

RESEARCH ARTICLE

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Immigrant Filipinos as Caregivers for Filipino Loved Ones with Chronic Illness in Canada

Abstract

Objective: The purpose of this study was to examine the type of care, factors influencing caregivers' strains, and caregiving outcomes of immigrant Filipino caregivers to senior patients with chronic and/or serious life-threatening conditions in Canada.

Design: This study employed a qualitative method with five female caregivers and five female and male patients who were Filipino immigrants in Winnipeg, Canada. Audio-recorded interviews were guided by a semi-structured open-ended interview script. Transcripts of audio-recorded interview data were analyzed using content analysis.

Findings: Findings of the study revealed that female caregivers' tasks included providing personal care, assisting with mobility and giving medications, as well as, performing care management tasks like arranging social services and transportation. Caregivers' economic, financial, physical, emotional and time strains were influenced by their employment arrangements, household status, income, social networks, the life cycle stage, housing, and neighborhood. Caregiving outcomes for employed female caregivers resulted often in economic and emotional distress and even poor health.

Conclusion: The study's results showed how health care providers need to provide more support for immigrant caregivers dealing with patients and with chronic illness, memory loss, and/or mental health issues --- especially those caregivers and patients who live in impoverished neighborhoods. Furthermore, removing factors contributing to caregivers' strains such as employment arrangements, housing conditions, and the promotion of culturally appropriate health practices will enable immigrant caregivers and patients to enhance quality of care living in Canada.

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Introduction

In Canada, approximately 8.1 million adults (28% of population) provide care to a family member or a friend with chronic and/or serious life-threatening conditions, disability, or aging needs (Statistics Canada, 2013). Senior citizens are one of the fastest growing age groups. In 2011, people over 65 years of old comprised 5.0 million (total population 33,476,688): a number that is estimated to double in the next 25 years and reach 10.4 million by 2036. In addition, it is expected that in 2051, one in four Canadians will be over 65 years of old (Government of Canada, 2014). Manitoba has one of the highest rates of caregivers at 33% that is higher than the national average of 28% in 2012 (Statistics Canada, 2013). It is estimated that caregivers provide 80% of care to a patient with long-term conditions and contribute annually more than \$25 billion of unpaid labour to the health care system (Canadian Caregiver Coalition, 2008). Many of these unpaid family caregivers are juggling work and caregiving responsibilities too. Hence, similar challenges of caregiving are likely being experienced in the growing immigrant community in Canadian society.²

Previous research found that for many immigrant family caregivers, the problems of adapting to a new health environment are linked to economic, cultural, and linguistic factors which contribute to social isolation (Kobayashi & Funk, 2010; Zanchetta & Poureslami, 2006). Immigrant female caregivers often experience difficulties in reconciling work demands and family caregiving influences leading to caregivers' role strains and depressive symptoms (Wang et al, 2011). They often experience deskilling, have low incomes, and are more likely to change from full-time to part-time positions to reduce their working hours, or worse, quit their jobs due to heavy obligations as caregivers to ill family members (Lai & Leonenko, 2007; Man, 2004; Stewart et al. 2006; Weerasinghe & Mithcell, 2007). Filipino immigrants in the United States, especially recent immigrants experience job-related stressors that are associated with poor health outcomes (De Castro, Gee, Takeuchi, 2008). Immigrant women often experience caregiving conflicts with work and family expectations resulting in their stress, burn-out, guilt, and frustration as they may feel overwhelmed by the amount of tasks to perform (Gulati et. al., 2012; Wang & Sanglang, 2005). Female caregivers also often report having chronic illness such as cancer, kidney, arthritis, headaches, and dementia. Moreover, as immigrant caregivers experience resettlement, they must frequently deal with isolation and loneliness, family conflict, economic dependence, and coping (Leung, 2000; Pratt, Pendakur, & Columbia, 2008). Immigrant communities tend to be unacquainted with the new health care system and experience challenges in accessing health-related information and navigating the Canadian healthcare services.

Filipino culture and family caregiving. Filial piety, cultural values of caregiving in families, and respect for the elderly are central values in Filipino families (McBride & Pareno, 1996). In Filipino culture, care meanings and experiences are shared and built into the social life of kinship structure and gender division of labour. For Filipino individuals, the shared culture prioritizes the following: 1) family as the main socio-economic unit of kinship structure; 2) reciprocal obligations among kin members and filial respect and responsibility for the care of one's own parents; 3) a sense of respect and gratitude towards parents and family; and, 4) avoidance of the disclosure of information that may bring shame to the families and put them at risk (Natividad, 2000; Pacquiao, 2011). Children reciprocate the care they receive from their parents and, in turn, take care of their elders. End-of-life health care decisions often require a social ethics of care. In other words, serious illness is usually discussed with family members before a shared decision is made to notify the patient about his or her terminal condition (Munoz, 2013). Filial obligations and gender aspects of caregiving in the Filipino culture that are linked to cultural norms, practices, and expectations require further investigation to understand family dynamics, caregiving strains, and outcomes.

As far as we know, there is currently none or limited information available on the caregiving experiences of Filipino caregivers to senior patients and factors influencing caregiving strains and outcomes as they settle into the new Canadian socio-economic, political, and health care environment. The purpose of this study is to address this gap by presenting accounts of immigrant Filipino family caregivers' experiences in providing care to patients with chronic and/or serious life-threatening conditions and show how their care was influenced by social and economic factors.

Methodology

The main focus of this qualitative study was to examine the type of care and factors influencing care and caregiving outcomes of immigrant Filipino caregivers who provide care to patients with chronic and/or serious life-threatening conditions. The field work was conducted between June and October 2013.

Guiding theories. This study was conceptualized by transcultural nursing, critical ethnography, and feminist research. Madeline Leininger, a nurse anthropologist, developed a theory of transcultural nursing that focused on human care in diverse cultural contexts. Leininger (1991, 1988, 1999) argued that with care being universal, individuals, nevertheless have diverse meanings, values, and norms that influence their decisions, patterns, and practices of care. Culturally congruent health care

requires a holistic understanding of individual, family, group, and institutional modes of care while considering the broader aspects of social structure, worldview, language, and the environmental context. Three modes are required to achieve culturally congruent care: 1) culture care preservation and/or maintenance that recognizes people's unique cultures to main cultural values related to care and health are conditions, 2) cultural care accommodation and/or negotiation helps people from diverse cultural backgrounds to negotiate care to attain the shared goals to achieve positive health outcomes, and 3) cultural care re-patterning and/or restructuring that enables patients to modify personal behavior while respecting their cultural values (Leininger, 1985, 2002). Through a critical ethnography lenses, researchers attempt to understand women's caregiving experiences, challenges that they experience and decisions they make with patients and health care providers (Leininger, 1990, 1997; Grewal, Botorff, & Hilton, 2005). As guided by the feminist standpoint and intersectionality theories, researchers attempt to be open to hearing women's perspectives, knowledge and experiences of caregiving in their lives, choices, and constraints they have to overcome (Hooks, 2000). In this study, the feminist approach enabled the researchers to listen to female caregivers' distinctive experiences of knowing and living in the caregiver role as immigrant Filipino females.

Sample and recruitment. A purposeful sample of caregiver-patient dyads in this study included: patients over 55 years of age who were the first generation of Filipino immigrants in Manitoba. The lead author (ZT) recruited participants by not only distributing a written announcement about the study but also by displaying posters in Asian grocery stores, churches, and at the University Manitoba. ZT used a snowball recruitment technique and asked participants to identify eligible participants from the community and help ZT to connect with them. This method of sampling is useful in helping researchers to locate and find people who are difficult to reach (Macnee & McCabe, 2008). ZT immersed herself in the Filipino community by attending cultural events and Sunday service at the local church. ZT built positive relationships with community members and spent time socializing with them, sharing information about the study and hearing their perspectives on caregiving in the community. These informal encounters helped ZT to learn more about the Filipino community life and verify information obtained during the study. ZT provided caregivers with a brochure on caregiving that was published by the Government of Manitoba (Government of Manitoba, 2013). Each participant received a ten dollar grocery gift card for their participation in the study.

Data collection. The interviews were conducted mostly in participants' homes. A few interviews were held in hospitals and

participants' workplaces. One interview was held in ZT's University office because of its convenient location for the participating caregiver. ZT and the research assistants administered written consents to participants that were followed by the demographic survey and audio-recorded interviews. Prior to the conduct of the study, written ethical approvals were initially obtained from the Research Ethics Board of the University of Manitoba and the University of Winnipeg.

ZT trained two research assistants (Ras), who were fluent in Tagalog, on how to conduct interviews and gain consent from participants in this study. The RAs, together with ZT, conducted six semi-structured interviews and four more during September to October 2013. Interviewers held separate interviews with female caregivers and with patients that were mainly organized at different times and sometimes at different locations. ZT also participated in the respective interviews and posed other questions. The audio-recorded interviews lasted about an hour. The participants had a choice to have the interview conducted in English or Tagalog. RAs conducted four interviews in Tagalog. Some interviews were also mixed with English based on participant preference or when the RAs did not speak Ilocano, one of the dialects in the Philippines. Since the RAs had limited experience in conducting interviews, ZT addressed RAs' concerns or questions during scheduled breaks in interviews and clarified whether or not they understood participants' responses. Moreover, ZT conducted four interviews with participants in English while Tagalog-speaking RAs translated and transcribed interviews in Tagalog. ZT also hired and trained a third RA, a non-Tagalog speaking individual, to transcribe the interviews done in English. Pseudonyms were used to protect the anonymity of the study's participants.

Data analysis

Data collection and data analysis were carried out. Content analysis was used to code and identify main themes that emerged from the transcribed interviews (Leininger, 1991; Graneheim, Hällgren, & Lundman, 2004). Two months after the interviews were completed, researchers communicated with the ten participants of the study to obtain their feedback, clarify any misunderstandings in the data, and to check on the accuracy of information captured in the transcripts. The interviewers' extended engagement with participants in their homes at scheduled visits helped to ensure the trustworthiness of information received during the interviews. The findings of the study were also presented at a community meeting and at academic events attended by Filipino community leaders, retirees, and private and public sector employees where ZT received feedback regarding this study's findings.

Findings

A sample of six caregiver-patient dyads was used. In one dyad, only the caregiver was interviewed because the patient left for the Philippines and had been in Canada for a visit. In another dyad, only the female patient was interviewed and her husband preferred not to be interviewed.

As shown in Table 1, all caregivers were female, around the age of 52 years, and Catholic, and had graduated from college or a university in the Philippines and/or in Canada. The caregivers identified themselves as either the wife, daughter, sister, or granddaughter to the patient. The caregivers provided care to the patient between three months and 16 years.

The patients (n=5) were generally 70 years of age, Catholic, retired, had worked as a labourer, and had an annual income that was below \$20,000. Three patients were widows who lived with their children, one patient was married and the other patient was single living on social assistance by herself. One male and four female patients were diagnosed with either stroke, tumor and stroke, diabetes and schizophrenia, kidney disease, or glaucoma and high blood pressure. One caregiver and two patients experienced memory loss. All patients received home care ranging from two to forty hours per week. A female patient on social assistance had received home care twice a week for a total of two hours. Patients with low or no income also seemed to have the lower home care hours provided to them.

Table 2 describes caregiving relationship characteristics. It is interesting to note that more caregivers than patients reported that caregivers often talked openly with the patient about his or her concerns and assisted the patient in dealing with issues arising from his or her illness.

Caregivers' tasks

Caregiving was shared among extended household members depending on their gender roles and identities. Female caregivers' care provision included such tasks as assistance with personal care (feeding, toileting, bathing, and dressing), mobility (walking, climbing stairs, transferring to the chair, the bed, and the toilet), and giving medications. Female caregivers cooked, cleaned the house, did laundry, changed beds, and changed patients' clothes. Female caregivers also took a lead role in care management tasks such as making appointments with doctors, case coordinators, social workers, and calling the emergency services. They also managed transportation, money, and made a schedule for the extended family members to bring food to the hospital. And they were assisted in care management by male and other extended household members.

Gender differences in care provision and care management tasks were significant. The findings of this study are consistent with previous studies on caregiving which document that women provided more "hands on" assistance than men including food preparation, household chores, shopping, laundry, and personal care (Pinquart & Sörensen, 2006; Luna, 1994). Some studies reported that male caregivers were more likely to arrange social services and transportation (Chang & White-Means, 1991). In contrast, this study revealed that female caregivers were more likely to arrange financial and social services than their extended kin male members. Women tended to take a lead role in negotiating care among extended household members.

Most caregivers in this study described that their tasks included health-promoting and healing practices in caring for their ill loved ones to provide spiritual, emotional and social support. For both caregivers and patients, prayer was a major health-promoting activity and also a matter of religious observance that helped to them to create a spiritually healthy place in the home and in the hospital. Praying together at dinner time, saying the rosary at home or in the hospital, and asking for communion if the patient could not attend chapel services or prayer time were all part of multiple responsibilities that caregivers assumed in their cultural and religious way of caring. In other words, prayer was integrated into the everyday caregiving routine of Filipino caregivers for members of their own families.

When carrying out multiple caregiving tasks while working, caregivers found time to address spiritual, physical and emotional well-being of patients and themselves. Religious rituals were one of the major activities that fostered bonding, support, and warmth between the caregivers and patients. Female caregivers also used religious rituals as a coping strategy to recover and address their own health issues, as well as, their feelings of anxiety and tension while working outside their home and caring for their respective patients. Belinda, a caregiver, shared how her husband used to read a Bible for four hours and she learnt a great deal from him. In this dyad, commitment and appreciation of each other's strengths were sources that fostered their strength-based relationship and communication. This dyad's strength-based communication was influenced by the caregiver's and patient's abilities to learn from each other, transfer knowledge, and engage in open dialogue, creativity, collaboration and commitment with and for each other.

For Filipino families in this study, the ritual structure in the family was a basic unit of social organization which empowered positive interactions amongst caregivers, patients, and extended family members. Some caregivers indicated flexibility and adjustments for prayer time such as going to the church not only on the weekends, but also during the week. Karen, a 21-year old caregiver shared this in her interview:

Table 1. Socio-economic characteristics of family caregivers and patients

Characteristics of family caregivers and patients	Family caregivers (n=5)	Patients (n=5)
Gender:		
Female	5	4
Male		1
Average age	52	70
Marital status:		
Married	2	3
Widowed	1	1
Single	1	1
Divorced	1	
Education:		
No education		1
Some/completed high school in the Philippines	1	2
College in the Philippines	1	1
University in the Philippines	1	1
University in Canada		
Currently an undergraduate student in Canada		
Relationship between family caregivers and patients:		
Wife	1	
Daughter	2	
Sister	1	
Granddaughter	1	
Religion:		
Catholic	5	4
No religious preference		1
Income:		
No income (social assistance)		1
Below \$20,000	2	2
\$20,00-\$39,999	3	11
\$40,000-\$59,999		
Chronic illness:		
Diabetes		2
Schizophrenia and diabetes		1
Stroke		1
Kidney disease		1
Care provided by caregivers		
Duration	From 3 months to 16 years	
Current treatment		
Yes		4
No		1
Type of current treatment		
Dialysis		3
Insulin		2
Medications		5
Past treatment		
Dialysis		4
Surgery		2
Physiotherapy		1
Duration of home care		
Frequency of home care per week	10 - 180 months 2-5 days/week	

Table 2. Degree of perceived communication and assistance between family caregivers and patients

Characteristics of family caregivers and patients	Family caregiver	Patient
Degree of assistance:		
Always	4	2
Frequently	1	1
Sometimes		1
Never		1
Degree of accompanying patients to medical visits:		
Always	3	2
Frequently		
Sometimes		2
Never	2	1
Perceptions on the caregiving contact:		
Daily	4	2
Less than weekly	1	1
Weekly		2
Degree of communication about illness:		
Always	4	1
Frequently		1
Sometimes	1	2
Never		1
Degree of perceived knowing patients' concerns about the illness:		
Very well	3	2
Somewhat well	1	1
Have some knowledge	1	1
Not very well		1

Interviewer: Yes. Uh, and uh, could you please share if you use some cultural knowledge like foods, or remedies, or prayers, or rituals with your Grandpa?

Karen: Um. My cultural, uh, I guess we always went to church together.

I: Yes.

Karen: And we also prayed together. As a whole family, so not just me and him. But my whole family would pray with him. Um, I know we'll go, we'll go to church to church on a weekday even. It doesn't have to be a weekend. But that would be... I guess one thing that kept my family together, would be church. Um. [pause]. Daily food. Uh, Filipino food. He really likes his coffee and this type of bread.

Through religious observance and making modifications in ritual activities, the caregivers "kept families together" by extending healing practices from private places such as home to public, churches and hospitals. Clearly, they re-inscribed

spatiality and temporality of their activities to create meaning through a new context in their lives. They stressed that the Filipino culture is based on the centrality of family and the collective well-being of all family members that are founded on religious observance and rituals. Love, respect, and care toward family members were integral parts of caregiving as captured in this study's sample of caregivers and patients.

In the interviews, some caregivers who described their experiences with severe caregiving strains preferred that patients live independently and be visited during the weekend. Patients who lived independently showed different ways of resilience in performing health promoting practices and religious observance to create healthy spaces in impoverished neighborhoods. Healthy spaces speak to individual's sense of agency through routine practices of food preparation and consumption, traditional healing and religious observance in forging healthy spaces within the specificities of migrant settlement (Dyck & Dossa, 2006). First, they prayed with non-family members of different religious backgrounds. For patients struggling with schizophrenia,

depression, and diabetes, they described that individuals who practiced other religions (e.g., Mormon, Jehovah's Witness) helped them to pray. Second, they watched religious programs on television to find spiritual help to deal with health conditions, cope with distress, and move on to a desired future. One of the patients declared that she attended TV Mass on Sundays and that she also attended prayer meetings in a tenant club in the Manitoba housing located in the North End.

Caregivers also described other tasks such as preparing meals especially since caregivers had a profound knowledge of the Filipino cuisine and pointed out that eating Filipino food was a key to the recovery and well-being of aging patients. Participants stressed that preparing Kare-Kare, Sinigang, Nilagang Baka, Menudo, Chopsuye, Pancit, Tinola, Chicken Adobo, Chicharon and other traditional Filipino dishes were part of their caregiving tasks. They believed that eating Filipino food is a pathway to their family members gaining strength and recovery. Like the South Asian and Afghani women in Ontario and women in Uzbekistan (Dyck & Dossa, 2007; Tursunova, Kamp, Azizova, Azizova, 2014), this study's caregivers acted as cultural brokers and d public spaces that were predominantly Eurocentric as demonstrated in dominant food consumption patterns (e.g., in hospital settings). Often Filipino caregivers say that they would meet with dietitians to consider accommodating Filipino diet or food preferences of patients. One senior patient participant, in particular, spoke about *lechon*, a roasted pig, as an important part of the Filipino diet. *Lechon* tends to be restricted to people with high blood pressure due to its high cholesterol content:

Actually they are trying to restrict the....they want her on diet. They want her to eat the food that they have here because they are having hard time regulating the sugar and cholesterol. It's harder so I used to talk to the dietitian and finally I said "Look Anna, I can't do that anymore because all the one you have on the list is a Canadian guideline—food guide. It's not going to work to my mom (sic). She will not eat potatoes or carrots. She will not eat that and I said "My mom is old, let's just give her what she wants." Since rice is a staple food and an integral part of the Filipino dishes, the 83-year-old patient who likes eating lobster and fish revealed, "I don't think I would've lasted this long if I didn't eat rice. One for breakfast, one for lunch."

Filipino patients did not like food in North America, especially food that was served to them in the hospital. These patients' caregivers would bring Filipino food to them daily.

Since the majority of Filipinos live in the Maples and West End districts predominantly populated by immigrants in Winnipeg, some Filipino caregivers had access to the Asian food stores with

ethnic food. For some low-income caregivers, the issue of affordability was prevalent and often resulted in high calorie intake and less nutritious food choices. The issues of availability of stores and its accessibility was an issue to caregivers and patients living on fixed incomes especially in the North End. The high price of limited healthy food choices offered by convenience stores in the North End have been linked to the growing epidemic of diabetes among marginalized communities (Redekop & Crosier, 2013). Large grocery stores such as Food Fare, Extra Foods, Zellers had been driven out of business because there were 62 convenience stores with inflated prices and no large grocery stores located in the North End in Winnipeg. Convenience stores often do not offer healthy food. This type of situation forces people to buy cheap processed foods (Baxter, 2012). Oliver De Shutter (2012), the UN Special rapporteur on the Right to Food said that "In Manitoba alone \$300 million went to treating diabetes. The costs will continue to increase and this will be one major reason why Canada cannot ignore adopting a national food policy" (p. 3). Thus, the lack of available healthy food and prevalence of processed foods are one of the major contributors toward increasing rates of diabetes in Manitoba that can reduce the well-being of caregivers and patients.

The caregivers in this study, moreover stressed, that they also modified Filipino food and reduced the patient's intake of salt and oil, preferred fully grained foods, offered lots of fruits and vegetables, and provided no genetically modified food to patients. Caregivers explained that they gained knowledge about a healthy diet through different sources, such as the Internet, doctors, television, and journals. Female caregivers stressed that cooking from scratch and sharing recipes and knowledge among household members were central in helping them maintain good health in the families they care for. Some caregiver tasks and caregiving roles extended as well into providing physical therapy and traditional remedies. In addition, they also knew reflexology and massaged ill family members and even offered traditional Filipino massage therapies. One young caregiver described that her grandparents who lived in the Philippines had shared traditional remedies with her such as White Flower. White flower is an ointment that is used for the temporary relief of minor aches and pains of muscles and joints due to backache, arthritis, or strains. Karen, a young caregiver described:

Ok, well, uh... He brought this medicine actually from the Philippines, uh, I don't know what it is. But it's a green ointment, and you put it on your skin when you have a sore back or something. It actually, I guess, makes your... Makes you feel better the next day.

The study also showed that Filipino immigrant caregivers and patients who have been in Canada for a long time have often been acculturated to the health care system. Most caregivers in this study came mostly from urban areas in the Philippines and they did not know much about home remedies and traditional Filipino healing methods. Studies of health practices among Filipino Americans suggested that people who immigrated from rural areas in the Philippines often knew about home remedies, traditional healing techniques, and supernatural ailments. On the other hand, those individuals immigrating from the urban areas in the Philippines tended to rely more on Western medical interventions and over-the-counter medications (Montepio, 1986).

Factors contributing to caregivers' strains

Employment, household status, and age were critical factors in predicting caregiving workload and strains for immigrant caregivers. All Filipino caregivers in this study described how they balanced caregiving responsibilities. Retired caregivers described that they had relied on a diverse range of coping mechanisms such as rotating responsibilities among siblings and/or being protective of the amount of their personal commitment. Arlene, a seventy-year old caregiver, said:

I would say 3/4 of the time I ignore my own needs and he has 3/4 of my time meeting his needs. But you see in the long run assessing your own situation for the long run, I need to take care of myself so I may be able to provide the care that he needs. So I'm at a point now where I said 'I have to be healthy so that I can provide help to him. And sometimes I go out of myself to make him comfortable and to make sure I meet his needs. So I would say 60 (laughter) for myself and 40 for him (laughter).

Retired caregivers seemed to balance their caregiving responsibilities successfully. In general, retired caregivers aimed to stay healthy to protect their personal, emotional, and physical well-being. They would spend leisure time with friends, go out for dinner, and watch Tagalog soap operas on television together. Some of them even volunteered at cultural events.

In contrast to retired caregivers, employed female caregivers experienced economic, financial, physical, emotional and time strains influenced by employment arrangements, household status, income, social networks, the life cycle stage, housing, and their neighborhood. Employed female caregivers also often experienced economic strain due their inability to generate income for their household. The caregiving strains mentioned were experienced by employed female caregivers' in specific ways. An example of such strains is that they had to juggle

several jobs, accommodate their schedules or quit their jobs due to their caregiving responsibilities. One caregiver who was pregnant experienced multiple stressors and poor health outcomes. While working seven days a week as a health care aide and also taking care of her children and a relative with chronic illness, she, sadly, had to give birth to a child with several disabilities. For some employed caregivers, caregiving affected their personal health and resulted in sleep deprivation and memory loss. Consequently, poor health often reduced these caregivers' work productivity and increased absenteeism resulting in a loss of human capital in the organizations. Other caregivers struggled to find jobs and quite often experienced overt discrimination during recruitment and marginalization when seeking employment.

Caregiving experiences and outcomes

Five caregivers in the study adhered to filial responsibility and norms. They appreciated the availability of the health care services which helped them meet their family members' health care needs. In addition, caregivers had a strong sense of commitment and responsibility to their caregiver roles and tasks. They highlighted that the most meaningful experience as a result of their caregiving responsibilities was being able to bond with their loved ones by going for walks, eating together, observing improvements, and seeing their family members survive and thrive after surgery. Karin, a 21-year-old caregiver, took care of her grandfather, Ernesto, who came to visit Karin in Winnipeg for three months. Ernesto had glaucoma since he was 21 years old. Among the daily activities they engaged in were praying with the family, going to church, and going for walks to the park or shopping centres around Winnipeg. Karin's family took Ernesto to the provincial beach, parks, and resorts before he returned to the Philippines. For Karin, it was important for her to engage in as many joint activities with her grandfather as possible in order to give value to their remaining time together, not knowing how long they would see each other again if ever he would decide to return to his home country.

One of the most transformative experiences for caregivers was feeling acknowledged for the work they do and being recognized as "good daughters". Maureen shared:

I'm the only daughter, but I'm not my mom's pet. So I'm not really. But that's the time when my mom see maybe that I'm the one to never leave her (starting to get emotional) from the start to the end and I'm so lucky when my mom (didn't finish thought). Because she went out of the hospital May 13 and my birthday is May 15 and when she come home that's the first time my mom told me that "I am lucky to have you in my life, because without you I don't

know what's happening to me." That's the first time I heard that from my mom.

Almost all caregivers spoke of their caregiving roles and behaviors as being tied to their identity as a daughter, a spouse, or a granddaughter. Montgomery, Rowe and Kosloski (2007) asserted that caregivers not only change their activity patterns but also the way in which they perceive their role identity in relation to the patient. Caregivers in this study reported how they incorporated their new activities into everyday life and also became the main decision-makers. Some caregivers argued that their identities were defined by their increasing involvement and intensity of caregiving tasks. Others, especially employed caregivers who could not meet caregiving expectations and adapt to the new caregiving tasks, resented to some extent their new caregiving identities.

Emotional distress and radical changes in their physical, emotional, and mental health were outcomes described by the majority of female caregivers who were employed. Some caregivers experienced health issues such as insomnia, dizziness, "almost leukemia," low hemoglobin, and bleeding. They also experienced emotional distress such as anxiety, frustration, and stress. Moreover, employed caregivers described that they had limited opportunities to spend good quality time with their patients, family members, and friends. In the end, all caregivers in this study had experienced positive bonding with their loved ones whom they looked after and developed a personal appreciation for their roles. Still, it is alarming to note that caregiving appeared to cost the health and well-being of caregivers in this study that is widely mentioned in other studies (Spitzer, 2006; Heidenreich, Koo, & White, 2013).

Discussion

The major findings in this qualitative study offer insights into caregiving tasks consisting of personal care and care management tasks. The division of caregiver roles and tasks in this study sample seemed to be gender-based that is similar to other study findings with different populations or caregivers in general (Koehn, 2009; Scharlach et al., 2006). For instance, the study on gender differences in caregiving among Chinese Canadian caregivers revealed that contrary to public belief that sons and daughters-in-law are main caregivers in the Chinese culture, daughters played more of a significant role in family caregiving (Lai, Luk, & Andruske, 2007) as revealed in the current study.

This study's findings also offered a deep and comprehensive understanding of the intensity of involvement of female Filipino family members (daughters, wives, sisters, and granddaughters)

in performing care tasks. These female caregivers were willing to provide care as driven by cultural and social values. Caregiving tasks included assistance with personal, medical, financial, and household care management. Female caregivers also engaged in health promotion to meet physical, emotional, and spiritual needs of their dependent family member.

Health promoting practices that were particularly important to Filipino caregivers included: observing healthy traditional food patterns, observing religious rituals, and engaging in prayer time with family members. These said practices were vital coping strategies in enhancing holistic health outcomes and quality of life in the Filipino culture. Barriers to accessible healthy food choices were significant for patients with low income and/or limited social networks. However, caregivers demonstrated their resourcefulness in being able to locate alternative sources of support and access to healthy food choices.

Caregivers' agency and deliberate strategic actions were shown through this study's caregivers. With their description on how they had integrated healing rituals into their everyday life activities, they were able to build healthy places in homes and hospitals for patients. Prayer was a central element of their identity, culture, and tradition as well--- that helped caregivers and patients to overcome difficulties in their lives. Moreover, Filipino caregivers with a Catholic background engaged in a range of negotiation activities to ensure that their patients could continue to participate in regular religious observance. The use of healing and health promoting practices is widely reported in other studies in Hindu, Chinese, and other immigrant communities (Mazumdar, 2009; Chiu, 2001). Whether there is a difference in caregiving and health promoting practices between non-Catholic versus Catholic caregivers, and when patients live on their own or with their caregiver deserves further inquiry.

Factors influencing care in many ethnic communities are related to a low socio-economic status that is also a predictor of poor health. However, many ethnic communities have strong kin networks of support in old age (Chappell & Funk, 2011). In this study, a sub-group of female caregivers appeared to experience distress due to their poor social networks. Filipino caregivers with poor informal social networks (e.g., family or friends) also inevitably lacked support from their community's social services. As described by Chow, Wong, and Poon (2007), structural factors such as family size, employment, housing, and stage of life cycle can reduce the ability of caregivers to secure filial piety as a support mechanism to reduce their caregiver distress.

Furthermore, many caregivers were challenged in balancing caregiving obligations with employment demands. The effects of work demands, employment status, and work

inflexibility can pose challenges to meet work demands and reconcile work and family caregiving that is well documented (Wang et al, 2011). Other studies drew attention to the effects of caregiving on employment and economic costs associated when caregiving demands were high (Lai, 2007). Caregivers' age, income employment, caring for an additional patient, types and intensity of care, and patients' financial security were key predictors of economic costs. Main predictors for male caregivers were age, caring for an additional patient, and their financial situation. Meanwhile, for female caregivers, financial situation and higher levels of caregiving tasks as compared to male caregiving were the main predictors of economic costs (Lai, 2007). The gendered nature of immigrant caregiver strains and predictors of economic costs requires attention by caregivers and health care providers to reduce caregiving stressors. Policy makers should take into account barriers that immigrant caregivers face in securing social support for themselves and not make assumptions about filial piety or duties that they believe exist in ethnic minority groups like the Filipino population (Lai, 2010).

Finally, this study demonstrated that caregivers' abilities to avert negative outcomes were important in balancing caregiving tasks and taking care of their emotional, mental, spiritual, and economic well-being. These findings suggest that it is crucial for caregivers to learn how to negotiate caregiver roles and set boundaries for themselves to stay healthy. Also, caregivers' abilities to share or distribute caregiving tasks' turns among extended family members were acknowledged by Filipino caregivers. More investigation is required to uncover the dynamics of caregiving in complex immigrant family units as impacted by filial obligations, socio-cultural and economic factors, and the gender dimensions of caregiving.

This qualitative study has several major limitations. Also, findings of this study cannot be generalized to all immigrant family caregivers living in urban and rural places in Canada. It was impossible to recruit male caregivers as well since they refused to participate in the study and share their experiences. Although the current sample was comprised of caregivers with a specific range for their socio-economic status, it was difficult to recruit caregivers who held several jobs or had a low-income. It must be noted too that community members who assisted in the study's recruitment of participants affirmed challenges in being able to recruit female caregivers who are distressed due to their dual work and caregiving obligations. Hence, future studies should examine the experiences of both immigrant female and male caregivers to better comprehend gender differences in caregiving experiences, its dynamics, and the economic strains in meeting both caregiving and employment role expectations.

Conclusion

Major findings in this qualitative study offer insights as to the linkage among caregiver tasks, influencing factors, and outcomes of the caregiver role in the Filipino culture. Employed immigrant female caregivers especially experienced multiple economic, emotional, and time strains. For instance, they had to deal with physical demands placed on them and on their own health outcomes which often reduce their economic productivity. Health care providers and policy makers should, therefore, provide special attention to the needs of employed immigrant caregivers through home care, especially those with low or no income.

Filial obligations and expectations in the Filipino culture for females to assume caregiving tasks were consistently expressed by caregiver participants. These caregivers' main concerns were for the physical, psychological, and spiritual well-being of senior patients and themselves. In this study of caregiving in the Filipino culture, there were gender-related role expectations for female family members to manage the majority of caregiving tasks. Health care providers and policy makers, thus, should be aware of and focus their attention on the intersectionalities of caregiving and caregivers' financial adequacy, poverty, and gendered nature of caregiving in the perplexing context of resettlement in Canada. Policy and clinician decision-makers who are informed about immigrant caregiver issues can better address the intensity of caregiver strains and familial obligations when designing effective systems and individual level interventions to support immigrant family caregivers. •

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