I stock images in my mind and prepare to the parting.

Interviewer: Do you think about his death? Do you fear that?

Participant: Yes, many times, many times. I thought about that. In fact, each morning I think about that. Each morning, I wake him up for breakfast. I prepare his breakfast before going to work and I go to wake him up. I'm always scared to find him in his bed. You know to find him dead in his bed. I say one day, he'll be like this. Anyhow, I try not to think about that because I can't take it. Caregiver 05-F

As for husband caregivers, it is also difficult for them to witness their wives' losses, especially the older husband, George, since his wife no longer recognized him as being her husband. He is very distressed and cannot hide his broken heart:

Participant: You know what? This morning Anna and I went to the Mass. The chapel is located downstairs and I bring her on her wheelchairs. As we were heading there, she told me: "Sir, I don't live here. Where am I? I want to go to my parents. I want to see mummy. She looked at me and asked: "Who are you? I don't know you sir. Can you tell me your name? I told her: "I'm your husband, George. We've lived together for (number of years)". She replied: "I don't know you." Can you see how much it is to care for her? Can you see my state of mind? Look at her…She's like a child. She's as powerless as a child can be. Caregiver 04-M

James also explained the impact that his wife's illness and caring activities have on his entire life, especially at work. Caring has impacts on working activities and the opposite is also observable as it seems that work affects the process of caring. Perhaps the impact of caring on women's work has been more extensively studied due to the gendering of caring activities. Nonetheless, it can be assumed that if the number of men caregivers increases, it is likely that they, too will be affected by some problems at the workplace. Without implying that men will face the same problems as women face at work, I suggest that some working issues are likely to appear. For instance, James talked about his work and how, since his wife' illness, he cannot take pressure at work:

Participant: I acknowledge that Leila's illness impacts on my work. Silence. Oh yes, illness impacts on my work. If Leila hasn't been so sick, I'd have been promoted earlier. I know I can go far but now I just can't do it. There are managers' postings and I know I can do this work but I don't apply.

Interviewer: Why?

Participant: I'm just not interested. I can't take pressure anymore. I can't take it so why would I want to be a foreman? I've enough stress here. It's already enough here with my wife and the kids. I avoid pressure and challenges. Basically, I avoid challenges at work since it's too heavy here. I can't get promoted and I'm stuck there. My boss knows I can be a good foreman. He told me; "For heaven's sake, why didn't you apply?" I can't take stress it's scary. Before Leila's illness, I wasn't like this, I liked challenges at work, but now I avoid any form of stress. Perhaps I'm a bit disillusioned, I don't know....

Interviewer: And it has an impact on your budget? I mean indirectly since you no longer apply for job promotion?

Participant: Sure it does. I'm losing money but what can I do? I can't do overtime so I lose money. Since my wife's illness, I can no longer do overtime. I must be available for her and on the weekends to work here. I must look after her and I must run the business here. I've my kids too, you know, I must care for them too.

Interviewer: Perhaps you're worn out...

Participant: Worn out, yes. That's it. I'm completely worn out, drained.

Caring cannot be studied without considering its impact on care-receivers, both positive and negative. Caring implies reciprocity and exchange; the affective relationships between aging parents and primary caregivers runs deep. Haitian Canadian' elders can count on their children to delay institutionalization as much as possible. Despite the negative outcomes, all caregivers see more pros than cons in keeping older parents at home. Fear of institutionalization and the lack of respect that elders may encounter in the public health care system were reported. A majority of Haitian Canadian primary caregivers do not rely on home care services but nevertheless expect these services to be available and accessible, in the case of a parent's severe loss of autonomy. They expect to receive respite and other CLSCs home services to support their caring commitment.

Aging Parents' Positive Outcomes

Haitian Canadian caregivers compared the negative impact of institutionalization to the positive outcomes of caring for aging people at home. Keeping older parents at home increases their quality of life. John reported:

> Participant: Well, I found that government does not want to…it looks like it's a waste to invest in aging persons. Government says I will invest in the youth. Yes, I agree, it's true and they have to invest in the youth. It's not necessary to speed up the last stage of life, to push the elders to give up and quit. We must not push them to die [euthanasia]. It's true they could live a couple of years more, but the way they're treated in nursing homes, they'll want to quit, they'll sleep almost all the time, they're put on medications, to speed up the final process, in a sense. I mean it's inhuman, I mean it's unfair and I think elderly must not be placed. I don't only speak about Haitians but in general. I saw Italian, Portuguese, Spanish, and Canadian elders, well they don't want to be placed, but they're forced by their children to move in these places. It would be better for them to maintain them in their apartment or to go to live with their children. I think they'd feel better. I mean they'd be treated with dignity, being surrounded by family members, but in nursing homes or hospitals, it's not the case, since aging people are mostly abandoned. Aging people feel abandoned. These elders who don't want to be placed, well they refused to eat, they don't want to take their medications, despite these medications can help them to give up earlier, and they feel abandoned. Institutionalization is a garbage bag; it's like putting elders in a bag and thrashed them. For some people, being institutionalized, it's almost like being put in a garbage bag and kicked out of the house. I'm against this practice. I'm really against that. If I want dad to pass away as soon as possible, I just need to tell him that I'm placing him and mummy in a nursing home. He couldn't take it and he'd let himself go away. Caregiver 03-M

Caring for aging parents at home also nurtures socialization since grandparents are not isolated from the rest of the family. They can interact with grandchildren and participate in family life. This is also helpful for delaying further cognitive losses. As James puts it:

> Participant: Parents help us and it's very helpful, very helpful. Because aging parents, children, and grandchildren, we live together and the family is the site of the social life. Caregiver 03-M

Eva supports this assumption when referring to her mother's last hospitalization. Things went really poorly at the hospital since the mother was confused, restless, and agitated. The mother could not communicate with the staff and was distressed by being hospitalized. She became confused at the hospital, compared to how she usually behaved at her daughter's home. Eva described her mother's hospitalization and made connections to nursing homes and institutionalization:

> Interviewer: During previous discussions, I met caregivers and wanted to know their views on institutionalization. I'd very much like to get your input on this topic as well.

Participant: Sigh. I'm not really in favour of placing aging parents in nursing homes. Unless there's no other choice, when there's no choice, you have no choice. Anyhow, my sister is also against this idea because we had tough times when mummy was hospitalized. A couple of months ago, mummy fell very ill. First, it's related to the categorization they do with the elderly. It goes with age, agreeing it or not, you must go to this unit. It was a real disaster. She arrived at the emergency. She passed the first night there at the ER. The second night, they transferred her on a general ward under close monitoring. She was better, she was moving in her bed, and wanted to get discharged. The third night, they put her on another unit and the fourth night she was transferred to the long-term care unit. It wouldn't have been a great deal to stay on this long-term care but they installed in a bed right next to a very confused lady. The woman yelled days and nights long. One evening, after having prepared mummy for bedtime, my husband and I left the hospital at 8.30 PM. In the meantime, they came in to prepare the other lady for bedtime. They phoned at 1 AM, asking us to go to the hospital immediately.

Interviewer: For what?

Participant: They wanted us to calm her down. Mummy was totally lost. She was totally lost. My sister went to the hospital since I couldn't stay the night at the hospital with mummy. My sister was shocked when she saw how they treated mummy. They put containments to immobilize mummy since she was agitated. She wanted to jump over the bedrails. She was yelling: "Where am I? What am I doing here? Who are you? Why did you bring me here? Why did they tie me to the bed?" My sister was very distressed and told me after: "I'll never place mummy in a nursing home. I really think that if she would stayed there, at the hospital, we'd lost her for sure". Caregiver 08-F

Aging Parents' Negative Outcomes

When referring to my experience in the field and in being close to some Haitian Canadian families, during participant observation sessions and interviews, I saw more positive, rather than negatives outcomes, for aging parents when they are cared for at home. The only negative aspect that I observed during my fieldwork, was that some aging persons can be socially isolated in private Haitian nursing homes. The private nursing homes cannot be compared to the homes of adult children since the affective component is less likely to be present in private nursing homes, compared to the adult children's homes. In the former, caring is a paid work and is less likely to provide aging persons with a warm environment such as in the family home. In private nursing homes, especially where social activities are not present, some elders can be deprived of socialization, which can be boring. In some cases, however, it may be better for the aging

persons to be placed in a private nursing home instead of staying with adult children who cannot adequately care for them. I did not witness such instances during my fieldwork, though a woman caregiver reported the reluctance of some adult children to look after their aging relatives at home.

Martha told me that some adult children were not pleased about keeping their older parents at home since they had to make sacrifices to make it work. Couples had to find ways to manage their social life, while giving care to their aging relatives, as well. Also, an increased risk of elder abuse is present when the primary caregiver is isolated, and receives or demands no help. If caregivers become stressed or depressed, elder abuse can become a sad reality. Caregivers must know their limits and when they have reached them, and must ask for help or support if necessary. During my fieldwork, I noticed that caring for an aging relative is still attributed to one person in particular, who is usually chosen by the aging parent. In this study, the amount of support given by the extended family was not substantiated. Even though I had expected to observe a greater involvement by members of the extended family when I was visiting the primary caregivers, in fact, I observed the opposite. Few Haitian Canadian caregivers were receiving help from members of their extended family to support their caring commitment. This may be explained by the fact that many of their extended family members had been left behind in Haiti, or the members were scattered across North America or in other countries. Even when an extended family was present, the same individuals were usually being asked to help. Some caregivers clearly stated that growing older in Haiti was easier since the elders were respected and the extended family and friends could more readily give a helping hand. Some of the other caregivers, who were actively involved in their churches, could rely on members of their spiritual community to get some support.

Summary

I have attempted to demonstrate that caring for aging relatives at home influences every domain, area of activity, and sphere in which the primary caregiver lives. Caring is a process of transition that requires caregivers to adapt to their new roles and to adjust and cope with new challenges. Caring is also a means to adapt to a new country by relying on Haitian traditional cultural values to maintain family dynamics and functioning as if it was in Haiti. It is like 'transplanting' Haiti in Canada and the home becomes the cradle of the Haitian culture. Caring as a cultural entity is also aimed at reducing the impact of late immigration on older parents since they remain culturally surrounded. Despite the benefits of implementing patterns of cultural continuity among Haitian Canadians caring for aging relatives at home, the re-arranging or re-patterning of family roles is not without its problems. Cultural continuity affects women since integrating with a Western society cannot be carried out without modifying women's roles in the private or domestic sphere. To protect the aging parents and alleviate the shock of late immigration, women and men need to negotiate the division of work that was naturally and culturally attributed to Haitian Canadian women in the homeland.

Caring is also a daily process that involves a dialectical or paradoxical process of learning, with the daily unfolding of rewards and losses. Although I have described Haitian Canadian caregivers' reciprocity and losses separately, they occur simultaneously in the everyday lives of the caregivers. Therefore, caring as a process of reciprocity and mourning-in-becoming must be treated as an entity, unfolding just as does life itself. Caring should also not be studied out of the family and social context within which the caring activities occur.

Caring is composed of two components: work and love, but I extend Hilary Graham's (1983) definition to include a cultural component to caring. I also draw on Mayeroff's (1990) notion of caring to define caring as a process of reciprocal growth for both caregivers and care-receivers. Far from being a straightforward process, caring is a social and cultural process that

intersects with many other layers of complexities such as race, ethnicity, gender, and social class. Culture represents one of the layers around which Haitian Canadian primary caregivers construct aging and caring. As well, cultural beliefs represent only a part of the rationale explaining why Haitian Canadians prefer to look after aging relatives at home.

In using a postcolonial feminist approach to explore Haitian Canadian caregivers' ways of caring, the social, cultural, economic, geographical, and political contexts must be taken into account since these structural factors intersect with race, gender, ethnicity, and social class to mediate ways of caring. The larger social context has an impact on Haitian Canadian primary caregivers' utilization of the health care system and on the relationship with mainstream health care practitioners and home cares nurses.

As demonstrated in Chapter Five, the impact of caring on Haitian Canadian women's caregivers, who juggle with the triple task of working full-time in the labour force, raising children, and looking after aging parents, was one of the major issues raised among the participants in the study. More precisely, the impact of maintaining the cultural continuity in caring for aging parents at home seems to be greater for some Haitian Canadian women involved in marital or conjugal unions where the redistribution of domestic tasks and the underlying equalization of asymmetrical power relationships within the couple, were neither addressed nor successfully negotiated.

In the next chapter, the Haitian Canadian primary caregivers' relations with the mainstream health care system, and more precisely, with home care services, are described. What home care services are provided to support Haitian Canadian caregivers' commitment to caring for aging parents at home? What services would need to be re-activated or developed to fulfill Haitian Canadian primary caregivers' needs? Furthermore, the relationships between Haitian Canadian primary caregivers' and visiting nurses are addressed to examine nursing professional practice and delineate what nursing interventions can be developed to support

Haitian Canadian caregivers' caring commitment for aging relatives at home. I extend the analysis to illustrate the intersection between ways of caring, gender, race, ethnicity, and the health care system to locate Haitian Canadian primary caregivers' ways of caring and everyday life experiences in the broader social world.

CHAPTER EIGHT
HAITIAN CANADIAN CAREGIVERS' PERCEPTIONS ON THE HEALTH CARE SYSTEM: IMPACT ON THE WAYS OF CARING AND THE UTILIZATION OF HOME CARE SERVICES

Introduction

In the preceding chapter, findings pertaining to Haitian Canadian caregivers' ways of caring for aging relatives at home illustrated that a majority of caregivers tend to keep aging parents at home and to underutilize the mainstream health care system, more specifically, home care services. Some Haitian cultural beliefs related to aging and caring may, in part, explain the caregivers' choice, but other factors related to the health care system *per se* need to be assessed. Ways of caring are socially and culturally constructed and vary with the context in which caring activities unfold.

In this chapter, the main issue is the exploration of whether or not Haitian Canadian primary caregivers' everyday lives impact on caregivers' perceptions of the mainstream health care system and health practitioners. The results suggest how the utilization of home care services intersects with gendered, classed, and economic issues. Haitian Canadian primary caregivers' social and economic positions influence the perceptions of the mainstream health care system and home care services. As the fieldwork was unfolding, four major issues developed from the interviews and participant observation sessions in relation to the health care system: 1) the cultural inadequacy of home care services, 2) the Haitian Canadian caregivers' needs for home care services, 3) the nature of nursing professional activities, 4) the impact of health care reform on home care programs. These issues share a common denominator, which is to constrain the accessibility to home care services and limit the array of services offered to the aging persons.

As public institutions, community health centres reflect dominant ideologies pertaining to care, caring, aging, health, and illness. Dominant ideologies represent relations of ruling that

influence policy-makers when it comes to elaborating health care priorities and specifying which programs are to be cut back. In other words, the impact of health care reform on home care programs must be carefully explored to assess Haitian Canadians' 'real' accessibility to these services to support the caring commitment at home. In the next section, I present interview excerpts illustrating Haitian Canadian primary caregivers' perceptions pertaining to the cultural inadequacy of home care services.

Caregivers' Perceptions of Cultural Inadequacy of Home Care Services

In this research, a pattern of non-utilization of home care services was noticed and the composition of the sample supported this observation. In fact, 12 out of 16 Haitian Canadian caregivers did not rely on home care services to support their caring commitment. In a study carried out in 1997, Guberman and Maheu reported the same trend of underutilization of home care services among Haitian Canadian caregivers of the greater Montreal area. In using a postcolonial feminist lens to examine this pattern of underutilization of services, caring is seen to be mediated by social forces that intersect with race, ethnicity, gender, social class, creating social inequities in accessing home care services. In turn, these social inequities in the designing of culturally adapted home care services influence Haitian Canadian primary caregivers' health and social welfare.

Lack of Cultural Adequacy

Haitian Canadian caregivers' perceptions of lack of cultural adequacy are related to issues of institutional racism and lack of health care providers' cultural education. Institutional racism can be reflected in some health care providers' disrespect towards non-Western aging people. As well, the lack of knowledge about Haitian culture among the mainstream health practitioners and the lack of Creole interpreters in CLSCs and other health care facilities represent structural barriers that impinge on the utilization of services. These social and cultural

barriers preclude aging Haitian Canadian elders from fully accessing public home care services and restrain the primary caregivers' support to caring for aging relatives at home. Cultural and social barriers also create a dehumanized and culturally unsafe health care system for both Haitian Canadian primary caregivers and care-receivers. Some caregivers, who may or may not have been receiving home care services, talked about their perceptions about the dehumanization of the health care system where "humans are treated like numbers" (Caregiver 09-M). Some caregivers were working in health care facilities and one mentioned, "we know the system, we know how it works" (Caregiver 03-M). It can be safely argued that the more caregivers know about the health care system, the less likely they are to request services for their aging parents. Coupled with Haitian cultural beliefs on aging and caring, these issues affect Haitian Canadian primary caregivers' utilization of home care services. Nevertheless, primary caregivers also discussed their anticipated needs of home care services, hoping to get some help from the public health care system to support their commitment.

Perceptions of Disrespect Towards 'Racialized' Aging People

Some caregivers reported instances of disrespect towards aging people directed at racialized groups. The interview excerpts illustrate a lack of equality between residents of some nursing homes. In other words, some mainstream health care practitioners did not recognize foreign-born Canadians or non-Western elderly as being equals[72], and therefore, would decline to care for them adequately. This lack of respect towards aging people observed among the mainstream health care providers constrains the utilization of the health care system, and is not only restricted to home care services. For instance, an adult son caregiver talked about the lack of respect towards aging persons in the health care system:

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[72] The notion of equality of rights is a fundamental component of the Canadian Charter of Rights and Freedoms. Black and Smith (1989) differentiate "the right to treatment as an equal and the right to equal treatment, which is the right to equal distribution of an opportunity, resource or burden" (p. 569). The authors assert that "the right to treatment as an equal is the more fundamental of the two rights" (Black & Smith, 1989, p. 569).

Participant: Aging persons deserve our respect and as a matter of fact they ought to be treated with much more respect than the way they're treated now. They ought to be treated with respect and dignity. It's not currently the case in the health care system.

Interviewer: Can you tell me more about that?

Participant: Everybody should be treated the same way, equally, with respect and dignity. And these people helped constructing Canada and see how they're treated now. If we live here, in Canada, and I'm saying Canada, it's because of the elders' work. They would deserve a far better treatment than what the one they're receiving now. They deserve a lot better you know. (Caregiver 03-M)

A woman caregiver talked about issues of inequality that she witnessed while visiting Haitian Canadian elders in a health care facility:

Participant: I went to visit aging people who were hospitalized since they had no relatives in Canada. They were completely alone, without family members. It's hard you know to be alone like this. No family is present to defend the aging persons' rights. During one of these visits, I entered a room and the air…the odour was so bad, it was so poignant that I almost couldn't breathe.

Interviewer: You worked as a volunteer in a hospital and you were confronted with such issues…

Participant: Yes. I went to the hospital to wash her hair since her hair had not been washed for weeks. I have to provide care that staff wasn't giving to them. And a filthy odour was coming from the urine collector bag. I can tell you, it was awful, absolutely awful.

Interviewer: So there are people who are not well treated…

Participant: Not at all! Not at all! [Upset voice]

Interviewer: They don't receive the required care?

Participant: No. They aren't treated, as they would need to be, with respect and equality. Caregiver 15-F

Observation: I could no longer explore this issue since the woman's spouse interrupted the interview.

Perceptions of Institutional Racism

On the other hand, Edward, a male caregiver perceived that dehumanization of the health care system could not be dissociated from institutional racism:

Participant: It has always been like this. There is racism in nursing homes.

Interviewer: Racism?

Participant: Of course! Blatant racism. I worked in the health care system a long time. And I witnessed instances of racism in nursing homes.

Interviewer: Towards?

Participant: Towards customers, employees, well towards whoever isn't a Quebec-born.

Interviewer: Did you witness instances where care was denied to clients pertaining to their racial or ethnic background?

Participant: I mostly saw nursing aides refusing to care for a non-Quebecer. They don't want to approach or touch a non-Quebecer. For instance, they won't feed a non-Quebecer; they won't help this person to go to the bathroom; they don't care about non-Quebecers. But nurses they do their jobs. I saw no problems with nurses.

Interviewer: Men and women included? [I mean among nursing aides]

Participant: Yep. They don't care at all. Whether clients are Vietnamese, Italian, Haitian, they don't care for these people. They only care for Quebecers. Nursing aides do not intend to help an immigrant at all. They won't feed non-Quebecers. They only care for Quebecers.

Interviewer: So the food stays on the table and the client is not attended?

Participant: Well another immigrant [who is a health care worker] will help these people but Quebecers won't help. They don't care about these peoples. I don't know about other nursing homes but it was the atmosphere at my workplace. Caregiver-09M

In an interview excerpt, John's comment lends support to Edward's perceptions in describing instances of institutional racism. John's parents were not receiving home care services. He described why, as a former health care worker, he associated politics, ageism, with institutional racism as factors that motivated his decision to keep his parents at home. In the same way, he asked his children not to place him in a nursing home. Prior to discussing the lack of respect towards racialized aging persons and institutional racism, I present the interview excerpt where John raised the political issue, to indicate the context:

Participant: I want to tell you (hits the table with his closed fist) that decisions are taken at a very high political level. A head of state once said that he lost his referendum because of this cultural community, (hits the table with his closed fist more strongly than the first time), this one, this one, and this other one. So, it tells a lot you know. Hopefully, we have the Canadian Charters of Rights and Freedoms. Otherwise, I think we'd be trampled on. Can you imagine what would be the fate of our aging persons?

Interviewer: The elderly. Do you fear something can happen to aging persons?

Participant: Yes. So listen to me okay? Listen to me well! I'm living in Canada (hits the table with his closed fist), it's a multiethnic country, (hits the table once again with his closed fist), when people don't know their rights, their citizens' rights well they're trampled on. It's tough you know…

Interviewer: It's a tough world. It's a struggle….

Participant: Oh yes! That's it! So for the aging persons, it's even worse. Those who can't speak up, those who can't fight for their rights to be respected, if you can't shout at them [health care providers]: "Hey!" You won't get anything. You won't get any service. This is our health care system!

Interviewer: Can you tell me more?

Participant: I mean if the families know aging persons' rights, then family members will speak up for the aged. But families must be on their guards, and fight on behalf of the aged. When you're still independent, you can yell but if you're not independent [Refers to the level of autonomy] you can't shout for your rights to be respected, then you're done. This is the health care system, here in Quebec.

Interviewer: Okay. So let's figure out the situation of the less privileged; those who are left out of the society [mainstream's society]. Do you find that aging people are respected?

Participant: Not at all! Not at all! Especially, when aging people come from an ethnic group, if they are Jewish, Italian, Greek, or whoever….

Interviewer: Aging people are even more devalued? As if they would not exist at all?

Participant: That's it! They're not considered at all.

Interviewer: So, there is discrimination. It looks like the jungle law. Is that it? Is this the message you want to pass on?

Participant: Nodded his head for yes. Caregiver03-M

What is striking is the fact that the health care system appears as a snapshot of the larger social world. To the already existing issues of racialization and gendering of the social world,

another layer of complexity is added. This layer constitutes the politicization of the health care system where political Othering is used to marginalize the health and social needs of racialized groups. Therefore, institutional racism would not be only based on the skin colour but would also be related to the so-called visible minorities' political allegiances. The workplace becomes an arena where political debates not only pervade labour relations, but also have an impact on the delivery of care to 'culturally different Others'. Put another way, it may be contended that some mainstream health care practitioners come to perceive other cultural communities as political opponents, indirectly affecting the quality of services offered to racialized groups. This new exclusionary process is characterized by a radical politicization of the health care system and this phenomenon cannot be analyzed without examining its links to colonialism. For instance, James reported that an English-speaking person had not been harassed for the language issue at his workplace, but 'allophones' were reminded to speak French:

> Participant: I recalled one day I was speaking with a Haitian co-worker at the (name of the health facility). We were speaking in Creole. Somebody came to remind me that I was working in Quebec, a French-speaking environment, and because of the law, I must speak French at the workplace. So what? (Hits the table) I told them: "I'm just speaking with a co-worker, we have the right to speak Creole! I mean it's a private matter." And I told them to mind their business. Three years ago, an Anglophone worked with us and she never spoke a word of French. She always spoke English and was a Quebecer as well.
>
> Interviewer: Huh huh (Listening)
>
> Participant: Well she was not treated the same way as I was. They never complained about the language. She could speak English without having any problems. They never told her to speak French. But for me, it wasn't the same thing. Why did they pick me? Why didn't they pick that woman?
>
> Interviewer: Did you ask the staff? [Why weren't they warning the English-speaking woman to speak French]
>
> Participant: Yes. I asked: "Why did you pick me up?"
>
> Interviewer: What did they say?
>
> Participant: Nothing. They were frustrated. Caregiver 03-M

When examining this interview excerpt, it seems that the influence of the 'two founding people' in assuming the direction of the country is still very present. The 'two founding' peoples dictate the relations of ruling and then, what applies to the society at large is replicated, on a smaller scale, in the health care system. From this perspective, the health care system represents a microcosm of the larger social world, reflecting its political tensions and patterns of social exclusion, based on an ambiguous policy of multiculturalism. As many authors point out, the lack of political commitment to change the fundamental structures and institutions of our nation, only perpetuates injustice and violates the notion of equality of all Canadians (Anderson & Reimer Kirkham, 1998; Li, 1999; Roberts & Clifton, 1990). Anderson and Reimer Kirkham (1998) state:

> Despite the Charter of Rights, and, in particular, Section 15, which speaks to equality rights of all Canadians, the notion (often implicit) that Canada is a northern country peopled by northern races still lingers, and it might be recalled that the Meech Lake Accord 'was premised...on the notion that Canada consisted of two "founding people" (Bliss, 16), thus excluding First Nations peoples and other groups who are not part of the "two founding peoples". (p. 251)

This raises questions about the cultural adequacy of services offered to Haitian Canadians. Which clienteles are privileged or targeted in health policies? During fieldwork, I visited a couple of CLSCs and noticed the presence of four large posters hanging on the walls near the main entry of each facility. I closely examined these posters as well as the written information provided. What services were being asked? What languages were being printed on these posters? What was the race and gender of the people represented on these posters? The four were aimed at encouraging people to rely upon health care services. Who were they representing? Pure wool[73] or 'old-stock, white, francophone Quebecers who were requesting

[73] 'Pure wool' refers to French Canadians born in Quebec who are considered as 'real' Quebecers as opposed to French Canadians born outside Quebec who are seen as 'French Canadians' and not 'pure wool' since they were not born or do not reside inside Quebec (Eller, 1999; Maclure, 2003; Robin, 1996) For instance, Franco-Ontarians or Franco-Columbians are not considered as 'pure wool' since they do not reside in Quebec or were not born in

services. A grandmother in a wheelchair was asking the CLSC for some support to help stay in her home. She did not ask her children but she asked the State to help her to stay in her apartment. A middle-aged woman was asking the CLSC to provide help in caring for a sick husband due to an early hospital discharge (the ambulatory shift). In another poster, a smiling, five or six-year-old boy was asking to be helped in developing his skills and human potential. The last poster depicted a young man, seated on a park bench, head in his hands (suggesting an acute mental distress), who was requiring help for mental health.

What was the targeted population? Nobody coming from racialized groups was represented in these posters. At one CLSC, posters were written in French but in two other places, English, Spanish, and French were used, as well. What is striking is that a high proportion of Haitian Canadians were living in these CLSCs' neighbourhoods. How can we explain that these posters were not printed in Creole as well? How can we explain the erasure of the ethnic and cultural differences observed in these CLSCs? Only Whites were represented, as if the health programs and services were specifically designed for them.

A question, remaining unanswered, pertains to the extent to which these services and programs correspond to Haitian Canadians' health and social needs. What constitute the 'real' access of Haitian Canadians to home care programs, if their health and social needs are minimized or simply not considered? To address the question, I point out that the government of Quebec knows about issues of racial intolerance in the health care system. According to a report published by the Ministry of Immigration and Relations with Citizens (1996), people coming from different ethnocultural groups tend to underutilize public health care resources. This trend was noticed in all health care facilities and therefore, was not restricted to CLSCs. In response to the formal health care system's incapacity or unwillingness to address their health and social

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Quebec. Eller (1999) argues that this very territorial division among French Canadians is highly political since it is aimed at reinforcing Quebec's national identity.

needs in a culturally appropriate way, ethnic or cultural communities have created their own parallel 'health care' systems to bypass the State system.

In 1987, the Quebec's Council of Cultural Communities found that the barrier of language and the lack of cultural adaptation of services would explain this generalized pattern of underutilization of mainstream health care services among non-Western immigrants and refugees (Commision d'enquête sur les services de santé et les services sociaux du Québec, 1987). This would also support the emergence of ethnic parallel health care systems, as exists among the Jewish and the Italian Canadian communities of Montreal. The Haitian Canadian community began organizing a parallel system but the funding issues precludes them from achieving what older cultural communities have built so far. In 2003, the same question is asked: Why do people coming from cultural communities prefer not to utilize public health services? In other words, are issues of institutional racism being simply overlooked and not judged as a priority to address?

Quebec's Ministry of Immigration and Relations with Citizens (1996) recognizes that mainstream health practitioners' lack of intercultural education, lack of Creole speaking skills, and lack of knowledge of Haitian Canadians' cultural beliefs and values, are factors that constrain the accessibility to health care services. Problems of racial intolerance and institutional racism towards Haitian Canadians were also reported. Are Quebec's health institutions, like those in other Canadian provinces, remaining, as Anderson and Reimer Kirkham (1998, p. 251) point out, "Eurocentric and classist"?

This points to examining Haitian Canadian caregivers' perceptions on the lack of cultural adaptation of services. Mostly, caregivers reported issues demonstrating the lack of recognition of cultural differences in the health care system. This lack of recognition is translated into a lack of cultural education among mainstream health care practitioners despite the need of Haitian Canadian caregivers to obtain public home care services in a near future.

Caregivers' Perceived Lack of Cultural Adaptation of Services

Paula described the services given to her mother and shared her perceptions on the lack of cultural adaptation of services to the needs of Haitian Canadian clientele:

> Interviewer: We were talking about nursing homes. Well, I talked to you about these homes, and you answered that your mother, she couldn't tolerate, well she'd feel like being abandoned?
>
> Participant: Oh yes! [Emphasis] She'd feel completely abandoned. She'd feel rejected.
>
> Interviewer: Rejected?
>
> Participant: Yes she'd feel that I reject her.
>
> Interviewer: And how would you feel about that?
>
> Participant: I'd feel guilty. I'd not be in peace with such a decision. I wouldn't feel good.
>
> Interviewer: And in these homes, there's no Haitian traditional food?
>
> Participant: None! There's no traditional food, there's no communication, and there's a lack of respect of the person's cultural background.
>
> Interviewer: Communication is important, isn't it? Do you speak Creole with your mother?
>
> Participant: Yes mummy and I speak both languages, Creole and French, but most of the time we speak Creole. Caregiver 02-F

Fears of institutionalization and the underutilization of health care services seem related to the lack of respect of Haitian cultural differences, occurring in the mainstream health care system. James and Eva, who do not receive home care services to support their caring commitment, spoke about how institutionalization is perceived as an act of abandonment in the hands of strangers. Fears of institutionalization cannot be explored without referring to the perceived cultural inadequacy of the mainstream health care services, with regard to the Haitian culture, for example, without serving traditional food or having Creole interpreters or Creolophone staff in place. This perceived cultural inadequacy of services has an impact on the utilization of home care services. In that sense, Haitian Canadian caregivers do not want to

expose aging relatives to racial discrimination and by keeping them at home, their aging parents are shielded from culturally unsafe nursing services. Eva expressed her perceptions on the lack of adaptation of nursing homes and CLSC home care programs to the Haitian Canadian reality, after having visited some nursing homes on behalf of her aging relatives. She also described why she does not contemplate institutionalization in public nursing homes for her aging mother:

> Participant: Anyway, nursing homes aren't prepared. I've visited some nursing homes and I found that ethnic groups have no place there. I don't see them in these places. Perhaps I've visited the wrong ones but the quality is not the same [as in the home setting]. As well, there are ways of doing things; it's just not the same. I find that if a person is unconscious it's fine since we have no choice. But when people are conscious and they have to go there…In these places, you have to be…Sometimes, even if the person speaks French… But those who don't speak French, they're completely powerless. Those who speak Creole they're powerless. They can't be understood. Caregiver 08-F

After reporting about this lack of cultural adequacy, the woman caregiver spoke about her perceptions of public home care services provided by CLSC. She explained why she could not rely on CLSC home care services to support her caring commitment:

> Interviewer: So, you find that nursing homes [services provided in nursing homes] have to be readjusted to the cultural differences of the population….
>
> Participant: It's coming, it's coming extremely fast. It must be organized. Otherwise, we'll be up against it. And for these reasons, Haitian elders don't use CLSC services or attend CLSC social activities. They just don't go there. Sure, we can still use Haitian community centres and all that. But in the CLSC, will Haitian elders find somebody to understand them? Of course, if they speak French they won't have any problems being understood. But for those who only speak Creole, who can speak Creole to them? Nobody there can speak Creole. Caregiver 08-F

The lack of culturally adapted services in Creole in Local Community Service Centres (CLSC) and nursing homes, seems to explain why Haitian Canadian primary caregivers do not rely on health care system resources and home care services. Home care services remain underutilized despite the needs of some Haitian Canadian caregivers to access home support services. Clearly, the presence of Creole-speaking interpreters would facilitate working women's caring commitment since aging mothers or fathers could attend community health centres' social

activities or daycare centres. If this option were available, the workload of Haitian Canadian women caregivers would be alleviated. I now turn to examine the expectations of Haitian Canadian caregivers' in terms of need for home care services.

Haitian Canadian Caregivers' Needs for Home Care Services

During fieldwork, many caregivers expressed their concerns about obtaining public home care services in the future. Both men and women caregivers talked about respite service especially as they see their aging parents losing autonomy. They expressed a willingness to carry on caring activities at home but also expressed concerns about receiving more CLSC home services to support their commitment. For instance, a woman caregiver had already taken steps with her local CLSC in case she might need respite services. She described her future or anticipated needs for services:

> Participant: I opened a file for mummy at the CLSC. I don't know, perhaps one day, I'll need help. At least, her record is already opened. They know mum. If I can't stand or manage the situation anymore, and if I need help, they will be able to…Anyhow the file was opened. They know the case.
>
> Interviewer: You think they [CLSC home care services] will help you. Are you confident?
>
> Participant: I don't know to what extent they can help me. Her file is opened but I don't know which services are currently offered. I didn't ask to get these services yet. This is why I don't really know the services. I must call them to get information about services but I know that each CLSC varies, regarding the amount and the kinds of services.
>
> Interviewer: Yes. And this is, this is the problem…[I mean that each CLSC offer a different array of home care services]
>
> Participant: As I told you before, actually it's not a problem to care for my aging relatives. They're still independent but when you work full-time in the labour force, it becomes more and more difficult for me.
>
> Interviewer: Since they're still independent. Then, in these cases, the best approach consists of helping caregivers to keep their aging parents at home?
>
> Participant: Yes. It means to keep the aging persons at home, in their natural environment. I don't agree to keep them in a deleterious environment of care. Of course, the family context must be favorable to caring, a context which is supportive. We can't

keep elders in deleterious conditions since it's very unpleasant for them to live in a disruptive context.

Interviewer: Neither for care-receivers nor for caregivers.

Silence.

Interviewer: And now you are more interested in knowing about the CLSC home services. In a sense, you're planning for the future…

Participant: That's right! I pay more attention to the CLSC than before. I want to know the services I can receive. Because. *I want to know if they can offer respite, how many days or hours I can obtain. Otherwise, if I can't get any help, I'll pass away. I'll die.* [Italics added]

Interviewer: Would you agree, if needed, to receive services?

Participant: Absolutely.

Interviewer: For you and your relatives, I mean to avoid institutionalization?

Participant: Yes. That's it. But the most blatant problem is the lack of organizational structures. *I can say that when we look at the situation, for caregivers like me, nothing has been done for us. Nothing has been done yet for us.* [Italics added] [She is whispering]

In this interview excerpt, three major issues are illustrated. It is true that home services are not the same across the province. The 'basket' of home care services is related to the CLSC's budget and to the priorities established by the steering committee. For instance, some CLSCs can offer a couple of hours of respite to caregivers but others do not offer any. Most of the housekeeping services are provided by the private sector. Eva also pointed out the need to design home support services to sustain the caregivers' commitment, especially for women participating full-time in the workforce. If the conditions of aging parents worsen, if they lose independence, it would become more difficult for full-time working-women to assume caring activities at home. The deterioration of physical and/or cognitive conditions of the aging parents is closely associated with expected requests for services, especially respite services.

Nevertheless, respite programs have been downsized to meet health care reform demands to develop and implement programs for early discharged hospitalized clients. Eva underlined the

need to develop programs to help caregivers and provide respite or other services to alleviate caregivers' workload from time to time. This would facilitate Haitian Canadian primary caregivers' caring commitment since they want to keep elderly parents at home but they need support and resources to carry on their caring commitment.

Zahara is a woman caregiver who works full-time, and looks after children while caring for her aged mother would like to get some respite, too. She is isolated as a caregiver, and not supported by extended family or friends or close relatives. In an interview excerpt, she said:

> Interviewer: Do you receive CLSC services? Did you ask for family auxiliaries?
>
> Participant: I'll be honest with you. I haven't asked for CLSC services. I haven't made any request to the CLSC. If I had requested services, perhaps I would have received some. Each day, mummy is losing her strength; each day she's losing independence. Sometimes I asked her: "Would you like me to ask for some help?" She answered: "It's not necessary. If there's somebody else in the home, I will have to speak all the time."
>
> Interviewer: So you don't need somebody to stay with her during the day?
>
> Participant: Not yet, but it could happen you know. I'd very much like to get somebody to stay with her now and then. Since sometimes, it's a problem. I cut leisure activities since I feel guilty if I leave her alone in the house.
>
> Interviewer: But if you need to go out of town or let's say that you're tired and would need a little time off, what do you do?
>
> Participant: *I'd try to get some help from the extended family but still I'm almost alone.* [Italics added] But I don't seek these services [from public home care services] despite I'd like to get some respite for a weekend or so. I'd like to know a place where I can leave mummy for a weekend, so I can have a vacation or attend a social activity. I'd like to have a respite service like this where I can drop her for a weekend or a day knowing that she would not stay alone in the house.
>
> Interviewer: If this respite would be available, would you use it? Would you feel more comfortable?
>
> Participant: Yes, but I don't want to look as if I want to get rid of her. Do you understand? *I don't want to cheat her.* [Italics added] And I don't want to place her in a nursing home. I just want a little respite now and then. Since I can't get respite, I can't take any engagement in advance since I don't know how things will unfold. I can't predict the events. I don't live one hour at once, nope, in my case it's one minute at once.

> Interviewer: As well, you don't really know to whom you can address your concerns or talk about your needs of services?
>
> Participant: That's it! Caregiver 16-F

When examining Zahara's comments, it seems that racialization intersects with gender and class to influence caring and the utilization of home care services. What is striking in Zahara's lived experience is the fact that home care services mainly comes up as a financial issue. She would like her mother to attend CLSC social activities but she does not have the money to afford taxi rides. Accessibility is not only a matter of physical or geographical distance but also a financial issue. Zahara clearly expressed her need for respite to continue her caring commitment. She does not see institutionalization as a remedy and rather than placing her mother in a nursing home, she would appreciate receiving a few hours or a couple of days of respite. Respite would respect her cultural values on caring since it would not betray her commitment to care for her mother while at the same time would provide her with some time off to care for herself.

During fieldwork, I noticed that respite is a crucial issue that needs to be accounted for by the health care system and decision-makers. Respite becomes a financial issue that may jeopardize caregivers' health. Charles, a man caregiver, mentioned: "I've asked for a person to come in to keep them a couple of hours since I had to go to the physician's office. I called the CLSC and they told me that respite services aren't offered. So, I called a friend up and he came to keep them, and I had to pay the guy" (Caregiver 09-M). Henry who looks after his wife, Rosa, also talked about the impact of having had his respite hours cut down by the CLSC. Henry reported that the loss of respite hours had an impact on his health since caring for Rosa is demanding. She has Alzheimer's and needs close monitoring:

> Participant: I'm very upset with the CLSC for cutting my hours. They cut (number of hours) of respite. It impacts on me, on my health. I can't recuperate and catch up with my sleep.

Interviewer: How many hours were you receiving?

Participant: I used to receive (number of hours) hours of respite per week and now they [CLSC] cut (number of hours). These hours were mine! It was the time I had to look after myself a little. I could enjoy some time off and catch up some sleep as well.

Interviewer: Did you have to pay for this respite?

Participant: No. There were no charges. I just told them which days and hours to come in.

Interviewer: So, it's more work, in the sense that now you're receiving (number of hours) of respite instead of (number) hours?

Participant: Yes. So when I sleep only 2 or 3 hours per night, one day or another I won't be able to carry on. I'll be exhausted. And who will care for Rosa? The fewer patients they have, the best it is for them [health care system]. But they [CLSC] push us on the verge of exhaustion but when I'll be completely drained, they will need to look after her. I don't understand the rationale under this respite cutback.

Interviewer: This cut of hours brought more work and less time to care for yourself…

Participant: Of course! I'm tired but how could it be otherwise? I'm very upset and not satisfied with their services. Caregiver 04-M

Henry's comment reflects the isolation of some caregivers. Haitian Canadian caregivers' feelings of social isolation partly explain their need for respite services. The need for caregivers to be supported shows the impoverishment of the family support network due to immigration. Data also demonstrates the void, in terms of public home care services to fulfill Haitian Canadian caregivers' needs and support the caring commitment at home of aging parents.

In an interview excerpt, Dawn confirmed Haitian Canadian primary caregivers' concerns about home care services. She expected to need public home care services to support her caring commitment, since her mother has become less and less independent. Dawn even mentioned that she would prefer to spend her old days in another country where care is humanized. She was decided about sending her mother back to Haiti:

Participant: I want to go elsewhere because becoming older here is very tough. I work full-time, ok? I have to work full-time; I've no choice. And let's say that mum becomes less and less independent. How will I manage that? She will have to stay alone in the

house all the time. Who will look after her? Who will cook her meals? I must work to pay the mortgage! (Claps her hands). I can't say I'll leave my work to look after mummy.

Interviewer: I see…

Participant: So let's say I place mummy in a nursing home. They'll never care for her the way I do it. When aging persons are placed, they feel abandoned. They feel abandoned and want to pass away. If I place mummy, I know she'll give up and let herself die. She will waste away and she doesn't speak French. She won't be able to talk with the staff. She won't be understood. So, can you figure that out now?

Interviewer: It's a big issue…[The non-acknowledgment of cultural differences in the health care system to serve Haitian Canadian aging persons and primary caregivers]

Participant: Remained silent.

Interviewer: Do you worry about the future?

Participant: Of course! I very much worry about that. I even think to send mummy back in Haiti. Sure, she won't have the medical care she can get here but at least she'll have people to look after her and fulfill her needs. They speak Creole and cook Haitian traditional food. She'll get humanized care. This is why I'd like to plan my life in order to live my older days elsewhere. Caregiver 13-F

When examining why CLSCs do not try to reach caregivers by advertising respite or housekeeping services, it may be argued that the availability of such services have become limited since the health care reform and privatization of some services. Nevertheless, caregivers' perceptions of the dehumanization of care and the non-adaptation of services to cultural differences reveal deeper concerns. At stake, and hidden behind the words, is the impact of immigration on women caregivers' social support network. The presence of an extended family and friends that was left behind in Haiti is missed when it comes to care for an aging person at home. The family and social support is missing and caregivers feel isolated in the host society. Immigration cuts caregivers away from their natural sources of support, which, as a consequence, isolates them. From the standpoint of these women caregivers, culturally adapted care is under-developed or non-existent within the health care system. Dawn raised the point of immigration and its consequences to cut off women from their natural support network:

Interviewer: You'd like to grow older in a place where there is human warmth…

Participant: That's it. Since you can't count on your neighbours to help you, even if they're Haitians like you, since they integrated that individualistic mentality. They won't help you at all. But in Haiti, if you're sick, hungry or whatever else, neighbours will come to visit you and share with you the few resources they have. That's solidarity and here I don't see that. It's a whole different story here. People live in their own place and mind their business. They don't care about neighbours, if they suffer or if they need something. It's the lifestyle.

Interviewer: What happens to the others, the sufferings or being into trouble, neighbours aren't concerned….

Participant: In Haiti, you share with the needy the few resources you have and you're happy to do it. But when they [Haitians] immigrated here, they completely changed. They become individualists and only care for themselves. They learned the system and that's it! But anyhow, we don't have any choice to learn it.

Interviewer: When you say 'system,' learning the 'system,' what do you exactly mean?

Participant: The system of individualism. Haven't you noticed that? People mind their business and that's it. They don't care for others. And, I'm not only speaking of Quebecers, many Haitians who arrived here shifted to this mentality. It has to be said. Caregiver 13-F

We must go beyond Dawn's discourse to delineate the impact of immigration in weakening or impoverishing Haitian Canadian women caregivers' family support and friends' networks. These networks are the basis upon which immediate or emergency help or respite can be obtained. Despite the availability of support from Haitian churches, it is not the church or the CLSC that caregivers would call upon first to obtain emergency help. In fact, they would rely on family members. Perhaps, this is why Dawn said that she would prefer to grow older in Haiti where community values are present. In other words, she would like to grow older in a place where close relatives and friends are present to support and give a helping hand when needed. I want to reiterate that no State support for care for the aging persons is available in Haiti. People must develop community values to achieve their caring commitment, so they rely on a network of support composed of extended family members, friends, and even neighbours.

In a society marked by individualism, health and care become a personal matter and it becomes easier to overlook the social and collective inequities pertaining to caring among Haitian Canadian or other non-Western immigrants who cannot access high-wage work. It may also deflect the professional nurses and health care practitioners' consciousness from disturbing issues like the impact of racism, sexism, classism, on culturally different Others' health, since cost containment, efficiency, and time management are the 'real' objectives of the health care system.

A lack of information also impinges on the utilization of CLSC home care services. Many caregivers do not know about the services but become interested since they expect one day or another to require public home care services to support the caring commitment. As well, what is the need for CLSCs to advertise home care services that are either not offered or curtailed to a minimal level? A lack of information is associated with a lack of advertisement since cutbacks have had an impact on home care services. Next, I present an interview excerpt to show the importance for explaining what services are available and if fees are required to access these services. If these issues are left unexplained, both caregivers and care-receivers may be led to think that racial discrimination is the motive behind the denial of services, as opposed to the non-availability of these services.

Lack of Explanations on Home Care Services Availability

William described how difficult it was for him to obtain home care services to help him support his caring commitment. This interview excerpt demonstrates how important it is to provide exact information about the availability or non-availability of services. If questions are left unanswered, primary caregivers, given their encounters at work or at school with ethnocentrism, racism and social exclusion, might perceive the refusal of services as an instance of institutional racism:

Participant: I would have very much appreciated to receive some services but I couldn't find them out! It was just impossible to get services. I can't get services because I can't afford them. I must pay for services. If I want somebody to come in to help but I must pay and I can't pay. So…I don't have enough money for that, I'm not a rich man.

Interviewer: Have you met somebody from the CLSC? Usually, they send somebody in to assess the needs…

Participant: What do you say? Never!

Interviewer: Do you feel the CLSC is willing to help you? Did they listen to your concerns?

Participant: Not at all! Not at all! They were completely closed and they didn't listen to my concerns. It's all or nothing…

Interviewer: How can you explain that?

Participant: Well, they gave me a phone number and told me to call this number to get domestic services. I called them but they told me that I must pay for 3 hours of services. It's nothing more nothing less. They charge $36.00 dollars for 3 hours, and you must register for 3 hours, otherwise they won't come in.

Interviewer: It's $36.00 for 3 hours or nothing?

Participant: That's it! (Upset voice)

Interviewer: So, you're penalized…

Participant: Yes. Since I work but my earnings aren't higher than those of people who receive social security and I've a family to support. So when we talk about home care services, I don't have many services. I can't qualify for domestic aid, so I must pay to receive a cleaning lady. Secondly, I wanted to get some aid from the food bank but I can't qualify there as well. When you ask for services, you're almost asked to sell your house! Automatically, they think that you're wealthy because you own a house. So in order to get services, I'd need to sell my house. Do you understand? Sell your house and you'll get the money to buy services, that's the bottom line! I don't understand why they don't offer the same level of services to all the population. It doesn't make sense to me. In a CLSC you can get the services without paying and at the other CLSC you must pay for the same services. I can't get the services some of my co-workers can receive! How do you explain that?

Interviewer: I'd like to hear you about that. How do you explain that?

Participant: Really, I can't tell you I don't know. I don't know.

Interviewer: What kind of services? Do you know?

Participant: I called at the CLSC and somebody told me: "I have no idea of what you're talking about." They told me: "Sir, we have no idea of what you're talking about. That's it!"

Interviewer: Did you talk with the nurse about that issue of domestic aid and respite?

Participant: I told the nurse who is coming in now. I told the other nurse who was coming before her. It's not better. It doesn't work at all. The other nurse told me she did not know about the services provided by the CLSC. So now you know I'm shy and I shut up. I prefer not to talk about that. It's a shame for me now.

Interviewer: Do you think this lack of services could be related to discrimination?

Participant: Yes. I do think so. I feel that. I feel it's a kind of discrimination.

Interviewer: But this discrimination would be based on what? Do you think it would be related to the fact you're Haitian Canadian?

Participant: Remained silent. Later he answered:

Participant: Perhaps... Perhaps...

First of all, my question on racial discrimination was not well worded, since it suggested an answer to the participant, though, I must say that William remained silent and then responded: "perhaps." This interview excerpt demonstrates the importance for visiting nurses and other health care providers to be precise about the availability of services. More importantly, this interview excerpt shows the impact of the economic issue when it comes to getting home support services. Lower-income families are more likely to encounter problems to access home support services since most of these services have been privatized since health care reform. When questions are left unanswered, this can be misleading and be interpreted as a blatant issue of discrimination when, in fact, services are not available at the CLSC.

Behind the principle of universality, social inequities pertaining to race, gender, social class, and income intersect on caring and accessibility to home care services. William cannot afford to pay for respite or domestic services, and this will end up to jeopardize his health. He asked: "Who will care for her when I'll be exhausted? If I'm sick, who will come in to look after

her?" Home care program cutbacks must be assessed for the impact or consequences they bring to caregivers' health. It seems that caregivers and care-receivers' voices have not been heard in the chaos of health care reform and the gusty winds of liberalism[74]. Health care structures and programs that perpetuate health and social inequities must be addressed to break this cycle of injustice. Privatization of services deserves a careful examination and its consequences on primary caregivers' health must be scrutinized before a two-tiered system, one for the rich and the other for the poor, becomes officially implemented in our country. I interpret the voices of William and other caregivers as calls for devoting efforts in research projects aimed at challenging social inequities in the health care system. I now turn to examine nursing professional practice since some Haitian Canadian primary caregivers raised issues such as the lack of time for visits, perceptions of non support, and nurses' individualistic approach, as constraints to the reliance on home care services.

Nature of Nursing Professional Activities

The examination of nurses' professional activities illustrates the difficulty that visiting nurses have to promote and implement a family-centred approach when caring for Haitian Canadian families. The lack of staffing and lack of financial resources reduce the nurses' efforts to implement this family-centred approach in their everyday practice. This may explain why visiting nurses have to provide strictly physical care and proceed to the assessment of biological parameters. The home visit is completed in a relatively short time without significant interactions with primary caregivers and care-receivers being established. It must be pointed out that Haitian Canadian caregivers receiving home care services noticed this individualistic approach to care as used by visiting nurses, despite the claim in the official literature that nursing practice is based on a family-centered conceptual model. Many of the CLSC nursing management members opted

[74] Williams (1976) mentions: "Liberalism is a doctrine based on individualist theories of man and society and is thus in fundamental conflict not only with socialist but with most strictly social theories. ...Liberalism is then a doctrine of certain necessary kinds of freedom but also, and essentially, a doctrine of possessive individualism" (p. 181).

for this conceptual model, underlining the importance of a family approach to inform nursing practice in community health centres. A Western individualist approach to care seems not to concur with Haitian cultural values since the opinions of family members must be taken into consideration, in the nurse's assessment of the caring family needs. The lack of time devoted to talking to primary caregivers, and other family members shows the importance of conceptualizing home care from a broader perspective that includes the whole family. This lack of time can be also related to factors that neither nurses nor caregivers can control, and I point to the consequences of health care reform on the provision of services. This topic is again examined in more detail, in a later section.

Lack of Time for Home Care Visits

The lack of time devoted to the home visit contributes to dehumanize Haitian Canadian caregivers' perceptions of nursing professional practice, and documents caregivers' perceptions of non support from home care nurses. Sonia suggested developing a humanistic approach by allowing more time per visit. She found that home care visits are task-oriented or biologically-driven. She felt that nurses, in applying this biomedical worldview in their professional approach, overlooked her mother's psychological and social needs. It can be seen that Haitian Canadian primary caregivers' conceptualization of health, illness, and caring is holistically defined. According to Sonia's framework, wellness is a holistic concept where illness cannot be simply reduced to physical impairments or health being the absence of disease. This dualistic conceptualization characterized the Western biomedical disease-oriented framework of reference. Sonia also mentioned that nurses have other clients to visit, but would appreciate that a helpful relation could be established between her mother and the nurse, and between the nurse and herself, as well.

> Interviewer: Do you have some suggestions to enhance the quality of care regarding nursing professional practice?

Participant: I'd say more…Not only providing the technological aspect of care but the other side of it. How could I say this? I want to point out the psychological aspect of care. I mean the human part of care is missing. The helping relation with clients would need to be improved.

Interviewer: Do you mean developing a more humanistic approach?

Participant: Yes. That's what I mean. The approach must be human, a true commitment of caring, truly caring for the person…

Interviewer: Does it lack? [Humanistic and caring approach] Has it to be developed?

Participant: It has to be developed [Increased voice tone], I mean it's not developed at all. It's missing! They come in, they bathe her, they bathe mummy, they only stay with her for the bath, and after they run out. Minutes are counted; they don't have time.

Interviewer: If I understand well, it's task-oriented?

Participant: Yes it's task-oriented and moreover it's never the same nurse who comes in. There's always new staff, new auxiliaries, new nurses. It seems there's a high turnover among the staff.

Interviewer: From your perspective, what's the hallmark of a humanized approach?

Participant: *It consists of being present to the client. It's to give more time for caring. It's not just a question of doing the job and that's it. It's much more than that. That's not enough, and visits are too short.* [Italics added] They do the job and rush out since they have other clients to visit. Caregiver 02-F

Barbara observed a similar constraint of time when nurses came to visit her aging mother. I had in mind a home visit and wondered if it would unfold the same way. From a participant observation session at a caregiver's home, visiting nurses seem not to have the time to listen to primary caregivers' concerns. This interview excerpt illustrates how Barbara perceived home visiting nurses:

Interviewer: I know that your parent is receiving home care services. Can you tell me if you consider home care nurses as support resources? I mean, for caregivers like you, who care for aging relatives at home?

Participant: Actually, I can't say this since nurses aren't supportive. Psychologists and social workers are the only professionals from whom I can get support. For instance, I can call the social worker and I know she'll take care of that. I know she will help me. I can't say the same for nurses. So far, no nurses have supported me like other professionals do.

Interviewer: The nurse when he or she comes in, she doesn't have the time to sit down and ask you 'how does it go'? Has it ever happened?

Participant: I never got this chance!

Interviewer: Therefore, if I understand it seems that the nurse role is mainly directed at monitoring biological parameters. I mean to provide physical care. Basically, they provide physical care. Nurses go directly to the patient…

Participant: That's it! There's no interaction with the caregiver.

Interviewer: No interaction and visit last about 5 minutes. Is it always like this? On the long run, did you observe the same pattern over time in prior visits?

Participant: Remained silent.

Participant: Once I talked with a visiting nurse because a couple of weeks ago, I had to go to the CLSC. Otherwise, when I asked a question, they behave as if they want to tell me: "Oh stop talking! I don't want any other trouble. I don't have time to deal with problems." Caregiver 05-F

Primary caregivers who were receiving home care services reported that nurses could not be perceived as a source of support. Two women caregivers could not confide their needs or express their concerns since they felt their messages would not be received. In the sense that nurses rush in and out of the home and do not appear in terms of non-verbal behaviour to welcome the primary caregivers' concerns. Nurses are in a hurry to perform the work, as if cost efficiency and time management issues were driving nursing practice. Health care reform seems to have had an impact on nursing professional activities. Apparently, nurses only come to visit the care-receiver, perform the care, and simply do not have time to listen to informal caregivers. Paula described how she felt to be not supported by visiting nurses:

Interviewer: Do you perceive home care nurses as source of support? Do you find them supportive?

Participant: Remained silent.

Interviewer: We talked about family auxiliaries but what do you think of visiting nurses. Can you describe a visit?

Participant: I'd say it's very technical.

Interviewer: Technical? Do you mean, huh…biologically oriented?

Participant: That's it. They came in, they change the (name of the intervention), and that's it! Nurses are not really involved in mummy's care. I don't know why. I'd say the other health practitioners, the social worker or the occupational therapist, are much more involved than nurses are.

Interviewer: So, to make a long story short, nurses' visits are 'short and sweet'?

Participant: That's it!

Interviewer: They come in and they do the work.

Participant: Yes. They do the job and get out since they have other visits to do. They don't really have time to give to the person, to the approach of the person. I can understand that since I know how things go in the health care system. Caregiver 02-F

Harold observed the same pattern among those who were coming to visit his relatives. So far, he had not needed CLSC home services for himself and pointed out that some issues pertaining to caring activities must be kept in the family circle. It seems that distrust towards mainstream health care practitioners is present and has an impact on the relationships between Haitian Canadian caregivers and nurses. Harold talked about distrust or lack of confidence:

Interviewer: Do you perceive home care nurses as supportive? Would you confide in the nurse for…

Participant: What are they doing exactly?

Interviewer: Let's say that you need help, that you feel you're drained, exhausted, tired. Would you tell the nurse about that?

Participant: What do you want me to do?

Interviewer: Well. What you would do if you become overwhelmed, depressed by the amount of work. [In caring for relatives at home]

Participant: I would rather confide to my family, to relatives. I would work out the problems with them. This would be the only way to proceed to solve a caring issue. And it would be my personal problem as well. If I can't do the job, then it's my problem. So, what can we do in that case? I would tell it to the right persons but I would not pass by the CLSC. I won't ask them for help. I will manage that by myself. And I'll tell you something. I've never asked CLSC services. I'm all right. Nurses come in to check out the blood pressure, to draw blood samples, well that's fine. They come in to change the dressing that's all right too. But I don't ask these services for me. Caregiver 09-M

During fieldwork, I noticed that bureaucratic tasks and meetings were overwhelming the nurses. On average, a nurse had a workload of 5 or 6 visits per day, generally performed in the morning. Nurses may be asked to attend emergencies, if needed. An evening staff was also put into place, to attend clients who needed to have dressings changed or other treatments twice a day, and so on. Afternoons were generally devoted to completing diverse bureaucratic tasks that were indirectly related to caring activities. For instance, nurses completed clients' records, made telephone calls to physicians, pharmacists, or other health care practitioners for referrals or to work out problems encountered when visiting clients, and also prepared for the next working day. It happened that some staff meetings were scheduled for the morning, and to facilitate attendance by regular staff, nurses of private agencies were hired to replace regular staff in performing home care visits. If a nurse could not be replaced, then she or he had to make the home visit before attending the meeting — leaving even less time for the visits, especially if a meeting was planned for 9.30 or 10:00 AM. Nurses had to rush in for the visit to draw blood samples and perform required nursing interventions. Some interventions, however, can be longer than others and more painful, or distressing, to the clients.

I witnessed a situation where a nurse had to perform a difficult intervention and was pressed for time to attend a meeting at her workplace. The situation became uncomfortable for the nurse and the care-receiver who felt she was the cause of the nurse's problems. In fact, the nurse was short for time to perform an intervention that should have been done without rushing. The nurse was required to attend a meeting on wound dressings that same morning and because of the conflict, her work schedule and services were affected.

Managerial teams seem to be a little disconnected from the reality of care by forcing nurses to perform professional activities in a pressured context. For instance, some managerial decisions like having staff meetings in the mornings have an impact on the continuity of care since they increase staff turnover. Regular staff must be replaced by private nurses. One care-

receiver told me: "It's always a new nurse who comes in to visit me. I don't know why." This issue was also raised by primary caregivers and seemed to have an impact on the relations between nurses and Haitian Canadian primary caregivers. When caregivers and care-receivers have to get acquainted with new nurses at almost every home care visit, communication and development of trusting relations is not facilitated, which increases the perception of the dehumanization of care and non-support. Thus, people feel like they are being treated as "numbers." A closer examination of nursing professional activities also demonstrates that nursing services were affected by the last health care reform in Quebec.

In general, I noticed that nurses' home visits are short and mostly task-oriented, where the visits are aimed at performing nursing interventions. Few verbal interactions with either the care-receiver or the primary caregiver were observed during participant observation sessions of home care visits, possibly explaining why nurses were not perceived as a source of support for caregivers. Caregivers did not feel they could confide with nurses because nurses seemed too busy. Primary caregivers interpreted the visiting nurses' behaviours as if they did not have time to listen to their concerns. In fact, nurses hurried to leave caregivers' homes.

The issue is thus raised about the impact of social, political, and economic ideologies on the provision of nursing professional home care services. Results illustrate that nurses could be considered as subalterns in the health care system since the impact of health care reform is acutely felt in CLSCs. A home care manager reported a high level of sick leave, burnout, and other health problems among the nursing staff. The manager said: "We can even not satisfy the needs of our clientele. We're crumbling under the workload and we must re-allocate already burdened staff to other home programs." Basically, nurses were exhausted and could not meet the increasing demands of services, imposed on CLSC during the last health care reform. Nurses' lack of cultural education must be addressed, especially in the pluralist CLSCs, where a

lack of cultural knowledge decreases the chances to develop culturally safe nursing interventions.

Lack of Culturally Safe Nursing Interventions

The lack of recognition of cultural difference was first described when caregivers spoke about the lack of interpreters speaking Creole in nursing homes and community health centres. Haitian Canadian caregivers discussed issues of dehumanization, lack of respect towards the elderly, and lack of Haitian traditional foods in health care facilities. Lack of cultural safety can also be translated through not acknowledging Haitian Canadians' past experiences of racism and gender discrimination in the civil society. This is also a way of not acknowledging Haitian Canadian women's different ways of learning and knowing.

Before presenting interview and participant observation excerpts, I want to clarify how the concept of cultural safety was interpreted in this study. Cultural safety was used in a bicultural context, in contrasting Haitian and French Canadian cultures, and assuming that mainstream health care providers and visiting nurses hold privileged positions related to race, ethnicity, and social class. In that sense, cultural safety remains close to its initial application in the bicultural New Zealander context. Papps and Ramsden (1996) define cultural safety as "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on her/his own cultural identity and who recognizes the impact of the nurses' culture on her/his own nursing practice" (p. 491). I conceptualize cultural safety as a means to develop culturally safe nursing interventions to support Haitian Canadian caregivers by sensitizing mainstream health practitioners to neocolonial practices that sustain injustice in the health care system. Oppressive social, cultural, economic, and political factors intersect with race, gender, and class to generate inequities in the accessing of public home care services. These structural factors also have impacts on the provision of nursing professional care to Haitian Canadians. Mainstream health practitioners' cultural ethnocentrism and lack of knowledge about

Haitian cultural values place Haitian Canadian caregivers and care-receivers in a culturally unsafe situation of care. On the other hand, the concept of cultural safety must not be seen as a fixed concept since globalization, migrations, and economic liberalism contribute to the blurring of strict categories of 'colonizers' and 'colonized' (Anderson et al., 2003). The authors point out:

> There are no "hard" categories; instead we are reminded that social categories are fluid and dynamic across time and histories. White men and White women, Black women and Black men, may inhabit the categories of "oppressed" or "oppressor", depending on historical and socioeconomic positioning. (Anderson et al., 2003, p. 201)

Therefore, the results pertaining to the lack of cultural safety must be interpreted from a particular historical, social and economic positioning of the two cultural communities. Anderson et al. (2003) report instances where people who were seen to occupy positions of privilege were also disenfranchised in their relations with the health care system. The concept of cultural safety can be applied to many social contexts and must not be limited to its original conceptualization.

I now present an interview excerpt where the caregiver felt almost attacked by the nurse. The caregiver felt incompetent since she thought the nurse meant something different when giving her a package describing the services offered to aging persons by the local CLSC. Cecilia described caring as a career that she had been taught by her sisters (female members of her church), but she felt the nurse was implying that her mother was not receiving good care at home:

> Interviewer: So, you'd say that it's important for caregivers to seek support somewhere?
>
> Participant: Yes. There must be some support groups in the community [mainstream society] since when I go to the CLSC for mum's injections, there's always a nurse over there to ask me: "And how is it going with your mother?" "Is it going well?"
>
> Interviewer: Nurses asked you questions like this…
>
> Participant: Oh yes. They wanted to know if mum was eating well at home, if she was having a good appetite and so on. They wanted to know how things were going on at home. Oh yes!
>
> Interviewer: Did you perceive nurses' questions as inquisitive or comprehensive?

Participant: It just happened one time. I went to the CLSC with mummy for (name of the treatment). The nurse gave mummy her medication and after she gave me a questionnaire to complete. She was asking if mum was going to the doctor regularly, I don't know, a kind of questionnaire. Then, I erupted like a volcano, I don't know why but I got upset and shout to the nurse that I was looking after mummy very well. I told her to mind her business.

Interviewer: In a sense, you felt as if the nurse was judging you, was implying that you were not providing good care…

Participant: Probably because she gave me a toolkit with all information pertaining to services and programs given at the CLSC, housekeeping and respite services. I was terribly tired that day and I was very upset by her manners, her behaviour. I did not catch her point, I couldn't figure out where she was getting at in providing me with such information. I thought she judged me as a bad caregiver, she reproached me the way I was caring for mummy. That's what I felt and I can tell you it was not a good day to tell me such things. I was really not ready to get such message. She told me that for obtaining respite I had to inscribe mummy on a list and for daycare centres as well. But you know later, in subsequent visits, I thanked her now.

Interviewer: Perhaps the way the message had been brought to you was not convenient…

Participant: She did that in a hurry, so fast, without explanations, perhaps she had other patients to see and she had to rush. Caregiver 07-F

Sylvia reported her perceptions that a mainstream nurse did not respect her ways of knowing:

Participant: I told the nurse that mummy presents respiratory problems (name of the problem) and she responded that a little exercise would be good for her. I know how mum get drained rapidly after physical exertion! I know mum's limitations….

Interviewer: You mean you know your mother [More than the nurse did]

Participant: That's it! And I didn't go farther with that [with the respite request]. We worked the issue out in the family. We could do without them. Hopefully we [the family] were able to deal with the problem and work it out without them.

Interviewer: What would you suggest to enhance nurse's approach…

Participant: I would have like it presented less formally, let's say around a coffee. Having the time to talk, to discuss. This was done very fast, while giving my mum's shot, and after she provided me with the toolkit. And that's it! It was too fast….

Interviewer: The way the message was sent…

> Participant: That's it! It was rudely addressed. I mean there's a way to pass a message on. The nurse pitched me the toolkit without providing any explanation. Read this and get out of here, I've work to do. I was frustrated and got very upset. I read the toolkit, it is very well done indeed, but it's not a way to approach people. Caregiver 06- M

This vignette demonstrates how the client may interpret a nurse's attempts to provide assistance and illustrates what Cicourel (1993) meant by saying that different schemata of interpretation come into play to influence the exchange and the processing of information during health professional/client encounters. None of the regular staff reported enrollment in intercultural courses prior to hiring or after being hired at the CLSC. Findings show the need for CLSCs to invest in cultural education as a means to enhance the utilization of home care programs or health services. I now examine the impact of health care reform on nursing professional home care services. Social forces influence nursing practice, and in some instances, nurses can be seen as 'subalterns' in the health care system.

Impact of Health Care Reform on Nursing Professional Home Care Services

The context of visiting home care nurses practice must be examined to delineate the impact of the reform on nursing practice. For this reason, I decided to present short participant observation excerpts to locate caring in the whole picture and not leave nurses aside since they must deal with a difficult working context. A description of home care visits provides a starting point from which to examine the impact of health care reform on nursing professional practice, and indirectly on informal caregivers. The impact of health care reform with its cost containment, efficiency, time management, and budget constraints in time allocations for care, are illustrated in these participant observation excerpts. I want to point out that caregivers' and care-receivers' gender, treatments or nursing interventions, and nurse's name and gender were altered to protect participants' confidentiality. In the first excerpt, I noticed that the visit was performed under the principle of efficiency, with no minutes being lost in the process:

> Observation: The nurse said: "Hi Madam X. It is Francine (altered name) and I'm coming to change your (name of the intervention). How are you doing today? The nurse was smiling to the lady and her movements were smooth. "First, I will check out your blood pressure." Then, the lady asked: "How is it?" The nurse replied: "Your blood pressure is fine. It's fine. Very good." The nurse did not inform the woman about her blood pressure. No digit (systolic or diastolic) was given to the care-receiver. Then, the nurse went on to describe the steps of the procedure. She bends towards the lady who lies down in her bed. She put a hand on her shoulder as for reassuring while explaining the treatment. She explained: "Madam X., this morning I am coming to (name of the intervention). So, today it's time to do it. Then, nurse performed the treatment and said: "Okay. This is done. Was it painful?" The lady said: "Not at all." Then, the nurse informed the lady: "This is okay for today. It's over. I'll come back in a (length of time) In the meantime, if there's any problem, do not hesitate to contact me at the CLSC. I think you have my phone number?" The care-receiver said: "Yes." The nurse replied: "That's fine. Okay. Have a nice day Madam X!" She greeted the lady and exited the room. I did not see if the nurse had talked with the primary caregiver since I was still in the care-receiver's bedroom. I asked the woman caregiver "Did she talk with you?" She responded: "Nope. I didn't talk with her. She was already gone."

During the visit, the nurse was polite, respectful, smiling and not pushy with the care-receiver. She performed her work without talking a lot. The home visit lasted about 15 minutes and was mostly devoted to verifying biological parameters like blood pressure, pulse, and performing the nursing intervention, and so forth.

As fieldwork unfolded, I developed a consciousness about the influence of social locations such as being a French Canadian nurse. I thus changed my way of observing home care visits to let people know that I was not associated with any CLSC or any other governmental agency. I next present an excerpt of a home care visit to demonstrate the individualistic approach adopted by the nursing staff. Like in the first participant observation excerpt, details were altered to protect participants' confidentiality.

> Observation: The nurse seemed in a hurry. She told the person that she was coming today to (name of the intervention). The care-receiver then responded: "It's puzzling. It's almost never the same nurse who comes to visit me. I don't know why." The nurse remained silent and later left the care-receiver's room. The nurse said: "Good morning Madam. Then, she turned towards me and discussed the procedure. The nurse addressed me as if I was assessing her competency. Although I met with the home care staff to put the record straight about that issue of competence, it seems it was difficult for her to think otherwise.

Finally, while observing participants during home care visits, I noticed that some nurses relied on medical jargon to communicate with both caregivers and care-receivers. I do not know the extent to which caregivers could understand the nurses' explanations. I guess that some Haitian Canadian caregivers understood the biomedical discourse since some worked in the health care system. Punctual observations risk leading a researcher to superficial sharing of data but in my case, I could only find a few nurses to participate in the study. Tang and Anderson (1999) mention that "rather than suggesting that biomedical experts should be 'written out,' we propose to rewrite health care providers as 'reflexive practitioners' through the construction of transformative knowledge" (p. 83). I agree that results point to revisiting nursing practice for nurses to become more reflexive of the influence of culture and biomedicine in their everyday practice. I would also argue, given the data, that nursing practice is ruled by a powerful relation of ruling — the relation of economic liberalism, where downsizing services, massive lay-offs of nurses, hospital emergencies or unit closures are conducted for the sake of profit, cost containment, efficiency, time management, and budget or health expenditure control measures. I now shift the discussion to explore the impact of health care reform on Haitian Canadian caregivers' access to home care services.

Impact of the Health Care Reform on Home Care Services

Haitian Canadians represent one of the larger groups of new Canadian citizens. Torczyner and Springer (2001) reported that their demographic representation has been underestimated by 40 percent. This skewed representation, perhaps related to some extent, to illegal immigration, affects claims or demands for health and social services since it minimized Haitian Canadian demographic weight. Minimizing demographic weight contributes to silence Haitian Canadian caregivers' voices in expressing their needs for health and social services. In this section, the impact of health care reform is acutely felt at two particular levels for Haitian Canadian caregivers. The first issue pertains to the downsizing or cutting of CLSCs services that

were previously publicly funded. The second issue is related to some Haitian Canadian caregivers' economic limitations for accessing privatized home support services to support the caring commitment.

Downsizing Support Services to Caregivers

For instance, a woman caregiver talked about the fact that some CLSCs' services are not adapted to the reality of men and women caregivers' lives. Alexandra pointed out that some women would like to attend support group sessions for family caregivers but they cannot attend since these sessions are conducted during daytime. It was impossible for them to cancel a day of work to attend these sessions, however, Alexandra mentioned that these sessions were helpful for her. In the study, most of the women caregivers were helped and supported by members of their church. It seems that the need to support women who do not belong to a church are silenced. CLSC should consider women's needs for support and organize sessions while respecting women's working hours. Not all women want to rely on the church organizations and the CLSC is not present to offer an alternative. This lack of consideration for the need to develop support sessions for women caregivers who participate in the labour force is a means of Othering these women since support is restricted to some specific groups only.

Alexandra reported that most of the members attending the evening session were French or Italian Canadians. The fact that few Haitian Canadian women caregivers were attending the support sessions, illustrates the extent of their difficulty to rely on their family network to support their caring commitment. They simply cannot call somebody to come in and keep the aging mother or father while attending the support sessions. The other issue is related to the extent to which caregivers can take time off to attend sessions since most of the women and men caregivers were not able to leave the home, leaving the aging persons without supervision. These two issues not only apply to Haitian Canadian women caregivers but to all women caregivers, as well. The provincial government disengagement of the home care sector becomes even more

tangible with the enactment of the last health care reform. The so-called 'ambulatory shift' further pressured women and families into caring for recently discharged hospitalized family members at home. In this interview excerpt, Alexandra describes her need for support and mentions that services are not adapted to the reality of working-women:

> Participant: It's true that the CLSC mission is to protect aging people against adult children's abuse. Some elders are abused but at the same time the CLSC provide caregivers' with reasons to abuse them. For instance, the CLSC organizes support group sessions for primary caregivers like me. I attended 15 or 20 sessions but we were only 4 or 5 informal caregivers in the room for evening sessions. They also provide a weekly day session but I can't attend it since I work. They reach caregivers who don't work in the labour force. They cancelled the evening session because of the lack of attendees. But I can't attend the day session since I'm working. But it really helped me when I attended the evening session.
>
> Interviewer: If I understand your point, support resources for primary caregivers would be needed? Like this support group session?
>
> Participant: Yes. It helped me a lot when I could go there. But now who will help me?
>
> Interviewer: If evening sessions resume, would you attend them again? Would you return back there to attend evening meetings?
>
> Participant: Of course! Of course! I missed these sessions since it was a tool to help caregivers like me to work out problems and to carry on.
>
> Interviewer: According to you, it's a priority? [To support primary caregivers]
>
> Participant: Oh yes it is!
>
> Interviewer: Did you see lots of women caregivers at these evening sessions? Were they more women attending the sessions than men?
>
> Participant: Yes. More women were attending but I also saw some men, too. Few Haitian women were present though. [She did not say Canadian]. Very few Haitian women were attending these sessions. Caregiver 05-F

The woman also described the lack of financial resources to develop or maintain already existing programs. CLSCs, like any other health care facilities in the province, must have a balanced budget. Thus, financial choices must be made and they seem to be made at the expense of aging persons, and indirectly have an impact on primary caregivers.

Economic Impact of the Health Care Reform on Caregivers

The impact of health care reform cannot be glossed over when assessing the accessibility of home care services. Barbara describes how health care reform or the 'ambulatory shift' has increased pressure on families and women. State disengagement, in an area mostly represented by women, underpins the financial or economic issue of increasing the State treasury at the expense of women caregivers and aging persons. In a report published in 1999, the Quebec Women's Council[75] mentioned that maintaining an aging person at home is much cheaper by its exploitation of women's unpaid work of caring. The total cost of nursing and personal care to maintain an aging person at home, without the involvement of public health care service, is $5.60 per day. On the other hand, if the State is involved, the amount soars to $38.26, if caring was remunerated at the public state rate. It is reported in French:

> Le coût total des soins infirmiers et des soins personnels, de la surveillance, du transport et des fournitures est de $5.60 par jour quand les personnes ne reçoivent pas de services publics et sont maintenues à domicile grâce au travail gratuit. Il en coûterait $38.26 si ce travail bénévole était valorisé au coût du public. (p. 61)

Barbara pointed out that when you target aging persons, you indirectly cause an impact on primary caregivers:

> Participant: The point is, and we can't work that issue out today, that CLSC have to deal with the impact of the health care reform. The 'ambulatory shift' you know and we all have to bite the bullet. Ok? The government mandated CLSC to providing post-hospitalization care. They want to decrease hospitalization time, you know the 'early discharge,' in order to make room in hospitals. Well, then all of this falls within the CLSC mandate. They have the mandate but they don't have the budget, the staff, and the organizational structures to fulfill it. You could do many things on a piece of paper but to apply them in the reality, that's quite different! It's really nice but the picture of the everyday reality it far less beautiful. Written guidelines don't help a lot in the everyday reality.
>
> Interviewer: In other words, the health reform by implementing the 'ambulatory shift' had impacted on CLSC, and this impact has been transferred to families. Families have to deal with it [ambulatory shift] and basically absorb it.

[75] Le Conseil du Statut de la Femme du Québec.

Participant: Yes.

Interviewer: They seem to offer many services but in fact, in the reality, it is not offered. There's a gap between what is said and what is done. The written health policy doesn't correspond to the reality…to the lived experience of informal caregivers… So, then they [health care system] won't be inclined to develop programs to support [for primary caregivers]

Participant: Yes. This is my point. CLSC programs for the aged are either downsized or simply cut off. It indirectly impacts on caregivers. When they choose not to put money for the elderly, they affect family caregivers. And when it goes bad, then kids suffer too. It's an infernal circle; you can't break it. For instance, if I can't devote times to my kids, tell me what will be their future? And if I'm exhausted, who will help me? So it's all related, do you see? They cut programs for elders and it impact on caregivers like me, and it has consequences on the youth as well since their parents are exhausted. Do you understand?

Interviewer: If I understand your point, you mean that this health care reform impacts on caregivers' lives with regard to its hidden effects. Effects that are left under silence, not assessed, and not measured, in terms of the extent to which they impact on caregivers and their families. Is it what you mean?

Participant: Yes it is. Caregiver 05-F

In the same line of thought, James reported the impact of health care reform on aging persons. He mentioned that health care reform was conducted inappropriately, having impacts on primary caregivers and aging persons, and leaving them without services or with a smaller 'basket' of public services:

Participant: Moreover, the situation worsens since the health care reform, the 'ambulatory shift,' you know. Aging people health conditions are worst since the health care reform. It has been conducted blindly and intermediate levels are missing to provide services.

Interviewer: So, you think that the health care reform has deteriorated the health of the elderly?

Participant: Of course it has! In my opinion, the government wants to get rid of them, it looks as if the government don't want them. They say there's no profit in investing in old stock like the elders, let's put the money in services for the youth. I agree this is true to some extent but what will we do with the elderly? Caregiver 03-M

These program cutbacks have an impact on caregivers' everyday lives and also reveal negative stereotypes for aging people characterizing the host society. Ageism reflects the host society's lack of respect towards aging people and how aged people's contributions to build

Canada and Quebec were erased. Western society ageist values do not correspond to Haitian Canadian values towards elders since the hallmark of Haitian culture is to respect and recognize the elders' accomplishments in life and to see their wisdom in supporting younger generations. It can be argued that the voices of aging persons have been lost in the realms of the health care reform.

Summary

In this chapter, I have endeavoured to demonstrate how Haitian Canadian caregivers' perceptions of mainstream health care providers influence the utilization of home care services. Some health care practitioners' lack of respect towards 'racialized' aging persons is a factor that weighs heavily on decisions to keep older parents at home in the Haitian Canadian community. Avoidance can also be translated into fears of institutionalization that represents an abandonment of aged parents into the hands of 'strangers' who do not know about Haitian culture. Therefore, it illustrates a lack of cultural adaptation of services and a need to correct the situation of cultural risk, as was identified in the provision of home care services. It also points to educating mainstream health practitioners who work in multicultural environments.

It may be further assumed that racial and gendered discrimination influences Haitian caregivers' perceptions of health care practitioners coming from the dominant ethnic group. Moreover, health care reform has increased primary caregivers' workload by downsizing programs for elders to their minimal level. Since most of these home support services have been privatized, the accessibility to these services, based on their cost, is limited for low-income families. Also, women caregivers could not attend the few activities organized to support home caring because the activities were conducted during working hours. Services must be adapted to the needs of caregivers and not the other way around, as it appears to be in the case of daytime support sessions.

The issue may be raised about the extent to which these sessions are culturally meaningful for Haitian Canadian women caregivers, since few Haitian Canadian women caregivers were attending. Also, it may be argued that Haitian Canadian women and women of other ethnic groups, who are family caregivers, are too busy to attend these support sessions. It also underlines the impact of immigration on women caregivers' family support network. Women are isolated and cannot leave the home to attend support sessions at the CLSC. Some Haitian Canadian women caregivers attend church support sessions, but the fact that not all attend churches, must be accounted for in the public health care system. The voices of this group of women caregivers must be heard by the State. Additionally, the development of culturally adapted and safe home care services remains as a priority to be addressed to support Haitian Canadian caregivers' caring commitment. The lack of support services for primary caregivers, the non-adaptability of CLSCs services to fit with caregivers' everyday lives, and issues of cultural risk are among the major factors that have an impact on Haitian Canadian caregivers' relations with the health care system. In exploring the relations between Haitian Canadian caregivers and the health care system, the findings demonstrate that caring for aging relatives at home is a multilayered process, embedded in a complex nexus of power relations, intersecting with race, gender, ethnicity, social class, culture, and political and economic factors. In the final chapter, I make conclusions based on the study's findings and offer recommendations for nursing practice, education, research, and health policy development.

CHAPTER NINE
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The two research questions guiding this study were to understand Haitian Canadian caregivers' ways of caring for an aging relative at home and to explore the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services. A critical ethnography informed by a postcolonial feminist theoretical approach was used to guide data collection and analysis for this nursing cultural[76] study. In using a postcolonial feminist approach to study Haitian Canadian caregivers' ways of caring, my aim was to unmask health and social inequities that intersect with race, gender, ethnicity, and social class on non-Western peoples who suffered the hegemony of Western colonialism and its consequences in marginalizing their identities and subjugating their knowledge. Hence, postcolonial feminism is aimed at decentering the process of inquiry to redefine and replace culture and race in a transnational and translational contemporary context (Bhabha, 1994).

In this study, results describe how 'race', gender, and social class intersect with other factors like the social, cultural, economic and political context, to structure Haitian Canadian caregivers' ways of caring. These factors also have an impact on Haitian Canadian caregivers' everyday lives and therefore, influence caregivers' perceptions about the mainstream health care system. Among the major findings, I have argued that caring for an aging relative at home is a process of cultural continuity, and a process of reciprocity and mourning in becoming. Second, the consequences of immigration on Haitian Canadian caregivers' ways of caring cannot be left

[76] I prefer to refer to my study as a 'cultural nursing research' rather than a 'cross-cultural' nursing study. The aim of postcolonial feminism is to move beyond the limitations of culturalist theories in addressing health issues related to non-Western immigrants and refugees'. These health issues arise from social inequities in the host country's civil society and health care system. These social inequities could only have been uncovered by exploring Haitian Canadian caregivers' ways of caring for an aging relative from a postcolonial theoretical and methodological approach, where it becomes possible, as Stuart Hall (1994) points out, to contrast 'culture' and 'non-culture' while unmasking the interlocking system of race, gender, and social class oppression. In other words, postcolonial feminism enables the researcher to explore 'culture' from a broader viewpoint where historical and social conditions that model and shape cultural meanings and understandings, unveiling issues of power relations and oppression.

aside when examining caregivers' isolation from the family support network. Third, the impact of 'Othering', by which I refer to caregivers' past or actual experiences of perceived racism and gendered discrimination in the civil society[77] adds another layer of complexity to Haitian Canadian caregivers' everyday lives. Fourth, Haitian Canadian caregivers' perceptions of the lack of cultural adequacy of home care services, coupled with mainstream health practitioners lack of intercultural education, cannot be overlooked in understanding why Haitian Canadians tend not to rely on public home care programs. Finally, the impact of health care reform in restraining Haitian Canadian low-income caring families accessibility to home care support services was documented. Health care reform has also influenced women's everyday lives since the disengagement of the Welfare state in the area of home care, has pushed women and men caregivers (mostly women), to take on the State's responsibilities. At the same time, women caregivers attempt to reconcile paid work with caring for aging relatives at home, and parenting of young children and teenagers. These results share a common thread by restricting the accessibility to the already scarce public home care resources.

Previous studies, carried out by anthropologists and sociologists have shown that the underutilization of health care services among the Haitian Canadian community was previously known (Bibeau, 1987; Guberman & Maheu, 1997; Massé, 1983; Massé, 1995). According to these authors, barriers related to language, health practitioners' lack of intercultural education, institutional racism, lack of knowledge about the availability of home care support services, and Haitian Canadians' cultural beliefs related to health and illness, were among the main factors explaining the underutilization of health care services among the Haitian Canadian community in Quebec. Despite the richness of information provided by these earlier inquiries, little was known

[77] I refer to workplaces and schools as being different from federal, provincial, and territorial governing bodies that pertain to the federal, provincial or territorial levels of government.

in nursing, about how cultural communities were facing demographic aging and the care of aging persons at home, in the host country.

Thus, the important study of Guberman and Maheu (1997) in the Haitian Canadian community was used as a point of departure to extend the analysis of the context of caring. I wanted to explore if the interlocking oppressive nature of race, gender, and class could have an impact on Haitian Canadian caregivers' ways of caring and their perceptions on the health care system. This conceptualization of the research led me to opt for a postcolonial feminist theoretical approach inspired by Black feminist thought. Patricia Hill Collins (2002a) mentions, that as a White feminist, I can advocate Black feminist thought and its ultimate goal of promoting social justice and ending non-Western men's and women's oppression. In the same line of thought, Anderson (2002) points out:

> [Postcolonialism] provides a theoretical lens for unmasking the colonising processes that have shaped the construction of gendered and racialised identities, and for reframing the ways in which we think about identity and culture. More importantly, a post-colonial feminist perspective recognises the need for knowledge construction from the perspective of the marginalised female subject whose voice has been muted in the knowledge production process. (p. 10)

I concur with Anderson (2002) and Patricia Hill Collins (2002a) to assert that Western hegemony and colonization shape racialized groups' social experiences, though it must be underlined that postcolonial feminists speak from different racial, ethnic, cultural, social, political, and economic locations or positions. Still, a common theoretical objective among postcolonial feminist scholars consists of voicing the muted health and social needs of marginalized men and women, while acknowledging the disparity of scholars' speaking positions to avoid universalizing peoples' experiences. The totalizing discourse of cultural diversity has been pointed as the major weakness of culturalist theories when addressing non-Western men's and women's health issues. As many scholars suggest, the notion of cultural awareness or cultural sensitivity, glosses over the impact of the oppressive forces in shaping racialized groups'

everyday lives in Western pluralist countries (Anderson, 2000a; Anderson, 2000b; Culley, 1996; Dyck & Kearns, 1995; Papps & Ramsden, 1996; Polaschek, 1998).

I will not elaborate on these concepts but mention that my aim is to illustrate that postcolonial feminism opens up the space to build new cultural identities and understandings. Bhabha (1994) cogently mentions: "It is from those who have suffered the sentence of history, subjugation, domination, diaspora, displacement, that we learn our most enduring lessons for living and thinking" (p. 172). The most striking finding of this study was to see the impact of perceived racism, gendered discrimination, and social exclusion on ways of caring and utilization of health care system and home care programs, among Haitian Canadian caregivers. I now describe the features of this new knowledge that was uncovered in this research.

Caring: A Process of Cultural Continuity, of Reciprocity and Mourning in Becoming

When beginning the research, I expected to find results that would be similar to those describing caregiving activities, burden, and other negative outcomes. On the contrary, I observed and heard of different activities that encompassed caregiving since caring, for both Haitian Canadian men and women caregivers, is a process of personal growth, and reciprocal help and support (reciprocity) with their aging relatives. It is also a process of anticipating the loved ones losses and deaths since caregivers are saddened when witnessing their aging mother's or father's loss of memory. Caring husbands were also affected by their wives' physical or cognitive losses. In a study conducted among a group of Eastern Canadian women caregivers, Wuest (1998) found that caring is a process of personal growth based on reciprocity, love, and commitment. The results of this study are consistent with those from previous researchers who asserted that caring is a process of growth and self-actualization for both care-receivers and caregivers (Mayeroff, 1990; Watson, 1985; Watson, 1997; Wuest, 1998; Wuest, 2000).

When describing caring as a pattern of cultural continuity, I refer to the activities undertaken by caregivers to protect Haitian Canadian aging persons from institutional racism and cultural ethnocentrism while trying to re-implant Haiti's ways of caring in the host country. Therefore, keeping aging parents at home is a natural process of life as opposed to institutionalization which is seen as an abandonment of aging parents into the hands of strangers (e.g. mainstream health care providers) who do not know about the paramount Haitian cultural value of respecting aging persons. Also, it is important for primary caregivers to speak Creole and serve traditional meals to their parents since they know that it will not be the case in mainstream nursing homes. Aging people's proximity with grandchildren, other family members, and friends recreates the warm context of the Haitian home in Canada. Caring, therefore, cannot be defined from a reductionist viewpoint since it is a process that intersects with structural social factors to shape Haitian Canadian caregivers' ways of caring for an aging relative at home.

The motives underlying caring also cannot be isolated since they complement each other. I argue that caring is entangled in a network of interrelated motives to explain why a primary caregiver cares for aging parents at home. Motives of caring cannot be dissociated from the respect that Haitian Canadian adult children owe to their aging parents. Respect of aging persons is the core value that underpins caring as a process of cultural continuity and reciprocity. Haitian Canadian caregivers' social and cultural construction of aging, based on respecting Haitian Canadian elders' values, is the platform on which motives of caring are derived. In this study, the motives were identified as: 1) cultural values, 2) filial duty and recognition, 3) love and attachment, 4) protecting parents' or spouses' dignity, 5) fear of institutionalization, and 6) pressure of extended family. Moreover, the nature of caring activities ranges from providing hygienic care, fulfilling physical needs, 'being with' the person, giving instrumental or hands-on care, attending psychological needs, promoting socialization (driving to social activities), and enabling leisure activities (listening to the television or going to the restaurant). Caring also

means to supervise health care management, give medication, go to the doctor or the dentist's office, book appointments, drive the mother or the father to the medical clinic, and do the financial management.

The nature of caring activities and some motives are consistent with those obtained in previous studies among the French and Italian Canadian caregivers in Quebec (Guberman, Maheu & Maillé, 1993; Guberman & Maheu, 1997). Haitian Canadian caregivers, however, keep aging parents at home as a means to shield them against real or perceived racism and gender discrimination that can occur in mainstream society. This is the major difference between Haitian Canadian caregivers and French or Italian Canadian caregivers. Haitian Canadian caregivers' knowledge is based on past encounters with perceived racial or gendered discrimination in workplaces, schools or the civil society. Caregivers do not want to expose their aging parents to these oppressive forces since aging parents did not feel Othered in Haiti because the ideology of Whiteness played out at a different level in the homeland (e.g. a means of social stratification) than it was the case in Canada. In the host country, the degree of fairness of the skin does not provide lighter-skinned Haitian Canadians with greater social, economic, or political privileges. The hegemony of dominant ideologies in designing health care programs and services, must also be accounted for when examining Haitian Canadian caregivers' relations with the health care system (Anderson & Reimer Kirkham, 1998).

Some authors, in asserting that caring is based on work and love (Graham, 1983; Pepin, 1992; Reverby, 1987), gloss over the effect of culture on caring. It would be safer to argue that caring is a 'labour of love' that unfolds in a historical, cultural, and social context where the interpretation of caring as a labour takes varying forms. It can be tiring, especially for working-women, but never is it said that caring was a burden. Caring is a process of cultural continuity and mutual growth that is re-implemented in the host country, as a means to facilitate the aging of older parents in a Westernized society. In the homeland, children are used to living with

grandparents in the same house, since no safety net or State financial assistance is provided to support aging persons and caring activities. Children are precious since they represent parents' safety net for their older days. At the time of the interviews, daughters did not report feelings of being burdened, but worried about the future, and were worried about their aging parents' deterioration in terms of loss of independence. "What will happen if?" It was a leitmotiv. It is expected that, as the parents' level of functional ability decreases, the daughter's involvement in activities (i.e., doing for, assisting, providing, giving, or feeding) would likely increase. In other words, for caring daughters or daughters-in-law, an increased amount of instrumental or hands-on care would be needed.

Culture plays a major role in the social and cultural construction of caring and burden since no Haitian Canadian primary caregivers reported being burdened by the activities of care *per se*. As shown later, the larger social context within which caring activities unfold is more likely to induce this burden than is caring itself. I argue that culture represents a third component of caring because the phenomenon cannot be isolated from the larger social and cultural context. Haitian Canadian caregivers' experiences of caring are mediated by social forces that intersect with race, gender, ethnicity, and social class. Furthermore, the cultural component to which I refer is not crystallized, since ways of caring differ among ethnic groups depending on the impact of this broader social world and its structural forces.

Results show that the cultural component of caring is fluid and hybrid, and brings a redefinition of traditional family roles for adapting activities of caring to a new social context, with the demands for women to participate in the paid workforce in Canada. I define caring as being culturally constructed and mediated by social forces according to contexts as well as to caregivers' positions in the social world. For instance, Haitian Canadian women caregivers must renegotiate and re-pattern family dynamics in the host society to implicate their husbands or spouses in sharing domestic tasks. Renegotiation of family dynamics sometimes generates

clashes between spouses but nevertheless constitutes the basis upon which Haitian Canadian women caregivers can alleviate the triple-task of working outside, parenting children, and caring for aging parents at home. I do not aim to apply Wuest's theory of 'precarious ordering and repatterning' to Haitian Canadian women caregivers, however, I contend that the repatterning of family dynamics associated with immigration represents a strategy used by Haitian Canadian women to balance the competing demands of caring with those of the social world. Wuest (2000) defines the process of repatterning as a strategy aimed at "reorganizing caring activities, to reduce or overcome the negative effects of caring demands" (p. 393).

The economic and social context of caring for aging parents at home is also different in the host country because domestic aid is not as easily available as it was in Haiti. In the homeland, members of extended families or friends were accountable for providing domestic aid while in Canada, most of these services are privatized and are not affordable by low-income families. This availability of domestic aid is another reason why Haitian Canadian men were not involved in the sharing of domestic tasks, but the new social, cultural, and economic context of the Canadian society, coupled to women's requirements to enter the workforce, push Haitian Canadian men to reassess their roles in the family. This study also deconstructs the myth of extended family support since most of the caregivers were cut off from this source of immediate support during their immigration process. Most of the caregivers were relying on their churches' support, but social isolation becomes an issue for caregivers who do not use churches or community resources to support their commitment to look after aging parents at home. This points to highlighting the consequences of immigration on Haitian Canadian caregivers' ways of caring.

Consequences of Immigration on Haitian Canadian Caregivers' Ways of Caring

How can this isolation be explained and how does it pertain to immigration? For a majority of women participants, who were mainly middle-aged women dealing with the triple-task issue, the consequences of immigration on ways of caring was observed at two levels: the lack of family support, and the impoverishment of women's natural support network. Women caregivers thus were left almost alone to account for caring responsibilities, while still carrying on other duties related to the public sphere (i.e., working outside the home). The second issue, while associated to the first, may explain the salient need, expressed by many Haitian Canadian women and men caregivers, to receive public respite services to help them sustain caring activities at home. Perceptions of isolation translated into expressions like *being a prisoner, being alone, crumbling under the task, wanting to die if not helped.* Despite the involvement of Haitian churches and community organizations to support Haitian Canadian caregivers' caring commitment, respite services emerged as the most important service that was requested by Haitian Canadian caregivers from CLSCs home care services.

The findings also showed that women caring activities are almost continuous, and leave little space for women to look after themselves; thus increasing women's social isolation. Men caring for spouses also share these feelings of social isolation, but not to the same extent as reported by middle-aged working women, who must assume the triple-task of participating full-time in the labour force, looking after children, and caring for aging parents at home.

The gendering of caring activities has been 'the' major factor for some political decisions being made in relation to health care reform that were taken at women's expenses. The division of the private and the public sphere has an impact on both women of the North's and of the South's everyday lives (Climo, 2000; Doyal, 1995), however, the public/private dichotomy must be examined in different historical, social, cultural, and economic contexts to acknowledge

the diversity of women's experiences. Immigration influences ways of caring since it explains how social isolation intersects with health care reform and the process of social Othering, to increase the isolation of men, and especially of women caregivers who cannot benefit from the support of kin or members of extended families left behind in Haiti. Additionally, the influence of past or current encounters with racism and gender discrimination in school or the workplace adds a layer of complexity to the phenomenon of caring for an aging relative in the Haitian Canadian community. Haitian Canadian caregivers' experiences of Othering influence caregivers' perceptions of mainstream society, and indirectly have an impact on how they relate with the health care system and health care practitioners. It illustrates the hardships of caring for aging relatives in, as Anderson and Reimer Kirkham (1998) put it, a "racialized and gendered" world.

Impact of Othering on Haitian Canadian Caregivers' Ways of Caring

The impact of race, gender, and social class on Haitian Canadian caregivers was uncovered when exploring caregivers' ways of caring for aging relatives at home. Race, gender, and social class intersect with other relations of ruling (Smith, 1987), like the ideologies of Whiteness (Frankenberg, 1993), Canadianess (Lee & Cardinal, 1998), and Quebecness (Maclure, 2003), derived from Canada's colonial past and supported by an ambiguous political model of multiculturalism (Bannerji, 2000; Li, 1999) to model Haitian Canadians' caring activities. These hidden relations of ruling not only contribute to erase Haitian Canadian caregivers' voices, but also maintain the invisibility of unpaid caring work.

While I am cautious not to universalize women's experiences of caring, I can safely argue that women of the South and of the North often must care for children or aging parents. Nevertheless, the racial, gendered, cultural, historical, social, economic, and political contexts in which caring activities unfold cannot be compared or universalized. Universalizing women's

experiences would be highly discriminative for non-Western women who face issues of racial, ethnic, and gendered injustices since Western women are trapped in a process of 'Whiteness defensiveness' (Roman, 1993) that blinds them to perceive and counteract racism in Canada as well as in other former White settlers' colonies. White feminists must acknowledge that 'white' is not a neutral colour since it underpins the ideology of Whiteness and the process of Othering. Minh-ha (1990) cogently points out "hegemony works at leveling out differences and at standardizing contexts and expectations in the smallest details of our daily lives" (p. 372). Thus, the constraining effects of racism, cultural ethnocentrism, gendered, and class discrimination are not visible. Caring appears as a natural social phenomenon but in acknowledging that caring is socially and culturally constructed, it also varies with political, geographical, and economic contexts of the countries. The fact was also shown in this study that some Haitian Canadian caregivers struggle with issues of racial discrimination and sexual harassment at their workplaces. Therefore, these contextual factors must be accounted for, to understand ways of caring, caregivers' relations with mainstream health care practitioners, and the underutilization of home care services. Hence, it is of paramount importance for health practitioners and nurses to move beyond the superficial level of cultural awareness or sensitivity, in providing culturally safe nursing home care interventions to non-Western populations. In other words, nurses must strive to understand caring from the standpoint of Haitian Canadian caregivers and develop a personal and social consciousness about the impact of race, racialization, gender, and social class in structuring Haitian Canadian caregivers' ways of caring, and, indirectly, the caregivers' utilization of home care services. Racial and gendered discrimination also affects caregivers' health and well-being. The harmful effects of racial and gendered inequities constitute an important issue for nurses and other health care practitioners to acknowledge, if culturally safe interventions are to be developed in CLSCs (community health centres).

Haitian Canadian Caregivers' Perceptions of the Lack of Cultural Adequacy of Home Care Services

Haitian Canadian caregivers, in both receiving and not receiving home care services, report perceptions about the lack of cultural adequacy in these services. Lack of cultural adequacy is a contextual factor that precludes Haitian Canadian caregivers from relying on public home care services to support their caring commitment. It can be assumed that the more often Haitian Canadian caregivers perceive or encounter racism and gender discrimination at the workplace or at school, the less likely they are to rely on mainstream home care services. This may also partially explain why Haitian Canadian caregivers tend to delay institutionalization in mainstream nursing homes. Haitian cultural beliefs related to aging and the respect of aging parents also must not be downplayed when analyzing caregivers' choice not to institutionalize aging parents. Results show that caregivers' everyday lives are enmeshed in a constellation of cultural, social, political, and economic factors that structure the ways of caring and utilization of health care services.

The interactions between Haitian Canadian caregiver's and mainstream society, in the course of daily activities, must also not be underestimated when it comes to understanding ways of caring and decisions made to rely or not rely on public home care services. In assuming that Othering also occurs within the health care system, it likely influences Haitian Canadian caregivers' perceptions of the mainstream health care programs and health care practitioners, to explain the underutilization of services among participants of this study. Anderson and Reimer Kirkham (1998) noticed, in the Report of the BC Royal Commission on Health Care and Costs (1991) that "many people of minority ethnic background are not using existing services because those services are not culturally responsive or accessible to them" (p. 251).

In this study, Haitian Canadian caregivers connected the lack of cultural adequacy with the lack of Creole interpreters in CLSCs, lack of visiting nurses' intercultural education, and lack

of services provided in Creole for their aging parents. These factors preclude Haitian Canadian caregivers from sending their aging parents to CLSC social activities. The lack, and more often, the non-existence of services for fulfilling the needs of a large Creolophone population illustrates how the lack of cultural adequacy has an impact on the utilization of health care services. It can be argued that the lack of cultural adequacy not only limits Haitian Canadian caregivers' and care–receivers from accessing public home care services, but also constrains the utilization of health care services, by other people coming from 'racialized' ethnocultural groups.

Caregivers also witnessed situations where Haitian Canadian elders or other non-Western aging people were not treated as equals in some mainstream health care facilities. Racialized aging persons are seen as 'second-order' citizens, which considerably undermines the notion of equality of rights for all Canadians. Processes of social, cultural, economic, and political Othering also come into play to categorize non-Western men and women as 'subalterns.' Social exclusion and violations of equality contribute to create a culturally unsafe context of care where issues of institutional racism pervade the provision of care in the Canadian health care system. The violation of equality can be seen as an instance of institutional racism that demonstrates the failure of the Multiculturalism Act in implementing the equality of rights in the nation's social institutions (Anderson & Reimer Kirkham, 1998; Li, 1999; Roberts & Clayton, 1990). This brings me to discuss the impact of health care reform on Haitian Canadian caregivers' utilization of home care services.

Impact of Health Care Reform on Haitian Canadian Caregivers' Utilization of Public Home Care Services

Anderson (1986) emphasizes the need to understand "how human experiences are located within a social context, the central issue is the ways in which dominant ideas are perpetrated by those who plan, organize, and administer health care services" (p. 1281). Results show that health care reform represents an ideological discourse inspired by neoliberal economic values

that is aimed at encouraging the State disengagement from the private (domestic) sphere. In shifting care responsibilities to families and individuals, health care reform negates the social and collective responsibility of promoting and enhancing the determinants of health.

In Quebec, the major impact of health care reform was to restructure the configuration of home care services delivery. New mandates were devoted to the CLSCs and among these was the challenge of providing home care services to recently hospitalized clients. This has created impacts on elders' home support programs since reform was conducted without allocating the money or the organizational structures to reconfigure programs and services. Health care reform was a means to an end, and consisted of downsizing home support services as the way to open the doors to privatization of home services like housecleaning and respite. Services that were previously offered without charge by CLSCs are now offered by private agencies, which clearly impacted on the access by low-income caring families to these services. Caring becomes a financial issue where wealthy families can afford to pay for private home care services, but the economic impact of health care reform has increased for low-income families.

Health care policies, in using an economic discourse of cost-effectiveness, have shifted caring responsibilities to women and families. The hidden goal of the reform rhetoric was to reduce institutionalized services due to economic constraints (Anderson, 1990; Wuest, 1993). Anderson, Blue and Lau (1991) point out that "illness management is often reduced to individual capabilities, divorcing the personal from the complex sociopolitical, cultural and economic context" (p. 102). This shifting to a greater community involvement was not preceded by the implementation of social, physical, and economic structures that would have supported families' endeavours (Anderson, 1990; Wuest, 1993).

Some feminist authors contend that viewing caring as women's natural work explains the lack of supportive structures in the health care system and in society (Bunting, 1992; Covan, 1997; Hooyman & Gonya, 1995; Wuest, 1993). Wuest (1993) argues that Western women are

socialized to fulfill caring roles within the traditional family structure, and the current societal expectations and social policy reinforce this value system, tending to lend credibility to that claim. Wuest (1993) contends that the ideology of 'familism[78]' upon which health care reform is based, has contributed to reinforce women's dependency and poverty. On the other hand, Doyal (1995) emphasizes the cross-cultural gender effect of domestic work among non-Western women.

The impact of caring for the sick and elders on women's health is important since more than 85 percent of care to aging Canadians is given by family members, especially women at midlife, mostly aged 35 to 55, who provide unpaid care to aging relatives (Chapell, Strain & Blandford, as cited in Wuest, 1993; Health Canada, 1998). Nevertheless, the cost of this invisible work and its consequences are judged as being individual failures, which have little impact on the formal health care system. Health policies seem to replicate power and gender inequalities, as well, to legitimate the invisible work of women as caregivers (Anderson, 1990; Conseil du Statut de la Femme du Québec, 2000; Wuest, 1993) where the voices of women and the elderly tend to be marginalized, if not silenced. In the midst of health care reform, both aging persons and primary caregivers seem to be considered as subalterns or second-order citizens. The fact, that most aging persons and caregivers are women is particularly disturbing since it implies that women must shoulder the health care reform and its family, social, cultural, and economic consequences.

Impact of Health Care Reform on Haitian Canadian Women Caregivers

Lewis (2000) contends that the very notion of subjective experience has to be broadened to account for the meanings attached to race, gender, and social classes occurring in various

[78] Wuest (1993) mentions that familism is an ideology that "fosters relationships of domination and subordination, patterns of domestic labor, altruistic caregiving of children and the elderly, and patterns of dependency, all of which serve women poorly" (p. 408).

historical moments. In other words, Haitian Canadian caregivers are constituted through experiences of oppression, gendering, and racializing, which characterize the multiplicities of 'locations' or 'positions' from which caregivers speak, creating multiple subjectivities and positionalities (Anderson, 2000b; Lewis, 2000; McRobbie, 1997; Racine, 2003). Since caring activities are mostly performed by women and for women, I argue that Haitian Canadian women caregivers are particularly affected, like other Canadian women, by health care reform.

How can I support this argument in this study? Data point to the fact that in adopting the ideology of liberalism, health care reform has an impact on the development of culturally adapted home nursing services while downsizing home support programs to save money. Moreover, health care reform, in encouraging privatization of home support services increases the hardships of low-income caring families in accessing these services. Most of the caregivers met in the study could not afford to pay for private agencies services, establishing an economic barrier that cannot be easily by-passed since the CLSCs have dramatically cut elderly home care programs to re-invest in post-hospitalized clienteles.

Therefore, caring for aging relatives at home intersects with gender, race, and social classes, and income, to structure Haitian Canadian caregivers' ways of caring as well as everyday life experiences. This exploration of Haitian Canadian ways of caring and the relationships between caregivers' and the health care services is clearly influenced by caregivers' *positionalities* or *locations*, notions referred to by what Lewis (2000) describes as the *positionality of experiences*. Applying Lewis's notion of positionality of experiences to this study moves the analysis of caregivers' ways of caring beyond the limitations of subjectivity, to acknowledge the multifaceted and complex differences of locations, in modeling Haitian Canadian men and women caregivers' lives and their ways of caring.

Health care reform is rooted in dominant societal ideologies, as pointed out by Anderson (1986) in a study on the caretaking experiences of Anglo-Canadians and immigrant Chinese

families. Anderson (1986) mentions, "dominant ideas are perpetrated by those who plan, organize, and administer health care services" (p. 1281). In this study, a power imbalance related to race, gender, and social class was clearly identified. The struggle of Haitian Canadian women to attend CLSCs' support sessions for caregivers is an example. In fact, women cannot attend these sessions because of their participation in the paid workforce. As well, the non-respect for women's working hours in planning the time to hold these caregivers' support sessions violates the notion of equality and cultural adequacy of services. Other instances such as the non-respect of the caregiver's or families' opinions in assessing aging persons' needs, and the imposition of nurses' Western biomedical model as being experts of care when visiting families, also represent issues of power differentials documented in this research. The persistence of social inequities illustrates how some groups (e.g. racialized groups) are unequal, despite the claim for universal equality in accessing health care services.

Conclusions

Through this research, I have come to conclude that caring cannot be studied outside of the social, cultural, political, and economic context within which it unfolds. As well, I learned that caring cannot be defined straightforwardly since it is far from being a linear process. Instead, I see caring as a complex process that is socially and culturally constructed in particular historical, social, cultural, political, and economic contexts, that intersect with race, gender, and social class to mediate Haitian Canadian caregivers' ways of caring. The impact of health care reform on the provision of home care support services and its consequence, in terms of transferring the responsibilities of caring for the elderly to women, while downsizing public services and privatizing home support resources, can no longer be silenced. Privatization of home care support services, coupled to the curtailing of these services in the public sector, directly affects accessibility to home support services for low-income families.

Subaltern knowledge is the basis upon which culturally safe nursing interventions and social changes can be brought about, since it integrates marginalized knowledge in nursing theorization to bridge the gap between research and clinical practice. For this reason, this study must be translated, as Antonio Gramsci pointed out, into a science of praxis (Crehan, 2002; Hoare & Nowell Smith, 1999; Lather, 1991), to bring about social changes in the health care system and nursing professional practice. In other words, this research must be used as a vehicle of social activism to promote social justice in the health care system and this social justice will be translated in delineating interventions aimed at enhancing the accessibility of culturally adapted home care services for Haitian Canadian caregivers looking after aging relatives at home. Based on the interpretation of data, I put forward the following conclusions:

1: Caring for aging relatives in a racialized and gendered world distinguishes Haitian Canadian caregivers' experiences of caring from White Canadian caregivers' experiences. I contend that Haitian Canadian caregivers' ways of caring translate a constant struggle to counteract the process of Othering and a process of cultural continuity to alleviate Haitian Canadian elders shock of late immigration in a Western and ageist society.

2: The process of Othering permeates each level of the caring commitment and has an impact on Haitian Canadian caregivers' decisions pertaining to the utilization of home care services. Therefore, I argue that Haitian Canadian caregivers' experience of caring are embedded in a constellation of social, political, cultural, and economic factors that constantly interact with mainstream society values and beliefs.

3: Caring for aging relatives at home is a means for caregivers to protect aging parents from individual and institutional racism. I assume that the more likely Haitian Canadian caregivers are to encounter perceived racism in school, work, or the civil society, the less likely are they to rely on public home care services. Caregivers do not want to expose aging relatives to racial discrimination; therefore, keeping them at home shields them from institutional racism.

4: Cultural beliefs related to respect of elders and past experience in a country where State resources were unavailable to support caring activities have impacts on Haitian-born caregivers' ways of caring in the host country. I contend that Haitian-born caregivers will try, as much as possible, to adhere to cultural beliefs related to aging and caring while at the same time negotiating these values to adapt to the new social context of caring, developing – what I would refer to as 'in-between' ways of caring that stem from a hybrid culture.

5: I argue that Haitian Canadian caregivers' past experiences of perceived racism and sexism influence the decision-making process for using or not using public home care resources and caregivers' decisions pertaining to the delay of aging parents' institutionalization. I assume that experiences of racial, social, cultural, political, and economic Othering have impacts on the Haitian Canadian caregivers' ways of caring by utterly undermining caregivers' trust in mainstream society. These experiences of Othering are the premises upon which distrust develops towards the civil society and can be extended to the health care system and to health practitioners.

6: I assume that the undermined trusting relations between Haitian Canadian primary caregivers and mainstream's society health care system and health practitioners can partly explain Haitian Canadians' tendency to underutilize health care resources, home care services, and to manage caring activities by themselves.

7: I hypothesize that the underutilization of home care services by Haitian Canadians is related to their perceptions of a 'raced' health care system.

8: Lack of intercultural education contributes to maintaining negative stereotypes of Haitian Canadian men and women in the health care system.

9: The impact of health care reform is acutely felt by Canadian caregivers but especially by low-income families. I argue that the privatization of home care support services like housecleaning and respite services has an impact on Haitian Canadian caregivers. A need exists for receiving housekeeping and respite services, but on a free basis, to ensure fair access to home care services for all Canadians.

10: The impact of health care reform has hit women and it can be seen that Haitian Canadian women caregivers are affected like other Canadian women caregivers. Nevertheless, I contend that Haitian Canadian women caregivers can be affected by the restraining measures promulgated by health care reform since their caring experience is closely associated with the context of immigration. For many caregivers, the support of the extended family is no longer available in Canada since many of their family members and friends were left behind in Haiti. This context of social isolation coupled with the financial constrains in accessing home support services jeopardize Haitian Canadian women caregivers' health. The upshot is to limit accessibility to home support programs and services while increasing Haitian Canadian working women's workload. If women cannot access respite services, I argue that Haitian Canadian women caregivers' health and social well-being is jeopardized since some also encounter racism and sexual harassment at the workplace.

Recommendations

Lather (1991) points out that "research approaches inherently reflect our beliefs about the world we live in and want to live in" (p. 51). I locate this inquiry in Gramsci's philosophy of praxis where nursing research must be directed at promoting social justice in integrating marginalized knowledge in our theorization and thereby adjusting our professional practice. Thus, this research brings insights to provide culturally adapted home care services to Haitian Canadian caregivers and care-receivers. The findings also suggest designing strategies to foster social justice and equality in the health care system. Therefore, this study directs me to articulate recommendations while bearing in mind two major concerns. The first concern is to find means to address issues of neocolonialism in the health care system. The second concern relates to institutional racism and calls for the development of anti-racist strategies in the discipline of nursing that can be implemented in our everyday practice. Far from suggesting that I have the answers to these questions, this study leads me to put forward the following recommendations to enhance Haitian Canadian caregivers' and care-receivers' accessibility to home care services and

to foster the cultural adaptation of public home care services to Haitian Canadian caregivers' and care-receivers' health needs. In the second part, the implications for nursing research, practice, education, and public policy are delineated

Enhancing Haitian Canadian Caregivers' and Care-Receivers' Accessibility to Public Home Care Services

This study highlighted the need to redirect public health care resources to support family or primary Haitian Canadian caregivers' caring commitment. Chapter Five demonstrated that caring is still a woman's domain despite the greater involvement of men in caring for a spouse or an aging parent at home. Results also illustrate the impact that working full-time in the labour force has on women caregivers' everyday lives, uncovering the difficulties for middle-aged women caregivers, reconciling private and public sphere without sacrificing health, children, aging parents, marital or familial life, employment, salary, leisure activities, and joy of living. I articulate recommendations for enhancing Haitian Canadian caregivers' and care-receivers' accessibility to public home care services around five axes: 1) developing support services for caregivers; 2) adopting fiscal measures to alleviate caregivers' financial burden; 3) sensitizing women's advocacy groups to the reality faced by Haitian Canadian women caregivers who look after aging relatives in a racialized and gendered society; 4) revising money and staff allocations to CLSCs home care programs; and 5) supporting the Haitian Canadian community in developing alternative services for aging persons.

Developing Support Services for Haitian Canadian Caregivers

First, the situation of working-women who face the triple task of caring for the children, looking after aging parents, and working full-time in the labour force must not be overlooked or underestimated. In addition, issues of racial discrimination and sexual harassment affecting some Haitian Canadian women at the workplace must be considered when assessing risks of developing health problems or creating situations where elders' abuse may occur. This specific

context of caring must be accounted for when meeting Haitian Canadian women caregivers, though public health care system seems to leave them aside when it comes to supporting them. Primary caregivers' health and social well-being needs appear to be obfuscated because primary caregivers are not seen as the State's priorities. Rather, primary caregivers are seen as a means to an end, which is to keep the health care system afloat without investing public funds.

In Chapter Seven, the consequences of immigration on caregivers' support network were delineated. The myth of extended family members' support was deconstructed since the results show the social isolation of some women and men caregivers. Caregivers' isolation and lack of familial and social support can lead to extreme levels of emotional distress. Caregivers are also at risk to develop health problems and at a greater risk to encounter elders' abuse, especially in the context of an adult child or a spouse's deteriorated illness. Alexandra, a woman caregiver, pointed out that lack of support for caregivers might increase the risk of elders' abuse since caregivers can become emotionally and physically drained. Martha and other caregivers requested public respite services to continue carrying out caring activities while working outside. Wuest (1993) documented how caring has an impact on women's employment and earnings, while affecting the emotional and physical cost on women. She states: "A major consequence of a social policy that supports caregiving in the family is the increased demand on women and the isolation of women and those for whom they care in their homes" (Wuest, 1993, p. 413).

As George emphasized, respite services have been curtailed to achieve health reform. This research, however, illustrates the acute need to obtain such services, as identified among Haitian Canadian caregivers. Home care programs and services must be designed to serve the population and not to serve the State's bureaucratic institutions for which the reality of caring is very distant. Consequently, they must be adapted to the needs of primary caregivers' and care-receivers'.

Results of the study call to recommend two strategies to help caregivers deal with issues of social isolation and needs for respite (issues closely linked to each other). The first recommendation consists of developing programs to enhance middle-aged women caregivers support network. Women must be able to find accessible and affordable support resources for caregivers in the public health care system. The notion of accessibility must be understood from the perspective of working women who cannot attend daytime sessions but would be willing to take part in evening sessions, if such sessions were available. Barbara reported that she appreciated the support sessions, but because of the poor attendance, CLSC authorities decided to cancel the evening sessions. One can understand the notion of cost containment but a question remains unanswered. Did the authorities really take into account women's needs when dropping the evening sessions? Whose interests were served by this administrative decision? Whose health care system? The drawback is to constrain working-women's access to support sessions that could be helpful for them. This also limits the availability of support to a restricted segment of the population. Developing support services for caregivers would be particularly useful for CLSCs located in multicultural neighbourhoods to help other groups of immigrant women who may face similar issues as those encountered by Haitian Canadian women caregivers. The second recommendation is to revise programs of respite to free some funds to be re-invested in that sector. Demands for respite is high among Haitian Canadian caregivers since some of them care for more than one aged person and must reconcile work and family issues. Investing in respite services is less expensive than institutionalization, while knowing that Haitian Canadians prefer to keep aging parents at home. It is also an issue of social justice since the State must offer alternatives to caregivers who cannot afford private respite services. Finally, the extent to which these services are to be adapted for the cultural needs of the Haitian Canadian community is addressed in the next section where recommendations are presented to foster the cultural adequacy of home care services. I now discuss what fiscal strategies could be developed to

alleviate caregivers' financial burden and to correct the complex issue of economic inequity in accessing home care services.

Adopting Fiscal Measures

The State disengagement from the sector of home care has opened the doors to the privatization of these home aid services. On the other hand, privatization has increased the financial burden of families for obtaining home support services such as housekeeping and respite services. In Chapter Eight, the compelling story is told of Matthew, who cares for his spouse. This caregiver addressed the issue of financial inaccessibility to services for middle- and low-income families. The accessibility to home care services is undermined and a two-tiered health care system is installed to facilitate caring activities of the privileged social classes while jeopardizing the capabilities of low-income families to financially support caring activities at home.

Enhancing access to home care services also consists of developing fiscal measures to alleviate the cost of caring among low-income families. It can be argued that the State disengagement from the area of family caregiving, so that responsibilities of caring for aging persons were transferred to the 'community,' but indirectly to women, was performed for the sake of preserving the State financial resources.

If services cannot be offered by the public health care system, then other strategies must be explored to alleviate the economic cost of caring. One of these avenues could be to provide publicly funded alternatives to privatized home care support services like housekeeping, cleaning, and respite services for low-income families. Even though I am not an expert in finance, I suggest developing fiscal tools to help low-income caring families. I recommend implementing measures to provide low-income families with federal and provincial tax credits. Families could use income tax credits to 'buy' private services that would facilitate activities of caring by broadening the accessibility to privatized services. Without adopting economic or

fiscal measures, privatized home care services are not affordable by middle- and low-income caring families. Tax credits could also be used to alleviate the cost of materials like pads, disinfectants, and other medical supplies. Nevertheless, fiscal measures cannot be implemented without the political willingness of the federal and provincial governments. Moreover, this recommendation cannot be achieved without implicating women's groups to advocate for women in showing the financial impact of unpaid caring activities among low-income families and the challenge for racialized women caregivers to look after aging relatives at home.

Sensitizing Women's Advocacy Groups

I recommend that coalitions be created with women's advocacy groups to lobby the social and political elite in understanding the reality of adopting financial measures to alleviate the cost of caring on women and low-income families. In Quebec, women, nurses, and groups must direct efforts to sensitize the Quebec's Council of Women on the Haitian Canadian women's caring experiences. This also applies to other immigrant women as well as to low-income Canadian families who must face the financial impact of caring. The Quebec's Council of Women can develop strategies of political lobbying to advocate for Haitian Canadians and other immigrant women caregivers. The Council can lobby Quebec's political leaders and elite and influence their decisions. Other organizations, like Quebec's Council for Aging Persons, Quebec's Order of Nurses, and Quebec's unions such as the FIIQ (Quebec's Nurses Union), and other smaller advocating groups can also be involved in the lobbying process. Social and financial measures would thus be aimed at replacing caring for aging relatives or frail spouses at home in the larger socioeconomic context within which caring activities unfold. These measures also help to sensitize the private society (the 'ordinary' citizens) to the reality of caregivers' experiences. Public opinion often influences governmental decisions. The influence of grass roots organizations also must not be underestimated in the process of gaining financial equality for low-income caring families and developing public services to support immigrant women

caregivers. Another measure is to revise the CLSCs' home program budget and staffing to adapt services for demographic aging and cultural diversity.

Revising CLSCs' Home Care Programs

I also suggest revising the staffing and funding of the CLSCs home care programs that were affected by health care reform, the aim being to have the organizational, financial, and staffing structures to help CLSCs achieve their mandate to serve both post-hospitalized clients and aging persons, without curtailing or downsizing the services to the latter group. A standardization of home aid services in the province is also proposed. Actually, each CLSC decides and advertises which home aid services are to be allocated or not allocated. This has led some caregivers to think that they are being discriminated against when, in fact, the requested program or service is simply not offered by the CLSC. The standardization of a 'basket' of public-funded home care services must be realized along with respecting the demography and cultural diversity of the populations where the CLSCs provide health care services.

Supporting the Haitian Canadian Community in Developing Alternative Home Services

For Quebec's provincial government and policy-makers, a priority would be to help the Haitian Canadian community in developing alternative home care support resource like as meals-on-wheels, volunteering, respite services, and creation of Haitian Canadian nursing homes. Older ethnocultural communities, like the Jewish and the Italian Canadian communities, have succeeded in supplying their members with services that are either privatized or not offered by the public health system. The Haitian Canadian community, with its demographic weight, must be acknowledged by the political elite and supported in its endeavour to develop the same services for its population in the greater Montreal and Laval areas. To this end, the provincial government can consult Haitian Canadian religious and community leaders to determine the Haitian Canadian community needs. The lack of political representation of the Haitian Canadian

community, in terms of members of the National Assembly (MLAs), has to be compensated for by men and women who have been elected to serve all Quebecers, regardless of race, ethnicity, gender, and political affiliation. I now turn to describe the second recommendation of the study that consists of fostering the development of culturally adequate home care services for the Haitian Canadian community.

Fostering the Cultural Adequacy of Public Home Care Services

In Chapters Six and Eight, issues of neocolonialism in the health care system were documented. The lack of cultural adequacy of home care services to Haitian Canadian caregivers,' which may be safely extended to other non-Western immigrants' needs, represents an instance of neocolonialism. It illustrates the ideological hegemony of the two 'founding people' in determining health priorities. I argue that the social and economic agenda of the elite is also reflected in the health care system, which constitutes, as Anderson and Reimer Kirkham (1998) put it, a microcosm of the larger society. Based on the findings, I contend that French Canadians/Quebecers determine priorities that must be addressed by Quebec's health care system. This lends support to Anderson and Reimer Kirkham's (1998) assertion that English Canadians influence the health and social agenda of other provinces' health care systems. This dualistic reality perpetuates the domination of the two founding people while silencing the voices of Aboriginals and non-Western immigrants and refugees in shaping health programs and policies. How can we correct social inequities related to neocolonialism in the health care system? I contend that interventions aimed at developing culturally adequate home care is a means to correct social inequities in the health care system. It is a way to voice marginalized knowledge, to hear the voices of the subjugated or marginalized groups that have been silenced. Nevertheless, cultural adequacy can only be achieved if mainstream nurses, other health practitioners, managers, and administrators acknowledge and respect clients' cultural differences.

In other words, this study calls to develop culturally safe home care programs and nursing interventions. Where shall we begin?

I suggest to increase visiting nurses' and other health professionals' intercultural education, develop CLSCs' home care services to serve Creolophone-speaking Haitian Canadian elders, augment the number of Creolophone interpreters and staff members in CLSCs located in neighbourhoods where the Haitian Canadian community is highly represented, and designing culturally adequate strategies of health education as a means to respect Haitian Canadians' ways of learning and knowing. Finally, I propose to revisit nursing practice in CLSCs as a means for community nurses to experience the process of cultural alterity to develop culturally safe nursing interventions. Nurses thus have to step out of the colonial boots of the biomedical model to better understand the needs of Haitian Canadian caregivers' and care-receivers.

Increasing Visiting Nurses' and Health Practitioners' Intercultural Education

My first recommendation is to increase nurses' and other health care providers' level of intercultural education. In Chapter Eight, participant observation and interview excerpts demonstrated that nurses must deal with the consequences of health care reform such as cost effectiveness, time management, and staff shortages in their everyday practice. Thus, nurses can be considered as 'subalterns' in the health care system. Nurses can be seen as an oppressed group despite being members of the dominant ethnic group. In their article, Anderson et al. (2003) describe this shifting notion of oppression when they refer to historical and social positions. Knowing that sources of oppression are multiple and play out simultaneously in the social world precludes me from isolating one oppressive force from another, however, I contend that nurses are positioned as being both the oppressor (due to the ideology of Whiteness) and the oppressed (subalterns of physicians and bureaucrats), putting them in a situation to develop a consciousness of the effects of racial, gendered, and class discrimination. Some will contend that issues of

"White defensiveness" (Roman, 1993) can intervene to blur the raising of this consciousness. I argue that potentialities to bring about social change is present in our discipline, if nurses want to see the effects of racism and racialization on people's health and well-being.

During fieldwork, I witnessed that these issues seemed to be obfuscated or not considered as educational priorities. I noticed that many continuing education sessions were directed at increasing nurses' knowledge on wound care or diabetes (e.g., on biomedical problems). Furthermore, no intercultural formation was provided prior to hiring. This lack of attention to the cultural issues related to nursing practice creates a culturally unsafe environment that can impinge on the quality of care offered to culturally different Others. In this research, culturally unsafe situations of care were documented and can be seen to be constraining factors that influence Haitian Canadian caregivers' perceptions of mainstream health care system. To some extent, lack of cultural safety can explain why Haitian Canadian primary caregivers do not rely on home care services. Caregivers do not want to deal with 'strangers' who do not know about the Haitian cultural beliefs and customs or with health practitioners who are locked into discriminative stereotypes ascribed to the Haitian Canadians. Such a culturally unsafe context of care can induce distrust towards mainstream health care providers.

Developing Home Care Services for Creolophone-speaking Haitian Canadian Elders

Second, an issue of social justice is to develop CLSCs' home services to serve the important Creolophone population of the Montreal and Laval urban areas, especially the aging Haitian Canadian people. Some of them, due to late immigration or lack of knowledge, cannot attend French courses, which impinge on the communication with mainstream health care providers. As well, these aging persons cannot attend CLSCs' social activities due to this barrier of communication. The absence of services in Creole was observed when services were publicized. Pamphlets and posters, used to advertise CLSCs' services or programs, are written in

French, English, or Spanish. These languages were the languages of the former colonial powers, and their use in the health care system seems to replicate colonial hegemony by relegating culturally different Others as subalterns. Therefore, developing activities aimed at encouraging the participation of Creolophone elders in the CLSC social and daycare centres activities would be beneficial at three levels. It would increase the accessibility to services by Haitian Canadian elders who do not speak French. It would also promote the notion of equality, or the rights for Haitian Canadians to be treated as equals, with regards to other Canadian cultural communities. Finally, greater access to health and social services for Haitian Canadian elders would alleviate women caregivers' workload. In particular, the needs of women caregivers must be prioritized, especially those who work full-time in the paid workforce while caring for children and aging persons at home.

Increasing the Number of Creolophone Interpreters and Staff

Third, increasing the number of Creolophone interpreters and staff in the CLSCs located in neighbourhoods where Haitian Canadian constitute an important segment of the population must be considered for reaching the Creolophone clientele that does not utilize CLSC home care and other health services. Nevertheless, the chances of developing culturally adequate home services cannot be realized without establishing partnerships with Haitian Canadian churches and community organizations that are already involved in supporting caring activities among the community. Why should such partnerships between CLSCs and Haitian Canadian religious and secular organizations be suggested? This brings me to my fourth recommendation.

Designing Culturally Adequate Strategies of Health Education

In this recommendation, I highlight the needs to respect Haitian Canadian caregivers' and families' assessment of their aging parents' needs. I also point to recognize cultural differences in providing and sharing health information. More precisely, I recommend developing education

programs and strategies to integrate Haitian Canadian women's knowledge and ways of knowing. Patricia Hill Collins (2002b) emphasizes the interdependence of experiences and consciousness in knowledge building and knowledge transmission among African-American women:

> Black women's work and family experiences and grounding in traditional African-American culture suggest that African-American women as a group experience a world different from that of those who are not Black and female. Moreover, these concrete experiences can stimulate a distinctive Black feminist consciousness concerning that of material reality. ...Many African-American women have grasped this connection between what one does and how one thinks. (p. 158)

This lends support to a caregiver's comments when she reported an incident that occurred between herself and a nurse. When examining the situation from the Haitian Canadian standpoint, Audrey's perceptions were congruent with Hill Collins's observation about different ways of learning. Home care services must be tailored to acknowledge cultural differences in caregivers' ways of learning. This has an impact on how nurses must pass along information to respect Haitian Canadians different patterns of learning. This pattern of knowing or learning, while being less 'Westernized' (e.g., less structured in written information like pamphlets) is focused on 'hands-on experience' in the everyday lives. Cultural adaptation means to respect the 'Other' differences and require nurses and health care managers to adjust to their clientele. The whole domain of health education must be revisited to reach Haitian Canadians, and adapt services to this population's health and social needs.

Revisiting Nursing Practice in CLSC

Finally, I recommend that nurses and other health care providers be able to step out of the expert role and the so-called 'colonialist boots' as Schutte (2000) puts it. She mentions: "The West needs to learn how to step out of its colonial boots and start experiencing the reality of its subaltern environment and the cultures of the peoples it has disenfranchized and continues to disenfranchize" (Schutte, 2000, p. 63). In other words, mainstream health care practitioners must

accept that they are not the only 'experts' in defining or determining people's health needs and services. I do not intend to erase nurses' voices since I consider them as key actors for bringing about social changes in the health care system. I want to underline that other interpretive frameworks must be accounted for in the professional encounter between nurses, primary caregivers, and care-receivers. Good (1994) contends that the delivery of health care services is shaped by social and political factors that are enmeshed in power relations. Good (1994) contends that social elite shapes the definition and the provision of services: "The question of when illness representations are actually misrepresentations which serve the interests of those in power, be they colonial powers, elites within a society, dominant economic arrangements, the medical profession, or empowered men" (Good, 1994, p. 57).

The binary dualism between health and illness is not always supported in non-Western frameworks and the importance of the collectivity and the family over the individual must be seriously addressed to culturally adapt home care programs and services. If nurses were able to apply the family-centred approach as promulgated by CLSCs official literature, it would be a step towards providing family care as it would correspond to Haitian Canadian values on family and community. Efforts must be devoted to letting nurses apply this discourse in the reality of their practices. I noticed how nurses rushed to leave the homes of caregivers and care–receivers to visit other clients or to complete records and compute statistics at their headquarters. This also points to the implications of this study for nursing research, practice, education, and the development of health and social policy.

Implications For Nursing

Research

In this study, two major issues for nursing research, and more specifically for cultural nursing inquiries, were delineated. First, the results point to considering the utilization of new

paradigms of inquiry like postcolonial feminism[79] nurse researchers to develop projects aimed at correcting social inequities in the health care system. Postcolonial feminism enables looking at nursing phenomena through a conceptual lens to provide, as Anderson (2002) puts it, "the groundwork for the analysis of gender, 'race,' and class relations as simultaneous, contextualised and historicized" (p. 19). In exploring Haitian Canadian caregivers' ways of caring for an aging relative at home from a postcolonial feminist standpoint, issues of injustice that are located at the intersection of race, gender, and class with social, cultural, economical, and political factors, become tangible. Therefore, the ethical and social aim is to construct transformative knowledge that will be aimed at correcting social inequities in the health care system. Anderson (as cited in Reimer Kirkham, 2000) defines transformative knowledge as "knowledge that is, first of all, undergirded by critical consciousness on the part of health care providers, and that unmasks unequal relations of power and issues of domination and subordination, based on assumptions about 'race,' 'gender,' and class relations" (p. 358).

Second, this study illustrates the need to move beyond the limitations of cultural theories in conceptualizing culturally adapted nursing care. In using a postcolonial feminist theoretical approach, this points to the need for nurses to be critical when analyzing notions of cultural awareness and cultural sensitivity because these notions are derived from a problematic definition of Western multiculturalism. Spivak (1999) warns us about the pitfalls of Western multiculturalism in crystallizing culture as a static entity, in asserting that "culture alive is always on the run, always changeful" (p. 355). Therefore, postcolonial feminism, as a paradigm of inquiry, does not conceptualize culture from an essentialist viewpoint but as a fluid and hybrid entity that varies, due to the impacts of migration, neocolonialism, and globalization. In using a postcolonial feminist approach, researchers become aware of the needs, as Meleis and Im (1999)

[79] It is more accurate to say postcolonial 'feminisms' to recognize the plurality of positions and locations among postcolonial scholars, as suggested by Anderson (2002) and Schutte (2000).

put it, to develop marginalized knowledge without further marginalizing populations. They state: "Cultural knowledge is important, but knowledge about how populations are marginalized is vital for research enterprise in nursing" (Meleis & Im, 1999, p. 97). This points to the need to examine the nature of the results generated by nursing postcolonial feminist research. Results are said to be 'praxis-oriented' or oriented at addressing and correcting social inequities pertaining to race, gender, and social class that have impacts on people's health.

Postcolonial feminist approaches in nursing research also enable the development of anti-racist strategies as a part of nursing's social mandate. The impact of relations of dominance, subordination, and racialization on health can be unmasked and findings can be translated into interventions directed at correcting social inequities and health issues arising from social injustice in the health care system. A part of nursing's social mandate must be directed at developing and implementing anti-racist interventions to bring about social justice and equity.

Directions for research are provided, too. First, this study points to further explore the relationships between daughters-in-law or sons-in-laws with aging parents, the caring patterns of daughters-in-law and sons-in-law for a father-in-law since much knowledge has been developed from daughters-mothers relationships. It also points to further explore the impact of immigration on women caregivers' social network support and to find ways to sustain women's caring commitment in defining culturally adequate support services. Research must also be conducted with other ethnocultural communities to explore the impact of caring on caregivers for an aging relative, a spouse, or a sick child. Racialized groups must be contacted since their voices are likely to be marginalized in the shaping of health care programs. Furthermore, I suggest conducting research with nurses and other health practitioners. In my study, nurses were not interviewed since the study aims were directed at understanding Haitian Canadian caregivers' ways of caring. As was pointed out, I consider nurses as a marginalized group since their voices in multidisciplinary teams tend to be erased. During the fieldwork, I noticed that nurses tend to

be 'Othered' by other health care professionals, and their practice reduced to controlling biological parameters. Research must provide nurses with tools to affirm the legitimacy of nursing professional practice in a multidisciplinary and multicultural context.

Practice

I suggest that, in coming years, nurses more than ever will be confronted by social injustice and its harmful effects on health. Chopoorian (1986) and Stevens (1989) remind us that nursing must escape from its dominant ideology to address social and economic discrimination that have an impact on people's health. Chopoorian (1986) suggests examining the social, political, and economic structures and how they influence human relations. She underlines the importance of studying people's everyday life events, since individual behaviours and routines depend on the forces playing out in the social world. Chopoorian (1986) states:

> To understand the dilemmas and issues that influence human beings and hence create conditions for health or illness, nurses must reach beyond the privatized concerns of the individual to the surrounding world for explanation and action. Nurses need to turn their attention to the conditions that control, influence, and produce health or illness in human beings. Out of concern for individuals, nurses must look to the larger social world for analysis and explanation. (p. 53)

The key issue for nursing practice is to develop culturally safe nursing interventions. The concept of cultural safety becomes the salient point to address and implement in CLSCs where nurses encounter people coming from a large array of ethnocultural backgrounds. I argue that cultural safety starts by recognizing one's racial biases as the point of departure to acknowledge the impact of race and racialization in creating injustice. Moreover, I contend that this recognition is a step towards developing a culturally safe nursing practice. Issues of cultural safety must be addressed in the CLSCs because of the lack of cultural adequacy of home care services that is translated to the lack of nurses' intercultural education, which impinges on the utilization of health care services. Recognizing the impact of racism on health and developing a culturally safe nursing practice are issues of community or public health.

Based on the results of the study, directions for nursing practice are delineated. Visiting nurses need to develop methods or tools to screen at-risk caregivers among immigrant women. Specifically, I urge nurses to be aware of the risk for immigrant women caregivers who face the triple-task issue and may be isolated and at risk of developing health problems. In the study, the impact of racial and gendered discrimination at the workplace was documented, and some women caregivers reported issues of emotional distress. Evaluation of caregivers' social support network must also be carefully examined since the myth of extended family support was deconstructed to show the social isolation of men and women caregivers. Therefore, demands of services coming from Haitian Canadian caregivers must be treated as priorities because of the impact of immigration and the process of Othering on caregivers' health and well-being.

The need for nurses to apply a family-centred approach is highlighted when visiting Haitian Canadian caring families. Although I acknowledge that nurses do not have the time to apply this family-centred approach as enacted in CLSC nursing councils, nurses must be able to practice to fulfill their clienteles' needs as well as not be burdened or overwhelmed by clerical tasks or meetings that do no fit their working schedule and have an impact on care. To this end, and to enhance the quality of professional nursing care in the CLSCs, I suggest developing a culture of nursing research in CLSC. Nurses could work in a supportive environment where research is seen as a means to improving nursing interventions and working conditions. It seems that research is often perceived as being a hindrance. It is suggested that doctoral educated nurse researchers be hired in CLSCs to implement a culture of research as a means to integrate nurses in research activities, grant proposals, and publications. Universities play an important role in promoting the development of a culture of research in the CLSCs. Small CLSCs must be treated similarly to those facilities that provide care to large populations. Few of the CLSCs disseminated across the province have succeeded in developing a culture of nursing research. A 'social' disparity exists between the CLSCs since only 'privileged' CLSCs, in terms of financing

and staffing, can develop research teams. Faculties and Schools of Nursing in the province must play a proactive role in teaming up with these less-privileged CLSCs to stimulate the implementation of a culture of research among all nurses, regardless of the level of education. This would serve as a means to advocate for nurses, by nurses, and for the advancement of the state of knowledge.

Finally, I strongly encourage CLSCs' nurses to attend continuing intercultural education session. It can become a part of the program of continuing education and be at the same level as wound treatment or diabetes. CLSCs' authorities must also provide cultural training when hiring new staff, nurses, or other health care practitioners. As a consequence, the development of culturally adequate home care services and culturally safe nursing interventions would be enhanced.

Education

Despite my lack of expertise in nursing education and teaching, I recommend some directions for education that have come from this study. I argue, however, that these directions are more likely to be applied in Quebec where cultural nursing research and education are less developed than the other Canadian provinces. Still, this field of inquiry is flourishing as an increased number of publications related to culture and care may be found in Quebec's nursing professional journals. The major challenge for nurse educators is to introduce anti-racist strategies in the curriculum. In other words, courses must be introduced to develop the utilization of criticalist approaches in nursing such as feminists, social critical, postmodern, and postcolonial theories. Students must demystify concepts like hegemony, colonialism, neocolonialism, ideology, praxis, power, subjugation, and cultural safety to develop the intellectual motivation for adopting these more 'liberal' paradigms of inquiry. Varcoe (1997) points out:

> Revolutionary praxis draws attention from the educational context to the wider context of nursing, that is, to the practice context. Locating praxis for nursing education within practice extends the focus of reflection beyond the student-teacher relationship to nurse-client relationship, and challenges not just the structures that maintain the status quo of the context of health and health care. (p. 186)

Thus, nurse educators must be committed to developing programs to increase the quality of general knowledge of nurses in areas like anthropology, sociology, education, philosophy, and political sciences. To this end, I contend that fieldwork experiences are the best ways to experience cultural alterity as a step to understanding cultural safety. Freire (2000) contends that "solidarity requires that one enter into the situation of those with whom one is solidary: it is a radical posture" (p. 49). Nevertheless, the shifting nature of oppressive forces must be acknowledged as a means to avoid essentializing oppressed and oppressors into fixed categories (Anderson et. al, 2003). Fieldwork experiences are a means by which students can translate theoretical assumptions into practice and see the interrelations between research, theory, and practice. I now examine the directions for the development of health and social policies since a praxis-oriented study must be aimed at changing the sociopolitical status quo.

Health and Social Policies

This study suggests an opportunity to develop a national or provincial social policy aimed at promoting family caring. This policy is based on three objectives that are interrelated to sustain caregivers and provide the resources to achieve caring commitment. The goal is to protect primary caregivers' health and social welfare. This new policy can be enacted to redefine working conditions, review labour relations and laws, and finally, revise national home care guidelines and federal transfers to provinces. This social policy would implement an anti-racist feminist perspective in workplaces to facilitate women's caring activities.

Redefining Working Conditions

This redefinition of working conditions is aimed at providing paid caring day-offs to caregivers to support caring commitment at home. It is aimed at accounting for women caring

activities at home. Caring days for aging relatives can be given so that women would not have to quit the workforce and lose earnings that are vital for them and their families to survive. This would alleviate women's workload by giving them time and money to care for aging parents at home. In that sense, the federal and provincial governments, governmental institutions, private sector, and employers must demonstrate a leadership in providing employees with such working conditions.

Creating Healthy Working Environments

I also suggest carrying out a reform of federal, provincial, and territorial labour relations to enact laws related to racial and gendered discrimination at work. In Chapter Six, the findings show that racial discrimination and sexual harassment can lead to work accidents, burnouts, threats of being fired, and could be in some instances be associated with poor and degrading working conditions for 'racialized' men and women. The results also demonstrate that some women could be exploited as cheap labour or considered as objects. Therefore, issues of racial and gendered discrimination have impacts on women's health, which is not without affecting their caring commitment at home.

For instance, fines could be applied to employers and owners who do not create a healthy working environment by avoiding racial and gendered discrimination practices. This law would be aimed at protecting women from racial and sexual harassment at workplaces, especially for women coming from 'racialized' groups who are at a greater risk of being 'sexualized'. Employers must be severely penalized or fined for violation of this new law. Laws must be developed and enacted to protect women's rights in the workplace, especially for women who are working in non-unionized enterprises, where racism and sexism are more likely to occur. Additionally, women must be encouraged to document issues of race, ethnic, and gendered discrimination at the workplace without fearing being fired or being increasingly threatened by owners, managers, or other employees.

Women's advocacy groups must also be alerted to the reality of racialized women in the workplace. These groups must be involved to counteract instances of institutional racism encountered in workplaces. Strategies to help women face issues of racial discrimination and sexual harassment must be developed in CLSCs. Creating a healthy environment in workplaces must be seen as a governmental priority, as it must in private society and unions.

Revising National Guidelines for Home Care Services

This study also calls to apply national guidelines for home care services and to encourage federal money transfer to provinces. The study highlighted the fact that the Haitian Canadian community cannot afford to build a parallel system of care to support its population, as is the case for older cultural communities. The results demonstrate how race, ethnicity, gender, and class intersect to create constraining factors for accessing public home care services. Policy-makers must revise the basis for home care service allocations and account for the economic factors for immigrants and lower-income families to obtain services. Moreover, national home care guidelines must be clearly delineated for provincial and territorial programs to be funded. In a sense, the federal government must use its spending power as a means of financial attraction for provinces and territories to establish affordable and accessible health and home care services for Canadians.

Final Conclusion

This study brings new knowledge to describe the impact of caring for an aging relative at home in a racialized and gendered society. Above all, this study points to addressing issues of neocolonialism that intersect with race, gender, and class, which still pervade in the nation's health care system. Nursing cultural research must be redefined to document issues of racial and gendered discrimination that affect the health of non-Western immigrants' or other marginalized groups'.

For advancing nursing as a science and as a discipline, new concepts and theoretical approaches must emerge and be explored among members of the discipline, as it happened for caring, two decades ago. The debates can be viewed as small-scale scientific revolutions, as Kuhn (1996) put it, devoted to freeing knowledge from the pitfalls of radicalism and polarization, which are often associated with older paradigms:

> Scientific revolutions are inaugurated by a growing sense, again often restricted to a narrow subdivision of the scientific community, that an existing paradigm has ceased to function adequately in the exploration of an aspect of nature to which that paradigm itself has previously led the way. (p. 92)

Nevertheless, Thorne et al. (1998) point out that debates in nursing have been thwarted in radicalizing nurse theorists' worldviews, instead of collectively reconfiguring nursing theorization and practice to further advance the development of knowledge and to fulfill nursing's social mandate. Cultural research must be advanced in adopting new paradigms of inquiry for addressing heath and social inequities of the health care system in pluralist countries. I suggest moving beyond the limitations of culturalist theories to explore and correct social inequities pertaining to race, gender, and social class, that influence the health and well-being of non-Western populations or any other marginalized groups in societies like Canada and Quebec. Despite the usefulness of cultural awareness in cultural studies, nurses must move beyond the notion, since it fails to address the crux of the issue in health and social disparities related to race, gender, and social class. More than ever, in this era of market globalization, migration, and neoliberalism, the implementation of social justice in the health care system should be part of the social mandate of nursing in Canada and in other pluralist Western countries.

REFERENCES

Aamodt, A.M. (1991). Ethnography & epistemology: Generating nursing knowledge. In J.M. Morse (Ed.), *Qualitative Nursing Research. A contemporary dialogue* (pp. 40-53). Newbury Park, CA: Sage.

Abel, E.K. (1990). Informal care for the disabled elderly. A critique of recent of recent literature. *Research on Aging, 12*(2), 139-157.

Acker, J., Barry, K., & Esselveld, J. (1983). Objectivity and truth: Problems in doing feminist research. *Women's Studies International Forum, 6*(4), 423-435.

Adamson, J., & Donovan, J.L. (2002). Research in Black and White. *Qualitative Health Research, 10*(6), 816-825.

Adler, P.A. & Adler, P.A. (1994). Observational techniques. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377-392). Thousand Oaks, CA: Sage.

Ahmad, W.I.U. (1993). Making Black people sick: 'Race', ideology, and health research. In W.I.U Ahmad (Ed.), *Race and Health in Contemporary Britain* (pp. 11-33). Buckingham, UK: Open University Press.

Ahmad, W.I.U. & Atkin, K. (Eds.). (1996). *'Race' and community care.* Buckingham, UK & Philadelphia, PA: Open University Press.

Alcoff, L.M. (1991). The problem of speaking for others. *Cultural Critique,* 5-31.

Alcoff, L. M. (2000). What should White people do? In U. Narayan & S. Harding (Eds.), *Decentering the center: Philosophy for a multicultural, postcolonial, and feminist worlds* (pp. 262-282). Bloomington & Indianapolis, IN: Indiana University Press.

Allen, D.G. (1992). Feminism, relativism, and the philosophy of science: An overview. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance, and action: Working papers in the politics of nursing* (pp.1-19). New York, NY: National League for Nursing.

Anderson, G.L. (1989). Critical ethnography in education: Origins, current status, and new directions. *Review of Educational Research, 59*(3), 249-270.

Anderson, J. M. (1986). Ethnicity and illness experience: Ideological structures and the health care delivery system. *Social Sciences and Medicine, 22*(11), 1277-1283.

Anderson, J. M. (1990). Home care management in chronic illness and the self-care movement: An analysis of ideologies and economic processes influencing policy decisions. *Advances in Nursing Science, 12*(2), 71-83.

Anderson, J.M. (1991a). Current directions in nursing research: Toward a poststructuralist and feminist epistemology. *The Canadian Journal of Nursing Research, 23*(3), 1-3.

Anderson, J. (1991b). Reflexivity in fieldwork: toward a feminist epistemology. *Image: Journal of Nursing Scholarship, 23*(2), 115-118.

Anderson, J.M. (1996). Empowering patients issues and strategies. *Social Sciences and Medicine, 43*(5), 697-705.

Anderson, J.M. (2000a). Writing in subjugated knowledges: Towards a transformative agenda in nursing research. *Nursing Inquiry, 7*(3), 145.

Anderson, J.M. (2000b). Gender, 'race', poverty, health and discourses of health reform in the context of globalization: A postcolonial feminist perspective in policy research. *Nursing Inquiry, 7*(4), 220-229.

Anderson, J.M. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher: The International Journal of Research Methodology in Nursing & Health Care, 9*(3), 7-17.

Anderson, J.M., Blue, C., & Lau, A. (1991). Women's perspectives on chronic illness: Ethnicity, ideology and restructuring of life. *Social Sciences and Medicine, 33*(2), 101-113.

Anderson, J.M., & Reimer Kirkham, S. (1998). Constructing nation: The gendering and the racializing of the Canadian health care system. In V.Strong-Boag, S.Grace, A.Eisenberg & J. Anderson (Eds.), *Painting the maple. Essays on race, gender, and the construction of Canada* (pp. 242-261). Vancouver, BC: UBC Press.

Anderson, J., Perry, J., Blue, C., Browne, A. Henderson, A., Basu Khan, K., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project. *Advances in Nursing Science, 26*(3), 196-214.

Angus, J. (1994). Women's paid/unpaid work and health: Exploring the social context of everyday life. *Canadian Journal of Nursing Research, 26*(4), 23-42.

Anzaldua, G. (Ed.). (1990). *Making face, Making soul. Haciendo Caras. Creative and critical perspectives by women of Color.* San Francisco, CA : An Aunt Lute Foundation Book.

Archbold, P.G. (1983). Impact of parent-caring on women. *Family Relations, 32*, 39-45.

Ashcroft, B., Griffiths, G., & Tiffin, H. (Eds.). (1997). The post-colonial studies reader. New York, NY & London, UK: Routledge.

Ashcroft, B., Griffiths, G., & tiffin, H. (1997). Introduction. In B.Ascroft, G.Griffiths, & H. Tiffin (Eds.), *The post-colonial studies reader* (pp. 1-11). New York, NY & London, UK: Routledge.

Atkin, K. & Rollings, J. (1996). Looking after their own? Family caregiving among Asian and Afro-Caribbean communities. In W.I.U. Ahmad & K. Atkin. (Eds.), *'Race' and community care* (pp. 73-86). Buckingham, UK & Philadelphia, PA: Open University Press.

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248-261). Thousand Oaks, CA: Sage.

Baker, C., Varma, M., & Tanaka, C. (2001). Sticks and stones: Racism as experienced by adolescents in New Brunswick. *Canadian Journal of Nursing Research, 33*(3), 87-105.

Bannerji, H. (2000). *The dark side of the nation. Essays on multiculturalism, nationalism, and gender.* Toronto, ON: Canadian Scholars' Press.

Barer, B.M., & Johnson, C.L. (1990). A critique of the caregiving literature. *The Gerontologist, 30*(1), 26-29.

Baumgarten, M. (1989). The health of persons giving care to the demented elderly: A critical review of the literature. *The Journal of Clinical Epidemiology, 42*(12), 1137-1148.

Beaudoin, G.A., & Ratushny, E. (Eds.). (1989). *The Canadian Charter of Orights and Freedoms.* (2nd ed.). Toronto, ON: Carswell.

Benner, P., & Wrubel, J. (1989). *The primacy of caring. Stress and coping in health and illness.* Menlo Park, CA: Addison-Wesley.

Bhabha, H.K. (1990). The third space. Interview with Home Bhabha. In J. Rutherford (Ed.), *Identity: Community, Culture, Difference* (pp. 207-221). London, UK: Lawrence & Wishart.

Bhabha, H.K. (1994). *The location of culture.* London, UK & New York, NY: Routledge.

Bibeau, G. (1987). *À la fois d'ici et d'ailleurs : les communautés culturelles du Québec dans leurs rapports aux services sociaux et aux services de santé.* Groupe interuniversitaire de recherche en anthropologie médicale et en ethnopsychiatrie. Québec, QC : Publications du Québec.

Biegel, D.E., Sales, E., & Schulz, R. (1991). *Family caregiving in chronic illness. Alzheimer's disease, cancer, heart disease, mental illness, and stroke.* Newbury Park, CA: Sage.

Bishop, A.H., & Scudder, J.R. (1997). Nursing as a practice rather than an art or a science. *Nursing Outlook*, 45(2), 82-85.

Black, W., & Smith, L. (1989). The equality rights. In G.A. Beaudoin & E. Ratushny (Eds.), *The Canadian Charter of Rights and Freedoms* (2nd ed.). (pp. 557-651). Toronto, ON: Carswell.

Blasinsky, M. (1998). Family dynamics: Influencing care of the older adult. *Activities, Adaptation & Aging, 22*(4), 65-72.

Bordo, S. (1990). Feminist, post-modernism, and gender-scepticism. In. L.J. Nicholson (Ed.), *Feminist/Postmodernism* (pp. 133-156). New York, NY & London, UK: Routledge.

Bouchard, A. (2002, April 24). Pas plus d'immigrants dans les postes publics qu'il y a 10 ans. *Le Soleil*, p. A9.

Boutain, D.M. (1999). Critical nursing scholarship: Exploring critical theory with African American studies. *Advances in Nursing Science, 21*(4), 37-47.

Bowers, B.J. (1987). Intergenerational caregiving: Adult caregivers and their aging parents. *Advances in Nursing Science,* 9(2), 20-31.

Boyd, R., Gasper, P., & Trout, J.D. (Eds.). (1993). *The philosophy of science.* Cambridge, MA: The MIT Press.

Brody, E. M. (1985). Parent care as a normative family stress. *The Gerontologist, 25*(1), 19-29.

Brodkey, L. (1996). *Writing permitted in designated areas only.* Minneapolis, MN: University of Minnesota Press.

Brown, R. & Brown, C. (1996).Comments: Reflections on racism. In C.E. James (Ed.), *Perspectives on racism and the human services sector. A case for change,* (pp. 47-50). Toronto, ON: University of Toronto Press.

Browne, A.J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry, 8*(2), 118-129.

Browne, A.J., & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing aboriginal women. *Nurse Researcher: The International Journal of Research Methodology in Nursing & Health Care, 9*(3), 28-41.

Bull, M. (1990). Factors influencing family caregiver burden and health. *Western Journal of Nursing Research, 12*(6), 758-776.

Bunting, S.M. (1992). Eve's legacy: An analysis of family caregiving from a feminist perspective. In J. Thompson, D.G. Allen & L. Rodrigues-Fisher (Eds.), *Critique, resistance, and action. Working papers in the politics of nursing* (pp. 53-68). New York, NY: National League for Nursing Press.

Campbell, L.D. (2000). Caring sons: Exploring men's involvement in filial care. *Canadian Journal on Aging, 19*(1), 57-79.

Campbell, J.C., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-15.

Canales, M.K. (2000). Othering : Toward an understanding of difference. *Advances in Nursing Science, 22*(4), 16-31.

Carty, L., & Brand, D. (1993). Visible minorities' women. A creation of the Canadian state. In H. Bannerji (Ed.), *Returning the gaze. Essays on racism, feminism, and politics* (pp. 169-181). Toronto, ON: Sisters Vision Press.

Carruth, A.K. (1996a). Motivating factors, exchange patterns, and reciprocity among caregivers of parents with or without dementia. *Research in Nursing and Health, 19*, 409-419.

Carruth, A.K. (1996b). Development and testing of the caregiver reciprocity scale. *Nursing Research, 45*(2), 92-97.

Carspecken, P.F. (1996). *Critical ethnography in educational research: A theoretical and practical guide.* New York, NY: Routledge.

Chappel, N. L., & Kuehne, V.K. (1998). Congruence among husband and wife caregivers. *Journal of Aging Studies, 12*(3), 239-255.

Cheek, J. (1999). Influencing practice or simply esoteric? Researching healthcare using postmodern approaches. *Qualitative Health Research, 9*(3), 383-392.

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research.* Thousand Oaks, CA: Sage.

Cheek, J., & Porter, S. (1997). Reviewing Foucault: Possibilities and problems for nursing and healthcare. *Nursing Inquiry,* 4, 108-119.

Chopoorian, T.J. (1986). Reconceptualizing the environment. In P. Moccia (Ed.), *New approaches to theory development* (pp. 39-54). New York, NY: National League for Nursing Press.

Cicourel, A.V. (1993). Hearing is not believing: Language and the structure of belief in medical communication. In A.D. Todd & S. Fisher (Eds.), *The social organization of doctor-patient communication* (pp. 49-66). Norwood, NJ: Ablex.

Clifford, J. (1986). Introduction: partial truths. In J. Clifford & G.E. Marcus (Eds.), *Writing culture. The poetics and politics of ethnography,* (pp. 1-26). Berkeley, CA: University of California Press.

Climo, J.J. (2000). Eldercare as "women work" in poor countries. *Journal of Family Issues, 21*(6), 692-713.

Coburn, D. (2000). Income inequality, social cohesion and the health status of population: The role of neo-liberalism. *Social Science & Medicine, 51,* 135-146.

Collière, M.F. (1986). Invisible care and invisible women as health-care providers. *International Journal of Nursing Studies, 23*(2), 95-112.

Collins, P.H. (1989). The social construction of Black feminist thought. *Signs: Journal of Women in Culture and Society, 14*(4), 745-773.

Collins, P.H. (2000). It's all in the family: Intersection of gender, race, and nation. In U. Narayan & S. Harding (Eds.), *Decentering the center. Philosophy for a multicultural, postcolonial, and feminist world* (pp. 156-176). Bloomington & Indianapolis, IN: Indiana University Press.

Collins, P.H. (2002a). Reflections on "Defining Black feminist thought". In P.Essed & D.T. Goldberg (Eds.), *Race critical theories* (pp. 445-446). Malden, MA & Oxford, UK: Blackwell Publishers.

Collins, P.H. (2002b). Defining Black feminist thought. In P.Essed & D.T. Goldberg (Eds.), *Race critical theories* (pp. 152-175). Malden, MA & Oxford, UK: Blackwell Publishers.

Commission d'enquête sur les services de santé et les services sociaux. (1987). *Problématiques et enjeux.* Québec, QC : Publications du Québec.

Conseil du statut de la femme. (1999). *Virage ambulatoire: Le prix caché pour les femmes.* Québec, QC : Publications du Québec.

Conseil du statut de la femme. (2000). *Avis du Conseil du statut de la femme. Pour un virage ambulatoire qui respecte les femmes.* Québec, QC : Publications du Québec.

Cook, T.D., & Campbell, D.T. (1979). *Quasi-Experimentation. Design & analysis issues for field settings.* Boston, MA: Houghton Mifflin.

Cornell, S., & Hartmann, D. (1998). *Ethnicity and race. Making identities in a changing world.* Thousand Oaks, CA: Pine Forge Press.

Cotterill, P. (1992). Interviewing women. Issues of friendship, vulnerability, and power. *Women's Studies International Forum, 15*(5/6), 593-606.

Covan, E. K. (1997). Cultural priorities and elder care: The impact of women. *Health Care for Women International, 18,* 329-342.

Couvalis, G. (1997). *The philosophy of science. Science and objectivity.* London, UK: Sage.

Crehan, K. (2002). *Gramsci, culture and anthropology.* Berkeley & Los Angeles, CA: University of California Press.

Creswell, J.W. (1998). *Qualitative inquiry and research design. Choosing among five traditions.* Thousand Oaks, CA: Sage.

Culley, L. (1996). A critique of multiculturalism in healthcare: The challenge for nurse education. *Journal of Advanced Nursing,* 23, 564-570.

Day, J.F. (2000). *Multiculturalism and the history of Canadian diversity.* Toronto, ON: University of Toronto Press.

Dautzenberg, M.G.H., Diederiks, J.P.M., Philipsen, H., & Tan, F.E.S. (1999). Multigenerational caregiving and well-being: Distress of middle-aged daughters providing assistance to elderly parents. *Women & Health, 29*(4), 57-74.

Dejean, P. (1980). *The Haitians in Quebec. A sociological profile.* Ottawa, ON: Tecumseh Press.

Denis, W. (1999). Language policy in Canada. In P.S. Li (Ed.), *Race and ethnic relations in Canada* (pp. 178-216). (2nd ed.). Toronto, ON: Oxford University Press.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Denzin, N.K. & Lincoln, Y.S. (1994). Entering the field of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-17). Thousand Oaks, CA: Sage.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (2000). *Handbook of qualitative research.* (2nd ed.). Thousand Oaks, CA: Sage.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (2000). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-28). Thousand Oaks, CA: Sage.

DeSantis, L. (1990). Fieldwork with undocumented aliens and other populations at risk. *Western Journal of Nursing Research, 12*(3), 359-372.

Doland, D.L., & Sims, S.L. (1996). Family care giving at home as a solitary journey. *Image: Journal of Nursing Scholarship, 28*(1), 55-58.

Dougé, D. (1982). *Caribbean pilgrims. The plight of the Haitian refugees.* Smithtown, NY: Exposition Press.

Doyal, L. (1995). *What makes women sick. Gender and the political economy of health.* New Brunswick, NJ: Rutgers University Press.

Drevdahl, D., Kneipp, S.M., Canales, M.K., & Dorcy Shannon, K. (2001). Reinvesting in social justice: A capital idea for public health nursing. *Advances in Nursing Science, 24*(2), 19-31.

Dyck, I., Lynam, J.M., & Anderson, J.M. (1995). Women Talking. Creating knowledge through difference in cross-cultural research. *Women's Studies International Forum, 18*(5/6), 611-626.

Dyck, I., & Kearns, R. (1995). Transforming the relations of research: Towards culturally safe geographies of health and healing. *Health & Place, 1*(3), 137-147.

Dzurec, L.C. (1989). The necessity for and evolution of multiple paradigms for nursing research: A poststructuralist perspective. *Advances in Nursing Science, 11*(4), 69-77.

Dzurec, L.C. (1995). Poststructuralist science. An historical account of profound visibility. In A. Omery, C.E. Kasper, & G.G. Page (Eds.), *In search of nursing science* (pp. 233-260). Thousand Oaks, CA: Sage.

Earl, C.E., & Penney, P.J. (2001). The significance of trust in the research consent process with African Americans. *Western Journal of Nursing Research, 23*(7), 753-762.

Ebersole, P., & Hess, P. (1990). *Toward healthy aging: Human needs and responses.* St. Louis, MO: The C.V. Mosby Company.

Edwards, R. (1990). Connecting method and epistemology. A White woman interviewing black women. *Women's Studies International Forum, 13*(5), 477-490.

Elbaz, M., Fortin, A., & Laforest, G. (Eds.). *Les frontières de l'identité. Modernité et postmodernisme au Québec.* Sainte Foy, QC & Paris, FR : Les Presses de l'Université Laval & Éditions de l'Harmattan.

Eller, J.D. (1999). *From culture to ethnicity to conflict.* Ann Arbor, MI: The University of Michigan Press.

Emerson, R., Fretz, R.I. & Shaw, L.A. (1995). *Writing ethnographic fieldnotes.* Chicago, IL: University of Chicago Press.

Eriksen, T.H. (1993). *Ethnicity and nationalism. Anthropological perspectives.* London & Chicago, IL: Pluto Press.

Fanon, F. (1967). *Black skin, white masks.* New York, NY: Grove Press.

Farganis, S. (1989). Feminism and the reconstruction of social science. In A.M. Jaggar & S.R. Bordo (Eds.), *Gender, Body, Knowledge: Feminist Reconstructions of Being and Knowing,* (pp. 207-223). New-Brunswick, NJ: Rutgers University Press.

Farran, C.J., Keane-Hagerty, E., Salloway, S., Kupferer, S., & Wilken, C.S. (1991). Finding meaning: An alternative paradigm for Alzheimer's disease family caregivers. *The Gerontologist, 31*(4), 483-489.

Farran, C.J. (1997). Theoretical perspectives concerning positive aspects of caring for elderly persons with dementia: Stress/Adaptation and existentialism. *The Gerontologist, 37*(2), 250-256.

Fast, J.E, Williamson, D.L., & Keating, N.C. (1999). The hidden costs of informal elder care. *Journal of Family and Economic Issues, 20*(3), 301-326.

Fawcett, J. (2000). *Analysis and evaluation of contemporary nursing knowledge: Nursing models and theories.* Philadelphia, PA: F.A. Davis.

Fawcett, J. (1993). *Analysis and evaluation of nursing theories.* Philadelphia, PA: F.A. Davis.

Fayerman, P. (2002, September 17). Doctors win $145,000 in discrimination suit. *The Vancouver Sun*, p. A12.

Fédération des CLSC du Québec. (1988). *Les services à domicile : Une responsabilité publique.* Montréal, QC : Fédération des CLSC du Québec.

Fetterman, D.M. (1998). Ethnography. In L.Bickman & D.J. Rog (Eds.), *Handbook of applied social research methods* (pp. 473-503). Thousand Oaks, CA: Sage.

Finch, J. (1993). It's great to have someone to talk to: Ethics and politics of interviewing women. In M. Hammersley (Ed.), *Social research: Philosophy, politics and practice* (pp. 166-180). London, UK: Sage.

Finch, J., & Groves, D. (1983). *A labour of love: women, work, and caring.* London, UK & Boston, MA: Routledge & Kegan Paul.

Flew, A. (1979). *A dictionary of philosophy.* London, UK: Pan Books.

Fontana, A. & Frey, J.H. (1994) Interviewing. The art of science. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks, CA: Sage.

Foster, C. (1996). *A place called heaven. The meaning of being Black in Canada.* Toronto, ON: Harper Collins.

Foster, C. (2002). Jan Carew and the reconstruction of the Canadian mosaic. *Race & Class, 43*(3), 3-17.

Frankenberg, R. (1993). *White women, race matters. The social construction of White women.* Minneapolis, MN: The University of Minnesota Press.

Fraser, N., & Nicholson, L.J. (1990). Social criticism without philosophy: An encounter between feminism and postmodernism. In. L.J. Nicholson (Ed.), *Feminist/Postmodernism* (pp. 19-38). New York, NY & London, UK: Routledge.

Frederick, J.A., & Fast, J.E. (1999). Eldercare in Canada: Who does how much? *Canadian Social Trends.* Ottawa, On: Statistics Canada.

Freire, P. (2000). *Pedagogy of the oppressed.* New York, NY: Continuum.

Gadow, S. (1980). Existential advocacy: Philosophical foundation of nursing. In S.F. Spicker & S.Gadow, (Eds.), *Nursing, images and ideals*: *Opening dialogue with the humanities* (pp. 79-101). New York, NY: Springer.

Garant, L., & Bolduc, M. (1990). *L'aide par les proches: mythes et réalités.* Québec, QC: Ministère de la Santé et des Services Sociaux.

Gandhi, L. (1998). *Postcolonial theory. A critical introduction.* New York, NY: Columbia University Press.

Gauthier, H., & Duchesne, L. (1991). *Le vieillissement démographique et les personnes âgées au Québec.* Québec, QC: Publications du Québec.

Gaynor, S.A. (1990). The long haul: The effects of home care on caregivers. *Image: Journal of Nursing Scholarship, 22*(4), 208-212.

Geertz, C. (1973). *The interpretation of cultures.* New York, NY: Basic Books.

Germain , A., & Rose, D. (2000). *Montreal. The quest for a metropolis.* Chichester, UK: John Wiley & Sons.

Gitlin, A. (Ed.) (1994). *Power and method. Political activism and educational research.* New York, NY & London, UK: Routledge.

Given, B.A., & Given, C.W. (1991). Family caregiving for the elderly. In J.J. Fitzpatrick, R.L. Taunton & A.K Jacox (Eds.), *Annual Review of Nursing Research, 9,* 77-101.

Globerman, J. (1996). Motivations to care. Daughters- and sons-in-law caring for relatives with Alzheimers' disease. *Family Relations, 45*, 37-45.

Golding, S. (1988). The concept of philosophy of praxis in the Quaderni of Antonio Gramsci. In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 543-563). Urbana & Chicago: University of Illinois Press.

Good, B.J. (1994). *Medicine, rationality, and experience. An anthropological perspective.* Cambridge, UK: Cambridge University Press.

Gorek, B., Martin, J., White, N., Peters, D., & Hummel, F. (2002). Culturally competent care for Latino elders in long-term care settings. *Geriatric Nursing, 23*(5), 272-275.

Government of British Columbia. (1991). *Closer to home: The report of the British Columbia royal commission on health care and costs.* Victoria, BC: Queen's Printer.

Government of Canada. (1990). The Multiculturalism Act. A guide for Canadians. Ottawa, ON: Multiculturalism & Citizenship Canada.

Grace, S., & Helms, G. (1998). Documenting racism: Sharon Pollock's The Komagata Maru incident. In V.Strong-Boag, S.Grace, A.Eisenberg & J. Anderson (Eds.), *Painting the maple. Essays on race, gender, and the construction of Canada* (pp. 85-99). Vancouver, BC: UBC Press.

Graham, H. (1983). Caring: A labour of love. In J. Finch, & D. Groves (Eds.), *A labour of love: women, work, and caring* (pp. 13-30). London, UK & Boston, MA: Routledge & Kegan Paul.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

Guberman, N. (1999). Daughters-in-law as caregivers: How and why do they come to care? *Journal of Women & Aging, 11*(1), 85-102.

Guberman, N., & Maheu, P. (1997). *Les soins aux personnes âgées dans les familles d'origine italienne et haïtienne.* Montréal, QC: Éditions du Remue-Ménage.

Guberman, N., Maheu, P., & Maillé, C. (1993). *Et si l'amour ne suffisait pas*...Montréal, QC: Éditions du Remue-Ménage.

Gubrium J.F., & Holstein, J.A. (1997). *The new language of qualitative methods.* New York, NY: Oxford University Press.

Hall, S. (1994). Cultural studies: Two paradigms. In N.B. Dirks, G. Eley, & S.B. Ortner, (Eds.), *Culture/Power/History. A reader in contemporary social theory* (pp520-538). Princeton, NJ: Princeton University Press.

Hall, S. (1996). On postmodernism and articulation. An interview with Stuart Hall. In D, Morley & K.H. Chen (Eds.), *Critical dialogues in cultural studies* (pp. 131-150). London & New York: Routledge.

Hall, S. (1997a). New ethnicities. In B. Ashcroft, G. Griffiths & H. Tiffin (Eds.), *The post-colonial studies reader* (pp. 223-227). New York & London: Routledge.

Hall, S. (1997b). *Representation. Cultural representations and signifying practices.* London & Milton Keynes, UK: Sage & The Open University.

Hammersley, M.,& Atkinson, P. (1995). *Ethnography. Principles in practice.* London & New-York: Routledge.

Harding, S. (1987). Is there a feminist method? In S. Harding (Ed.), *Feminism and Methodology,* (pp. 1-14). Milton Keyenes, UK: Open University Press.

Harding, S. (1995). The question of method. In A. Omery, C.E. Kasper & G.G. Page (Eds.), *In Search of Nursing Science* (pp. 106-123). Thousand Oaks, CA: Sage.

Harman, W.W. (1996). Shortcomings of Western science. *Qualitative Inquiry, 2*(1), 30-38.

Health Canada. (1999). *Canadian research on immigration and health: An overview.* Ottawa, ON: Health Canada Publications.

Health Canada. (1998). *The Canadian Council on Social Development for the Division of Aging and Seniors.* Retrieved May 15, 2003 from: http://www.hc-sc.gc.ca/seniors-aines

Health Canada. (2003). *Canada Health Act.* Retrieved August 12, 2003 from http://www.hc-sc-gc.ca/medicare/home.htm

Henry, F., Tator, C., Mattis, W., & Rees, T. (2000). *The colour of democracy. Racism in Canadian society.* Toronto, On: Harcourt Canada.

Herdman, E.A. (2001). The illusion of progress in nursing. *Nursing Philosophy, 2*(1), 4-13.

Hoare, Q., & Nowell Smith, G. (1999). *Selection from the prison notebooks of Antonio Gramsci. New* York, NY: International Publishers.

hooks, b. (1984). *Feminist theory. From margin to center.* Boston, MA: South End Press.

hooks, b. (1989). *Talking back. Thinking feminist. Thinking black.* Boston, MA: South End Press.

hooks, b. (1990). *Yearning. Race, gender and cultural politics.* Boston, MA: South End Press.

hooks, b. (2000). *Feminism is for everybody. Passionate politics.* Cambridge, MA: South End Press.

Hooyman, N. R., & Gonyea, J. (1995). *Feminist perspective on family care. Policies for gender justice.* Thousand Oaks, CA: Sage.

Hooyman, N. R., & Gonyea, J. (1999). A feminist model of family care: Practice and policy directions. *Journal of Women & Aging, 11*(2/3), 149-169.

Horowitz, A. (1985). Family caregiving to the frail elderly. In C. Eisdorfer, M.P. Lawton & G.L. Maddox (Eds.), *Annual Review of Gerontology & Geriatrics, 5*, 194-246.

Houde Crocker, S. (2002). Methodological issues in male caregiver research: An integrative review of the literature. *Journal of Advanced Nursing, 40*(6), 626-640.

Huberman, A.M., & Miles, M.B. (1998). Data management and analysis methods. In N.K. Denzin & Y.S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 179-210). Thousand Oaks, CA: Sage.

Hunt, C.K. (2003). Concepts in caregiver research. *Journal of Nursing Scholarship, 35*(1), 27-32.

Im, E.O., & Meleis, A.I. (1999). Situation-specific theories: Philosophical roots, properties, and approach. *Advances in Nursing Science, 22*(2), 11-24.

Im, E.O., & Meleis, A.I. (2001). An international imperative for gender-sensitive theories in women's health. *Journal of Nursing Scholarship, 33*(4), 309-321.

Jackson, E.M. (1993). Whiting-out difference: Why US nursing research fails Black families. *Medical Anthropology Quarterly, 7*(4), 363-385.

Jacox, A.K., & Webster, G. (1997). Competing theories of science. In L.H. Nicoll (Ed.), *Perspective on nursing theory* (3rd ed.). (pp. 423-431). Philadelphia, PA: Lippincott.

James, C.E. (1996a). Race, culture, and identity. In C.E. James (Ed.), *Perspectives on racism and the human services sector. A case for change* (pp. 15-35). Toronto, ON: University of Toronto Press.

James, C.E. (1996b). Introduction: Proposing an anti-racism framework for change. In C.E. James (Ed.), *Perspectives on racism and the human services sector. A case for change,* (pp. 3-12). Toronto, ON: University of Toronto Press.

Janesick, V. J. (1994). The dance of qualitative research design. Metaphor, methodolatry, and meaning. In N.K. Denzin & Y.S. Lincoln, (Eds.), *Handbook of qualitative research* (pp. 209-219). Thousand Oaks, CA: Sage.

Joubert, P., Laberge, A., Fortin, J.P., Paradis, M., & Desbiens, F. (1991). *Évaluation du programme québécois de services intensifs de maintien à domicile (SIMAD).* Québec, QC: Centre Hospitalier de l'Université Laval. Unité de Recherche en Santé Communautaire.

Kauffman, K.S. (1994). The insider/outsider dilemma: Field experience of a White researcher "getting in" a poor black community. *Nursing Research, 43*(3), 179-183.

Kaufman, S.R. (1994). In-depth Interviewing. In J.F. Gubrium & A.Sankar (Eds.), *Qualitative methods in aging research* (pp. 123-136). Thousand Oaks, CA: Sage.

Kermode, S., & Brown, C. (1996). The postmodernist hoax and its effects on nursing. *International Journal of Nursing Studies, 33*, 375-384.

Kikuchi, J.F., & Simmons, H. (1996). The whole truth and progress in nursing knowledge development. In J.F. Kikuchi, H. Simmons & D. Romyn (Eds.), *Truth in nursing inquiry* (pp. 5-18). Thousand Oaks, CA: Sage.

Kincheloe, J.L., & McLaren, P.L. (1994). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-155). Thousand Oaks, CA: Sage.

Klein, R.D. (1983). How to do what we want to do: Thoughts about feminist methodology. In G. Bolwles & R.D. Klein (Eds.), *Theories of women's studies* (pp. 88-194). London, UK: Routledge.

Kramer, B.J., & Kipnis, S. (1995). Eldercare and work-role conflict: Toward an understanding of gender differences in caregiver burden. *The Gerontologist, 35*(3), 340-348.

Kramer, B.J. (1997). Gain in the caregiving experience: Where are we? What next? *The Gerontologist, 37*(2), 218-232.

Kramer, B.J., & Lambert, J. D. (1999). Caregiving as a life course transition among older husbands: A prospective study. *The Gerontologist, 39*(6), 658-667

Krippendoff, K. (1980). *Content analysis. An introduction to its methodology.* Beverly Hills, CA & London, UK: Sage.

Kristeva, J. (1991). *Étrangers à nous-mêmes.* Paris: Gallimard.

Kuhlman, G.J., Skodol Wilson, H., Hutchinson, S.A., & Wallhagen, M. (1991). Alzheimer's disease and family caregiving: Critical synthesis of the literature and research agenda. *Nursing Research, 40*(6), 331-337.

Kuhn, T. (1993). Scientific revolutions. In R.Boyd, P.Gasper & J.D. Trout (Eds.), *The philosophy of science* (pp. 140-157). (3rd ed.). Cambridge, MA: MIT Press.

Kuhn, T. (1996). *The structure of scientific revolutions.* (3rd ed.). Chaicago, IL: The University of Chicago Press.

Kvale, S. (1996). *InterViews. An Introduction to Qualitative Research Interviewing.* Thousand Oaks, CA: Sage.

Laguerre, M.S. (1984). *American Odyssey. Haitians in New York.* Ithaca, NY & London, UK: Cornell University Press.

Laguerre, M.S. (1998). *Diasporic citizenship. Haitian Americans in transnational America.* New York, NY: St. Martin's Press.

Langner, S.R. (1993). Ways of managing the experience of caregiving to elderly relatives. *Western Journal of Nursing Research, 15*(5), 582-594.

Langner, S. R. (1995). Finding meaning in caring for elderly relatives: Loss and personal growth. *Holistic Nursing Practice, 9*(3), 75-84.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern.* New York, NY: Routledge.

Lather, P. (1994). Fertile obsession: Validity after poststructuralism. In A.Gitlin (Ed.), *Power and method. Political activism and educational research (*pp. 36-60). New York, NY & London, UK: Routledge.

Lawton, M.P., Moss, M., Kleban, M.H., Glicksman, A., & Rovine, M. (1991). A two-factor model of caregiving appraisal and psychological well-being. *Journal of Gerontology Psychological Sciences, 46*(4), 181-189.

Ledoyen, A. (1992). *Montréal au pluriel: Huit communautés ethno-culturelles de la région montréalaise.* Québec, QC: Institut québécois de la recherche sur la culture.

Lee, J.A., & Cardinal, L. (1998). Hegemonic nationalism and the politics of feminist and multiculturalism in Canada. In V.Strong-Boag, S.Grace, A. Eisenberg & J. Anderson (Eds.), *Painting the maple. Essays on race, gender, and the construction of Canada* (pp. 215-241). Vancouver, BC: UBC Press.

Leininger, M.M. (1985). *Qualitative research methods in nursing.* Philadelphia, PA: W.B. Saunders.

Leininger, M.M. (1991). *Culture care diversity & universality: A theory of nursing.* New York, NY: National League for Nursing Press.

Lewis, G. (2000). *Race, gender, social welfare: Encounters in a postcolonial society.* Cambridge, UK: Polity Press.

Li, P.S. (1990). Race and ethnicity. In P.S. Li (Ed.), *Race and relations in Canada* (pp. 3-17). Toronto, ON: Oxford University Press.

Li, P.S. (1999). The multiculturalism debate. In P.S. Li (Ed.), *Race and ethnic relations in Canada* (pp. 148-177). (2nd ed.). Toronto, ON: Oxford University Press.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, Ca: Sage.

Lindgren, C.L. (1990). Burnout and social support in family caregivers. *Western Journal of Nursing Research, 12*(4), 469-487.

Lipson, J. G., & Meleis, A.I. (1989). Methodological issues in research with immigrants. *Medical Anthropology, 12,* 103-115.

Lister, P. (1997) The art of nursing in a 'postmodern' context. *Journal of Advanced Nursing, 25,* 38-44.

Lugo, A., & Maurer, B. (2000).The legacy of Michelle Rosaldo: Politics and gender in modern societies. In A. Lugo & B. Maurer (Eds.), *Gender matters: Rereading Michelle Z. Rosaldo* (pp. 16-34). Ann Arbor, MI: The University of Michigan Press.

Lugones, M. (1990). Hablando cara a cara/Speaking face to face: An exploration of ethnocentric racism. In G. Anzaldua (Ed.), *Making face, Making soul. Haciendo Caras.Creative and critical perspectives by women of Color* (pp. 46-54). San Francisco, CA: An Aunt Lute Foundation Book.

Maclure, J. (2003). *Quebec identity. The challenge of pluralism.* Montreal, QC & Kingston, On: McGill-Queen's University Press.

Maeda Allman, K.K. (1992). Race, racism, and health: Examining the 'natural' facts. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance, and action: Working papers in the politics of nursing* (pp.35-52). New York, NY: National League for Nursing.

Malonebeach, E.E., & Zarit, S.H. (1991). Current issues in caregiving to the elderly. *International Journal of Aging and Human Development, 32*(2), 103-114.

Marchand, J. (1975). The Liberal government's immigration policy. White paper on immigration 1966. In H. Palmer (Ed.), *Immigration and the rise of multiculturalism* (pp. 62-68). Toronto, ON: Copp Clark Publishing.

Marotte, C., & Razafimbahiny, H.R. (1997). Living with Haiti's violent past. *Lancet,* 349, p. 1248.

Martire, L.M., & Parris Stephens, M.A. (2003). Juggling parent care and employment responsibilities: The dilemmas of adult daughter caregivers in the workforce. *Sex Roles, 48*(3/4), 167-173.

Massé, R. (1983). *L'émergence de l'ethnicité haïtienne au Québec.* Thèse de doctorat. Faculté des Sciences Sociales. Départment d'anthropologie. Université Laval. Canada.

Massé, R. (1995). *Culture et santé publique. Les contributions de l'anthropologie a la prévention et a la promotion de la santé.* Montréal, QC: Gaëtan Morin.

Mayeroff, M. (1990). *On caring.* (2nd ed.). New York, NY: Harper Perennial.

McCormick, J., & Roussy, J. (1997). A feminist postructuralist orientation to nursing praxis. In S.E. Thorne & V.E. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 267-283). Thousand Oaks, CA: Sage.

McCarthy, C., & Crichlow, W. (Eds.). (1993). *Race, identity, and representation in education.* New York, NY & London, UK: Routledge.

McLaren, P. (1992). Collisions with otherness:'traveling' theory, post-colonial criticism, and the politics of the ethnographic practice—the mission of the wounded ethnographer. *Qualitative Studies in Education, 5*(1), 77-92.

McRobbie, A. (1996). Looking back at new times and its critics. In D. Morley & K.H. Chen (eds.), *Stuart Hall. Critical dialogues in cultural studies* (pp. 238-261). New York & London: Routledge.

Meleis, A.I., & Im, E.O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry, 6*(2), 94-102.

Mensah, J. (2002). *Black Canadians. History, Experiences, Social Conditions.* Halifax NS: Fernwood Publishing.

Messecar, D.C., Archbold, P.G., Stewart, B.J., & Kirschling, J. (2002). Home environmental modification strategies used by caregivers of elders. *Research in Nursing & Health, 25,* 357-370.

Miller, S. (1997). Multiple paradigms for nursing: Postmodern feminisms. In S.E. Thorne & V.E. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 140-156). Thousand Oaks, CA: Sage.

Minh-ha, T.T. (1989). *Woman, native, other. Writing postcoloniality and feminism.* Bloomington & Indianapolis, IN: Indiana University Press.

Minh-ha, T.T. (1990). Not you/Like you: Post-colonial women and the interlocking questions of identity and difference. In G. Anzaldua (Ed.), *Making face, Making soul. Haciendo Caras. Creative and critical perspectives by women of Color* (pp. 371-375). San Francisco, CA: An Aunt Lute Foundation Book.

Ministère de la culture du Québec. (1995). *Profils des communautés culturelles du Québec* Québec, QC: Publications du Québec.

Ministère de la santé et des services sociaux du Québec. (1992). *La politique de la santé et du bien-être.*Québec, QC: MSSS.

Ministère de la santé et des services sociaux du Québec. (2000). *Organization of services: Current situation and outlook.* Quebec City, QC: MSSS.

Ministère des relations avec les citoyens et de l'immigration du Québec. (1996). *Le racisme au Québec: Éléments d'un diagnostic. Rapport final soumis au Ministère des Affaires internationales, de l'Immigration et des Communautés culturelles.* Montréal, QC : Centre d'études ethniques de l'Université de Montréal.

Ministère des relations avec les citoyens et de l'immigration du Québec. (1999a). *Statistiques sur l'immigration. Caractéristiques des immigrants admis au Québec, 1994-1998.* Québec, QC: Publications du Québec.

Ministère des relations avec les citoyens et de l'immigration du Québec. (1999b). *Les responsabilités fédérales-provinciales en matière d'immigration et la typologie des personnes se trouvant sur le territoire.* Québec, QC: Publications du Québec.

Mishler, E.G. (1986). *Research interviewing. Context and narrative.* Cambridge, MA: Harvard University Press.

Moccia, P. (1988). A critique of compromise: Beyond the methods debate. *Advances In Nursing Science, 10*(4), 1-9.

Mohanty, C.T. (1988). Under Western eyes. Feminist scholarship and colonial discourses. *Feminist Review,* 30, 51-80.

Morse, J.M. (Ed.). (1991). *Qualitative nursing research. A contemporary dialogue.* Newbury Park, CA: Sage.

Morse, J.M. (1991). Strategies for sampling. In J.M. Morse (Ed.), *Qualitative Nursing Research. A contemporary dialogue* (pp. 127-145). Newbury Park, CA: Sage.

Morse, J.M. (Ed.). (1994). *Critical issues in qualitative research methods.* Thousand Oaks, CA: Sage.

Morse, J.M. (1994). Designing funded qualitative research. In N.K. Denzin & Y.S. Lincoln, (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals.* Thousand Oaks, CA: Sage.

Muecke, M.A. (1994). On the evaluation of ethnographies. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 187-209). Thousand Oaks, CA: Sage.

Mui, A.C. (1995). Caring for frail elderly parents: A comparison of adult sons and daughters. *The Gerontologist, 35*(1), 86-93.

Narayan, U., & Harding, S. (Eds.).(2000). *Decentering the center: Philosophy for a multicultural, postcolonial, and feminist worlds.* Bloomington & Indianapolis, IN: Indiana University Press.

Nelson, C., & Grossberg, L. (Eds.). (1988). *Marxism and the interpretation of culture.* Urbana & Chicago, IL: University of Illinois Press.

Neufeld, A, & Harrison, M.J. (2000). Family caregiving: Issues in gaining access so support. In M.J. Stewart (Ed.), *Chronic conditions and caregiving in Canada* (pp. 245-273), Toronto, ON: University of Toronto Press.

Neufeld, A., & Harrison, M.J. (2003). Unfulfilled expectations and negative interactions: Nonsupport in the relationships of women caregivers. *Journal of Advanced Nursing, 41*(4), 323-331.

Nicholson, L. J. (Ed.). (1990). *Feminist/Postmodernism.* New York, NY & London, UK: Routledge.

Ng, R (1993). Sexism, racism, and nation building in Canada. In C. McCarthy & W. Crichlow (Eds.), *Race, identity and representation in education* (pp. 50-59). New York & London: Routledge.

Noonan, A.E., & Tennstedt, S.L. (1996). Making the best of it: Themes of meaning among informal caregivers to the elderly. *Journal of Aging Studies, 10*(4), 1-15.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H.Roberts (Ed.), *Doing feminist research* (pp. 30-61). London, UK: Routledge & Paul.

O'Neill, M., & Cardinal, L. (1994). Health promotion in Quebec: Did it ever catch on? In A. Persons, M.O'Neill & I. Rootman (Eds.), *Health Promotion in Canada. Provincial, national and international perspectives,* (pp. 262-283). Toronto, ON: W.B. Saunders.

O'Neill, G., & Ross, M.M. (1991). Burden of care: An important concept for nurses. *Health Care for Women International, 12*, 111-121.

Opie, A. (1992). Qualitative research, appropriation of the 'other' and empowerment. *Feminist Review, (40)*, 52-69.

Palmer, H. (Ed.). (1975). *Immigration and the rise of multiculturalism.* Toronto, ON: Copp Clark Publishing.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Healthcare, 8*(5), 491-497.

Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods.* Newbury Park, CA: Sage.

Paun, O. (2003). Older women caring for spouses with Alzheimer's disease at home: Making sense of the situation. *Health Care for Women International, 24*(4), 292-312.

Pearlin, L.I. (1992). The careers of caregivers. *The Gerontologist, 32*(5), 647.

Penrod, J.D., Kane, R.A., Kane, R.L., & Finch, M.D. (1995). Who cares? The size, scope, and composition of the caregiver support system. *The Gerontologist, 35*(4), 489-497.

Pepin, J.I. (1992). Family caring and caring in nursing. *Image: Journal of Nursing Scholarship, 24*(2), 127-131.

Perry, J. (2002). Wives giving care to husbands with Alzheimer's disease: A process of interpretive caring. *Research in Nursing & Health, 25*(4), 307-316.

Perry, J. & Olshansky, E.F. (1996). A family's coming to terms with Alzheimer's disease. *Western Journal of Nursing Research, 18*(1), 12-28.

Perry, J., & O'Connor, D. (2002). Preserving personhood: (Re)Membering the spouse with dementia. *Family Relations, 51*(1), 55-62.

Pierce, W.J., & Elisme, E. (1997). Understanding and working with Haitian immigrant families. *Journal of Family Social Work, 2*(1), 49-65.

Phillips, L.R., & Rempusheski, V.F. (1986). Caring for the frail elderly at home: Toward a theoretical explanation of the dynamics of poor quality caregiving. *Advances in Nursing Science,8*(4), 62-84.

Phillips, L.R. (1988). The fit of elder abuse with the family violence paradigm, and the implications of a paradigm shift for clinical practice. *Public Health Nursing, 5*(4), 222-229.

Pohl, J.M., Boyd, C., Liang, J., & Given, C.W. (1995). Analysis of the impact of mother-daughter relationships on the commitment to caregiving. *Nursing Research, 44*(2), 68-75.

Polaschek, N.R. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing,* 27, 452-457.

Porter, E.J., Ganong, L.H., & Armer, J.M. (2000). The church family and kin: An older rural Black woman's support network and preferences for care providers. *Qualitative Health Research, 10*(4), 452-470.

Punch, M. (1994). Politics and ethics in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 83-97). Thousand Oaks, CA: Sage.

Quantz, R.A. (1992). On critical ethnography (with some postmodern considerations). In M.D. LeCompte, W.L. Millory & J. Preissle (Eds.), *Handbook of qualitative research in education* (pp. 447-505). San Diego, CA: Academic Press.

Quayson, A. (2000). *Postcolonialism. Theory, practice or process?* Cambridge, UK : Polity Press.

Rabinow, P. (1986). Representations are social facts: Modernity and post-modernity in anthropology. In J. Clifford & G.E. Marcus (Eds.), *Writing culture. The poetics and politics of ethnography,* (pp. 234-261.). Berkeley, CA: University of California Press.

Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry 10*(2), 91-102.

Raveis, V.H., Siegel, K., & Sudit, M. (1988-1989). Psychological impact of caregiving on the careprovider: A critical review of extant research. *The Journal of Applied Social Sciences, 13*(1), 40-79.

Reed, P. (1995). A treatise on nursing knowledge development for the 21st century: Beyond postmodernism. *Advances in Nursing Science, 17*(3), 70-84.

Reinharz, S. (1992). *Feminist Methods in Social Research.* New York, NY & Oxford,UK: Oxford University Press.

Reimer Kirkham, S.M. (2000). *"Making sense of difference": The social organization of intergroup relations in health care provision.* Unpublished doctoral dissertation, University of British Columbia, Vancouver, BC.

Reimer Kirkham, S., & Anderson, J.M. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science, 25*(1), 1-17.

Reimer Kirkham, S., Smye, V., Tang, S., Anderson, J., Blue, C., Browne, A. et al. (2002). Rethinking cultural safety while waiting to do fieldwork: Methodological implications for nursing research. *Research in Nursing and Health,* 25: 222-232.

Remennick, L.I. (1999). 'Women with a Russian accent' in Israel. On the gender aspects of immigration. *The European Journal of Women's Studies, 6*(4), 441-461.

Reverbee, S.M. (2000). *Tuskegee's truths. Rethinking the Tuskegee syphilis study.* Chapel Hill, NC & London, UK: University of North Carolina Press.

Reverby, S. (1987). A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research 36*(1), 5-11.

Rimmer, L. (1983). The economics of work and caring. In J. Finch, & D. Groves (Eds.), *A labour of love: women, work, and caring* (pp. 131-147). London, UK & Boston, MA: Routledge & Kegan Paul.

Ristock, J.L., & Pennell, J. (1996). *Community research as empowerment. Feminist links, Postmodern interruptions.* Toronto, ON: Oxford University Press.

Roberts, L.W., & Clifton, R.A. (1990). Multiculturalism in Canada: A sociological perspective. In P.S. Li (Ed.), *Race and ethnic relations in Canada* (pp. 120-147). Toronto, ON: Oxford University Press.

Robin, R. (1996). L'impossible Québec pluriel : La fascination de la souche. In M. Elbaz, A. Fortin & G. Laforest (Eds.), *Les frontières de l'identité. Modernité et postmodernisme au Québec* (pp. 295-310). Sainte-Foy, QC & Paris, FR: Les Presses de l'Université Laval & Éditions de l'Harmattan.

Rodgers, B.L., & Knafl, K.A. (1993). *Concept development in nursing. Foundations, techniques and applications.* Philadelphia, PA: W.B. Saunders.

Roman, L.G., & Apple, M.W. (1990). Is naturalism a move away from positivism? Materialist and feminist approaches to subjectivity in ethnographic research. In E.W. Eisner & A. Peshkin (Eds.), *Qualitative inquiry in education: The continuing debate* (pp. 38-71). New York, NY: Teachers College Press.

Roman, L. G. (1993). White is a color! White defensiveness, postmodernism, and anti-racist pedagogy. In C. McCarthy & W. Crichlow (Eds.), *Race, identity, and representation in education* (pp. 71-88). New York, NY & London, UK: Routledge.

Romyn, D.M. (1996). Problems inherent in the epistemology and methodologies of feminist research. In J.F. Kikuchi, H. Simmons & D. Romyn (Eds.), *Truth in nursing inquiry* (pp. 140-149). Thousand Oaks, CA: Sage.

Roy, J. (1986a). *Bilan du maintien à domicile dans les CLSC. Problématique des services* Montréal, QC : Fédération des CLSC du Québec.

Roy, J. (1986b). *Bilan du maintien à domicile dans les CLSC. Problématique des resources.* Montréal, QC : Fédération des CLSC du Québec.

Roy, J. (1998). *Les personnes âgées et les solidarités. La fin des mythes.* Sainte-Foy, QC : Éditions de l'IQRC.

Said, E.W. (1979). *Orientalism.* New York, NY: Vintage.

Said, E.W. (2000). *The Edward Said reader.* New York, NY: Vintage Books.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Sandelowski, M.(1991). Rigor or rigor mortatis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.

Sandelowski, M. (1995a). Focus on qualitative methods. Sample size in qualitative research. *Research in Nursing and Health, 18,* 179-183.

Sandelowski, M. (1995b). On the aesthetics of qualitative research. *Image: Journal of Nursing Scholarship, 27*(3), 205-209.

Sanjek, R. (1990). On Ethnographic Validity. In R.Sanjek (Ed.), *Fieldnotes. The makings of anthropology* (pp. 385-418). Ithaca, NY: Cornell University Press.

Schroeder, C. (2003). The tyranny of profit. Concentration of wealth, corporate globalization, and the failed US health care system. *Advances in Nursing Science, 26*(3), 173-184.

Schumacher, K.L., Stewart, B.J., & Archbold, P.G. (1998). Conceptualization and measurement of doing family caregiving well. *Image: Journal of Nursing Scholarship, 30*(1), 63-69.

Schutte, O. (2000). Cultural alterity: Cross-cultural communication in feminist theory in North-South contexts. In U. Narayan & S. Harding (Eds.), *Decentering the center: Philosophy for a multicultural, postcolonial, and feminist worlds* (pp. 47-66). Bloomington & Indianapolis, IN: Indiana University Press.

Schwandt, T.A. (1994). Constructivist, interpretivist approaches to human inquiry. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, CA: Sage.

Seibold, C. (2000). Qualitative research from a feminist perspective in the postmodern era: Methodological, ethical and reflexive concerns. *Nursing Inquiry, 7*(3), 147-155.

Senghor, L.S. (1994). Negritude: A humanism of the twentieth century. In P.Williams & L.Chrisman (Eds.), *Colonial discourse and postcolonial theory* (pp. 27-35). New York, NY: Columbia University Press.

Sheehan, N.W., & Donorfio, L.M. (1999). Efforts to create meaning in the relationship between aging mothers and their caregiving daughters: A qualitative study of caregiving. *Journal of Aging Studies, 13*(2), 161-176.

Shragge, E., & Letourneau, T. (1987). *Community-Initiated Health and Social Services. Critical synthesis.* Québec, QC: Publications du Québec.

Sigsworth, J. (1995). Feminist research: its relevance to nursing. *Journal of Advanced Nursing, 22,* 896-899.

Skaff, M.M., Pearlin, L.I., & Mullan, J.T. (1996). Transitions in the caregiving career: Effects on sense of mastery. *Psychology & Aging, 11*(2), 247-257.

Skaff, M.M., & Pearlin, L.I. (1992). Caregiving: Role engulfment and the loss of self. *The Gerontologist, 32*(5), 656-664.

Skeggs, B. (1995). Introduction. In B.Skeggs (Ed.), *Feminist cultural theory: process and production,* (pp. 1-29). Manchester, UK: Manchester University Press.

Smith, D.E. (1987). *The everyday world as problematic. A feminist sociology.* Toronto, ON: University of Toronto Press.

Smith, D. E. (1999). *Writing the Social. Critique, Theory and Investigations.* Toronto, ON: University of Toronto Press.

Smith-Corbie, G., Thomas, S.B., & St.George, D.M. (2002). Distrust, race, and research. *Archives of Internal Medicine, 162*(21), 2458-2463.

Smye, V., & Browne, A.J. (2002). Cultural safety and the analysis of health policy affecting aboriginal people. *Nurse Researcher: The International Journal of Research Methodology in Nursing & Health Care, 9*(3), 42-56.

Spector, R. (1996). *Cultural diversity in health and illness.* Stamford, CT: Appleton & Lange.

Spivak, G.C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 271-313). London, UK: Macmillan.

Spivak, G.C. (1999). *A critique of postcolonial reason. Toward a history of the vanishing past.* Cambridge, MA: Harvard University Press.

Spradley, J. (1979).*The ethnographic interview.* New-York, NY: Holt, Rinehart & Winston.

Spradley, J. (1980). *Participant observation.* New-York, NY: Holt, Rinehart & Winston.

Stasiulis, D.K. (1990). Theorizing connections: Gender, race, ethnicity, and class. In P.S. Li (Ed.), *Race and relations in Canada* (pp. 269-305). Toronto, ON: Oxford University Press.

Statistics Canada. (1996). *A portrait of seniors.* Ottawa, ON: Ministry of Industry.

Statistics Canada. (2001). *Population selon certaines origines ethniques, Montreal.* Retrieved June 21, 2003 from http://www.statcan.ca/francais/Pgdb/demo43x_f.htm

Stepick, A. (1998). *Pride against prejudice. Haitians in the United States.* Needham Heights, MA: Allyn & Bacon.

Stevens, P.E. (1989). A critical social reconceptualization of environment in nursing: Implications for methodology. *Advances in Nursing Science, 11*(4), 56-68.

Stevenson, C. & Beech, I. (2001). Paradigm lost, paradigm regained: Defending nursing against a single reading of postmodernism. *Nursing Philosophy, 2*(2), 143-150.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory.* (2nd ed.). Thousand Oaks, CA: Sage.

Swanson, E.A., Perry Jensen, D., Specht, J., Johnson, M.L., Maas, M., & Saylor, D. (1997). Caregiving: Concept analysis and outcomes. *Scholarly Inquiry for Nursing Practice: An International Journal, 11*(1), 65-76.

Tang, S.Y., & Anderson, J.M. (1999). Human agency and the process of healing: Lessons learned from women living with a chronic illness—'re-writing the expert'. *Nursing Inquiry, 6*(2), 83-93.

Tardif, F. (1995). *Regard sur l'humanitaire. Une analyse de l'expérience haïtienne dans le secteur santé entre 1991 et 1994. Trois ans de crise, trois ans de sanctions, trois ans d'assistance humanitaire.* Montréal, QC : Harmattan.

Tator, C. (1996). Anti-racism and the human-service delivery system. In C.E. James (Ed.), *Perspectives on racism and the human services sector. A case for change,* (pp. 152-170). Toronto, ON: University of Toronto Press.

Taylor, C. (1995). The politics of recognition. In C. Taylor (Ed.), *Philosophical arguments* (pp. 225-256). Cambridge, MA & London, UK: Harvard University Press.

Taylor, J. Y. (1999). Colonizing images and diagnostic labels: Oppressive mechanisms for African American women's health. *Advances in Nursing Science, 21*(3), 32-45.

Thomas, J. (1993). *Doing critical ethnography: Qualitative Research Methods.* Newbury Park, CA: Sage.

Thorne, & S. E., & Hayes, V.E. (Eds.). (1997). Nursing praxis: Knowledge and action. Thousand Oaks, CA: Sage.

Thorne, S., & Varcoe, C. (1998). The tyranny of feminist methodology in women's health research. *Health Care for Women International, 19,* 481-493.

Thorne, S., Canam, C., Dahinten, S., Hall, W., Hendeson, A., & Reimer Kirkham, S. (1998). Nursing's metaparadigm concepts: Disimpacting the debates. *Journal of Advanced Nursing, 27*(6), 1257-1268.

Trahan, L., Bélanger, L., & Bolduc, M. (1993). *Une évaluation de la prestation des services dans les CLSC et les centres hospitaliers. Pour des services de qualité aux personnes âgées en perte d'autonomie.* Québec, QC: Ministère de la Santé et des Services Sociaux. Direction générale de la planification et de l'évaluation.

Torczyner, J.L., & Springer, S.(2001). *The evolution of the Black community of Montreal: Change and challenge.* Montreal, QC: McGill Consortium for Ethnicity and Strategic Social Planning.

Tuhiwai Smith, L. (1999). *Decolonizing methodologies. Research and indigenous peoples.* Dunedin, AU: University of Otago Press.

Ungerson, C. (1983). Why do women care? In J. Finch, & D. Groves (Eds.), *A labour of love: women, work, and caring* (pp. 31-49). London, UK & Boston, MA: Routledge & Kegan Paul.

Vaillant, Jeanne D'Arc., & Dumont-Lemasson, M. (1995). *Les centres locaux de services communautaires du Québec.* CHCS at the Centre of Health Care Reform. International Conference on Community Health Centres, Montreal, Quebec, Canada.

Varcoe, C. (1997). The revolution never ends. Challenges of praxis for nursing education. In S. E. Thorne & V.E. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 180-200). Thousand Oaks, CA: Sage.

Walker, A.J., Pratt, C.C., & Eddy, L. (1995). Informal caregiving to aging family members. A critical review. *Family Relations, 44,* 402-411.

Walker, L.O., & Avant, K.C. (1995). *Strategies for theory construction in nursing.* Norwalk, CT: Appleton & Lange.

Watson, C.W. *Being there. Fieldwork in anthropology.* London, UK: Pluto Press.

Watson, J. (1985). *Nursing: Human science and human care. A theory of nursing.* Norwalk, CT: Appleton-Century-Crofts.

Watson, J. (1995). Postmodernism and knowledge development in nursing. *Nursing Science Quarterly, 8*(2), 60-64.

Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly, 10*(1), 49-52.

Waxler-Morrison, N. (1990). Introduction. In N. Waxler-Morrison, J. Anderson, & E. Richardson (Eds.), *Cross-cultural caring. A handbook for health professionals* (pp. 3-10). Vancouver, BC: UBC Press.

Webb, C. (1993). Feminist research: definition, methodology, methods and evaluation. *Journal of Advanced Nursing, 18,* 416-423.

Williams, A.M, Forbes, D.A., Mitchell, J., Essar, M., & Corbett, B. (2003). The influence of income in the experience of informal caregiving: Policy implications. *Health Care for Women International, 24*(4), 280-291.

Williams, D.W. (1998). *Blacks in Montreal, 1628-1986.* Montreal, QC : VLB.

Williams, P., & Chrisman, L. (Eds.) (1994). *Colonial discourse and postcolonial theory.* New York, NY: Columbia University Press.

Williams, R. (1976). *Keywords. A vocabulary of culture and society.* New York, NY: Oxford University Press.

Williamson, D.L., & Fast, J.E. (1998). Poverty status, health behaviours and health: Implications for social assistance and health care policy. *Canadian Public Policy, 24*(1), 1-25.

Wolf, D.L. (1996). Situating feminist dilemmas in fieldwork. In D.L. Wolf (Ed.), *Feminist Dilemmas in Fieldwork* (pp. 1-55). Boulder, CO: Westview Press.

Wood, F.G. (1991). The meaning of caregiving. *Rehabilitation Nursing, 16*(4), 195-198.

Wuest, J. (1993). Institutionalizing women's oppression: The inherent risk in health policy that fosters community participation. *Health Care for Women International, 14,* 407-417.

Wuest, J. (1998). Setting boundaries: A strategy for precarious ordering of women's caring demands. *Research in Nursing & Health, 21*, 39-49.

Wuest, J. (2000). Repatterning care: Women's proactive management of family caregiving demands. *Health Care for Women International, 21*, 393-411.

Appendix B:

Recherche de participantes et de participants pour étude

de doctorat en sciences infirmières

LA SIGNIFICATION DU SOIN À DOMICILE AUPRÈS D'UNE AÎNÉE OU D'UN AÎNÉ SELON LA PERSPECTIVE DES SOIGNANTES ET DES SOIGNANTS D'ORIGINE HAÏTIENNE DE MONTRÉAL

RECHERCHE DE PARTIPANTES ET PARTICIPANTS POUR ETUDE DE DOCTORAT EN SCIENCES INFIRMIÈRES

Centre d'animation pour femmes haïtiennes de Montréal
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Je suis une étudiante au programme de doctorat en sciences infirmières à l'Université de la Colombie-Britannique. Cet automne, je vais entreprendre une étude portant sur la signification du soin à domicile auprès d'une aînée ou d'un aîné d'origine haïtienne. À cet effet, je cherche à contacter des soignantes et soignants d'origine haïtienne qui voudront bien participer à l'étude. La participation implique une période d'observation ainsi que la réalisation d'une entrevue. Cette étude aidre à comprendre la réalité du soin à domicile selon la perspective des soignantes et soignants et d'explorer l'impact des activités de soins dans leur vie quotidienne. Tout autre membre de la famille impliqué dans le soin de la personne aînée et qui souhaitera participer à l'étude sera accepté. La personne aînée devra être affectée d'un problème de santé physique et/ou d'un problème d'ordre cognitif comme la maladie d'Alzheimer. Le problème de santé devra nécessiter une présence intense d'un membre (époux, épouse, conjoint, conjointe, fille ou fils, belle-fille ou gendre) ainsi que d'autres membres de la famille.

Les résultats de l'étude permettront d'offrir des soins de maintien à domicile qui respectent les valeurs des membres des communautés culturelles du Québec et d'améliorer la qualité des soins offerts. La PARTICIPATION des soignantes et soignants est demandée sur une base **VOLONTAIRE. TOUTE INFORMATION SERA GARDÉE STRICTEMENT CONFIDENTIELLE**. L'étude et son protocole ont été approuvée par le Comité d'Éthique de l'Université de la Colombie-Britannique.

Appendix C:

Caregivers and care receivers' mean ages and kinship

	Caregiver's Age (years)	Caregiver's Status	Care receiver's Age (years)	Care receiver's Status N= 19 CR
	55	Husband	47	Wife
	40	Daughter	70	Mother
	46	Daughter	89	Father
	64	Nephew	85	Cousin (female)
		Nephew	89	Cousin (female)
	87	Husband	86	Wife
	49	Daughter	76	Mother
	52	Son	89	Father
		Son	83	Mother
	45	Step-Daughter	75	Step-Father
	58	Daughter	87	Mother
	49	Daughter	85	Mother
	59	Daughter	97	Mother
	45	Daughter	87	Mother
	50	Daughter	86	Mother
		Daughter-in-law	89	Mother-in-law
	55	Daughter	83	Mother
	39	Daughter	78	Mother
	53	Daughter	74	Mother
Mean Age (years)	52.88		81.84	
Median Age (years)	51.0		85.0	

Appendix D:

Caregivers and care receivers' length of stay in Canada in years

	Year of Arrival	Length of Stay in Canada (years)		Year of Arrival in Canada	Length of Stay in Canada (years)
	1986	15		1977	24
	1975	26		1981	20
	1975	26		1981	20
	1970	31		1991	10
	1976	25		1977	24
	1976	25		1981	20
	1976	25		1981	20
	1977	24		1981	20
	1966	35		1981	20
	1970	31		1981	20
	1978	23		1976	25
	1976	25		1981	20
	1973	28		•	•
	1974	27		1977	24
	1974	27		•	•
	1972	29		1969	32
	1979	22		1985	16
	1970	31		1975	26
	1972	29		1974	27
Mean length of stay (years)		26.63 (27)			21.65 (22)
Median length of stay (years)		26.50			20.0

Appendix E:

Brief Description of the Observations for Haitian Caregivers

The Meaning Of Home Care From The Perspective Of Haitian People In Montreal

BRIEF DESCRIPTION OF THE OBSERVATIONS FOR HAITIAN CAREGIVERS

As part of my study, I want to observe how caring activities impact on the caregivers' every day lives in order to understand aging and caring from the families' perspective. I wish to do 3 to 6 hours of observations with the person in charge of the aging relative and her /his family.

First, observations will be aimed at describing the environment in which activities of caring are taking place. Observations will focus on the nature of caring activities performed the primary caregivers as well as by any other member of the family who will be willing to participate in the study.

More specifically, observations will focus on providing a description of the persons who live in the house or the apartment (e.g. relationships between persons), the kind of housing (house or apartment). Observation will focus on describing the caring activities by asking –what is going on here? What are the activities that primary caregivers do for caring for her/his aging relative. Observations will also focus on exploring the interaction between Haitian caregivers and the home care nurses, e.g. patterns of communication, the kind of communication that is established, and the content of the conversation in terms of sentences and words that will be exchanged. Notes will be made of these observations.

Finally, I will be observing how caring activities can impact on caregivers' everyday life such as on leisure time, work schedule, and social activities to name a few.

Appendix F:

Brief Description Of the Observations For Home Care Nurses

The Meaning Of Home Care From The Perspective Of Haitian People In Montreal

BRIEF DESCRIPTION OF THE OBSERVATIONS FOR HOME CARE NURSES

The observation periods will last for 3 hours and will occur during the home care nurses' work time in the Haitian caregiver's home. Observations will be done concurrently with home care nurses and Haitian primary caregivers during the home care visit, for families receiving services from the community centre (CLSC).

Types of services provided by home care nurses will be selected for observational purposes. Treatments, wound dressings, drawing blood samples, medication assessment, vital signs, any other therapeutic intervention will be observed. I will observe the types and the contents of questions that will be asked by home care nurses to caregivers.

I will observe the amount of time that is devoted to the home care visit as well as any other services such as helping relation, active listening or any other kind of assistance that will be provided by home care nurses.

Appendix G:

Sample Interview Trigger Questions

Haitian Primary Caregivers Interview Guide

SAMPLE INTERVIEW TRIGGER QUESTIONS

Haitian Primary Caregivers Interview Guide

1. Can you tell me about your experience about caring for your mother, father, aunt, uncle?
2. What are your feelings about caring for her/him?
3. Do you encounter any problems? If so, what are they?
4. How do you solve these problems?
5. Can you describe your family life since you started caring for your mother/father/aunt/uncle or any other aging relative? Is family life different?
6. If family life were different, would you tell me more about it? What changes did you observe?
7. If you have children, how do they perceive the family situation?
8. If you are in the work force, tell me how your work affects your experience of caring?
9. What kinds of help do you receive?
10. What is help? Can you give me examples of supportive actions?
11. Are you currently receiving (for your mother/father/or other relative) home care services? If yes, can you tell me what things they do to help you? If no, do you think that your mother/father/other aging relative will need home care services?
12. Do you find those services helpful? If yes, can you tell me how you find the services helpful?
13. Do you perceive home care nurses as possible source of support?

Trigger questions or "grand tour" questions are aimed at developing rapport with participants and eliciting information. In subsequent interviews, Spradley (1979) suggests mixing descriptive and structural questions. Structural questions need to be adapted to each participant with respect to the topics discussed in precedent interviews. Other questions will be generated in the context of the interviews.

or 6 hours of observations with the person in charge of the elderly person and her /his family. I will be pleased to help you in doing tasks such as housekeeping while I will be at your home. However, I will not be intervening as a professional nurse, unless a life-threatening condition occurs. I have the right to exercise as a nurse in the Province of Quebec. Hours will be scheduled at your most convenient time and will respect your comfort. For instance, I will immediately quit the house, if you asked me to do so.

I am therefore looking for Haitian caregivers to volunteer to participate in my study by agreeing to let me observe them while carrying out caring activities and by agreeing to be interviewed. This will help me to understand the reality of caring from an every day life situation.

The interviews will last ¾ to 1 ½ hour each. Interviews will be scheduled at the caregiver's home or at their most convenient time. Any other family member who will wish to be interviewed will be accepted as a participant and will have to sign a consent form. Any other location will also be considered, if the participant prefers to be interviewed outside the home. Interviews will be tape-recorded. I would like to interview each primary caregiver from one to three times.

ANY CAREGIVERS' PARTICIPATION IN MY STUDY IS VOLUNTARY AND WILL IN NO WAY AFFECT YOUR FUTURE ACCESS OR THE SERVICES YOU ARE CURRENTLY RECEIVING FROM YOUR CLSC. FUTHERMORE, PARTICIPANTS ARE FREE TO WITHDRAW FROM THE STUDY AT ANY TIME, ARE FREE TO REFUSE TO ANSWER ANY QUESTIONS, CAN ASK FOR ANY TAPED INFORMATION TO BE ERASED, AND CAN ASK FOR SENSITIVE INFORMATION NOT TO BE DISCLOSED. A signed consent form for every participant whom I interview will be obtained.

CONFIDENTIALITY WILL BE MAINTAINED BY ASSIGNING EACH PARTICIPANT A CODE NAME FOR THE PURPOSE OF INTERVIEWING. SIMILARLY, OTHER INFORMATION, REGARDING CAREGIVERS, FAMILIES, STAFF MEMBERS AND INSTITUTIONS WILL REMAIN ANONYMOUS. BIOGRAPHICAL DETAILS WILL BE ALTERED AS NECESSARY, in published or unpublished work to mask caregivers', staff or institutions identity.

HAITIAN CAREGIVERS NAME WILL NOT APPEAR IN ANY MATERIALS, AND INTERVIEW MATERIALS (TAPES AND THEIR TRANSCRIPTIONS) WILL NOT BE

À titre de bénéfice possible, cette étude pourra permettre d'améliorer la prestation des soins infirmiers de maintien à domicile aux membres des communautés culturelles en favorisant une meilleure compréhension du vécu des soignants et soignants ainsi que de la réalité du vieillissement vécue par les aînées et aînés d'origine haïtienne. C'est avec une sensibilité profonde et un grand intérêt pour les réalités historiques, sociales et culturelles haïtiennes que je vais entreprendre cette recherche.

Je cherche donc des soignantes ou soignants d'origine haïtienne, qui voudront sur une base volontaire, participer aux entrevues et me donner accès à leur domicile pour quelques heures de la journée pour me permettre de connaître leur vécu quotidien.

Je désire observer la soignante ou le soignant 3 à 6 heures pour connaître son vécu quotidien ayant trait à la prestation des soins à la personne aînée. Au cours de cette période, il me fera plaisir de partager avec vous des tâches domestiques ou d'entretien ménager non liées à la pratique infirmière professionnelle. Je vous indique à l'avance que je ne pourrai pas intervenir à titre d'infirmière. Les heures d'observation seront fixées selon vos besoins. Je m'engage à respecter votre confort et à quitter immédiatement votre domicile, si vous me le demandez.

Je désire aussi réaliser des entrevues avec les soignantes ou soignants. La participation à l'étude implique une entrevue dont la durée pourra varier de 45 minutes à une heure et demie. Les entrevues seront fixées à votre convenance et seront faites à domicile. Toutefois, l'endroit de réalisation de l'entrevue pourra être modifié, si vous désirez que l'entrevue se fasse hors de votre domicile. Les entrevues seront enregistrées sur une cassette audio. Je désire rencontrer en entrevue chaque participant ou participante une à trois fois. Tout autre membre de la famille qui désire participer à l'étude sera accepté et devra signer le formulaire de consentement à l'étude.

VOTRE PARTICIPATION À CETTE ÉTUDE EST VOLONTAIRE ET N'AFFECTERA EN AUCUNE MANIÈRE LA PRESTATION DES SERVICES DE SOINS DE MAINTIEN À DOMICILE QUE VOUS RECEVEZ PRÉSENTEMENT OU QUE VOUS POURREZ RECEVOIR DE VOTRE CENTRE LOCAL DE SERVICES COMMUNAUTAIRES (CLSC).

TOUT PARTICIPANT OU TOUTE PARTICIPANTE PEUT SE RETIRER LIBREMENT DE L'ÉTUDE AU MOMENT JUGÉ OPPORTUN PAR CE PARTICIPANT OU CETTE

PARTICIPANTE SANS QUE CELA NE CAUSE AUCUN ENNUI. VOUS AVEZ LE DROIT DE REFUSER DE RÉPONDE À UNE OU DES QUESTIONS DE L'ENTREVUE. VOUS AVEZ LE DROIT DE DEMANDER QUE L'INFORMATION OU UNE PARTIE DE L'INFORMATION CONTENUE DANS L'ENTREVUE SOIT EFFACÉE. VOUS AVEZ LE DROIT DE DEMANDER QUE TOUTE INFORMATION DITE SENSIBLE SOIT NON DIVULGUÉE. Un consentement écrit sera obtenu de chaque participant ou participante avant la réalisation de l'entrevue.

LA CONFIDENTIALITÉ SERA ASSURÉE EN DONNANT À CHAQUE PARTICIPANT OU PARTICIPANTE UN CODE POUR LES FINS DE L'ENTREVUE. DE FACON SIMILAIRE, TOUTE INFORMATION PROVENANT DES SOIGNANTS ET SOIGNANTES, FAMILLES, PERSONNEL INFIMIER ET ADMINISTRATIF DU CLSC OU DE TOUTE AUTRE AGENCE, SERONT GARDÉES ANONYMES. LES DÉTAILS BIOGRAPHIQUES SERONT ALTÉRÉS AFIN DE MASQUER L'IDENTITÉ DES PARTICIPANTS ET PARTICIPANTES, pour les fins de rédaction de la thèse de doctorat ainsi que de publications d'articles scientifiques.

LES NOMS DES PARTICIPANTS ET PARTICIPANTES N'APPARAÎTRONT PAS DANS LES ÉCRITS ET LES ENREGISTREMENTS D'ENTREVUES (AUDIOCASSETTES ET LA TRANSCRIPTION DE LEUR CONTENU) NE SERONT PAS DISPONIBLES, POUR QUELQUE INSTITUTION QUE CE SOIT. LES ENREGISTREMENTS (AUDIOCASSETTES) SERONT CONSERVÉS DANS UN ENDROIT CONFIDENTIEL ET CONNU DE LA CHERCHEURE SEULEMENT. JE SERAI LA SEULE PERSONNE AYANT ACCÈS AU MATÉRIEL. Le matériel sera utilisé pour la rédaction de la thèse de doctorat qui sera rédigée en anglais, pour des fins de publications d'articles scientifiques et possiblement pour des fins d'analyse secondaire. L'analyse secondaire consiste à utiliser les données déjà collectées dans cette recherche pour faire d'autres études ou analyses de données, après avoir obtenu l'autorisation du comité d'éthique de l'Université de la Colombie-Britannique. Nul autre personne que Louise Racine fera l'analyse secondaire des données.

Des rencontres individuelles ou de groupe, selon le désir des participants et participantes, seront effectuées dès que les résultats de l'étude seront disponibles. Chaque participant aura le droit de consulter le texte écrit de son entrevue. Les participants et participantes auront droit d'accès à la thèse de doctorat. La thèse sera rédigée en anglais. Un résumé en francais sera offert.

NURSES TO VOLUNTEER TO PARTICIPATE IN MY STUDY BY AGREEING TO BE OBSERVED WHILE PROVIDING NURSING INTERVENTIONS WITH HAITIAN CAREGIVERS AND FAMILIES. THIS WILL HELP ME TO UNDERSTAND THE REALITY OF CARING FOR AN AGING RELATIVE IN THE HAITIAN COMMUNITYAS WELL AS TO EXPLORE THE INTERACTIONS WITH HOME CARE NURSES.

The observation period will last 3 hours and will occur when you will be visiting the Haitian families caring for an aging relative. Observations will occur during your work time, and should not interfere with your practice. I will be taking notes during these observations, and will tape record some conversations with you (with your permission).

ANY HOME CARE NURSES' PARTICIPATION IN THE STUDY IS VOLUNTARY AND WILL IN NO WAY AFFECT THEIR EMPLOYMENT. FUTHERMORE, NURSES ARE FREE TO WITHDRAW FROM THE STUDY AT ANY TIME, ARE FREE TO REFUSE TO ANSWER ANY QUESTIONS, CAN ASK FOR ANY TAPED INFORMATION TO BE ERASED, AND CAN ASK FOR SENSITIVE INFORMATION NOT TO BE DISCLOSED. A signed consent form for every home care nurse whom I observe will be obtained.

CONFIDENTIALITY WILL BE MAINTAINED BY ASSIGNING EACH HOME CARE NURSES A CODE NAME. SIMILARLY, OTHER INFORMATION, REGARDING CAREGIVERS, FAMILIES, STAFF MEMBERS, OTHER NURSES, AND INSTITUTIONS WILL REMAIN ANONYMOUS. BIOGRAPHICAL DETAILS WILL BE ALTERED AS NECESSARY, in published or unpublished work to mask caregivers', staff or institutions identity.

HOME CARE NURSES' NAME WILL NOT APPEAR IN ANY MATERIALS, AND OBSERVATIONS AND CONVERSATIONS MATERIALS (TAPES AND THEIR TRANSCRIPTIONS) WILL NOT BE MADE AVAILABLE TO ANY EMPLOYERS/ADMINISTRATION). INTERVIEW MATERIALS WILL BE KEPT SECURED WITH ONLY MYSELF AS THE RESEARCHER HAVING ACCESS, and will be used for purposes of the Dissertation research, future publications and presentations, and possible secondary analysis. Secondary analysis consists of using the research materials or collected data

À titre de bénéfice possible, cette étude pourra permettre de comprendre le vécu des soignantes et soignants d'origine haïtienne qui prennent soin d'une aînée ou d'un aîné à domicile tout en explorant la nature de leurs relations avec le personnel infirmier oeuvrant au service de maintien à domicile. Les résultats pourront aussi servir à enrichir le corpus de connaissances en soins infirmiers culturels au Québec. D'autre part, les résultats pourront aussi permettre d'améliorer la qualité des soins offerts aux clientèles provenant des communautés culturelles.

Au cours de cette étude, je serai à votre établissement de soins pour une étude de terrain qui durera de 4 à 5 mois. Je serai présente au CLSC vers la mi-novembre 2000. Je désire observer les interactions entre les infirmières et les infirmiers du service de maintien à domicile et les soignantes et soignants de personnes aînées d'origine haïtienne qui se produisent au cours des visites de soins à domicile.

Je cherche donc des infirmières et des infirmiers qui voudront sur une base volontaire, participer à l'étude en acceptant que je les accompagne pour effectuer des visites à domicile auprès de familles haïtiennes. Vous devez accepter d'être observée ou observé durant la prestation des soins et le déroulement de la visite à domicile. Les observations m'aideront à comprendre la réalité du vécu du soin à domicile chez les membres de la communauté haïtienne tout en explorant les interactions avec le personnel infirmier de maintien à domicile en ce qui a trait à la dispensation des services.

La période d'observation pour laquelle je sollicite votre participation volontaire durera 3 heures. L'observation se fera durant vos heures de travail et sera faite de manière à ne pas entraver la réalisation de vos activités professionnelles. Vous comprendrez que je devrai écrire des notes au cours de ces périodes d'observations. Je devrai aussi enregistrer des extraits de conversations sur audiocassettes, avec votre permission.

VOTRE PARTICIPATION À CETTE ÉTUDE EST VOLONTAIRE ET N'AFFECTERA EN AUCUNE MANIÈRE VOTRE EMPLOI AU CENTRE LOCAL DE SERVICES COMMUNAUTAIRES (CLSC).

VOUS POUVEZ VOUS RETIRER LIBREMENT DE L'ÉTUDE À TOUT MOMENT SANS QUE CELA NE CAUSE AUCUN ENNUI. VOUS AVEZ LE DROIT DE REFUSER DE

RÉPONDE À UNE OU DES QUESTIONS. VOUS AVEZ LE DROIT DE DEMANDER QUE L'INFORMATION OU UNE PARTIE DE L'INFORMATION CONTENUE DANS L'ENREGISTREMENT DE L'AUDIOCASSETTE SOIT EFFACÉE. VOUS AVEZ LE DROIT DE DEMANDER QUE TOUTE INFORMATION DITE SENSIBLE SOIT NON DIVULGUÉE. Un consentement écrit sera obtenu de chaque infirmière et infirmier du service de maintien à domicile avant la réalisation des séances d'observation participante.

LA CONFIDENTIALITÉ SERA ASSURÉE EN DONNANT À CHAQUE INFIRMIÈRE OU INFIRMIER UN CODE POUR LES FINS DE L'OBSERVATION. DE FACON SIMILAIRE, TOUTE INFORMATION PROVENANT DES INFIRMIÈRES ET INFIRMIERS, DES SOIGNANTES ET SOIGNANTS D'ORIGINE HAÏTIENNE, DES FAMILLES, DU PERSONNEL ADMINISTRATIF DU CLSC OU DE TOUTE AUTRE AGENCE, SERONT GARDÉES ANONYMES. LES DÉTAILS BIOGRAPHIQUES SERONT ALTÉRÉS AFIN DE MASQUER L'IDENTITÉ DES PARTICIPANTS ET PARTICIPANTES, pour les fins de rédaction de la thèse de doctorat ainsi que de publications d'articles scientifiques.

LES NOMS ET PRÉNOMS DES INFIRMIÈRES ET INFIRMIERS QUI ACCEPTERONT DE PARTICIIPER, N'APPARAITRONT PAS DANS LES ÉCRITS D'OBSERVATIONS ET LES ENREGISTREMENTS D'EXTRAITS DE CONVERSATIONS (AUDIOCASSETTES ET LA TRANSCRIPTION DE LEUR CONTENU) NE SERONT PAS DISPONIBLES, POUR QUELQUE INSTITUTION QUE CE SOIT. LES ENREGISTREMENTS (AUDIOCASSETTES) SERONT CONSERVÉS DANS UN ENDROIT CONFIDENTIEL ET CONNU DE LA CHERCHEURE SEULEMENT.

JE SERAI LA SEULE PERSONNE AYANT ACCÈS AU MATÉRIEL QUI SERA GARDES SOUS CLEF DANS UNE FILIERE À CETTE FIN. Le matériel sera utilisé pour la rédaction de la thèse de doctorat qui sera rédigée en anglais, pour des fins de publications d'articles scientifiques et possiblement pour des fins d'analyse secondaire. L'analyse secondaire consiste à utiliser les données déjà collectées dans cette recherche pour faire d'autres études ou analyses de données après avoir obtenu l'autorisation du comité d'éthique de l'Université de la Colombie-Britannique. Nul autre personne que Louise Racine fera l'analyse secondaire des données.

_____

Family member or legal representative signature and date (if needed)

_____

Witness signature and date

I acknowledge having read the information about this study_____

I acknowledge having received a copy of the "Letter & Consent Form for people cared for by Haitian primary caregivers".____

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(i.e. les activités de soin qui sont effectuées par votre soignante ou votre soignant).

2) J'observe la visite de l'infirmière ou l'infirmier de soins à domicile, si vous recevez des services du CLSC.
3) Je fasse des observations d'une durée de 6 heures, soit 2 périodes de 3 heures chacune, à votre domicile.
4) J'écrive des notes durant ces périodes d'observation et les visites du personnel infirmier.
5) J'enregistre des extraits de conversation entre vous et votre soignante ou votre soignant ainsi que des extraits de conversation entre vous et l'infirmière ou l'infirmier de soins à domicile, avec votre permission.

Votre participation est VOLONTAIRE et n'affectera en aucune manière la prestation des services de soins de maintien à domicile que vous recevez actuellement ou que vous pourriez recevoir plus tard.

Tout participant ou participante a le DROIT DE SE RETIRER de l'étude au moment jugé opportun sans que cela ne cause aucun ennui. Vous avez le droit de refuser de répondre à une ou des questions. Vous avez le droit de demander que toute information dite sensible soit non divulguée.

La CONFIDENTIALITÉ sera assurée en donnant à chaque participante ou participant aîné un code. Toute information provenant des soignantes et soignants, des familles, du personnel infirmier, personnel administratif du CLSC ou toute autre agence sera gardée anonyme.

LES NOMs des participants et participantes n'apparaîtront pas dans les écrits des notes d'observation et des extraits de conversation (transcriptions de leur contenu) et ne seront PAS disponibles, pour quelque institution de ce soit. Le matériel d'observation sera conservé dans UN ENDROIT SÉCURITAIRE dans une filière sous clef. L'accès à cette filière sera réservé à la chercheuse SEULEMENT.

Vous avez le droit comme participante ou participant de consulter le contenu écrit des extraits de conversation ainsi que la thèse de recherche. La thèse sera écrite en anglais mais un résumé rédigé en francais sera offert.

As part of her study, Louise will also conduct interviews. I agree to be interviewed. I have been told that the interview will last .75 to 1.5 hours each, will be scheduled at my convenience at my home or at any other location that Louise and I will agree on. I have been told that the interviews will be tape recorded and will take place from 1 to 3 times. Any other family member who will wish to be interviewed will be accepted as a participant and will have to sign a consent form.

I understand that my participation in this study is VOLUNTARY and will in no way affect my access to home care services. I know that I am free to withdraw from the study at any time. I am free to refuse to answer any questions. I can ask for any taped information to be erased and can ask for sensitive information not to be disclosed.

I understand that CONFIDENTIALITY in this study will be maintained by assigning me a code name for the purposes of the researcher's observations and interviewing. Other participants, families' surnames and names, CLSC staff and institutions will remain anonymous. Biographical details will be ALTERED AS NECESSARY in published and unpublished work to mask the identification of caregivers, families, staff and institutions.

I understand that caregivers' names will not appear in any materials, and observational notes and interview materials (tapes and their transcriptions) will not be made available to any agencies. Observational notes and interview materials will be kept secured in a locked filing cabinet in Louise's home. ONLY Louise Racine will be having access to the locked cabinet. Observational notes and interviews materials will be used for purposes of the Dissertation research, future publications and presentations, and possible secondary analysis. Secondary analysis consists of using the research materials or collected data for further studies after approval has been obtained from the UBC Ethics Board. No other researcher than Louise Racine will do secondary analysis.

I understand that Louise will offer follow-up meetings or group meetings and or educational sessions to myself and other participant so that we may have access to the study results once it is completed. I will have access to my own interview transcripts as well as the completed Dissertation. I understand that the Dissertation will be written in English. A summary will be provided in French.

Louise rédigera une thèse de doctorat sous la direction de Madame Joan Anderson. Louise observera mes activités de soins telles que je les prodigue dans le cadre de ma vie quotidienne.

Pour réaliser cette recherche, je sais que Louise prendra quelques notes au cours des séances d'observation à la maison et pourra enregistrer des extraits de conversation, avec mon accord préalable. Louise observera mes activités de soin pour une période pouvant varier de 3 à 6 heures. Louise sera heureuse de m'aider dans diverses tâches domestiques ou ménagères mais je comprends qu'elle ne pourra prodiguer de soins infirmiers professionnels au cours de ces périodes.

Elle effectuera aussi des entrevues dont le contenu sera enregistré, avec mon accord préalable. J'ai été informé que la durée des entrevues variera de 45 minutes à une heure et demie. Les entrevues seront fixées selon ma disponibilité et seront faites de préférence à mon domicile. Toutefois, l'entrevue pourra être faite dans un autre endroit physique, si cela m'est impossible de le faire chez-moi. Je discuterai avec Louise et nous conviendrons d'un endroit pour réaliser l'entrevue, si mon domicile n'est pas disponible. Je comprends aussi que le nombre total de rencontres prévues avec Louise pour fins d'entrevue peut varier de 1 à 3 rencontres.

Je comprends que ma participation est VOLONTAIRE et n'affectera pas la qualité ou la quantité de services de soins à domicile présentement reçus. Ma participation n'affectera pas toute demande de services qui pourra être formulée ultérieurement à cette recherche. J'ai été informé(e) de mon droit de me retirer de cette étude à tout moment, sans que cela ne me cause aucun ennui. J'ai le droit de refuser de répondre à une ou des questions. J'ai le droit de demander à la chercheure d'effacer l'information enregistrée. J'ai le droit de demander qu'aucune information dite sensible ne soit divulguée.

Je comprends que la CONFIDENTIALITÉ des renseignements donnés sera traitée avec une stricte rigueur. Des noms de code seront donnés à chaque participant ou participante pour les entrevues et les observations faites. Toute autre information relative à d'autres soignants ou soignantes, familles, organismes ou institutions resteront anonymes. Les données biographiques seront altérées pour les fins de publication de la thèse de doctorat et d'articles scientifiques, afin d'empêcher l'identification des participants et participantes à l'étude, de leurs familles, ainsi que de tout organisme ou institution.

_____

Signature du témoin et date

J'atteste avoir reçu le document intitulé 'Lettre d'information auprès des soignantes et soignants haïtiens pouvant être intéressés à participer à la recherche'. _____

J'atteste avoir reçu une copie du document intitulé 'Formulaire de Consentement' pour mes archives personnelles. _____

Version. 26 octobre, 2000.

_____

Home Care Nurse Participant's signature and date

_____

Witness signature and date

I acknowledge having received the "Letter of Information for Potential Home Care Nurse Participants"._____

I acknowledge having received a copy of the "Consent Form" for my own records. _____

Version. October 26, 2000.

services formels de soins de santé tels que représentés par les services de soins infirmiers à domicile.

Je comprends que Louise rédigera une thèse de doctorat sous la direction de Madame Joan Anderson. Louise observera mes activités de soins telles que je les prodigue dans le cadre de ma pratique professionnelle, lors des visites à domicile.

Je comprends que Louise sera présente dans mon établissement de soins vers la mi-novembre. Elle désire observer les interactions entre les infirmières et les infirmiers du service de maintien à domicile et les soignantes et soignants de personnes aînées d'origine haïtienne se déroulant lors des visites de soins à domicile.

Pour réaliser cette recherche, je sais que Louise devra faire des observations sur le contenu des visites à domicile auprès de la clientèle haïtienne. J'accepte d'être observée ou observé durant la prestation des soins et le déroulement de la visite à domicile. Je comprends que la période d'observation pour laquelle Louise sollicite ma participation volontaire sera de 3 heures. L'observation se fera durant vos heures de travail et sera faite de manière à ne pas entraver la réalisation de vos activités professionnelles. Je comprends que l'étudiante, Louise Racine, devra écrire des notes au cours de ces périodes d'observations. Elle devra aussi enregistrer des extraits de conversations sur audiocassettes, avec ma permission.

Je comprends que ma participation à cette étude est VOLONTAIRE et n'affectera en aucune manière mon emploi au centre local de services communautaires (CLSC).

J'ai été informé(e) de mon droit de me retirer librement de l'étude à tout moment sans que cela ne cause aucun ennui. J'ai le droit de refuser de réponde à une ou des questions. J'ai le droit de demander que l'information ou une partie de l'information contenue dans l'enregistrement de l'audiocassette soit effacée. J'ai le droit de demander que toute information dite sensible soit non divulguée. Un consentement écrit sera obtenu de chaque infirmière et infirmier du service de maintien à domicile avant la réalisation des séances d'observation participante.

Appendix R:

Haitian Primary Caregivers' Biographic Form

HAITIAN PRIMARY CAREGIVERS' BIOGRAPHIC FORM (CONFIDENTIAL)

The meaning of home care from the perspective of Haitian people in Montreal
(This form will be kept separate from the research data)

Name_____ Code_____

Age_____

Gender_____

Birthplace_____

Number of years in Canada_____

Marital status_____

Employment_____ Full-time Part-time Other

Number of children_____

Education_____ Secondary (High School) College University Other

Caring for Mother Father Aunt Uncle Other relative

Age of the person cared for_____

Health problems of the person cared for_____

How long have you been caring for her/him?_____

Number of siblings_____

Notification of results:

a. Copy of own interview transcript in French or in English_____

b. Copy of dissertation summary in French____

c. Copy of completed dissertation in English____

d. Other request_____

Mailing Address_____

Appendix S:

Home Care Nurses' Biographic Form

HOME CARE NURSES BIOGRAPHIC FORM (CONFIDENTIAL)

The meaning of home care from the perspective of Haitian people in Montreal
(This form will be kept separate from the research data)

Name_____ Code_____

Age_____

Gender_____

Birthplace_____

Employment_____ Full-time Part-time Other

Nursing Education_____

Work Experience_____

For how long have you practice nursing?_____

How many years have you practiced as home care nurse?_____

Did you receive intercultural education before being hired?_____ If yes, where_____

Have you attended a seminar on intercultural relations?

Notification of results:

a. Copy of dissertation summary in French____

b. Other request_____

Mailing Address_____