

African Migrant Women Working
in the Australian Aged Care
Sector

by

Temitope Olasunkanmi-Alimi

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ABSTRACT

There has been very little research that explores the experiences of migrant aged care workers in Australia, and none that focuses specifically on the experiences of women aged care workers who have migrated from Africa. This thesis fills this empirical gap. It is guided by two research questions:

1. What are African migrant women's experiences of racism in the aged care sector?
2. Can African migrant women meaningfully challenge racism while undertaking aged care work?

In answering these questions, the thesis aims to:

- identify expressions of racism against African migrant women workers in aged care; and
- conceptualise how African migrant women respond to racism in their aged care work.

In this thesis I draw on data generated through in-depth, semi-structured interviews conducted with 30 African migrant women working in residential care and home care in Adelaide, South Australia. My findings indicate that African migrant women working in aged care are subject to micro-aggressions and institutional racism. This racism manifests in ways that deny the ability of these workers to care for and care about clients, and that position them as not 'real' carers.

The data indicated that micro-insults are most commonly perpetrated by clients' families and co-workers and are often expressed through assumptions that the African workers are incompetent, thus devaluing their skills. The study participants also described experiencing institutional racism in the design and delivery of training and induction programs, with regard to expectations about their English language proficiency, and in formal complaints/reporting processes. Interactions, processes and practices that deny and overlook the racism experienced by these workers has left them feeling 'Othered'.

Participants reported that they respond to micro-assaults perpetrated by clients

and colleagues through asserting their professional identity and professional pride. This enables them to reinterpret client racism to allow a more meaningful framing of their work, and directly challenge racism directed at them by colleagues and, to a lesser extent, clients. Participants also communicated that they draw on their religious faith and the knowledge and support of others in similar positions. While symbolically important, strategies they use have done little to effect systemic change or prevent future racism towards them on the part of clients or colleagues.

While the focus of this thesis is the expression of interpersonal and institutional racism, I contextualise these by making links to the colonial foundations of racial micro-aggressions and institutional racism with reference to the work of Stuart Hall and Whiteness theory. In doing so, I highlight how micro-aggressions and institutional racism are underpinned by colonial discourses which 'Other' particular racial groups, constructing them as less capable and 'backward' in relation to the 'West'.

My findings give rise to a series of recommendations that are designed to shift the responsibility of managing racism from workers and embed them in institutional processes instead. However, any institutional strategies to redress racism through 'multicultural training' or 'cultural competencies' need to be sensitive not only to individual racist behaviours, but to the Whiteness that structures practices and expectations in the aged care system. The problem, I suggest, needs to be reframed from one of intercultural difference, understanding or communication, to the historical and colonial hierarchies that underpin individual and institutional racism – an issue that is far more complex.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text.

Temitope Olasunkanmi-Alimi

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1 INTRODUCTION

1.1 Origins of this Thesis

I am an African migrant woman. When I first started my PhD, I began reading publications on a range of aged care studies that describe ample employment opportunities in the sector (Isherwood & King, 2017; Xiao, Willis, et al., 2017a). However, many Australians do not consider the sector attractive (Negin, Coffman, Connell, & Short, 2016), because the conditions are stressful, and aged care work is considered low status (Heckenberg, Kent, & Wright, 2018; Howe, Charlesworth, & Brennan, 2019; Meagher, Cortis, Charlesworth, & Taylor, 2019). As a result, there are low staffing levels and a high staff turnover in the aged care sector (Howe et al., 2012). In contrast, and to my surprise, aged care is the 'go to' industry for my African friends and community. Many had been talked into working in the sector before they came into Australia; or heard recommendations from family members and friends.

The experiences of my friends and community reflect the increasing prevalence of African migrants in the Australian aged care sector (Mavromaras, Knight, & et. al, 2017; Negin et al., 2016). The questions I kept getting from my African friends were: have you registered for the aged care course? Do you work in aged care? Why are you researching in this area if you are not working in aged care? I pondered on these and I also found myself asking: why is there an increasing prevalence of African migrants in aged care work? And why do so many African women work in aged care, regardless of their professional experience and qualifications back home? What was it that motivated them to work in this sector? I began to understand that there is a relative ease in securing a job in this industry compared to other sectors in Australia. In 2013, the National Aged Care Census and Survey described skill shortages in this country across residential facilities and home care contexts (King et al., 2013). For others, the decision to work in aged care was made because they could not secure employment in Australia in their chosen areas of expertise (Charlesworth & Isherwood, 2020; Nichols, Horner, & Fyfe, 2015), which typically included nursing, public health, business administration and the education sector. The foundations for the research I present here were created from this intersection of my friends' experiences and expectations, and the significance of aged care as an employment sector for African migrant women.

The Australian aged care sector is a diverse workforce with a significant proportion of

migrants (see Berg, 2015; Boucher, 2009; Eastman, Charlesworth, & Hill, 2018a; Hawthorne, 2011; Khoo, McDonald, & Hugo, 2009). The proportion of African employees continues to increase (Australian Government, 2016; Negin et al., 2016; Willis et al., 2018), and they contribute significantly to the sector (Adamson, Cortis, Brennan, & Charlesworth, 2017). There have been some discussions in the literature around the need to better meet the care requirements of aged care clients from culturally and linguistically diverse (CALD) backgrounds, with use of migrants seen as a viable option (Adamson et al., 2017; King et al., 2013). Also, studies have noted difficulties within the aged care sector in including CALD workers and managing the multicultural workforce with a view to harnessing the benefits that could be derived from this workforce (Gillham et al., 2018; Parliament Australia, 2016; Xiao, Willis, et al., 2017b). One issue the sector has grappled with is that some workers migrate to Australia as students on temporary visas (Eastman et al., 2018a), and others lack sufficient English language competence (Adamson et al., 2017). These challenges have often been framed as intercultural challenges around Australian-born and overseas-born staff working together to care for residents (Gillham et al., 2018; Isherwood & King, 2017; Xiao, De Bellis, et al., 2017).

Other challenges in aged care that have been described in the literature include: the pressures on staff managing the complexity of clients' health challenges; the changes in aged-care delivery models, which give clients more control over services through consumer-directed care; and the de-professionalisation of the workforce in terms of the reduction in number of nurses and increase in the number of personal care workers (Commonwealth of Australia, 2017; Productivity Commission, 2011). These discussions have positioned migrant workers as a group facing many of the same challenges of Australian-born, typically White workers – albeit with additional language or cultural difficulties.

However, as I talked more with my circle of friends working in the sector, they began to share with me experiences which suggested very specific difficulties faced by migrant workers. They described how racism was perpetrated in their working relationships with clients, co-workers and by the institution at large. Their migration to Australia and work in the aged care sector conferred on them a realisation of their migrant status. They experienced a racialisation of their African bodies – a burden of being Black subjects in Australia (Mapedzahama & Kwansah-Aidoo, 2017), and Blackness became attached to their identities (Mapedzahama, Rudge, West, & Perron, 2011).

I realised that their experiences, and their vulnerabilities to an array of both obvious and more subtle workplace aggressions and disrespect, were shaped by an interplay of their gender, race and cultural background (Crenshaw, 2015). Being a migrant woman and a woman from an ethnic minority background places them at multiple levels of jeopardy, in terms of employment opportunities (Nash, 2014). In addition, the disadvantages which result from engaging in migrant labour affect their social identity, their everyday interactions with others in the work environment, and their sense of self-worth and significance in the workforce (Ashforth, Harrison, & Corley, 2008).

I wanted to pursue these issues more formally in my studies, because I have always loved to research areas relating to women in work and the experiences of migrant women settling in developed countries. These issues have also become important to me because staff from Africa – and specifically migrant women – have made increasingly significant contributions across many levels of the aged care workforce (Nichols et al., 2015; Willis et al., 2018). Immigrant care workers are increasingly mitigating the care crisis; filling the worker gap (Fine & Mitchell, 2007; Hugo, 2007), and meeting the care needs of old and vulnerable people in the context of the privatisation and de-familiarisation of care (Hugo, 2009b; 2013). Yet, as they make these significant contributions to the sector, the experiences of African migrant women of aged care work are markedly shaped by interpersonal and institutional racism. I am personally driven by the desire to see these women make contributions that are not only recognised and valued but made in a non-racist and anti-racist context. I want to be able to imagine a workforce where migrant women do not have to deal with racism on a regular basis; where they are given equal recognition; where they feel supported by their colleagues and managers; and where clients treat them with respect. This thesis cannot, by itself, achieve this ideal; but it is a necessary early step towards taking seriously the experiences of African migrant women working in residential care and home care in Australia.

I am aware that my focus on African women's experiences present a partial account of racism in aged care. In particular, I am sensitive to the importance of recognising the experiences of Indigenous Australians in aged care and in care work generally. Australia's long history of racism and colonialism was first and continues to be perpetrated against Indigenous Australians in ways that shape their access to aged care employment and how they are valued – or unvalued – in this space. These are complex issues, requiring a sustained analysis that is outside the scope of this thesis.

1.2 Aims and Research Questions

Specifically, the aims of this thesis are to:

1. Identify expressions of racism towards African migrant women workers in aged care.
2. Conceptualise how African migrant women respond to racism in aged care work.

These aims, in turn, inform the research questions driving this thesis, as follows.

1. What are African migrant women's experiences of racism in the aged care sector?
2. Can African migrant women meaningfully challenge racism while undertaking aged care work?

1.3 The Context of This Study: Aged Care in Australia

Aged care refers to the provision of care services to older people who have reduced capability to care for themselves as a result of physical or mental disability, and who therefore require support with: health care – nursing and medical attention; dietetics and accommodation; domestic tasks (cleaning, laundry) and social outings; and personal care, primarily toileting, dressing and feeding (Productivity Commission, 2011; Smith, 2019). Assistance can be given to elderly adults either in their homes, or in a residential aged care facility (nursing home) for those who can no longer live at home. In line with the Aged Care Funding Instrument (ACFI), older people are admitted into residential care on an 'ageing in place' basis (Australian Government Department of Veterans' Affairs, 2014, p. 1). This means that clients' needs are assessed, and they are accepted into residential care based on their needs, the availability of vacancies in nursing homes, and the provider's agreement. According to the Australian Bureau of Statistics' 2015 *Survey on Disability, Ageing and Carers*, about 94.8% of clients who required care in 2015 received it in their personal homes, while 5.2% received care in residential care (Australian Bureau of Statistics, 2015). The women who participated in my research worked in aged care in both residential and home care settings.

Aged care is described as one of the largest industries in the Australian workforce. The most recent figures indicate the industry hires about 366,027 workers (Mavromaras et al., 2017), with 240,317 in direct care roles, which amounts to approximately 3% of the total Australian workforce (Parliament Australia, 2016). In response to the Senate

Inquiry report (Parliament Australia, 2016) on the need to recruit more workers for aged care providers and the aged care industry, the Australian government allocated \$33 billion in funding to recruit workers trained in different specialisations including dementia care, palliative care, and general practitioners and other health professionals, to meet the needs of the increasing ageing population (Australian Government, 2018).

In 2015, 52% of residential aged care facilities were owned by the not-for-profit sector, 37% by private for-profits and 11% by the government (StewartBrown, 2014; Willis et al., 2018). In South Australia – where this study was conducted – the most recent data reported there are more than 115 aged care providers in the state, with more than 400 residential aged care facilities (Service SA, 2010) providing services to 17,000 residential aged care homes (Australian Institute of Health and Welfare, 2010; Service SA, 2010). These mostly cater for Australian-born clients. Unfortunately, these data are now over 10 years old. Between 2017 and 2018, over 1.3 million Australian clients received care; a greater proportion of these were in home-based care, with fewer in residential aged care facilities (Smith, 2019).

The socio-demographics of the aged care sector are strikingly different from the Australian workforce overall, in terms of gender. The sector employs predominantly female workers. In 2017, 87% of residential aged care workers and 89% of home care and home support workers were female (Mavromaras et al., 2017). In terms of educational level, 90% of aged care workers had post-secondary qualifications in 2016, with 75% in possession of a Certificate III in Aged Care (Mavromaras et al., 2017). Seventy-eight per cent of aged care workers in residential aged care facilities were employed on permanent part-time contracts, 12% on full-time permanent, and 10% on a casual/contract arrangement (Mavromaras et al., 2017).

1.3.1 The 'problem' of aged care

There has been a fast growth in the ageing population in Australia (Cotis, 2005; Hugo, 2007; Pocock, 2005), and a projected increase in the number of people who will be living with disabilities related to advanced age from 1.4 million in 2003 to 2.5 million in 2021 (Hugo, 2007, p.172), and will be needing support in residential aged care facilities or home care (Fine & Mitchell, 2006, 2007; Hugo, 2007). Challenges with staff shortages to meet the care demands of older adults has also been reported (Mavromaras et al., 2017).

Due to pressures arising from the increasing needs of the ageing population, commentators over the last decade or more have been identifying a 'care crisis' (Fine & Mitchell, 2007; Hugo, 2007; 2009b), and note the increased significance of care as key problem in policy and social life (Fine, 2006). This has partly emerged from a change in family structures and practices, with many offspring living far away from their parents and unable to provide care. This has been further exacerbated by the greater proportion of women working outside the home (Hugo, 2007; 2009a), which has altered the dynamics of family care. Previously, women were the predominant unpaid care givers for their families (Datta et al., 2006; Yeates, 2005) – a pattern that reflected the gendering of labour, which defined care as feminised work. In the context of these social changes, there have been changes to aged care provision from a family-based practice to more formalised, privatised and commercialised aged care (Green & Lawson, 2011; King, 2007). Migrants, including African migrant women, are playing an increasing role in solving the care crisis (Adamson et al., 2017; Fine & Mitchell, 2007; Howe, 2009; Hugo, 2009b).

These changing aged care needs have been defined as a policy 'problem' to be solved through improving staff recruitment and training processes. For example, a Department of Health report (2017) and an earlier Productivity Commission Inquiry report (2011) described the need for a bigger aged care workforce, requiring a growth in workers from 366,000 in 2017 to 980,000 people in 2050 to meet the demands of older adults requiring aged care services (Department of Health, 2017; Productivity Commission, 2011). The Senate Inquiry into the Future of the Aged Care Workforce noted that to meet these demands, the sector needs to recruit younger people, mature adults, mothers returning to work, migrants and people looking for a new career (Parliament Australia, 2016). The recruitment of migrants, including African migrant women, have also been seen as a viable means of addressing the care crisis (Adamson et al., 2017; Fine & Mitchell, 2007; Howe, 2009; Hugo, 2009b).

On top of increasing pressures and demand, the aged care sector has "faced regular scandals" (Smith, 2019, p. 1) about the quality of work conditions, and is "struggling to attract and retain skilled workers" (Parliament Australia, 2016, p. 43). Several government inquiries, including a Senate Inquiry into the Future of the Aged Care Workforce, found that some of the reasons for low staff retention are the poor reputation of the sector; poor working conditions, including high client staff ratios, high workload and low remuneration; and a low ratio of registered nurses to personal care attendants

(Department of Health, 2018; Parliament Australia, 2016; Productivity Commission, 2011). In policy terms, these are understood as hindrances to expanding the workforce, leading to a workforce shortage.

The need for more workers sits alongside concerns about the quality of care being provided in the aged care sector. These concerns are a core focus of the recently concluded Royal Commission into Aged Care Quality and Safety in Australia (2018). The findings of this Royal Commission concur with those of the earlier Productivity Commission Inquiry report, which stated:

The aged care sector suffers key weaknesses that are difficult to navigate. Services are limited, as is consumer choice. Quality is variable. Coverage of needs, pricing, subsidies and user contributions are inconsistent or inequitable. Workforce shortages are exacerbated by low wages and some workers have insufficient skills. (Productivity Commission, 2011, p. xxii)

Previously, the Senate Inquiry into the Future of the Aged Care Workforce concluded that aged care requires an appropriate mix of skilled workers – including nurses, allied health practitioners, medical professionals and personal care attendants – to meet the complex health and living needs of older adults who require palliative care, and those with dementia and cognitive impairment, mental illness and communication disorders (Parliament Australia, 2016). Thus, in the context of needing to attract, train and retain more individuals for the aged care workforce to meet the growing client demand, the Senate Inquiry report cites an argument by Professor Graeme Samuel:

To ensure quality care, aged care services must have an adequate number of skilled, qualified staff committed to providing person-centred care. The workforce must have appropriate education, training, skills and attributes to provide quality care for older people, including people with dementia, who frequently have complex care needs. To attract and maintain the right workforce, equitable pay conditions and appropriate career paths will be needed. (Samuel, 2016, p. 29; see also Parliament Australia, 2016, p. 43)

These reports into aged care tend to frame problems within the sector as structural: an ageing population, a labour force that is too small and unskilled, and poor workplace conditions. Little attention is paid to the experiences and needs of the workers. Charlesworth and Isherwood (2020) note that there have been no migration strategies to assist the migrant workers who have been defined as one solution to meeting the challenges of aged care demand.

In Australia, there has been ambiguous acknowledgement of the challenges of embracing

cultural diversity in the workforce. Rather, the emphasis has been on the need for cultural awareness on the part of clients (SA Health and Community Services Skills Board, 2011). In terms of racism from co-workers and management, the SA Health and Community Services Skills Board (2011, p. 8) reported that Australian workers do not want to work with CALD workers, but this has been attributed to concerns over adding to their "workload rather than race". This report did acknowledge the existence of racism in the aged care sector, perpetuated by elderly people, management and staff; however, this was not its focus. Further, the solutions offered were aimed at enhancing cultural awareness within the sector, rather than a more robust tackling of racist attitudes and processes (SA Health and Community Services Skills Board, 2011). The 2013 National Aged Care Census and Survey also found that CALD workers experience racism in relation to cultural and language barriers. However, this experience of racism was not unique to those employed in aged care, but faced by CALD workers throughout the Australian society in general (King et al., 2013). Overall, the literature to date has tended to downplay the existence and impacts of racism on migrant aged care workers.

1.3.2 Positioning migrant workers in the aged care sector

In the Australian policy context, there has been a growth in the proportion of the overseas and migrant workforce, from 25% in 2012 to 32% in 2017 (Mavromaras et al., 2017). More than half of this workforce come from home countries where English is not the primary language (King et al., 2013). The countries sending the most migrants to work in aged care in Australia in 2012 were India, China and the Philippines (Isherwood & King, 2017; King et al., 2013). More recently, there has been a growing number of migrants from Asia, the Middle East, South America and, more rapidly, workers from Africa (Australian Government, 2016; Mavromaras et al., 2017). The number of aged care facilities hiring CALD workers recorded an increase from 79% in 2012 (King et al., 2013) to 91% in 2017 (Mavromaras et al., 2017), with 32% of those born overseas employed in residential aged care, and 23% of these overseas-born staff employed in home care and home support work (Mavromaras et al., 2017). It is worth noting, however, that the data available from the most recently published studies on aged care do not make visible the proportion of women from ethnic minority backgrounds working in the Australian sector (Howe, 2009; King et al., 2013; Mavromaras et al., 2017).

1.4 Why This Study is Significant

1.4.1 Understanding the specific needs and experiences of African migrant women working in aged care

In the context of the aged care crisis, migrants have been identified as an important cohort for meeting the staffing requirements needed to service an ageing population in Australia (see Adamson et al., 2017; Fine & Mitchell, 2007; Howe, 2009; Hugo, 2007; 2009b) and internationally (Callister, Tortell, & Williams, 2009; Fujisawa & Colombo, 2009; Simonazzi, 2009; Williams, 2012). Aligned with this focus, the bulk of the academic/government discourse on aged care to date has centred on the importance and challenges of harnessing the cultural competency of the multicultural workforce (see all Barnett, Howard, & Moretti, 2015; Chen, Xiao, Han, Meyer, & Müller, 2020; Parliament Australia, 2016; Siewert, 2015; Spencer, 2010; Xiao, Willis, et al., 2017; Xiao et al., 2020); and the need to raise the cultural awareness of individual workers and aged care providers, in order to meet the needs of a multicultural client group and promote client-centred care through enhancing cross-cultural understanding (Gillham et al., 2018; Nichols et al., 2015; Willis, et al; 2018; Xiao, Willis, et al., 2017a; 2017b; Xiao, De Bellis, et al., 2017; Xiao et al., 2018; Xiao et al., 2020). In this framing, the raced or ethnic identity of workers is almost solely discussed in terms of their capacity to connect clients to their ethnic background, or with the aim of improving worker skills in order to maintain quality standards in the provision of care to clients (Adamson et al., 2017; Cangiano & Shutes, 2010; Martin & King, 2008; Mavromaras et al., 2017). There is very little emphasis on the experiences of the migrant workforce as a group of people with their own professional needs and experiences.

There is a growing body of research being undertaken on migrants, including African migrants, employed in different forms of care work in Australia, most notably nursing (Mapedzahama, Rudge, West, & Kwansah-Aidoo, 2018; Mapedzahama, Rudge, West, & Perron, 2012; Omeri & Atkins, 2002; Willis et al., 2018; Xiao, Willis, & Jeffers, 2014). A considerable number of studies have also been conducted internationally (Alexis & Vydelingum, 2004; Allan, Cowie, & Smith, 2009; Allan, Larsen, Bryan, & Smith, 2004; Larsen, 2007; Larsen, Allan, Bryan, & Smith, 2005; Likupe, 2006; 2013; 2015; Likupe & Archibong, 2013; Showers, 2015). In Australia, there is no specific research with African migrant aged care workers as the sole focus, although some studies have included their experiences as part of a focus on ethnic minorities generally in the aged care workforce (Adebayo, Nichols, Albrecht, Brijnath, & Heslop, 2020; Adebayo, Nichols, Heslop, &

Brijnath, 2020; Gillham et al., 2018; Goel & Penman, 2015; Nichols et al., 2015; Willis et al., 2018; Xiao et al., 2018; Xiao, Willis, et al., 2017b). Given that African migrant workers play an increasingly significant role in the provision of aged care, it is important that their particular experiences be addressed.

Isherwood and King (2017) draw attention to the fact that much of the existing research has explored the experiences of 'migrants' as a single group, and categorised the work experiences of migrant workers in aged care as a single group, as if migrants from different cultural backgrounds all face the same challenges. A study by Charlesworth and Isherwood (2020) determined that migrants from non-English speaking backgrounds who work in home care in Australia are more likely than their Australian-born colleagues to be placed in casual positions and experience work insecurity (underemployment), while their migrant counterparts from English-speaking countries experienced underemployment. Charlesworth and Isherwood concluded that the employment conditions of migrant workers from non-English- and from English-speaking backgrounds in aged care differ from those of their Australian-born colleagues (Charlesworth & Isherwood, 2020).

Research undertaken in the European context has similarly determined that the country of origin and ascribed race identity of migrant workers tend to shape their experiences of aged care work. In the Irish long-term care sector, workers from Africa, South-Asia and Europe reported different experiences of work relationships with clients and colleagues (Timonen & Doyle, 2010), as did migrant workers from Nordic compared with non-Nordic nations in relation to working conditions in the Swedish care sector (Jönson & Giertz, 2013). Willis et al. (2018), on the other hand, noted similarities in the experiences of Indo-Asian and African care workers in not-for-profit, faith-based aged-care organisations in Australia with a strong emphasis on cultural diversity. Neither of the Australian studies by Charlesworth and Isherwood (2020) and Willis et al. (2018) were focused on race. This thesis, as one of the few research studies dedicated to African migrant workers in aged care, fills an important gap in building empirical knowledge of the experiences of African migrant workers.

1.4.2 Recognising micro-aggressions and institutional racism in aged care

In addressing this empirical gap, I also extend existing theorising on the experiences of African migrant workers in aged care to provide an in-depth analysis of race and racism,

using the theoretical tools of micro-aggressions and institutional racism. Australia is a racist country, with roots in invasion, genocide and dispossession and a history of racist policies such as the White Australia policy (Dunn, 2004; Huggan, 2007). Contemporary Australian workplaces are also racist. In the broader care sector, research has indicated that racism towards workers is particularly evident in nursing – taking the form of either manifest racism and racial prejudice perpetrated by other nurses (Mapedzahama et al., 2012; 2018), and workplace bullying (Allan et al., 2009); or a lack of recognition of nurses’ overseas qualifications and English language proficiency (Allan & Larsen, 2003; Hawthorne, 2001; Likupe & Archibong, 2013; Omeri & Atkins, 2002). In aged care, racism is commonly manifested through a lack of institutional support for migrant care workers (Goel & Penman, 2015; Nichols et al., 2015).

In the literature on aged care, little attention has been paid to how client racism shapes the experiences of the migrant workforce. Mapedzahama et al. (2012) note that racism, at least nurse-nurse racism, is hardly mentioned or described in the nursing literature, effectively portraying a race-less workplace and downplaying the narratives of racism in this workforce. This critique is also applicable to studies of the aged care workforce, which do not adequately attend to how issues of cultural background and race shape the workplace experience of migrants (Goel & Penman, 2015; Isherwood & King, 2017; Nichols et al., 2015). Rather, attention and policy interest in Australia has focused on cultural competence and improving the skill mix of aged care workers in relation to meeting clients’ needs (Conway, 2007; Parliament Australia, 2016). A focus on workers’ accounts of race and racism will provide a more robust understanding of migrant workers’ experiences and the realities of working in aged care in the Australian context.

To centre racism in my research, I conceptualise African migrant women’s experiences using racial micro-aggressions theory, which was formulated by Sue, Capodilupo and Holder (2007) to identify and explain the typologies of everyday manifestations of racism and racial prejudice. Micro-aggressions are a form of everyday racism (Dunn, Forrest, Burnley, & McDonald, 2004; Essed, 1991; Kwansah-Aidoo & Mapedzahama, 2018a; Stratton, 2006; Walton, Priest, & Paradies, 2013). They are expressions of racism that are easily overlooked or dismissed, and are invisible to the perpetrator and, sometimes, the recipient (Sue, 2010; Sue, Capodilupo, & Holder, 2007; 2008). Victims who recognise the existence of micro-aggressions do so on the basis of a lifetime of experience and contextualised interactions (Sue, Capodilupo, et al., 2008).

A focus on micro-aggressions assists in my research to develop a more sophisticated understanding of racism in the workplace; an understanding that extends beyond 'big' or extreme expressions of racism, and attends to the subtle and pervasive racist acts that are frequently experienced by people from minority ethnic groups (Deitch et al., 2003; Sue, Capodilupo, & Holder, 2007; Sue, Capodilupo, et al., 2008). Micro-aggressions are a form of everyday racism most commonly encountered by people from ethnic minority groups and perpetrated against them. Therefore, to understand the experience of being a migrant worker in aged care, we need to understand day-to-day experiences of racism as well as the more obvious – and arguably more easily denounced – expressions of racism. Indeed, Deitch et al. (2003) suggest that in the workplace there has been a shift from extreme forms of racism towards 'modern' racism; i.e. the more subtle and everyday micro-aggressions. It is these everyday micro-aggressions that typically constitute African migrants' lived experience of racism (Essed, 1991; 2002; Keith, Nguyen, Taylor, Mouzon, & Chatters, 2017; Kwansah-Aidoo & Mapedzahama, 2018b; Sue, Capodilupo, et al., 2008; Torres, Driscoll, & Burrow, 2010).

Given that workplaces tend to have policies and rules that discourage obvious forms of racism (Dovidio and Gaertner, 2000), it is unsurprising that subtler forms of racism would be more widely manifest and experienced in the workplace. Even if the apparent decline of 'overt' or 'big' racism has no empirical grounding (and it is beyond the scope of the thesis to explore this question), investigating the more subtle forms of racism is an important step towards understanding racism experienced by marginalised groups, and the theory on micro-aggressions formulated by Sue et al. (2007; 2008) is an appropriate tool in this regard.

I extend my investigation on micro-aggressions and the interpersonal expression of racism to interrogate the processes of institutional racism and the interplay between interpersonal racism (micro-aggressions) and institutional racism, in order to create a holistic picture of workers' experiences of racism. Institutional racism refers to the existence of unequal opportunities through privileging one group and disadvantaging another group in workplace institutions, which is reflected in unequal access to material resources and professional opportunities for marginalised groups (Came, 2014). Institutional racism is manifested through the everyday practices and operations of institutions that discriminate, assume ignorance, are thoughtless, perpetuate racist stereotypes, place dominant groups at the centre of the organisation, and overlook the experiences of subordinate groups classified as the 'Others' (Berard, 2008; Bourke,

Marrie, & Marrie, 2019; Lipsitz, 2006; Macpherson, 1999).

Previous studies have acknowledged that institutional racism and prejudice exists in healthcare systems globally, including in the nursing and aged care sectors (see all Berard, 2008; Bourke et al., 2019; Doyle & Timonen, 2009; Goel & Penman, 2015; Henry, 2007; Johnstone & Kanitsaki, 2008; 2010; Miller & Garran, 2007; Nichols et al., 2015; Sethi & Williams, 2016; Timonen & Doyle, 2010). However, some authors have noted that there is still not enough focus on institutional racism, given that workplaces (a type of institution) are a key site for the expression of racism (Berard, 2008; Hobbs, 2018; Johnstone & Kanitsaki, 2010; Mapedzahama et al., 2012).

Indeed, there is a need to interrogate workers' experiences with reference to institutional processes, given that health care policy discussions understand the position and value of migrant workers largely in terms of their role in the care workforce. This need is intensified because of the negative consequences of institutional racism on marginalised groups (Goel & Penman, 2015), which affect their access to employment and promotion opportunities (Henry, 2007). Failure on the part of an institution to acknowledge migrant workers' experiences of racism both enables and reproduces racist acts perpetrated by clients and co-workers (Doyle & Timonen, 2009; Mapedzahama et al., 2012; Timonen & Doyle, 2010). An investigation of institutional racism offers a means of acknowledging racism that is not 'obvious' but is nevertheless recognised and deeply felt by ethnic minority groups. Researching and interrogating the experiences of racism beyond those rooted in individual intent facilitates a critical focus on the racial logics of workplace structures and practices that are too often taken for granted.

My thesis is innovative in that I not only elucidate the micro-aggressions and institutional racism experienced by African women in the aged care system, but I contextualise these in relation to the historical precedents that inform contemporary experiences of racism. I make links to the colonial foundations of racial micro-aggressions and institutional racism with reference to the work of Stuart Hall and Whiteness theory. Specifically, I reveal how experiences of racism originate from colonial discourses which 'Other' particular racial groups, constructing them as less capable and 'backward' in relation to the 'West' (Hall, 1992). I also use Whiteness theory to offer a broader historical context for how micro-aggressions and institutional racism are experienced. These theories extend our knowledge of how historical and colonial views of race and 'Otherness' continue to shape marginalised groups in current times, and how they underpin the racism that shapes

their work experiences.

1.4.3 Policy and practice significance

Finally, I want to emphasise the policy and practice significance of this research. Previous studies advocate for the need to explore and understand the experience of migrant workers to ensure an efficient and effective workforce to meet the demands of aged care (Mavromaras et al., 2017; Parliament Australia, 2016; Smith, 2019). These arguments generally refer to 'multiculturalism' or 'cultural competence and inclusivity' or 'migrant' workforces (Chen et al., 2020; Goel & Penman, 2015; Isherwood & King, 2017; Nichols et al., 2015; Tune, 2017; Willis et al., 2016; Willis et al., 2018; Xiao, Willis, et al., 2017a; 2017b; Xiao, De Bellis, et al., 2017; Xiao et al., 2018; Xiao et al., 2020), and they are particularly pertinent for African migrant workers, who comprise a growing proportion of the workforce tasked with providing appropriate care for clients. Within this 'multiculturalism' approach, it is imperative to make the workplace conducive for all workers to provide appropriate care to clients, in ways that are safe, supported and in a context that challenges interpersonal and institutional racism (Nichols et al., 2015; Willis et al., 2018). Thus, this research can inform recommendations for acknowledging and supporting African migrant workers in culturally sensitive ways.

I suggest that non-racist and anti-racist workplaces will better facilitate the ability and authority of care workers to provide clients with appropriate, quality care. This is not only vital for meeting the needs of clients; it is important for the carers themselves – irrespective of the workforce needs of the sector. Interrogating the subtle and more obvious forms of micro-aggressions experienced by African migrant women carers, and how these negatively impact their professional identities, this thesis takes seriously the lives of these carers.

1.5 Overview of the Thesis Findings

My findings indicate that African migrant women are subject to micro-aggressions and institutional racism in ways that deny their ability and claims to care for and care about clients. Through these processes, they are constructed as not 'real' carers, and are often made to feel unwelcome in particular interactions, workplaces and the aged care sector in general.

My data indicates that the study participants regularly experienced interpersonal racism, in the form of micro-aggressions, directed towards them by clients, clients' families and

by their colleagues in the aged care sector. Micro-assaults, in the form of rejecting care, racist epithets and racist stereotypes, were most commonly perpetrated by clients. Micro-insults were more commonly perpetrated by clients' families and co-workers, and often expressed through assumptions that the migrant carers are incompetent, amounting to a devaluation of their skills. African migrant carers also described institutional racism, which manifested in: workplace policies and practices that centred White expectations, experiences and privileges; in training and induction programs; in expectations about workers' English language proficiency; and in formal complaints/reporting processes. As a result, carers were left feeling 'Othered', through interactions, processes and practices that denied and overlooked their experiences.

The African migrant carers responded to racism, specifically micro-assaults perpetrated by clients and colleagues, through asserting their professional identity and professional pride. When responding to client needs, carers asserted their professionalism by centring or reinterpreting client racism as an expression of vulnerability arising from dementia, confusion or past trauma – a more meaningful framing of their work. Their sense of professionalism also drove the carers in making direct challenges to racism from colleagues (and to a lesser extent, clients) by referring to and asserting their professional skills, capacity and authority. Additionally, African migrant carers drew on the knowledge and support of others in similar positions to buttress their individual and group claims to professionalism. Finally, participants described their religious faith as a source of support and strength. Through these strategies, participants reasserted their ability and standing to care for and care about clients. However, while symbolically important, the strategies did little to effect systemic change or prevent future racism on the part of clients or colleagues.

While expression of interpersonal and institutional racism is the focus of this thesis, I contextualise these by engaging the work of Stuart Hall and Whiteness theory. Specifically, I reveal how experiences of racism originate from a history of positioning the 'Other' as inferior in relation to the 'West'. I also use Whiteness theory to offer a broader historical context for how micro-aggressions and institutional racism are experienced. These meanings and dynamics underpin and structure the ways in which interpersonal and institutional forms of racism are expressed against African migrant carers in the Australian aged care context.

I conclude that racism is a key element of African migrant women's experiences of aged

care work in Australia. This racism undermines individual workers' abilities to care for clients and also works to perpetrate the cultural devaluing of their skills, commitment and their very presence in aged care. My findings give rise to a series of recommendations designed to shift the responsibility of managing racism from those workers most likely to be subjected to it, and embed it in institutional processes instead. However, any strategies to redress racism through 'multicultural training' or 'cultural competencies' need to be sensitive not only to individual racist behaviours, but to the Whiteness that structures aged care practices and expectations. I suggest that the problem needs to be reframed from one of intercultural difference, understanding or communication to one that accounts for the historical and colonial hierarchies that underpin individual and institutional racism – an issue that is far more complex.

1.6 Chapter Outlines

To explore and build on these ideas, I use the first part of the thesis to present the empirical and theoretical context of my research study, highlighting the need to centre the issue of race in developing our understanding of the experiences of migrant workers in aged care. In Chapter 2, I discuss the experiences of ethnic minority workers in aged care and nursing in selected developed countries, providing an overview of the international context with regard to experiences of racism for ethnic minority women working in care professions. I then focus on the few Australian studies that speak specifically to the Australian context. Chapter 3 presents the theoretical tools I employ in this thesis: theories on micro-aggressions, institutional racism and colonial precedents of racism, and Whiteness theory. In Chapter 4, I explain the methods used to gather data for this study, including the sample characteristics, recruitment method and ethical considerations; and the process of data analysis. This chapter also includes a brief biography of each of the thirty women who participated in the study.

Chapter 5 spearheads the first set of findings, on the experiences of micro-aggressions. Here I investigate two of the three types of micro-aggressions defined by Sue, Capodilupo, Torino, et al. (2007): micro-assaults and micro-insults. I use these concepts to interpret within the data the often 'small' expressions of racism experienced by the participants in their interactions with clients and co-workers. Chapter 6 explores workplace practices in aged care that reflect and reproduce institutional racism. In Chapter 5 and 6, I draw on the work of Stuart Hall and Whiteness theory to explain how African migrant care workers are 'Othered' through both micro-aggressions and

institutional racism. Chapter 7, the final chapter on the study findings, is focused on the women's responses to micro-aggressions. I attend to how the carers use their professionalism to challenge racism and erode its effects. To conclude the thesis, in Chapter 8 I argue that racism is a major experience of African women's work in aged care, and suggest future research directions.

1.7 A Note on Terminology

I recognise the difficulties with regard to language and terminology usage in a thesis of this kind. I decided to use the term 'African migrant women' because this is the most specific and relevant term to this study. However, at different times I also employ the terminology used by different authors when referring to their specific studies: e.g. care workers, migrant care workers, minority Black immigrants, Black immigrant caregivers, immigrant caregivers, home care workers, women of colour, African carers, CALD workers, Black African, Black women, female care assistant, Black migrant nurses, immigrant women nurses, international nurses, overseas nurses and Black carers. In addition, in Chapter 2, I use 'ethnic minority', a term that best encompasses the range of ethnic and implicitly migrant identities that are referred to in the literature.

While I have made the decision to use the term 'African migrant women', I am also mindful that this term needs critical evaluation. Indeed, the literature highlights the importance of critically engaging with the term 'migrant'. As argued by Doyle and Timonen (2009), the experiences of care workers are significantly different depending on region/country of origin, employment mobility and long-term plans for remaining in the sector (see also Howe, 2009; Isherwood & King, 2017; Jönson & Giertz, 2013; Nichols et al., 2015; Willis et al., 2018). Researchers have also noted that migrants make a decision to leave their countries of origin for several reasons; one of which is better employment opportunities (Blythe & Baumann, 2009; Kingma, 2007), and Australia accepts migrants into the economy once they possess qualifications and experiences to meet skill shortages (Webb, 2014). However, upon migrant arrival in Australia, migrants generally experience a culture shock in adapting to the new environment (Vafeas, 2013). In moving to host countries, migrant workers often have to develop a new identity, new value system and replace their past experiences (Chok, Mannix, Dickson, & Wilkes, 2018; Konno, 2006).

The participants at the time of my research were working as personal care workers, support workers/community support workers and nurses. I define these roles based on

policy documents and the literature. The women I spoke to also described their own professional roles and how those differ with other aged care roles. Personal care workers assist clients with 'hands on' care (Charlesworth & Isherwood, 2020, p. 2) and the activities of daily life, such as feeding, showering and toileting (Charlesworth & Isherwood, 2020; King et al., 2013). 'Support worker' is a broader term for classifying care workers who function in different capacities such as personal carers, home care aides or health care assistants (George, Hale, & Angelo, 2017). 'Community support workers' differ as they provide support and direct care to clients in their personal homes. These home care workers perform duties such as assisting with cooking, laundry, taking clients out for appointments or social outings, and helping to shower, dress and feed them (Smith, 2019). Nurses in aged care, on the other hand, specialise in giving medication to clients and treating their wounds, as well as performing team leader roles and supervising personal care workers who report to them (Willis et al., 2018).

2 LITERATURE REVIEW

2.1 Ethnic minority workers in aged care in the UK, US, Canada and Australia

In this chapter, I review the literature on the experiences of migrant women from ethnic minority groups in the aged care sector (residential aged care facilities and home care) in the United Kingdom (UK), United States (US), Canada and Australia, with an additional focus on experiences in the nursing sector in those countries where the literature offers pertinent insights. These countries were chosen as sites where staff shortages in aged care have been addressed through the employment of migrant workers and migrant labour.

While aged care and nursing are different in terms of their professional status and education requirements, they are both forms of care work that are gendered and raced. Given the relatively limited focus on aged care in the literature, and its predominant emphasis on English language proficiency and skills (Colic-Peisker & Tilbury, 2006; 2007; Syed & Murray, 2009), the decision to include literature on nursing allows me to 'borrow' additional findings and concepts where they are useful in contextualising and interpreting the research which underpins this thesis. In the following paragraphs, I provide an overview of what care work is and its characteristics, and of perceptions regarding who is considered a 'good carer', to provide context to the experiences of ethnic minority workers in institutional settings (residential aged care facilities) and home care, and to the analysis I present later in the chapters on the study findings.

This literature directly and indirectly speaks to concepts of care. Care work is an activity engaged in to provide support to people with physical, cognitive and emotional needs that they cannot meet on their own (Dodds, 2007). This care is primarily understood as something that is provided to vulnerable and dependent people (Claassen, 2011) - although, as Toronto (1998) notes, we are all recipients of care at various points in our lives. Various studies have centred on the ethics and characteristics of caring labour and care work, which can be referred to as 'caring for' and 'caring about' clients (Dodds, 2007; Folbre & Weisskopf, 1998; Himmelweit, 1999; Tronto, 2010). According to Himmelweit (1999), care involves two aspects: "the activity of caring for" (physical); and "the motivation of caring for" (relational, and sometimes described as 'caring about') (Himmelweit, 1999, p. 27).

Scholars in the care context have argued that when workers engage in paid care, it is possible for them to go through the routines of care work with clients – caring for them – without actually caring about them (Dodds, 2007; Folbre & Weisskopf, 1998; Himmelweit, 1999; Stacey, 2011). Caring for clients includes attending to their needs and supporting their activities of daily living, while caring *about* clients requires a commitment to their well-being (Himmelweit, 1999). Researchers who study the labour of caring emphasise that carers often have a ‘caring motivation’ (Himmelweit, 1999, p. 29) or a ‘caring motive’ (Folbre & Weisskopf, 1998, p. 172). This is not borne out of self-interest, but a commitment to provide clients with quality care that meaningfully responds to their needs. The increasing commoditisation of care has been claimed by some authors to threaten to diminish the value of care work. Where carers are ‘paid’ to care for clients, the care may be seen as a form of market transaction (Himmelweit, 1999), centring the physical acts of care and marginalising the importance of ‘caring about’. This commodification of care also tends to position clients as consumers or purchasers, meaning that they may feel the authority to demand that a nursing home or agency respond to their personal definitions of appropriate carers, which can be manifest in their rejection of the labour of migrant care workers or, alternatively, their exploitation of that labour (Shutes & Walsh, 2012). However, there remains the expectation that carers will care for clients with a “motive of love or compassion” (Dodds, 2007, p. 502), even in commodified care contexts. Thus, good carers are expected to be both ‘technically proficient’ workers, capable of attending to their clients’ needs, and dedicated to the lives and wellbeing of those clients (Dodds, 2007, p. 503). This dedication entails having an emotional connection with clients, being responsive to their needs and genuinely caring for them (Dodds, 2007).

This chapter is divided into two sections. First, I explore the experiences of racism for ethnic minority workers. The literature highlights how these racialised experiences are manifested interpersonally in carers’ interactions with their clients, clients’ families, co-workers and managers/supervisors; and also, institutionally, through workplace policies and practices. I also explain how these workers resist racist practices in their workplace. In the second section of the chapter, I present a discussion of the literature that focuses specifically on African migrant women’s experiences of working in the aged care and nursing sectors in Australia. The literature describes how these workers tend to be viewed as ‘Other’ in their interactions with clients, clients’ families, and their colleagues and managers, in the context of work and institutional practices that are embedded in

systemic racism and Whiteness. I also discuss how these care workers resist such racism. Taken as a whole, the literature indicates that racism is a key element of migrant women's experiences in care work.

In this chapter, I align my terminology with that used in the respective studies I discuss. These terms include: care workers, migrant care workers, minority Black immigrants, Black immigrant caregivers, immigrant caregivers, women of colour, home care workers, African carers, CALD workers, Black Africans, Black women, female care assistants, international nurses, overseas nurses, Black migrant nurses, immigrant women nurses and Black carers.

2.2 Workers' Positive Experiences with Aged Care Clients

The literature on the relationship between ethnic minority women and aged care clients indicates there are some positive elements in these relationships. For example, in their study of 40 migrant care workers from Europe, Africa and South Asia working in different contexts in the Irish aged care sector, Timonen and Doyle (2010, p. 32) found these carers had a high degree of respect for their clients, and relationships with them that were often fun. These relationships frequently took on an informal, 'family-like' quality, with migrant care workers offering person-centred care beyond the scope of their duties – e.g. giving massages to clients and checking on them outside of work hours. This sometimes occurred where migrant carers had provided clients with live-in care for decades. This level of commitment to their clients might be an indication, in turn, of the workers' satisfaction with how they are treated. The authors suggest that these warm relationships might be peculiar to Irish home care (also termed domiciliary care in the literature), where clients can veto workers at the outset, limiting opportunities for racism or bad interpersonal relationships.

However, in institutional care settings, migrant care workers can also experience satisfying relationships with clients. These workers tend to have prior experience caring for their own elderly family members, and can transfer those skills into working respectfully with, and caring for, elderly clients. Additionally, they can relate well with dementia clients, and are often forgiving of their sometimes-aggressive attitude, which they interpret as an upshot of the illness (Timonen & Doyle, 2010). However, Timonen and Doyle (2010) conclude that race or visible difference contributes to varied experiences of work in aged care, with African carers reporting more racism from White co-workers than their European or South Asian counterparts.

Walsh and Shutes (2013) conducted a mixed-method study with 90 migrant care workers in the Ireland and UK aged care context. They collected data via a survey, six focus groups with 41 older adults, 46 semi-structured phone interviews with employers, and semi-structured, face-to-face interviews with 34 migrant care workers in Ireland and 56 migrant care workers in the UK (Walsh & Shutes, 2013). Many of the migrant workers in this study reported that they had developed relationships with clients that went beyond work. Specifically, Nigerian female care assistants reported how working with clients helped them to understand themselves, their clients' personalities, and their environment. They felt that working with clients contributed to their own personal growth and development; that dealing with clients' personalities helped to enhance their own character, and "re-affirm their capacity as care-givers" (Walsh & Shutes, 2013, p. 405). Other migrant care workers from the Philippines and India in Walsh and Shutes' (2013) study also reported friendship, companionship and familial-like relationships with clients.

Bourgeault, Atanackovic, Rashid, and Parpia (2010), who conducted a small focus-group study on the relationship between immigrant care workers, employers and older persons in home and long-term care in Canada, also observed satisfactory relationships between immigrant care workers from Africa and the Philippines and their clients. In that study, immigrant care workers reported that their older clients treated them with respect and dignity. The participants ascribed this treatment to their own friendliness, and willingness to assist and do things for clients outside of work hours, in order to satisfy them. The clients of these study participants stated that they preferred immigrant carers because they believed their cultures encouraged respect for adults and elders. African and Filipino carers had been brought up living with and caring for elderly adults in the home. Specifically, clients appraised Filipino women as 'soft' and caring.

In an earlier Canadian study, Aronson and Neysmith (1996, p. 66), determined that home care workers from Eastern and Southern Europe, the Caribbean and the Philippines develop close "friendship and family ties" with clients while caring for them. Both clients and care workers described sharing their problems with each other and forging a relationship beyond the scope of work. Despite these positive evaluations, Aronson and Neysmith (1996) found that racism was an ongoing and defining element of these carers' work.

Bourgeault and co-researchers (2010) found that aged care workers' ethnic/racial background, cultural differences and language barriers often constitute a problem in care

worker-client relationships. In addition to the 'positive' evaluations, such as the caring capacity of Filipino workers, clients' references to racial and racist stereotypes defined ethnic minority women as the 'Other'.

Based on her ethnographic fieldwork (involving participant observation) of the employees (mostly women of colour) in home care work and clients of two agency offices in Chicago, Buch (2013) reported positive relationships between the carers and the older people they provided care for in their homes. The workers engaged in mutually beneficial activities with the clients, such as offering them friendship, cooking for them outside of work hours, going to fast-food restaurants together, taking the clients to the beach, and bringing their own family members over to keep lonely clients company. Clients, in turn, appreciated the additional care and services, and acknowledged that care workers contribute to improving the quality of their lives (Buch, 2013).

Similarly, in a US qualitative study with 33 home care workers (27 females and 6 males), care workers from African-American, Latino and Asian-American backgrounds described a sense of fulfilment in their relationship with clients, knowing that their care work helped to enhance their clients' quality of life (Stacey, 2005). This additional care assisted them as workers to understand themselves also as moral persons who care for, and about, their clients. They enacted these identities through the level of attention and dignity they accorded to care tasks such as showering clients, bowel and bladder care – often referred to as dirty work. As a result of this attention to care, the women concluded that clients considered African-American, Latino and Asian-American carers better than White carers at providing support with daily living activities such as showering and other bodywork (Stacey, 2005).

In the Australian context, Xiao, De Bellis, et al. (2017), in their study with 23 residents and seven family members in four aged care homes, also found positive relationships between CALD carers and clients. In their interviews, participants described CALD workers as supportive and friendly, and kind and gentle in delivering their care, which enhanced the clients' experiences of staying in a nursing home. However, the findings also indicated communication challenges between residents and their carers – a point I return to later in the chapter (Xiao, De Bellis, et al., 2017).

Goel and Penman (2015) undertook a small qualitative study of seven immigrant workers who were employed in three community-based, residential aged care facilities in regional South Australia. The participant group was comprised of five personal carers,

one home support worker and one allied health assistant, with six workers from the Philippines and India. The participants reported an overall good experience in working with clients, and described their clients' appreciation of being supported in their daily living activities such as bathing, toileting and dressing. Nichols et al. (2015), in their qualitative study in Western Australia, found that migrant workers were able to utilise their language skills in caring for clients with similar language or cultural backgrounds, and clients were accepting of their services (Nichols et al., 2015). Such findings reflect the usefulness of having a language other than English in caring for clients from different cultures, as initially envisaged by policy (Martin & King, 2008; King et al., 2013; Mavromaras et al., 2017). In such situations, ethnic migrant workers have an advantage over White carers in the provision of appropriate care (King et al., 2013; Xiao, De Bellis, et al., 2017; Xiao et al., 2018).

Thus, there are indications in the literature, based on research undertaken in Australia and in diverse overseas contexts, that migrant care workers and their clients can form relationships in the care setting that are based on positive affect, support and appreciation. However, often times the relationship between migrant workers and their care recipients can be highly complex, unequal and racist (Scrinzi, 2003).

2.3 Racism in Home-Based Aged Care

Ethnic minority workers' more negative experiences with clients are, to some extent, structured by the context of their work and, in particular, whether the aged care work occurs in a residential aged care or home care setting. Care workers in home care settings in the UK, US and Canada can be employed either formally on regular contracts, paying tax and social security contributions; or informally – employed by agents, care recipients and their family members. In the latter case, workers are often paid cash-in-hand, and fall outside the safety net of formal social protection.

These varying work conditions contribute to different worker experiences. When employed informally in residential aged care, care workers become dependent on their clients for work or residency/sponsored visas. This can lead to considerable exploitation of live-in-carers (Bourgeault et al., 2010; Buch, 2013; McGregor, 2007; Timonen & Doyle, 2010). In Australia, this dynamic is not as evident, because care work takes place primarily in residential aged care homes or in clients' homes in once-off interactions (Howe 2009). Home care is often isolated work, with a single carer solely or primarily responsible for meeting a client's care needs. This is intensive work, and requires –

sometimes implicitly, sometimes explicitly – care workers to develop a strong sense of duty towards their clients. Building ‘caring relationships’ can result in a “breaking of professional rules” and burnout (Mears, 2009, p. 155). Care workers often find it challenging “negotiating professional and personal boundaries in providing care to clients in their homes” (Mears, 2009, p. 155). In addition, due to the constraints of home care funding, care workers face challenges in adequately meeting clients’ needs (Meagher, Szebehely, & Mears, 2016). This can be emotionally and physically draining, as care workers are expected to manage clients’ emotional and social needs as well as physical needs (Stacey, 2011).

A blurring of professional and personal boundaries in home-based care work was evident in the findings of the study conducted by Buch (2013). Entwined in home-based, family-like relationships, care workers (mostly women of colour) were found to develop a “deeply embodied empathy that enabled them to imagine and re-create the elders’ social and sensory worlds” (Buch, 2013, p. 637). However, this empathy led home care workers to go beyond providing basic physical care, creating an environment and engaging in activities that contributed to their clients’ life satisfaction. However, even when home care workers invested so much of themselves in caring work, clients were not necessarily satisfied (Buch, 2013). A study by Aronson and Neysmith (2001) found that home care workers in Canada are exploited. The care workers they interviewed described feeling a sense of duty, at times, to provide additional care to their clients. In most cases, this arises out of their sense of responsibility, moral principles, or their labour market positioning (Aronson & Neysmith, 2001; see also Stacey, 2005; 2011). When motivations to care beyond the formal requirements of their employment are connected to labour market positioning, it is a reminder that ethnic minority workers are structurally disadvantaged as a result of their race and migrant status. Providing ‘appropriate’ or ‘pleasing’ care is a reflection of the workers’ need to keep their jobs; it is about economic survival (Aronson & Neysmith, 1996, p. 72). These women are more or less coerced, because of their race, to offer extra unpaid services. Sometimes they even pay for clients’ expenses (Aronson & Neysmith, 1996).

Shutes and Walsh (2012) conducted a study with 56 migrant care workers in England and 34 in Ireland, with migrant participants from the Philippines, India, Poland and other Eastern European countries, and Africa (Zimbabwe and Nigeria). They found that older people preferred to be cared for in their homes by English carers rather than ethnic minority women, because of language and communication barriers. They reported

challenges with understanding the accents of African carers; and some clients expressed a preference for “English carers they could trust” (Shutes & Walsh, 2012, p. 91), which was necessary to enable the workers to provide them with care in the home. Some care workers from African countries reported rejections from older people who did not want their care services. Other Black carers, whose older clients did accept their care, experienced racism and difficulties in continuing to provide care, and ultimately had to stop working with these clients (Shutes & Walsh, 2012). Overall, the authors described home care providers in the UK resorting to a “racial matching of care user and care worker” as a means of managing racist clients (Shutes & Walsh, 2012, p. 94). Rather than addressing client racism, they provided clients with carers they were comfortable with.

A UK study by Walsh and Shutes (2013) determined that older people reject Black migrant carers and nurses caring for them in their homes. The majority of care workers from African countries in this study reported racism perpetrated by older people towards them. This took the form of clients not wanting to be cared for, touched by, or in close contact with a Black carer. Racism was also evident where clients obviously expressed a preference for White carers because of Black carers’ differently accented English. The dynamics of skin colour and issues with English language proficiency pose greater challenges for working in home care, creating more pressure on migrant carers to go beyond the formal scope of work to please clients, so that the workers will be accepted by clients into their homes (Walsh & Shutes, 2013). Another UK study found that clients threatened to call the agency to complain about migrant workers if they failed to stay longer. Often migrant carers feel obliged to comply, as they believe agencies are more likely to protect the interests of clients over those of migrant carers, and might punish workers through giving them fewer hours or even terminating their employment (Datta et al., 2006). Migrant workers are very aware of their positioning when negotiating their terms of work, and of the pressure to go beyond the call of duty when providing care, as an attempt to minimise the structural impacts of their race and migrant status.

The tasks associated with home-based care work can also inform particular expressions of racism. England and Dyck (2012), in an ethnographic study drawing on eight cases of care recipients, migrant care workers and family caregivers, showed that clients devalued the work of migrant women from Jamaica, Chile, Germany, Eritrea, Kenya and Morocco. Clients exhibited dissatisfaction with the carers’ work, such as the cleaning of their homes, describing it as ‘slipshod’ (England & Dyck, 2012, p. 1081). The migrant

carers worked under unreasonable time constraints to complete the tasks. Clients also used racist scripts about the work of migrant women, describing them as lazy, stupid and unintelligent, requiring explanations for everything and every task. For instance, one client described a Jamaican migrant carer's work as follows: "Like today I asked her to clean the bathroom, she stands in the hall and shoots Lysol through the door and that's the bathroom clean" (England & Dyck, 2012, p. 1081). Similarly, a study by McGregor (2007) on Zimbabwean carers in the UK found that African workers were regularly insulted by clients, who assumed they had to be taught basic domestic chores such as cleaning the toilet. These comments are racist. They judge workers' labour based on the assumed limits of their cultural knowledge, rather than the constraints of the increased marketisation of care (Charlesworth & Isherwood, 2020; Davidson, 2018; Henderson & Willis, 2020) and the limits of home care funding, which cut down the time a carer has to complete a cleaning task.

Migrant carers are also accused of theft. Studies associate these claims with client fears about opening their homes to strangers, because different carers may be sent daily (England & Dyck, 2012). Again – this is a result of industry re-structuring that does not prioritise continuity of care. And yet the racialised dimension to these accusations is also striking. Clients' concerns tend to be informed by the characteristics they associate with Black people. For example, a client in England and Dyck's (2012, p. 1081) study commented:

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

In Canada, Martin-Matthews (2007), describes how home care is complicated by what some clients experience as an intrusion of migrant carers into their private space. Care work requiring body work (the direct, private, often dirty work carried out on other people's bodies – see e.g. England & Dyck, 2011) further complicates the carer-client relationship. This is because such work involves dealing with dirt and disgust, sharing of bodily processes, and negotiating physically intimate practices with clients such as showering, touching of the body, massaging the body and dressing clients (Twigg, 2000). In the presence of physical and social vulnerability or dementia, which can result in an impaired form of personhood for the client (Bird-David & Israeli, 2010; Lock, 1996; Taylor, 2010), the everyday care practices offered by workers can go a long way in sustaining or eroding personhood (Taylor, 2010). Body work – and aged care work

generally – requires a level of trust and intimacy for clients to feel comfortable with their carer. Tensions and conflict, however, can arise when clients interpret that work within the lens of race or cultural background, as well as personal characteristics (Aronson, 2004b). For example, migrant workers from African cultural backgrounds are considered rough when delivering care while, as noted above, others such as carers from the Philippines are viewed as soft and caring (Bourgeault et al., 2010). Nichols et al. (2015) also confirm racist and cultural meanings associated with African migrant carers, who are ascribed as having 'hefty' bodies, and as such are perceived as poor carers. This is not due to their actual care practices, but because "their care giving approach is referenced to their physical attributes" (Nichols et al., 2015, p. 27).

Overall, the literature on home-based care indicates that experiences of ethnic minority workers – and specifically, migrant workers of colour – are structured by the inter-relationship of work practices, labour markets and racism, by which the 'failings' of carers are directly or implicitly attributed to their race. In the next section, I explore clients' racism and carers' vulnerability in institutional aged care contexts.

2.4 Racism in Institutional Aged Care Settings

In institutional aged care settings, clients' cognitive impairments and dementia are additional obstacles to successful communication and relationships with migrant workers, both in terms of understanding and being understood by these workers, and as a reason for clients using offensive or aggressive language towards them. Much of the literature associates unpleasant treatment and racist comments with clients' illnesses, specifically dementia (McGregor, 2007). Clients can at times use language that is explicit and aggressive, commenting on the visible difference of Black care workers: "Go to hell. I don't want you. I don't want Black people" (Bourgeault et al., 2010, p. 114); "You Black go back home. You Black this – You Black that" (Nichols et al., 2015, p. 26); "I don't want that Negro coming to my room" (Gillham et al., 2018, p. 21); and "Listen just go away! I don't want a Black nurse around me" (Shutes & Walsh, 2012, p. 92). Irish and English studies indicate that clients might also expressly state they prefer 'English girls' or 'Irish women' because they are 'perfect' care workers (Shutes & Walsh, 2012, p. 92) and, more generally, White workers caring for them (Shutes & Walsh, 2012). Some carers, however, note that racist clients are in the minority (Timonen & Doyle, 2010).

Closely associating racist comments with dementia can ignore the social and cultural bases of racism and the specifically racist expression of dementia. Migrant care workers

in the Irish care industry feel they are also treated differently by cognitively impaired clients, whose expressions of racism reflect their carers' nationality, visible difference and the low position the workers occupy as personal care attendants. For example, in Timonen and Doyle's (2010) Irish study, clients were reported as having threatened African carers with calling the police if they attempted to shower them. Other studies report how clients mistake carers from Asian countries for Japanese carers, not wanting to accept their care due to the memories these clients carry from World War II (Nichols et al., 2015). Some carers attribute clients' racism to being members of a colonial generation too old to change their perspectives (McGregor, 2007). Similarly, a Canadian study finds that clients' racism is more explicit and more commonly directed towards care workers who are immigrants from ethnic minority groups, those for whom English is a second language, and workers from developing countries (Bourgeault et al., 2010).

Client racism is also evident when clients make judgements about workers' care capabilities. With regard to in-home care, some clients hold racist assumptions about which carers can provide 'good care' based on their 'soft skills or training'. As noted earlier, Bourgeault et al. (2010) suggest Canadian clients prefer Filipino carers who are seen as soft and caring. In contrast, they reported that African carers are not considered 'ideal' carers and have been rejected and verbally attacked by clients. In addition to clients' racist interpretation of migrant workers not being 'ideal' carers, communication is also perceived as a 'challenge'. In the context of an increasingly diverse migrant workforce, researchers across different countries have established that many ethnic minority workers experience difficulties in communicating with clients – or their clients in communicating with them. Migrant carers have reported experiencing racism and criticism of their accent (see Hussein & Manthorpe, 2014; Small et al., 2015; Timonen & Doyle, 2010), and communication challenges leading to conflict (Negin et al., 2016). When there are communication challenges, clients may become frustrated and convey that frustration through rudeness and consequent rejection of the services of these carers, defining miscommunication as a fundamental problem that lies primarily with the failures of care workers (Bourgeault et al., 2010; Xiao et al., 2018). Gillham et al. (2018) found that clients' negative attitudes towards CALD carers are partially informed by their accent. Likewise, Xiao et al. (2018) present data on aged care residents recalling frustration in interactions with CALD staff because they did not know what the carers were saying, and due to the migrant workers not understanding them (see also Duff, Wong, & Early, 2000).

Other studies (Reitmanova, 2011; Small et al., 2015) have noted that differences in cultural background and language between clients and carers can lead to difficulties in communicating expectations for care, and in recognising and communicating illness. This can result in poor quality-of-life outcomes for residents. Research has also been undertaken to address staff learning needs with regard to cross-cultural communication between migrant care workers from different regions and clients, in residential aged care facilities and also in nursing (see Cooper & Roter, 2003; Gillham et al., 2018; Lyons, O'Keeffe, Clarke, & Staines, 2008). More pertinently for the current research, however, is recognising that the 'problem' of communication is typically attributed in the aged care setting to carers' failings, rather than clients' lack of understanding (see also Bourgeault et al., 2010; Duff et al., 2000; Gillham et al., 2018). This suggests that cultural competency is a one-way street: workers are expected to improve their cultural competency (language skills, understanding), but older people are assumed not to have the capacity to change, and nor are they expected to. Thus, migrant workers have to shoulder the burden of racism from clients, and make changes themselves (Bourgeault et al., 2010; Duff et al., 2000).

The literature shows discrepancies between clients' attitudes towards the care provided by migrant and ethnic minority workers, and that provided by local-born workers (Datta et al., 2006; Mattingly, 2001). Despite clients' typically negative perceptions about migrant carers' capacity and commitment, many migrant aged care workers take their care work seriously. In a UK study, migrant workers associated the professional qualities of respect and discipline with the care of elderly clients (Datta et al., 2006). Migrant workers from Africa may bring with them strong ideas regarding the value and respect that should be accorded to advanced age, as part of the traditional values they hold about caring for the elderly in their home countries (Mattingly, 2001). Informed by this background, migrant workers may attempt to establish family-like relationships with their clients and to treat them as they would their family members. They may engage in conversations with clients or sit with them. However, this is not always reciprocated (Datta et al., 2006). As discussed above, in institutional aged care settings, migrant workers report explicit racism from clients in the form of rejection of their care services, name calling, association of their capacity to care for clients with their physical attributes, and racist insults based on stereotypes regarding their country of origin and cultural background. Many studies in the literature describe the interpersonal expressions of racism in aged care work. However, aged care work needs to be contextualised within

the institutional processes that can limit – or, more commonly facilitate – such racism. I describe these processes in more detail later in this chapter, as a foundation for understanding the findings I present in Chapter 6.

2.5 Colleagues' Treatment of Ethnic Minority Workers in Aged Care

In common with the literature on clients, the research on co-workers and managers' treatment of ethnic minority workers and aged care workers highlights their ascription of negative characteristics to migrant workers – and specifically African workers. Associated with this, managers and supervisors often treat these workers differently in terms of their expectations and the tasks they assign to them.

Colleagues' racism is often evident in the assumptions they make about migrant carers' work capabilities, which echo the assumptions typically made by clients. McGregor (2007) highlights racialised tensions between temporary and permanent staff in residential aged care facilities in the UK; tensions which can be mapped onto African and migrant (temporary worker) and White (permanent worker) identities. Specifically, White co-workers label African carers as incompetent workers. The migrant care workers in Timonen and Doyle's (2010) study in Ireland reported experiences of racism and prejudice that referenced their skin colour, which marked their 'difference' in a way that it did not for White European and South-Asian carers in the Irish context. Sethi and Williams (2016) note that ethnic minority women from Africa report co-workers also using insults towards them that reflect incorrect ideas about Africa and Africans (e.g. that they live in bamboo houses); ideas that inform those clients' conclusions about the supposed incompetence of African carers, and that devalue the skills of African nurses (Allan & Larsen, 2003; Allan et al., 2004; Mapedzahama et al., 2012; Timonen & Doyle, 2010). An Australian focus group study revealed that White co-workers sometimes display unpleasant attitudes, rudeness and hostility when talking to migrant workers (Goel & Penman, 2015).

Communication 'problems' are a re-occurring theme in the relationship between migrant workers and their colleagues in the aged care sector (see Goel & Penman, 2015; Nichols et al., 2015; O'Keeffe, 2016; Xiao, De Bellis, et al., 2017; Xiao et al., 2018).

Misunderstandings arise from different accents and pronunciation of words, and as a consequence of different cultural backgrounds. O'Keeffe (2016) has suggested that colleagues may not have the patience to listen carefully enough to understand migrant

workers. They tend to pre-empt the discussion and make assumptions about what CALD workers are saying, either because of work pressure or because they perceive CALD workers as incompetent. Goel and Penman (2015) describe backbiting and politics among staff in the aged care sector, structured along the lines of migrant identity. These studies remind us that the 'problem' of communication and cultural competency is typically seen to lie with CALD workers.

Managers are also racist in their treatment of African care workers. In Timonen and Doyle's (2010) study, some migrant care workers claimed they had a neutral or generally amicable relationship with their managers, but most described receiving racist treatment. In the study by Nichols et al. (2015), all seven managers stated that they had benefited from recruiting from the multicultural workforce. However, one manager described African carers as "... bombastic, heftier, and of a darker colour", and judged these carers as lacking in "appropriate care-giving approaches" (Nichols et al. 2015, p. 27). These racist attitudes about not being 'ideal' carers are not only informed by managers' interpretations of carers' bodily characteristics. Migrant workers have also reported experiencing an array of racist behaviours, including being assigned more difficult tasks by management than their Australian co-workers, such as spring cleaning (Goel & Penman, 2015). Migrant workers believed better shifts were allocated to White carers, while they were assigned 'lousy' shifts (Goel & Penman, 2015). Managers overworked them and applied different expectations, compared to White permanent carers (McGregor, 2007; Nichols et al., 2015). They constantly critiqued the work of the migrant carers, and rarely offered positive feedback (see also Goel & Penman, 2015; Hussein, Stevens, & Manthorpe, 2010; 2011; Timonen & Doyle, 2010; Walsh & O'Shea, 2009). Managers may construct racial stereotypes based on carers' countries of origin (Nichols et al., 2015), so that carers from specific countries are preferred due to the expectation that they will possess specific skills and temperaments (see also Browne & Misra, 2003; Parreñas, 2000). Migrant workers in the study by McGregor (2007) attributed this to their managers' racism rather than their capacity to do their job, and reflected on the absence of such treatment of White co-workers. This treatment was experienced as demoralising and unfair.

Managers can also refuse to appropriately address the racism of colleagues or clients. Doyle and Timonen (2009) describe colleagues and managers colluding to support or ignore clients' racist behaviours. Their research found that migrant care workers feel out of place in their teams and believe their managers support, or fail to address,

institutionalised racist practices and attitudes. Additionally, institutions may have no formal complaint channels or support mechanisms in place that are designed to assist migrant carers who experience racism. Consequently, migrant carers have to work out their own measures to address workplace racism expressed both interpersonally and in unfair or unequal work relationships (Doyle and Timonen, 2009).

While much of the literature in this area focuses on Black carers' experiences of White racism, some studies also highlight the tensions and frictions between different migrant groups in the aged care sector. Timonen and Doyle (2010) and Nichols et al. (2015) discuss these tensions with regard to managers recruiting workers who share their own national or ethnic identity. When this happens, the workplace may be – or feel – dominated by carers from specific ethnic groups, which can then impact negatively on the experiences of those workers who fall outside of those groups. Workers may feel socially isolated or excluded when workers in one group speak to each other in their shared language. In these instances, Black carers feel like the 'Other'. This experience can lead carers to resign from their jobs. Furthermore, migrant workers usually ascribe positive characteristics to co-workers from their own country of origin and, conversely, ascribe negative characteristics to those who they perceive as different. For instance, in Timonen and Doyle's (2010) study, Filipino care workers believed "African care workers' minds were not on the job while Polish care workers believed Filipino carers were lazy" (Timonen & Doyle, 2010, p. 37). Such findings are a useful reminder that to understand the experiences of ethnic workers in the aged care sector, we need to move beyond homogenising them.

The research that describes ethnic minority workers' experiences and interactions with colleagues and managers/supervisors in aged care suggests that, for the most part, workplace relationships are marked by interpersonal racism that often interrelates with institutional roles and opportunities (O'Shea & Walsh, 2010; Stevens, Hussein, & Manthorpe, 2012). The findings on aged care concur with those from research undertaken in other care contexts, particularly nursing. The nursing literature also highlights the prevalence of racism directed by White colleagues towards ethnic minority workers, often expressed through racist judgments about their capacity to engage in care work and the legitimacy of their attempts to do so (Alexis & Vydellingum, 2004; Allan et al., 2004; Lazaridis, 2007; Mapedzahama et al., 2012; Xiao et al., 2014).

Overall, ethnic minority workers employed in care contexts tend to: experience negative

stereotypes imposed on them by colleagues and supervisors; have their skills devalued; be ignored and excluded in the workplace; and have the cultures and values of others imposed upon them. Thus, the literature suggests that care workplaces, including aged care workplaces, reflect and are structured by racist assumptions and raced power dynamics that exist in the broader society.

2.6 The Perpetuation of Racism Through Institutional Processes and Workplace Practices

In this section, I discuss migrant aged care workers' experiences of the institutions and institutional processes of their employers. The interpersonal racism experienced by ethnic minority workers in aged care is accompanied, and typically not addressed by, workplace practices and industry structures with impacts that go beyond any individual workplace. While this thesis focuses on interactional and institutional racism, it is also useful to note the existence and potential impact on migrant workers of part-time and contingent work, work intensification, and the erosion of 'good working' conditions in Australia and elsewhere. Here, I also canvas how training programs and workplace practices are delivered to workers, the implications of expectations of English proficiency, the lack of acknowledgment and belief in migrant workers' skills and capacities (deskilling and devaluation), and the failure to recognise different understandings of workplace culture and customs (see Chok et al., 2018; Nichols et al., 2015; Omeri & Atkins, 2002).

In Australia, work duties in aged care facilities are structured so that time is strictly allocated to each task. This reflects the shift to marketised care (Fine & Davidson, 2018; Harper, Anderson, McCluskey, & O'Bryan, 2015; Henderson & Willis, 2020; Lundsgaard, 2006). Importantly, this affects the amount and quality of care that can be given to clients, and contributes to the stresses of the work. Providing clients with good care means recognising and expressing their subjectivity and treating them as persons (Buch, 2013); interactions that are limited under strict time constraints (Henderson, Willis, Xiao, & Blackman, 2017; Kalisch, 2006). The ramifications of these institutional constraints, and workers' responses to them, are diverse. In a study conducted across 156 nursing homes in the UK, Zúñiga et al. (2015) found that nurses and care workers prioritised performing tasks related to showering and feeding, and sometimes missed completing documentation. A study conducted in Canadian aged care homes (Knopp-Sihota, Niehaus, Squires, Norton, & Estabrooks, 2015) revealed how health care workers had

insufficient time to talk to or walk with patients, or pay attention to their nailcare, oral care and toileting (see also Song, Hoben, Norton, & Estabrooks, 2020).

In residential aged care in Australia, Henderson et al. (2017), note that an inappropriate skill mix may account partly for missed care, because personal care assistants are sometimes kept busy performing tasks that are most appropriately performed by nurses instead, such as giving medication to clients and attending to treatment of wounds. Another study also describes missed care arising from a lack of teamwork between nurses, improper communication and delegation of duties, and excessive workload (Blackman, Henderson, Weger, & Willis, 2019).

Regardless of the particular expression of institutional challenges, the worker is typically viewed as the problem, and held responsible if a client does not receive adequate care. This results in an inability of carers to build relationships with clients, and can contribute to the conditions under which clients perceive ethnic minority workers incapable of providing good care. It is, however, important to emphasise the racist assumptions that also inform such judgements, as discussed earlier in this chapter.

When entering this system, migrant nurses in hospital settings report problems with managing the recognition of their training. They may not have had access to adequate information about nursing registration and licensing in their home country. This may result in their qualifications being downgraded upon migration into developed countries, forcing them to work as nursing aides. At other times, they are placed in care situations requiring new areas of expertise with which they are unfamiliar (see Baumann, Blythe, Rheame, & McIntosh, 2006; Chok et al., 2018; Omeri & Atkins, 2002; Wellard & Stockhausen, 2010).

Additionally, many Western countries do not acknowledge the formal training undertaken in other countries. In the UK and Australian nursing workplaces, the past work experience of African and other migrant nurses accrued back in their home countries is not recognised. As a result, they may be placed in less skilled roles, requiring them to take instructions from nursing assistants, and denied opportunities to utilise their nursing skills (Allan & Larsen, 2003; Omeri & Atkins, 2002). For example, one participant in Omeri and Atkin's study (2002, p. 500) reported working as a bedmaker in a nursing home rather than as an assistant in nursing, despite having undertaken training in her home country. Research in the UK has shown that Black African nurses who consider themselves competent are not allowed to perform some nursing procedures in hospital

settings because of assumptions that they are ignorant, and lack nurse education and expertise (Likupe, 2015; Likupe & Archibong, 2013). Likupe (2015) also notes how this assumed lack of training is evident where managers doubt the credibility of Black African nurses' experience, and scrutinise their work and require colleagues to monitor them.

Montague, Chhetri, and Lamberry (2011), in a study they conducted on migrant aged care workers in residential aged care facilities in Melbourne (Australia), observed that migrant workers from India, China and other developing countries who were trained and acquired qualifications and expertise in their home countries tended to be employed in lower placed jobs. Mapedzahama et al. (2012) found that Black migrant nurses in hospital settings experience a professional negation, feeling their skills and previous training are being wasted and their credibility and competence as nurses questioned (see also Buchan, 2003; Hardill & MacDonald, 2000; Likupe & Archibong, 2013; Nichols & Campbell, 2010; Omeri & Atkins, 2002; Withers & Snowball, 2003). The misrecognition implicit in these processes by management/employers and co-workers effectively positions migrants as unknowing learners, without adequate supporting training that is useful and appropriate.

In their work focusing on how racialised ignorance is constructed and maintained in Australian nursing workplaces, Mapedzahama et al. (2018) note how the professional capacities and knowledge of Black migrant nurses are not acknowledged. They describe an institution organised around Whiteness, such that the knowledge of Black African nurses is systematically ignored or denied, and an emphasis is placed on the technical skills and knowledge they are assumed *not* to have (Mapedzahama et al., 2018). Constructed as needing help, this has resulted in a diminishment of their professional competence, and inadequate use of their skills in Australian hospitals and health agencies (Mapedzahama et al., 2018). These findings concur with those of Likupe and Archibong (2013), who reported that the experiences of Black African nurses who participated in their study were not being recognised in their nursing workplaces in the UK. As African workers, they were not regarded as part of the main Whitestream culture and, consequently, "were looked down upon in every way, as workers who did not know anything" (Likupe & Archibong, 2013, p. 237).

The findings described above sensitise researchers to the complexities of acknowledging the experiences, skills and the training needs of migrant aged care workers and nurses. Managers who participated in the study conducted by Nichols and colleagues (2015) in

Australia reported that they do provide support for CALD workers who are new to their roles, assigning them onto buddy shifts in the morning and afternoon. However, CALD migrant carers still describe a form of culture shock when they begin aged care work – “feeling like a fish out of water” (Nichols et al., 2015, p. 27). They find it difficult adapting to the culture and customs of the Australian workplace, e.g. being unfamiliar with some ‘Australian’ foods required by clients, such as vegemite (Nichols et al., 2015, p. 27).

Researchers conducting studies on Black African and international nurses in hospital settings in the UK have noted that training and transitional programs provided by employers to equip workers for their roles are not detailed enough, nor tailored to meet their needs as migrant workers from different cultural backgrounds (Allan & Larsen, 2003; Matiti & Taylor, 2005). For example, a participant in Allan and Larsen’s (2003) study noted that four days after arriving in the UK, they were already given a patient to care for, with only a one-day orientation (Allan & Larsen, 2003, p. 42). In another example, Black African nurses in Likupe and Archibong’s UK nursing study (2013) reported injuring themselves performing tasks such as lifting a patient or making a bed, because they had not yet been given training by their employers in the proper techniques for lifting and handling. These nurses were “nonetheless expected to do everything asked of them” (Likupe and Archibong, 2013, p. 238). One participant in this study also emphasised the importance of recognising the cultural backgrounds of migrant nurses in order to understand their approaches to patient care. In her words:

I once gave an example to one of the nurses, I said you have been a nurse here for some time, if I take you home and just dump you in my ward, would you be able to perform the way you have been performing? She said no, you must be very courageous to come here. But you see, instead of giving us support even to show us, but people look at us if you fail to operate a hoist – a device for lifting patients. (Likupe & Archibong, 2013, p. 235)

This nurse felt that colleagues did not acknowledge the role and influence of cultural differences on workers’ engagement with technology in adapting to the work environment, failing to provide the support they needed (see also Xu, 2007). Allan and Larsen’s study found slight differences in the use of analgesics by Black African nurses in comparison with White nurses, which sometimes resulted in mistakes in patient care. These nurses requested that employers and colleagues recognise their different cultural backgrounds, rather than make judgements about their nursing practices (Allan & Larsen, 2003). The point of these findings is not that African nurses or aged care workers

lack the capacity to undertake their work, but rather that institutional processes are not sufficiently available or responsive to the particular needs of diverse groups working in the sector.

Still on the limits of institutional training in aged care work, in an Australian study, Gillham and colleagues (2018) determined that CALD workers' understanding and utilisation of training provided to them was hindered by limited English language skills and a lack of computer literacy. Migrant nurses and care workers are often initially trained in different cultural, national and industrial contexts, with different technology uses and care practices. In Australia, migrant nurses in aged care settings are frequently unable to express themselves confidently, which impacts relationships with colleagues who may have difficulty understanding, for example, their pronunciation of medication. This can lead to colleagues reporting additional work stress (Xiao et al., 2014). In the US, some African nurses have perceived themselves unsuitable to care for clients (Kawi & Xu, 2009) because of their language difficulties. Thus, Gillham et al. (2018) suggest the need for culturally sensitive training in workplaces that responds to the needs, and recognises the capacities of, aged care workers from CALD backgrounds. Based on the findings of their Australian study, Goel and Penman (2015) recommended that all staff (local and migrant) in aged care homes undergo cultural sensitivity training and education about the beliefs, practices and different cultural backgrounds of care workers and nurses in order to achieve harmonious work relationships and meet the needs of migrant workers.

In conclusion, migrant workers can experience a struggle to fit in and establish their professional identities within aged care and nursing workplaces (see Chok et al., 2018; Konno, 2006; Mapedzahama et al., 2012; Nichols et al., 2015; Xiao et al., 2018; Xiao et al., 2014). This can be attributed to a misrecognition or denial of their skills in the workplace, and limited training – amounting to professional negation (Allan & Larsen, 2003; Omeri & Atkins, 2002). As Feenan (2007) notes, migrant workers are seen as problems; defined with reference to a presumed 'lack' of prior knowledge, expertise and work experience. Differences in their cultural background are perceived as negative, with no acknowledgement of how the workplace is structured in ways that underutilise these workers' skills (Feenan, 2007). According to Medina (2013, p. 220), the workplace is a site where "White ignorance masquerades as White racial common sense, logic, or good intentions".

2.7 Resisting Racism in Care Workplaces

The experience of racism in the workplace can be confronting and upsetting for many migrant women. However, they actively navigate racism through a variety of strategies. Most of the literature discussion on these strategies focuses on the field of nursing, with few studies undertaken on this issue in the aged care sector. Nevertheless, it is important to acknowledge the agency and resistance of ethnic minority workers and so, in this section of the literature review, I draw heavily on the nursing literature to provide a context for my Chapter 7 discussion of African workers' responses to client and colleague racism in aged care.

I noted above that ethnic minority workers are often unsupported by any formal reporting mechanisms – however, there are some indications that ethnic minority workers in the nursing and aged care sectors do report to management instances of racism directed at them by clients and colleagues (Mapedzahama et al., 2012; Nichols et al., 2015; Timonen & Doyle, 2010), sometimes as a last resort (Showers, 2015).

This can provoke supervisors or matrons to talk with clients about racist behaviour in the health care sector, which may sometimes help immigrant women nurses when they are required to continue providing care for those particular clients (Showers, 2015). Another study suggests that managers may be more concerned about the "aesthetics and cleanliness of nursing homes" than dealing with issues of racism from clients, or racism in relationships between co-workers (Timonen & Doyle, 2010, p. 35). In the Irish context of aged care work, Timonen and Doyle (2010, p. 38) describe an incident when "an African carer was called an alien by a client, who reported to management, but no formal apology was made". Often, management failed to take action when African workers reported experiences of racism from clients and White colleagues (Timonen & Doyle, 2010).

Ethnic minority workers may respond to racism from older clients by positioning such racism in the context of more general satisfactory relationships. Some migrant workers who have been interviewed report that they tend to avoid focusing on negative feelings, such as the feeling of being invisible, rejected or having their contributions ignored or devalued (Gillham et al., 2018; Goel & Penman, 2015); others choose to emphasise how some older clients do treat them with dignity and respect. African, Asian and Caribbean migrants interviewed about their experiences in the UK nursing sector focused on the satisfaction they derived from gaining valuable experiences in the national health care

sector, and expressed positive views that things would change for the better (Alexis & Vydelingum, 2004). Similarly, the nurses in Larsen's (2007) research focused on the positive benefits at work and chose to remain comfortable at the lowest rungs of their nursing career, despite their high credentials.

Some Black African nurses choose to manage their cultural difference in the workplace by adopting strategies such as emphasising their professional identities and credentials. Showers (2015) describes instances where African nurses have sought work in predominantly White institutions and White specialisations, because this allowed them to claim an elite status. For instance, one Black African woman who was the only ethnic minority nurse working in an intensive care unit and oncology unit in a majority-White worker hospital reported being complimented as smart, because she was among the few visible minorities working in that institution. However, while these workers derive satisfaction from working in a predominantly White institution, they are not free from experiences of racism. They still experience the same communication and 'Otherness' challenges with clients and colleagues due to accent and language barriers.

To manage their difference or minimise racism towards them, other workers strive to attain certifications and credentials, which offer them a sense of personal achievement and evidence of their professional achievement (Showers, 2015). As one of the participants in a study by Showers (2015, p. 1825) notes:

Even though you are a charge nurse, because of the color of your skin or because of where you are from, you are not so much recognized. You would have another person who is way below you and your manager might be giving that person instruction for the unit, instead of giving it you, so based on that I just said, I have to go back to school. So, I went back to school to do my BSN and from my BSN, I went back to do my Masters. Now, I am a Masters prepared nurse, which is not so common. So that has placed me in a position where I feel I can do anything. If you don't respect me for who I am, you respect my certificate.

African women may feel the need to work harder than their White and non-African colleagues as a means of claiming exceptionalism. Australian studies in the nursing and aged care workforce also describe strategies by African and ethnic minority workers to emphasise their diligence, skills and facility in dealing with complex or challenging issues, as a means of contradicting the beliefs of their colleagues and managers that they are incompetent (Goel & Penman, 2015; Mapedzahama et al., 2012).

In a different form of claiming authority, ethnic minority workers sometimes adopt the

persona of the 'loud Black girl' or 'loud Black woman' (Ong, 2005, p. 607) when dealing with hostile treatment from co-workers. The 'loud Black woman' projects a demeanour of firmness, assertiveness and professional expertise, enabling the worker to assert her authority and be taken seriously within the White institutional space. This strategy is seen to be most effective for Black women in leadership positions (Ong, 2005; Wingfield, 2010). Ethnic minority workers direct this expression of identity towards clients as well as their colleagues and managers, with a view to preventing the re-occurrence of racism directed towards them (Showers, 2015).

The literature shows that while ethnic minority workers respond to racism in different ways, most responses are individualised; focused on either the assertion of skills and authority, or on downplaying the existence and effects of racism. Institutional responses are rarely available or effective, and so ethnic minority workers typically manage their individual responses in ways that do not directly effect change in their institutional contexts.

2.8 African Women's Experiences of Working in Aged Care and Nursing in Australia

Having contextualised my own study within the international literature on migrant workers in aged care, in this section, I discuss a number of studies that have been conducted on migrant African workers in the aged care and nursing sectors in Australia. Several of these are particularly relevant in providing an empirical context for this thesis. The first is a study conducted by Nichols et al. (2015) with 35 CALD participants from 18 countries, which I will address with regard to their findings on the experiences of African carers. The second is a qualitative study conducted by Willis and colleagues (2018) that examined the experiences of Indo-Asian and African aged care workers in two not-for-profit, residential aged care organisations. The third study, undertaken by Gillham et al. (2018), addressed cross-cultural communication in aged care homes, and also included African workers in the sample. The fourth study was conducted by Xiao et al. (2018) with care residents, family members and staff. A fifth mixed-methods study, recently published by Adebayo et al. (2020), focused on migrant care workers from Asia, Africa, Europe, North and South America across residential aged care facilities in five Australian states. Lastly, I also consider research published by Mapedzahama and colleagues (2012; 2018) on Black migrant nurses.

Racism by clients is a strong theme across these studies. Nichols et al. (2015) report

that clients frequently reject the services of CALD carers in aged care because of their visible difference, specifically their skin colour. This rejection is expressed through racial epithets: for example, a participant in one study recalled clients saying to her, "You Black this – You Black that" (Nichols et al., 2015, p. 26). Similarly, Gillham et al. (2018) report instances of clients referring to African workers as Negros. Participants in an Australian study conducted by Mapedzahama et al. (2012) described clients using racist language to reject care. One nurse spoke of trying to give medication to a patient, and that client said "get, get away from me you, you black filthy thing" (Mapedzahama et al., 2012, p. 159). At other times, patients have ordered migrant carers to "wash their dirty hands" before touching them, or told them to return to their home countries (Mapedzahama et al., 2012, p. 159). For the Black migrant nurses who participated in this study, this was a daily experience.

The studies also demonstrate the prevalence of racist treatment of African carers and nurses by their colleagues. Some of this stems from the cultural bias of White workers, their lack of knowledge of African culture and background, and their beliefs that African migrant women do not have any prior knowledge of care work because there are no nursing homes or hospitals in Africa. These beliefs manifest in racist assumptions about the (in)ability of African migrant women to be good carers and nurses. Young, registered nurses from CALD backgrounds in aged care work who hold values of respect for elders find it difficult to assert their authority with older White colleagues, even when they are in leadership roles and supervise older White colleagues on their team. This has resulted in African nurses taking instructions from older nurses who were junior to them (Nichols et al., 2015). Nichols and colleagues in their study also identified that other migrant groups can hold resentment towards African migrant groups, perceiving that, with their increasing prevalence in residential aged care homes, the African workers want to take over their jobs (Nichols et al., 2015).

Mapedzahama et al. (2018) found that Black migrant nurses in Australia experienced racism from their colleagues in various ways. In agreement with the findings of Nichols et al. (2015), their data showed that Black migrant nurses working in hospital settings were constructed as unknowing and ignorant because of their cultural background, and assumptions were made about the value of the nursing expertise they acquired in their country of origin (Mapedzahama et al., 2012). In a denial of their professional identity as registered nurses, African nurses were labelled 'Black nurse' by their White colleagues (Mapedzahama et al., 2012). Colleagues also systematically denied their previous

nursing knowledge in Africa, and assumed a deficiency in their technical skills, positioning Black migrant nurses as requiring the assistance of White nurses (Mapedzahama et al., 2018). Thus, the racialised category of the 'Black nurse' carries negative implications such as intellectual inferiority, lack of expertise, lack of clinical ability, incompetence and limited professional achievement. Mapedzahama et al. (2012) determined that this racial positioning was also perpetrated by the managers of African nurses, who treated them as inferior to White nurses. When Black nurses reported instances of racism by clients, managers chose to side with the perspective of the clients, and re-allocate patients to White nurses. This avoidance of the issue amounted to a refusal to acknowledge the feelings and professional identities of Black nurses. The studies by Nichols et al. (2015) and Mapedzahama et al. (2012) both indicate that racism from colleagues and managers is a significant part of workers' experiences, albeit more subtly expressed through racialised categorisations that devalue and undermine their skills.

Managers' accounts of racism tend to downplay racism. A study by Willis et al. (2018) in Australia explored if and how managers make their organisation a safe environment for CALD staff in aged care work through addressing client racism. Their findings suggest that managers perceived there was a harmonious and non-racist relationship between the multicultural workforce and clients, because they provided training and multicultural events as opportunities for clients to get to know the CALD workforce better, both in terms of their cultural background and as individuals (Willis et al., 2018). Although Willis et al. (2018) observed that these processes assisted clients to establish rapport with CALD workers, the workers continued to experience racism. In the study by Nichols et al. (2015), every manager reported that they treated all workers as equal. Two managers explicitly described what they saw as the benefits of CALD staff, such as the patient and caring attributes they engaged when providing services to clients (a racialised interpretation of CALD workers' caring and clinical skills).

The work interactions described by migrant participants in these studies occurred in the specific industrial context of the Australian care sectors. However, in these care sectors, there is a disconnect between the provision of workplace policies promoting diversity and non-racism, and the application of the policies to workplace practices (Nichols et al., 2015). Despite the existence of these policies, problematic workplace behaviours persist, in part because the care sector remains embedded in Whiteness. This is evident in expectations that workers use 'acceptable' accents and English expression

(Mapedzahama et al., 2012; Nichols et al., 2015), and that they hold particular technical skills (Gillham et al., 2018). This Whiteness is embedded in clients' preference for White bodies (Mapedzahama et al., 2012); in managers' association of specific cultures with care-giving traits; and in assumptions about the reasons for and meaning of aged care, and what 'counts' as good care-giving practices, which are culturally constructed definitions (Nichols et al., 2015).

How then, do African migrant carers respond to the racism that structures their work? Their strategies reflect those reported by migrant carer participants in international studies. These workers are reluctant to formally report racism and, when they do, they are dissatisfied with the responses of their managers (Mapedzahama et al., 2012; Nichols et al., 2015). Sometimes migrant carers will ignore racist remarks made by clients, or avoid situations that could lead to expressions of racism against them (Nichols et al., 2015). Mapedzahama et al. (2012) describe instances of Black nurses in Australia explicitly arguing for the benefits they bring to the Australian health care sector, asserting their identities as hard workers with the intellectual capacity to understand work tasks easily. CALD nurses take pride in the cultural values they hold with regard to how elderly people should be cared for, and highlight their respect for elders; values they note are in contrast with those typically held by White Australian colleagues (Willis et al., 2018). Overall, the range of strategies adopted by African migrant women in Australia show that they actively manage the racism perpetrated against them in the aged care sector – although the individualised focus of this resistance does not effectively counter the wider, culturally and institutionally embedded racism that structures interpersonal interactions.

2.9 Chapter Summary and Conclusions

In this chapter, I have highlighted the racism perpetrated against women of ethnic minorities working in aged care and nursing. Much of the literature focuses on interpersonally expressed racism as perpetrated by clients and colleagues. This racism can be explicit – as is more commonly the case when perpetrated by clients – or more subtle, for instance where colleagues and managers refuse to recognise workers' skills and perspectives. Regardless of workers' conformity to the expressed and unspoken expectations of aged care, clients and colleagues interpret their raced difference as an indicator of the workers' failings or as undesirable care. Thus, African migrant workers' experiences need to be understood with reference to interactional, institutional and

cultural processes.

In Chapter 3, I present three theoretical tools that are useful in explaining how and why these dynamics are so consistently experienced by ethnic minority workers and African migrant workers in aged care: (1) the theory of micro-aggressions (Sue, Capodilupo, & Holder, 2007; Sue, Capodilupo, et al., 2008); (2) the organisational logic of institutional racism (Came, 2014; Carmichael & Hamilton, 1967); and (3) Hall's insights into colonial frameworks (Hall, 1987; 1992; 1996), and related Whiteness theory (Fanon, 2008; Frankenberg, 1993).

3 THEORETICAL TOOLS

My review of the literature on ethnic minority workers working in the aged care sector (and relatedly, nursing) revealed that racism from clients, colleagues and co-workers is widespread, and that institutional or managerial responses to such racism are inadequate or lacking. The literature indicates the importance of understanding racism both as it is perpetrated interpersonally, and also as it is entrenched in organisations. In this chapter, I build on the literature review to provide an overview of the theoretical tools I will employ to understand racism as experienced by the women participating in this study. I overview the theory of micro-aggressions; explore gendered and racial micro-aggressions in work and institutional contexts and the impacts of micro-aggressions; and consider the strategies African migrant women use to respond to micro-aggressions. I also consider the limits of using the theory of micro-aggressions as a tool for exploring experiences of racism, specifically its traditional focus on the interpersonal rather than institutional dimensions.

I then discuss institutional racism, moving the focus to the organisational logic of racism in aged care. However, as with micro-aggressions, discussions in the literature on institutional racism have so far been limited, in terms of researchers' engagement with the question of why we see racism expressed and institutionally embedded in particular ways. The insights of Stuart Hall on colonial discourses are useful for considering the foundations of micro-aggressions and institutional racism. Hall's work points to a long history of colonial frameworks and understandings that construct particular groups of people as the 'Other'; frameworks that have bearing on the contemporary contexts of aged care. Lastly, I draw on theories of Whiteness, which help us to explain why particular groups are 'Othered', and how norms of Whiteness underpin and structure the ways interpersonal and institutional racism are expressed and enacted. Together with the literature review, this chapter presents the key tools I use for engaging with the experiences of African aged care workers.

3.1 Micro-Aggressions

Racial micro-aggressions are subtly degrading expressions of inequality experienced by people of colour in their everyday interactions across different settings, such as workplaces, families and neighbourhoods (Sue, Capodilupo, & Holder, 2007). Embedded in these brief and often daily interactions are insulting and unpleasant exchanges that

diminish people from marginalised groups. Micro-aggressions are often regarded as insignificant, harmless and negligible because they are usually exhibited through behaviours such as subtle snubs, dismissive looks, gestures and tones (Sue, 2003; Wheeler, 2016): i.e. 'small' acts. Nevertheless, the effects are profound, creating and reproducing injustice and sapping the psychological and emotional energy of people of colour (Franklin, 2004; Steele, Spencer, & Aronson, 2002; Sue, 2004).

My definition reflects those used by leading thinkers in the field of micro-aggression theory. Chester Pierce, a psychiatrist working with Black Americans, was the first to coin the concept of racial micro-aggression. As put by Pierce:

The most grievous of offensive mechanisms spewed at victims of racism and sexism are micro-aggressions. These are subtle, innocuous, preconscious, or unconscious degradations, and putdowns, often kinetic. In and of itself a micro-aggression may seem harmless, but the cumulative burden of a lifetime of micro-aggression can theoretically contribute to diminished mortality, augmented morbidity, and flattened confidence. (Pierce, 1995, p. 281)

Another commonly cited definition similarly highlights the nature of micro-aggressions as brief and ordinary expressions that communicate humiliating, degrading or negative messages towards individuals from marginalised groups (see Nadal et al., 2015; Sue, Capodilupo, & Holder, 2007; Wheeler, 2016). These definitions capture the central characteristics of micro-aggressions: they are often (but not always) subtle, and thus are easily glossed over and considered unimportant. However, they are reflective of powerful, often taken-for-granted, racialised stereotypes and negative attitudes that are perpetuated by individuals of dominant groups upon those in less powerful and less socially valued groups; that is, they are reflective of structural inequalities (Sue, Capodilupo, & Holder, 2007; Sue, Capodilupo, et al., 2008).

The theory of micro-aggressions was initially developed to identify and conceptualise racialised, unequal and demeaning interactions. However, the subsequent literature has been expanded to address multiple inequalities informing and expressed through micro-aggressions (Sue, 2010). Micro-aggressions have also been displayed towards transgender, lesbian, gay, bisexual, transgender and queer and gender-queer people (Gonzales, Davidoff, Nadal, & Yanos, 2015; Keller & Galgay, 2010; Nadal, 2013; Nadal, Griffin, et al., 2012; Shelton & Delgado-Romero, 2011; Wheeler, 2016; Woodford, Chonody, Kulick, Brennan, & Renn, 2015). Some studies have identified religious micro-aggressions (Nadal et al., 2015; Nadal, Griffin, et al., 2012; Nadal, Rivera, Corpus, & Sue, 2010), and others have explored micro-aggressions directed toward people with a

disability (Gonzales et al., 2015; Keller & Galgay, 2010; Palombi, 2013). Gendered micro-aggressions in particular have been the subject of a significant amount of research. Various studies have addressed this issue with regard to, for example: the career paths of Chicana and Chicano scholars (Solorzano, 1998); experiences of sexual harassment (Capodilupo et al., 2010); and Black Latina/o and White undergraduates' experiences in a predominantly White campus (Kohli & Solórzano, 2012; Museus, Ravello, & Vega, 2012; Solorzano, Ceja, & Yosso, 2000; Yosso, Smith, Ceja, & Solórzano, 2009). In the following discussion, I focus on racial micro-aggressions.

Micro-aggressions are interactional, but Huber and Solorzano (2015) argue that they are underpinned by institutionalised systems and procedures, and governed by ideas of White superiority that sustain racial inequality. Huber and Solorzano (2015) state that institutionalised systems, which they refer to as institutional racism, are the bedrock upon which racial micro-aggressions are built. Perez and Huber (2015, p. 303) use the term 'macro-aggressions' to conceptualise the intersection between institutional racism and racial micro-aggressions. They define macroaggression as:

the set of beliefs and/or ideologies that justify actual or potential social arrangements that legitimate the interests and/or positions of a dominant group (Whites) over non-dominant groups (Blacks in this context), that in turn lead to related structures and acts of subordination (Perez and Huber 2015, p. 303).

While micro-aggressions refer to the subtle and often-overlooked acts targeted towards people from marginalised groups, with the intention of degrading them (Sue, Capodilupo, & Holder, 2007), racist aggression can emanate from broader structures and are evident through the dominance of White identities over ethnic minority workers in organisations and the society at large (Embrick, Domínguez, & Karsak, 2017).

Thus, micro-aggressions emanate from a broader system and history of racism (Huber and Solorzano, 2015). They are everyday reflections and expressions of larger racist structures and ideological beliefs that impact the lives of people of colour. I will address this in more detail later in this chapter.

3.1.1 A typology of micro-aggressions

Sue, Capodilupo, and Holder (2007) created a taxonomy of three types of racial microaggressions: micro-invalidations, micro-assaults and micro-insults. Micro-invalidations are displayed through behaviours that omit, discredit or deny the thoughts, feelings or experiences of people of colour and other ethnic minority groups (Liegghio &

Caragata, 2016; Sue, Capodilupo, et al., 2008; Wheeler, 2016). For example, studies have shown that when Black women and other ethnic minority workers raise concerns relating to racial and/or gendered racism, they are dismissed through responses like “we are all human beings” (Sue, Capodilupo, Torino, et al., 2007, p. 274). In relation to their English language skills, they are ‘complimented’ with statements such as: “You are a credit to your race”, “You are so articulate”, or “You speak good English” (Sue, Capodilupo, Torino, et al., 2007, p. 276). In other examples, women have reported not being invited to sporting activities by their male colleagues, because they were not expected to have any interest in sports (Sue, 2010; Sue, Capodilupo, et al., 2008). Other women have raised an issue with men making assumptions about the tasks they are capable of performing at work, and upon expressing their concerns, being invalidated (Holder, Jackson, & Ponterotto, 2015). Or, when Black women have raised concerns about White men’s policing of how they should talk and conduct themselves, their concerns were regarded as irrelevant or unfounded (Lewis, Mendenhall, Harwood, & Hunt, 2013). Similarly, in a care context, when Black migrant nurses have reported to their bosses that patients were racist towards them, they were simply told the patient was very difficult, thereby dismissing the racism and its effects upon the victims (Mapedzahama et al., 2012).

Micro-assaults are an outright verbal or non-verbal racial act targeted towards people of colour. They are expressed through the use of racial epithets like ‘Nigger’ (Sue, Nadal, et al., 2008, p. 330) or ‘coloured’ or ‘Oriental’ (Sue, Capodilupo, Torino, et al., 2007, p. 274), and through avoidant behaviour or purposeful racist actions such as deliberately attending to White customers rather than people of colour at the front of a queue (Sue, Capodilupo, Torino, et al., 2007). Micro-assaults can also come in the form of racialised, racist or gendered jokes. Micro-assaults are easily identified because they are displayed in obvious ways that hurt, marginalise, belittle or oppress people of colour or other subordinate groups (Dovidio & Gaertner, 2000).

Micro-assaults are sometimes made in ways that might be obvious only to the victim but not to a group of people who have never experienced the victim’s structural positioning (Sue, Capodilupo, & Holder, 2007). While not naming them as such, the literature presents examples of micro-assaults in aged care and health care contexts. This is most evident in studies describing instances of clients and co-workers calling minority ethnic workers derogatory names; emphasising the colour of their skin rather than their professional discharge of duties (Mapedzahama et al., 2012; Nichols et al., 2015); and

rejecting workers' services on the basis of their racial identity. This is also evident when clients in nursing homes tell Black immigrant workers caring for them that they don't like Black people; and when managers victimise Black immigrant women based on their skin colour, telling them: "Your colour when you wash your hand, your colour will not change no matter if you wash for more than 2 min, how many times you wash your hands your colour will remain the same" (Sethi & Williams, 2016, p. 368).

The third type of micro-aggressions, micro-insults, are verbal, nonverbal or environmental behaviours that are hostile, insensitive and/or send humiliating messages to people from specific racial groups (Sue, Capodilupo, et al., 2008; Sue, Capodilupo, Torino, et al., 2007). They are not always obvious and may be perpetrated occasionally – sometimes intentionally, but often unintentionally – towards a marginalised group. In the context of aged care facilities, other institutional contexts and the society generally, Black women report being ignored in shared spaces and meeting rooms (Holder et al., 2015; Sethi & Williams, 2016); being spoken to rudely and treated differently because of their race (Donovan, Galban, Grace, Bennett, & Felicié, 2013); not being invited to work-related meetings or social gatherings; and assumptions being made that they are intellectually inferior and incapable of executing tasks (see Forrest-Bank & Jenson, 2015; Harris-Perry, 2011; Holder et al., 2015; Lewis et al., 2013; Li, 2019).

Some researchers have critiqued the idea of micro-insults, suggesting that they are essentially the personal interpretations of people of colour: for example where the well-intended actions of White colleagues are misinterpreted by people of colour as an attempt to patronise, marginalise or humiliate them (Sue, 2010; Sue, Capodilupo, Torino, et al., 2007; Wheeler, 2016). However, despite the unintentionality or otherwise of micro-insults – and other micro-aggressive acts – microaggression theory centres the experiences of marginalised groups, who are best placed to recognise microaggressions after a lifetime of being subjected to them.

3.1.2 Racial micro-aggressions in care work contexts

Prior studies have explored micro-aggressions in the health care sector, including the nursing sector and in aged care facilities. Black migrant care workers have experienced micro-assaults from clients in the form of outright rejection on the basis of their race and immigrant status (Nichols et al., 2015; Shutes & Walsh, 2012), and racist and demeaning language (Bourgeault et al., 2010; Sethi & Williams, 2016). Migrant care workers have also described experiences of micro-assaults where co-workers viewed

them as incompetent, based on assumptions that Africans live in mud huts and bamboo houses (McGregor, 2007; Sethi & Williams, 2016). Managers have also been shown to collude with racist co-workers where they fail to put measures in place to address complaints of racism shown towards the migrant workers (Doyle and Timomen, 2009).

A study conducted by Sethi and Williams (2016) found that workplace micro-aggressions against immigrant caregivers in Canada were focused on their race and immigrant status, reflecting and shaping these carers' relationships with colleagues, clients and managers. One type of micro-aggression perpetrated against Black immigrant caregivers included being looked at and talked to in a different manner from other colleagues, which the carers attributed to their skin colour. This is a form of micro-insult. In some instances, colleagues refused to talk to or greet them. Even though the immigrant care workers from minority ethnic groups did not refer to this as racism, they were sure their experiences differed from those of other co-workers (Sethi & Williams, 2016). White colleagues often made comments to them about "Africans being poor people" – more direct articulations of racism that can be categorised as micro-assaults (Sethi & Williams, 2016, p. 368).

Minority Black immigrants working in White nursing homes have also described experiences of racial micro-aggressions perpetrated by managers. One participant in Sethi and Williams' study (2016, p. 368) related an incident where a manager had made derogatory comments about her skin colour while she washed her hands on duty: "The manager said your colour will not change no matter how much you wash your hands, your colour would remain the same". This kind of micro-assault is deeply humiliating for Black immigrant women. Similarly, Allan et al. (2009) recorded international nurses in their UK study experiencing racist bullying and policing from White nurses and managers that constituted micro-assaults. Studies have reported micro-aggressions towards migrant nurses in the form of co-workers giving undue attention when migrant nurses make mistakes (micro-insults), and accusing migrants of entering the nursing sector only for monetary benefits (micro-assaults) (Allan et al., 2009; Likupe, 2015; Omeri & Atkins, 2002). International nurses and migrant care workers in various studies have also described experiencing micro-insults from managers who frequently assign them undesirable work shifts; an indication that their efforts are not valued and respected (Allan et al., 2009; Goel & Penman, 2015; Larsen, 2007; McGregor, 2007; Nichols et al., 2015).

The findings of Australian studies on nurses agree with the international findings (Mapedzahama et al., 2012; Xiao et al., 2014). These studies determined that migrant nurses in Australia, and specifically Black migrant nurses, experience micro-insults from colleagues in the form of a devaluation of their skills. Their overseas qualifications and experience are often not recognised by White colleagues. Believing Black migrant nurses are intellectually inferior and not capable of discharging nursing duties, White nurses overly scrutinise their work, and subject them to unnecessary coaching (see also Omeri & Atkins, 2002). Black migrant nurses who participated in the study by Mapedzahama et al. (2012) reported that micro-invalidations were also perpetuated towards them by managers, who overlooked their experiences of racism. Where a client rejected their nursing services, these managers simply re-allocated patients to non-migrant nurses, rather than addressing the underlying issue of client racism.

The literature highlights the widespread perpetration of racism in work contexts. The lens of micro-aggression theory assists scholars to categorise these behaviours, and highlights the social and sociological significance of behaviours that might otherwise be seen as 'minor' or 'unimportant'. In the following section, I discuss the impacts of these practices.

3.1.3 Impacts of micro-aggressions

Micro-aggressions create negative consequences for marginalised groups in societies more generally, and for people of colour in predominantly White societies. Some of these consequences manifest in psychological distress, affecting the mental state and well-being of marginalised groups (Sue, Capodilupo, & Holder, 2007; Sue, Capodilupo, et al., 2008). Micro-aggressions can erode people's identity and sense of self. African Americans in the US experience micro-aggressions that insinuate and classify them as intellectually inferior, second-class citizens. This downgrades their sense of integrity and status; negates their experiences as particular racial and cultural beings; and subjects them to the imposition of work practices, beliefs and modes of communication embedded in Whiteness (Sue, Capodilupo, et al., 2008). Consequently, for people from marginalised groups in the American society, a false reality of their racial identity is conferred on them. This has been observed for Mexicans (Solorzano et al., 2000), Black Americans (Sue, Capodilupo, et al., 2008) and African Americans living in the US (Franklin, 2004). Micro-aggressions can affect the emotional well-being of people of colour, manifesting in feelings of racial rage for individuals from African-American, Latina/o and multi-racial backgrounds (Nadal, 2011), and emotional exhaustion and distress, depression, and low

self-esteem for Asian Americans (Wang, Siy, & Cheryan, 2011). African Americans have also reported experiences of self-doubt, frustration and isolation (Solorzano et al., 2000). In relation to organisational structures, experiences of micro-aggressions can limit access to basic services and reinforce social marginality (Sue, 2010). For example, Liegghio & Caragata (2016) in their study on welfare-reliant lone mothers from marginalised groups in Canada, found that they had difficulty accessing benefits from the welfare system. As a result of their experiences of racial micro-aggressions with White welfare workers, which left them feeling shame and humiliation, they avoided subsequent contact, exempting themselves from benefits necessary to their survival, and to which they were entitled. For all kinds of groups marginalised in society, the cumulative effects of micro-aggressions can be devastating. Liegghio and Caragata (2016) concluded that every form of micro-aggression reflects and produces a hostile and unaccommodating environment for marginalised or subordinate groups. On a broader scale, micro-aggressions have been proven to inflict more devastating effects on marginalised groups than overt forms of racial hatred, because of their subtle and hidden, or seemingly unintentional, nature.

Micro-aggressions are often explained away as 'minor' or 'unintentional', but they create negative impacts on people of colour and marginalised groups (Sue, Capodilupo, & Holder, 2007; Sue, Capodilupo, et al., 2008). These impacts erode the wellbeing of individuals, and reproduce unequal power structures that shape marginalised people's experiences beyond individual interactions. However, a focus on the impacts of micro-aggressions should not be read to suggest that people do not actively manage and respond to micro-aggressions – and I turn now to discuss such responses.

3.1.4 Responding to micro-aggressions

Recognising people's resistance to micro-aggressions acknowledges their agency in their lives, and specifically in hostile interactions. Studies on Black women's experiences of racial micro-aggressions across work places, educational institution contexts and the society generally highlight a combination of strategies they use to respond to, resist and manage micro-aggressions (Holder et al., 2015; Lewis et al., 2013; Sethi & Williams, 2016). Some researchers discuss the use of individual coping strategies (Allison, 2010; Holder et al., 2015; Sethi & Williams, 2016; Shorter-Gooden, 2004; Thomas, Witherspoon, & Speight, 2008). The study by Lewis et al. (2013) identified three types of individual coping strategies used by Black women in the educational institution generally: resistance coping strategies, collective coping strategies and self-protective coping

strategies.

Individual coping strategies are strategies adopted by Black women in corporate leadership positions that do not focus on addressing the source of the micro-aggressions, nor on confronting the perpetrators (Holder et al., 2015). Some Black women share their experiences of workplace racial micro-aggressions with family members, friends and trusted co-workers, to validate if they indeed classify as cases of micro-aggressions. Other Black women avoid responding to racial micro-aggressions from a racial perspective (Holder et al., 2015). They adopt this approach because perpetrators find it easy to deny their acts of micro-aggressions. For instance, Black women in Holder et al.'s (2015) study have reported that, when they were excluded from social gatherings or work meetings, perpetrators claimed this was an oversight or that it had skipped their minds to include them. This left the women feeling angry, but unable to express their interpretation of such acts as micro-aggressions (Holder et al., 2015). Another individual coping strategy used by Black women in professional and administrative positions is to avoid situations and colleagues that do not allow them to participate in career advancement opportunities (Shorter-Gooden, 2004). This is a similar strategy to that reported by Black female students in college in the US, who experienced gendered racism, but chose to make light of the seriousness of the micro-aggression, and adopt avoidance as a way of managing the experience (Lewis et al. 2013). Holder et al. (2015), in their research on Black women in corporate leadership roles, similarly observed that these women suppressed their reactions to racism in the workplace, in order not to show the perpetrators how demoralising such acts made them feel. Thomas et al. (2008) found that some African American women in their study adopted an individual coping strategy called emotional de-briefing, where they avoided thinking about the negative consequences of micro-aggressions they experienced in society. Some participants in a study by Shorter-Gooden (2004) used a 'shifting' strategy; they avoided discussing anything outside of work-related matters with White colleagues, distancing their private life from their public life.

Black women in senior and executive positions have also used religion and spirituality as coping strategies in the workforce. Holder et al. (2015) report that some of their participants developed a routine of praying every day, which helped them to divert their attention from micro-aggressive acts to 'divinity' – a term one of the Black women used. Spirituality has also helped Black women to forgive perpetrators of such acts and concentrate on other issues of life (Bacchus, 2008; Lewis et al., 2013). Some women in

the study by Holder et al. (2015) chose to focus on what they called the 'benefits' of racial micro-aggressions. They felt that racial microaggressions had developed their personality and strength of character, and helped them become tougher and stronger. Self-care is the last individual coping strategy used by Black women experiencing micro-aggressions in the workplace. Some seek therapy, where they have opportunities to share their experiences of micro-aggressions and how it makes them feel (Holder et.al, 2015).

Resistance strategies are active strategies that utilise cognitive and behavioural measures to manage the perpetrators and the experience of micro-aggressions (Lewis et al., 2013). A resistance strategy to manage micro-aggressions involves Black women using their voice as power. Actively speaking up, they confront the perpetrator of a micro-aggression and report the incident to the necessary authorities and supervisors in order to avoid a replication. Black migrant women working in the aged care sector in Canada also resist micro-aggressions from colleagues and managers by taking action and speaking up (Sethi & Williams, 2016). Speaking up has been shown to reduce the re-occurrence of micro-aggressions. Indeed, Sethi and Williams (2016) found that Black women who discussed their dissatisfaction with their managers' racist behaviour reported that this had a positive impact on their relationship with the manager. Their manager apologised for the racist behaviour toward the Black immigrant carers, largely because the women had, in their discussion, articulated threats to report the manager to upper management. Also, Black migrant nurses in Australia have been shown to resist micro-aggressions by actively challenging negative stereotypes that paint them as lazy and devalue their skills, asserting that they are hard workers compared to their White Australian colleagues, with extensive prior experience of nursing in their countries of origin (Mapedzahama et al., 2012).

Lewis et al. (2013) describe the use of collective coping strategies, which involve seeking assistance from a social network of family and friends in order to manage (validate or normalise) experiences of micro-aggressions. In their study of Black women students in college settings in the US, they found that one collective coping strategy included armouring. This involved the Black women priding themselves and having confidence in their own self, family and culture, which helped them to function effectively at work despite their experiences of micro-aggressions (Lewis et al., 2013). The Black women in this study coped with gendered and racial micro-aggressions through leaning on the support and network of other Black women whom they considered trusted advisors and

mentors. They formed Black women associations and clubs in which they were able to get guidance, advice and coaching from mentors whenever they experienced micro-aggressions in the workplace, and this helped them to deal with racial micro-aggressions and advance in their careers. In these associations, they were also able to discuss issues that Black women face, and express their frustrations (Lewis et al., 2013).

Self-protective coping strategies are 'inactive' strategies used to avoid focusing on the experiences of micro-aggressions and to desensitise to or reduce their negative effects (Lewis et al., 2013). Black women college students in the study by Lewis et al. (2013, p. 64) sometimes adopted an identity of 'Black Superwoman' or 'Strong Black Woman', and worked hard to execute "multiple roles and responsibilities in order to demonstrate their strength, ability to succeed and resilience" in their educational programs, jobs and private lives. At other times, they adopted desensitisation, and avoided centring their experiences of micro-aggressions as an escape strategy. Some Black women college students coped by engaging in comfort eating and sleeping (Lewis et al., 2013).

The strategies described above have been explored across multiple work and educational contexts and society more generally. The above discussion highlights some of the multitude of ways in which Black women, and other individuals from marginalised groups, assert their agency in the face of micro-aggressions and the power disparities associated with them. My aim in presenting these studies is not to generate a comprehensive list of strategies, but rather to highlight the different expressions of resistance. In addition, I suggest there are limits to the effectiveness of these forms of resistance, which typically engage – or disengage – with perpetrators at the individual level, with little impact on the wider structures that inform and enable the expressions of micro-aggressions.

3.1.5 The limits of using the tool of micro-aggressions to explore experiences of racism

The theory of micro-aggressions was developed in the field of psychology in the 1970s and has since been adopted and adapted by other disciplines, including psychiatry, education, sociology and social work (Embrick et al., 2017). The bulk of studies that explore micro-aggressions have investigated how experiences of racism against people of colour emanate from interactional processes in different contexts (Sue, Capodilupo, & Holder, 2007; Sue, Nadal, et al., 2008). These studies have been fundamental in identifying the experiences and interests of marginalised groups and people from ethnic

minority groups, taking seriously the often-overlooked difficulties or otherwise mundane experiences that attack and diminish people (Sue, Capodilupo, Torino, et al., 2007). Thus, the theory of micro-aggressions offers a means of acknowledging and countering 'small' behaviours that impact negatively upon people. As noted by Huber and Solorzano (2015), the idea of micro-aggressions helps us to identify the tangible ways in which racism manifests in everyday conversations and other interactions. Seemingly small acts can be understood as expressions of wider racist attitudes.

Micro-aggression theorists keep advancing nuanced ways of understanding the experiences of people of colour. The term micro-aggressions was first coined by Chester Pierce in 1970. Much later, Sue, Capodilupo, and Holder (2007) discussed the racial micro-aggression experiences of Black Americans and recommended suggestions for future research in advancing the field. Rising to this call, many researchers in the field of psychology have developed different assessment tools to identify different types of micro-aggressions perpetrated against people who identify as belonging to marginalised groups. Many of these are quantitative measurement scales, such as the Sexual Orientation and Transgender Micro-aggression Scale (Nadal et al., 2010), the Racial Micro-aggressions Scale (RMAS) (Torres-Harding, Andrade Jr, Diaz, & Crist, 2012), the LGBTQ Micro-aggression Scale (Woodford et al., 2015); the Sexual Orientation Microaggressions Scale (SOMS); and the Gender Identity Micro-aggressions Scale (GIMS) (Nadal, 2019). These assessment tools have helped to validate the reliability of measuring the experiences of specific types of micro-aggressions for marginalised groups.

Attention has been drawn to the fact that most micro-aggression studies have been conducted as experiments in university settings, using participants from psychology and similar disciplines who had prior understanding of racial micro-aggressions and its consequences, potentially introducing some form of sample bias (Constantine & Sue, 2007; Solórzano & Yosso, 2002). In 2014, Wong, Derthick, David, Saw, and Okazaki called for more studies to be conducted outside of university settings, such as in work environments, sport centres, places of worship etc. My study responds to this call by building an understanding of the micro-aggression experiences of African migrant women working in the aged care sector in Australia. Questions of generalisability and bias are of less concern for this present research, which has been designed using a qualitative approach that emphasises depth of understanding and insights into racialised micro-aggressive interactions as they are lived and understood by the women who are subject

to them. The consistency of the findings from previous micro-aggression studies, and the applicability of the typology of microaggressions (micro-invalidations, micro-assaults and micro-insults) to people's experiences in a range of social and work contexts, suggest that the tool of micro-aggressions is an important and useful one for identifying and analysing racism in interaction. In the research design, my decision to capture lived experience is particularly important, because when micro-aggressions are explored through qualitative studies, participants can narrate their experiences in their own words. This gives a voice to previously marginalised groups and people of colour (Sue, Capodilupo, Torino, et al., 2007).

Sue, Capodilupo, and Holder (2007) point to the fact that while racial micro-aggressions exist beyond the interpersonal level, the bulk of studies in this area have not examined racial micro-aggressions as a result of racism at the systemic and environmental levels. This perhaps reflects the dearth of studies on micro-aggressions from the field of sociology. Embrick et al. (2017) reiterate the need for more sociological approaches to the study of micro-aggressions, suggesting that because the majority of studies on micro-aggressions were undertaken in the fields of psychology, psychiatry and educational psychology, they were focused on individual framings of micro-aggressions and coping strategies that could be adopted to deal with microaggressions.

A more multi-dimensional conceptualisation of micro-aggressions can be built with reference to Essed's (1991) foundational study of 'everyday racism'. Essed (1991) differentiates between cultural, institutional and individual racism. Cultural racism refers to stereotypical perceptions of Blacks and other minority groups in a society. Institutional racism refers to direct and indirect racialised structures in place in the society to confine the access and privileges of people of colour overtly or covertly. Individual racism is described by Essed (1991) as the forms of prejudice and bias manifested towards people of colour and marginalised groups. A fuller understanding of micro-aggressions might be gained by exploring their manifestation through each of these processes, to identify their interaction in developed countries with structures of oppression and hegemonic structures that value Whiteness (Shelton & Delgado-Romero, 2011).

Thus, micro-aggressions that occur at the individual level can be more fully understood in the context of broader social structures that produce racial micro-aggressions, and the dominance of White identities over people of colour in organisations and the society at large. Embrick and colleagues (2017) explain how racial micro-aggressions sit within the

systemic/institutional structure of the US, which has policies that discriminate against racial and ethnic minority groups with respect to preferential treatment in housing (Krysan & Farley, 2002), voting rights (Bonilla-Silva, 2012; Feagin, 2012), hiring and recruitment (Royster, 2003), and freedom and inclusion in the social space (Anderson, 2011). As will be argued later in this chapter, structural constraints embed Whiteness and White-centred policies in ways that segregate Black people and people of colour into lower economic, political and social strata – positioning them for more racism.

Overall, the value of a micro-aggressions approach lies in its capacity to identify and explain a series of specific – often mundane, but also destructive – expressions of racism perpetrated against people of colour. Initially, researchers using this approach tended to focus on the interactional dimensions of micro-aggressions, but there is now a slowly growing number of studies extending the field by focusing on the role of racialised structures and institutions in generating micro-aggressions (Embrick et al., 2017; Huber & Solorzano, 2015; Wong et al., 2014). However, there remains a dearth of research exploring the institutional, cultural and historical underpinnings of micro-aggressions. As will be explored below, colonial histories and meanings shape how racism is expressed in micro-aggressive acts. Turning to these histories is important because it helps us to understand the form and the content of micro-aggressions – what is said, what is left unsaid, and what experiences and ‘worldviews’ are overlooked in society. These histories also help to explain how the ‘Other’ is constructed through the ‘privileges’ and centered normativity of Whiteness in institutional contexts, such as the Australian aged care sector. In the next section, I discuss institutional racism, which is a useful framework for understanding the organisational logic of racism perpetrated against marginalised groups in the workplace (Berard, 2008).

3.2 Institutional Racism

The concept of institutional racism gained popularity through the work of foundational authors Stokely Carmichael (later known as Kwame Ture) and Charles Hamilton in their 1967 book *Black power*. These scholars defined racism as “the predication of decisions and policies on considerations of race for the purpose of subordinating a racial group and maintaining control over that group” (Carmichael & Hamilton, 1967, p. 3). They distinguished between individual racism and institutional racism, where individual racism refers to racist acts perpetuated by individuals; and institutional racism is attributed to the “total white community” (p. 4), or the “white power structure” (Carmichael &

Hamilton, 1967, p. 7). Carmichael and Hamilton explained that the nature of institutional racism is manifest in less overt, less subtle and less easily identifiable means than individual racism, because there are no specific/individual perpetrators of these racist acts. For example, African Americans' experiences of housing segregation in the US cannot be readily attributed to any specific individual perpetrator, but are a manifestation of institutional racism with roots in larger social structures such as social welfare policy, real estate markets, criminal justice institutions, educational institutions and health care systems (Carmichael & Hamilton, 1967).

The argument of Carmichael and Hamilton is twofold: (1) institutional racism is perpetrated by the 'White race' as a group in the US; and (2) institutional racism is perpetrated in many spheres by power holders and through decisions made by them (Carmichael & Hamilton, 1967). This racism in majority White contexts in the US consequently leads to the subordination and control of Black people and the subsequent sense of racial superiority over Black people. While Carmichael and Hamilton (1967) explored institutional racism against Black people in a majority-White society (the US), much later, researchers such as Murphy and Choi (1997) have interrogated its expression through the practices and processes of specific institutions.

Feagin and Feagin (1986) also conceptualised two types of institutional discrimination: direct and indirect. They described direct institutional discrimination as actions prescribed by organisations or communities that are intentionally perpetrated and targeted towards marginalised groups. Of particular relevance to this thesis study, they define indirect institutional racism in relation to:

practices having a negative and differential impact on minorities and women even though the organisationally prescribed or community prescribed norms or regulations guiding these actions [are] established, and carried out, with no prejudice or intent to harm lying immediately behind them. On their face and in their intent, the norms and resulting practices appear fair or at least neutral. (Feagin & Feagin, 1986, p. 31)

Paradies (2005), and Jones, Pringle, and Shepherd (2000), conceptualise institutional racism as a pattern of systematically unequal access to material resources and power, determined by race; affording one group of people particular benefits, while denying others those same benefits (Came, 2012). In a workplace institution, this unequal access is created through the processes, structure, governance, values, workplace culture, ideological beliefs, attitudes and behaviour of the institution's management, and its informal and formal processes and practices (Bourke et al., 2019; Spangaro et al.,

2016). As argued by Macpherson (1999, para. 6.34), “institutional racism is also reflected in the collective failure of an organisation to provide appropriate services to people of colour through discrimination, a lack of awareness, overlooking, insensitivity and racist stereotyping”. As I will argue in greater detail in the later discussion on Whiteness, institutional racism reflects histories and privileges of Whiteness, and is evident through the kinds of issues an institution considers worthwhile, and those that are overlooked (such as the experiences of ethnic minority workers).

3.2.1 Institutional racism in nursing and aged care

Institutional racism has not been discussed in detail or labelled as such in aged care studies to date. Previous researchers have reported institutional practices and absences that systematically disadvantage some groups, but did not explicitly conceptualise these as institutional racism – see, for example, Nichols et al. (2015) on CALD and migrant workers experiencing limited support in their roles; and King et al. (2013) on migrant workers finding it difficult to utilise training because of cultural barriers.

In care contexts, Mapedzahama et al. (2018) found that Black migrant nurses in an Australian hospital setting experienced indirect institutional racism that constructed them as ‘ignorant’ and ‘unknowing’ because of their migrant background. Henry (2007) describes the role of language and cultural barriers in impeding the career advancement and promotion of minority migrant nurses in the UK. Similarly, a number of studies conducted by Likupe and Archibong (Likupe, 2006; 2015; Likupe & Archibong, 2013) found that Black African nurses from Sub-Saharan Africa are denied the opportunity to utilise and develop their nursing specialty in the UK, and consequently are positioned as novices in the discharge of their nursing duties, which further results in a lack of respect from their colleagues. In all of these care contexts, the organisations employing the migrant carers failed to challenge White perspectives and privileges. These employers saw the workers as the problem, without considering how their institutions were structured around Whiteness, and the normative assumptions underpinning systemic processes in their workplace (Mapedzahama et al., 2018).

Tuttas (2015), in her UK literature review exploring indirect institutional racism for minority migrant nurses, summarises evidence from studies that indicate migrant nurses face a lack of recognition of their expertise in the workplace and a lack of support in accessing opportunities for promotion; and that workplace practices and policies tend to reflect favouritism towards White domestic nurses, who are allocated better shifts

compared to their migrant counterparts. A common practice in institutions is to re-allocate patients to White nurses if they reject a Black nurse, without addressing the client racism. These institutional practices are not intended to cause any harm to workers from minority groups, but nonetheless result in them feeling 'Othered' (Tuttas, 2015).

Allan et al. (2009) conclude in their study on nursing practices in the UK that 'indirect discrimination' (what I define as institutional racism) is hard to pinpoint; it is entrenched in the social structure of an institution, and reflected through organisational workplace practices and culture towards overseas nurses that do not take into cognisance the needs of the nurses or their peculiarities and qualities based on their migrant background. Johnstone and Kanitsaki (2010) and Henry (2007) describe the effect of Whiteness and institutional racism on minority and migrant nurses in the UK, including the unequal power structure and disparities in opportunities for promotion (Henry, 2007; Johnstone & Kanitsaki, 2010).

3.2.2 Limits and implications for understanding the concept of institutional racism

Writers have noted tensions and problems emerging from the conceptualisation of institutional racism in the literature (Berard, 2008; Cashmore, 1996), which has focused on institutional racism as emanating solely from institutions, neglecting to attend to how racism can be perpetrated at the level of individuals (Brown et al., 2003). Some scholars raise concerns about the definition of institutional racism portraying all White people as accomplices in institutional racism (Rydell, Hugenberg, Ray, & Mackie, 2007; Yzerbyt, Corneille, & Estrada, 2001; Yzerbyt, Judd, & Corneille, 2004). Berard (2008) argues that "the idea of a monolithic white power structure acting as a single, unified agent of repression could easily be objected to as stereotyping, overgeneralising and essentialising" (Berard, 2008, p. 737).

Theorists including Blauner (1972), Carmichael and Hamilton (1967), Haas (1992) and Le Blanc (2003) have been criticised for exploring the effects of institutional racism on marginalised groups and conceptualising institutional racism without adequately specifying how institutional processes play a significant role in causing this, or noting any social/ psychological determinants of discriminatory actions and outcomes (Berard, 2008). Berard (2008, p. 740) asserts that whenever a situation is labelled as institutional racism, there "must be a social-psychological basis". Institutions must be understood in

terms of human thought and actions; after all, they are constructed by people, who have beliefs and concerns. In other words, individuals are relevant to understanding institutional racism: "There cannot be racism without racists, discrimination without discriminators and intentional actions without purposeful actors" (Berard, 2008, p. 750).

While my study is not designed to adjudicate debates on the weaknesses of early theorisations of institutional racism, these debates have raised significant concerns about the divide between racism at the institutional and societal level, and the micro-level forms of racism that emanate from individual beliefs, actions, intentions and interpersonal relations. They have made it clear that interactions in interpersonal relationships could be sites for the manifestation of institutional racism (Berard, 2008). This supports Trepagnier's suggestion that studies should avoid simplistic discussions of attributing racism solely to "predetermined societal structures" (Trepagnier, 2006, p. 20). Leach (2005, p. 442) similarly argues that attention should be paid to both social structures and social psychology, as they are "mutually relevant and mutually informative".

In my analysis, I interrogate the expression of racism as it is manifest both through institutional processes and logics (institutional racism) and interactionally (through a consideration of micro-aggressions). I am also sensitive to the argument put forward by Berard (2008) that we need to attend to the ways in which normative assumptions – and by extension, social constructions of race – underpin how micro-aggressions and institutional racism are structured, produced and experienced. Thus, in the next section I turn to the work of Stuart Hall and other colonial discourses to reflect on the historical basis of micro-aggressions and institutional racism. I also draw on theories of Whiteness to elucidate why particular groups are 'Othered' through institutional racism, and how Whiteness underpins and structures the ways in which institutional racism is enacted.

3.3 Colonial Histories: Stuart Hall, and the West and the Rest

The work of Stuart Hall provides an important set of insights to help address colonialism, 'Othering', and perceptions of Black identities and people of colour, such as African migrant aged care workers in Australia. His works also explore issues of representation and how the colonial production of knowledge contributes to the production and reproduction of racism for people of colour in predominantly White societies.

The significance of Stuart Hall's work in shaping the field of racial and ethnic studies over the past four decades cannot be over-emphasised (Alexander, 2009). Hall was a foundational figure for academics and scholars in Britain, the US, the Caribbean and elsewhere in opening new avenues for exploring the discourses of race, politics, culture and identity (Alexander, 2009). Hall insisted on the role of theory, which functions like a tool box (Scott, 2005), as "a way of stirring up questions and debates and not a conclusion or an endpoint" (Grossberg, 2007, p. 10). Similarly, Scott describes Hall as "pre-eminently, a theorist of the present" (Scott, 2000, p. 263). Hall's work is useful for interpreting the 'present context' of aged care, because it helps us to understand where micro-aggressions and institutional racism come from. His thinking on colonial histories and colonial meanings continue to frame how 'Black' identities are constructed, imposed and responded to. His insights describe the experiences of migrants in the diaspora and the White space (Hall, 1987; Hall, Critcher, Jefferson, Clarke, & Roberts, 2013); a space which is inclusive of the aged care sector.

3.3.1 The West and the Rest

It could be argued that Hall's exploration of colonial frameworks is not relevant in contemporary society; that colonial meanings no longer guide our thinking nor have negative consequences on societies classified as the 'Rest'. However, as Hall, argues:

Discourses don't stop abruptly. They go on unfolding, changing shape, as they make sense of new circumstances. They often carry many of the same unconscious premises and unexamined assumptions in their blood stream. (Hall, 1992, p. 221)

Colonial meanings – and discourses of 'the West and the Rest' – still confer racial inferiority on the identity of the 'Rest'. In the context of my study on African migrant women, colonial ideas of 'Otherness' play out in the micro-aggressions that are perpetrated against aged care workers; functioning as "the inscriptions of identity between those who belong and those who do not, between those whose histories have been written and those whose histories have been written about" (Hall, 1999, p. 48). African migrant workers are subject to colonial meanings because Black identities and cultures have a long history of being 'Othered' (Hall, 1987). On a broader scale in the Australian context, Black migrant identities have long been 'Othered' through policies such as the White Australia policy (Tavan, 2004). This will be discussed in detail in Section 3.4.1.

3.3.2 Tools for categorisation

Hall argues that discourses of 'the West and the Rest' work to 'Other' colonised subjects in several ways. The representations of the 'West' serve as a 'tool for categorisation' that produces ways of thinking and producing knowledge as well as a fact of geography (Hall, 1992). Hall also notes that,

the concepts "West" and "Western" are not just referenced to place and geography and they do not have a simple or fixed meaning. What was originally termed "West" emanated from Western Europe but in current times, the "West" does not reside in Europe and not all of Europe is in the West. (Hall, 1992, p. 185)

For example, in terms of modern advancement and technology, Japan is Western, but in terms of geography it is in the East; while Latin America, which is geographically situated within the 'West', is considered one of the Third World countries 'lagging' in terms of development.

This East-West tool of categorisation is based on discourses of race that emerged in the 18th and 19th centuries. Theories of race and difference, such as Race Science, argued that races could be identified based on their anatomy and bodily differences (McConnochie, Hollinsworth, & Pettman 1988). These physical differences were believed to account for differences in individual abilities and temperaments, such that "race was the driving force and explanation for the rise and fall of cultures, civilisation and the dominance of white races over other races" (McConnochie, Hollinsworth, & Pettman, 1988, p. 14). The Great Chain of Being, another important theoretical framework from this time, was anchored on the premise that all life forms emerged from earlier and simpler forms, and all life forms evolved from the simplest to the most complex. This argument led to the idea that different races were positioned in hierarchies in the chain – with 'developed' and 'civilised' races considered the most complex forms, and the 'less civilised' and 'less developed' races classified as simpler forms (McConnochie et al., 1988).

The concept of Social Darwinism also reinforced racial hierarchies, in particular ideas about the 'struggle for existence' and 'survival of the fittest'; asserting that naturally weaker nations would die out while stronger nations would conquer, and this would result in a cycle of continuous improvement (Hofstadter, 1992, p. 6). Following this, Charles Darwin's original theory on natural selection (Darwin, 1987) was adapted into an explanation of "population and societal development about nature's indispensable

method for producing superior men, superior nations, and superior races" (Gossett, 1963, p. 145).

In short, theories of race and difference structured a powerful set of hierarchies for race, based on several underlying principles: 1) people can be classified into different groups based on their biological, genetic and physical characteristics; 2) the behaviour of people is linked with their biological, genetic and physical characteristics; and 3) these classifications can be used to construct some people (races) as superior to others – similar to constructs of 'the West and the Rest' (McConnochie et al., 1988). As argued by Fanon in the book *Black skin, white masks*, the 'Black' skin of subjects from non-Western countries came to signify savagery, brutality, ignorance and inferiority (Fanon, 1970).

My study is also informed by Spurr's (1993) work *The Rhetoric of Empire*, in which he explores how colonial discourses construct the 'Other' through frameworks of comparison. He discusses thirteen forms of rhetorical devices constructed by Western writers to represent non-Western, Third World countries (Spurr, 1993). While not all of these constructs directly apply here, some are particularly useful in explaining the micro-aggressions underpinning the experiences of African women in my study. First, the device of *Surveillance* describes the power wielded by colonising people and countries, which they can use to dominate and control colonised subjects. Throughout history, the privileges held by Western colonising countries afford them the power to assess, command or view colonised bodies in certain ways (Spurr, 1993). Second, Spurr refers to *Classification* as a form of ideology produced to assign races into a hierarchical order, where the White race is constructed as civilised and not primitive, and the 'Black race' as a backward and uncivilised class (Spurr, 1993). By extension, *Modernisation* encompasses the way non-Western people are evaluated with the Western classification, which judges their character as not up to the Modern – Western standard. Several other tropes work to set up colonial peoples as abject; framed through a set of negative connotations. *Debasement* is the classification of non-Western people as "filthy, inhuman and amoral" and the opposite (the dark side) of what the West is believed to represent. This classification results in non-Western people being feared and rejected (Spurr, 1993). My study data indicated that these particular forms of categorisation apply to African women working in Australian aged care, who are positioned in micro-aggressive interactions and institutional processes as backward, uncivilised and not quite achieving the Modern – Western standard – as I will discuss in more detail in the chapters on the analysis.

3.3.3 System of representation

Hall has argued that colonial discourses are a system of representation and a form of visual image that creates a picture in our minds of what Western or non-Western societies should look like (Hall, 1992, p. 185). These ideas are famously articulated by Edward Said in his book *Orientalism*. In this seminal work, Said explores how the West constructed a powerful set of representations of the 'East' as irrational, aberrant, backward, crude, inferior and inauthentic. The aim of this stereotyping was to construct a hegemonic system to dominate the Orient and enhance Western imperialism (Said, 1978). Those who belong to the 'West', on the other hand, were constructed as the "epitome of human progress". As argued by Said (1978, p. 12), "the discourses of 'Orientalism' have more to do with our world and less to do with the 'Orient'" (see also Mulholland, 2018).

According to Said (1978), the West's representation of the 'Orient' as the 'Other' serves as a way of wielding power, authority and dominance over people from marginalised groups. Typically, when people think of European societies, images of modernity come to mind. However, when people think of non-Western societies – including those of the African continent – "a visual representation of a rural, under-developed and a barbaric culture and uncivilised people calls up in our mind's eye" (Hall, 1992, p. 186). My study shows that these images are evident in the experiences of African migrant women in aged care in Australia, who are viewed by clients as inferior, crude and rural. Assumed to live in mud houses, they are seen as refugees and poor people.

3.3.4 Paradigm of comparison

The discourse of 'the West and the Rest' provides a paradigm of comparison and a yardstick for explaining difference. Measurements are established to denote to what extent societies classified as non-Western are "lagging behind" or "attempting to catch up" with Western societies in terms of modernisation and industrialisation. Hall states that the 'West' is seen as the standard of social progress and civilisation, rationality and development, and the 'Rest' are judged in comparison to Western progress. However,

the "Rest" has historically been a major anchor for the formation of the western Enlightenment and modernity, and without the "Rest", the "West" would not have been able to recognise and represent itself as the summit of human history. (Hall, 1992, p. 221)

These ideas provide a benchmark of assessment against which societies are appraised as either 'developed' or 'under-developed' and create positive or negative attitudes and

representations accordingly (Hall, 1992). What we now describe as 'the West and the Rest' is a function of an organising construct developed centuries ago. As put by Hall:

The so-called uniqueness of the West was, in part, produced by Europe's contact with other, non-Western societies (the Rest), very different in their histories, ecologies, patterns of development and cultures from the European model. The difference of these other societies and cultures from the West was the standard against which the West's achievement was measured. (Hall, 1992, p. 187)

Thus, Hall's work helps us understand how the discourses of 'the West and the Rest' continue to act as a categorising tool, a system of representation, and a paradigm of comparison: a benchmark of assessment (Hall, 1992). In my study, these discourses structured the form and content of the micro-aggressions experienced by the African women participants. Indeed, some studies on racial micro-aggressions draw attention to the histories of colonialism and interpersonal and institutional oppression in the home countries of people of colour and migrant groups, and how this can reproduce experiences of micro-aggressions in their host societies (Forrest-Bank & Jenson, 2015; Wong et al., 2014).

Forrest-Bank & Jenson (2015) have given examples explaining how the positioning of Filipinos and West Africans as colonial subjects, and history of oppression, slavery and colonisation in their countries of origin, are expressed through the perpetration of racial micro-aggressions today. As I show in Chapter 5, some of the experiences of racism reported by African women in this present study, such as being assessed as lagging behind their colleagues in English language proficiency and competence at work, also reflect longer histories of colonised subjects and those classified as the 'Rest'.

3.4 Whiteness

Insights gained from Whiteness theory can also be used to explain how 'Othering' occurs in contemporary contexts such as aged care, and through micro-aggressions and institutional racism, which are relevant to this study. Whiteness refers to "the production and reproduction of dominance rather than subordination, normativity rather than marginality and privilege rather than disadvantage" (Frankenberg, 1993, p. 236). The concept of Whiteness brings to the fore how Whiteness unconsciously privileges White people with opportunities and signifies "deeply embedded, structural, hard, enduring and solid-state features of race and racism" (Duster, 2001, p. 113). As argued by Huber and Solorzano (2015) in their use of critical race theory to understand racial micro-

aggressions in the US, racism is underpinned by the privileging of Whiteness in White-dominant societies. They state: "racist events are systemically mediated by ideologies of White supremacy that justify the superiority of a dominant group (Whites) over non-dominant groups – people of colour" (Huber & Solorzano, 2015, p. 298). Every act of racism perpetuated by an individual can be linked to broader institutional and ideological mechanisms that maintain the status quo of oppressing marginalised groups and people of colour. There are racialised structures in place in organisations and the society at large that uphold White supremacy (Huber & Solorzano, 2015).

These structures exist irrespective of individual desires to challenge, benefit from or reproduce Whiteness. As Bartky (2002, p. 154) explains:

Most white people in developed countries are complicit in an unjust system of race relations that bestows unearned advantages on them while denying these advantages to racial Others. Complicity in this system is neither chosen nor, typically, is it acknowledged, because there are both powerful ideological systems in place that serve to reassure whites that the suffering of darker-skinned Others is not of their doing and because the capacity of whites to live in denial of responsibility is very highly developed.

Applebaum and Leonardo argue that Whiteness remains invisible and occurs through marginalised groups being classified as 'Others', while a dominant group is used as the standard through which other groups are measured (Applebaum, 2003; Leonardo, 2007). In short, White norms, meanings and identities sit at the centre 'looking out'. This explains the normalised nature of Whiteness (Leonardo, 2007). I also note that Whiteness is reproduced through how certain groups are positioned at the centre of society based on their skin colour, educational status and class privileges. They are privileged, and yet they are also 'blind' to this. They are viewed as the 'normative' citizen while others are viewed as different, and conditioned to notice difference, but not be seen as different themselves.

3.4.1 Context specificity

The term Whiteness (Green, Sonn, & Matsebula, 2007; Guess, 2006; Leonardo, 2007) is context-specific and revolves around the dynamics of race locally and globally. Privileges of Whiteness vary depending on context, history, gender, class, region and sexuality (Gallagher, 2003). To understand Whiteness in Australia, it is vital to examine the role of the White Australia Policy. Australia as a nation was – and still is – committed to "maintaining her racial and cultural homogeneity" (Tavan, 2004, p. 112) and upholding its "Whiteness, Britishness and Australianness" (Tavan, 2005, p. 136). The White

Australia Policy was formalised in 1901 with legislation and administrative rules designed to restrict non-European migrants from coming into and settling in Australia (Tavan, 2004). Non-Europeans were discriminated against on the basis of race up until the early 1950s, after World War II, when a series of 'relaxations' began to open Australia's borders to (still limited) numbers of non-Europeans (Brawley, 1995; Tavan, 2004). The White Australia Policy was finally dismantled in 1973 by the Whitlam Labour government and the Racial Discrimination Act 1975 was introduced, which stated that it was against the law for anyone to discriminate on any grounds of race or colour of skin or nationality (Whitlam, 1985). However, Australia remains a deeply racist country, in which the expressions of Whiteness are manifest in contemporary ways.

3.4.2 Whiteness in institutions

Applebaum (2003) notes that to understand Whiteness and White privilege on a broader scale, we need to acknowledge the interplay between individual benefits of White privileges and those sustained by institutional and cultural practices (Applebaum, 2003). Lipsitz (2006) argues that Whiteness sits at the centre of organisations where the mainstream culture is White. As such, norms of Whiteness underpin the ways in which institutional racism is enacted and experienced. Other scholars also note that Whiteness reflects through the social structure of organisations (Berwald & Houtstra, 2003; Carangio, Farquharson, Bertone, & Rajendran, 2020; Moreton-Robinson, 2004). Some workplaces and occupations are normatively 'White' (Curington, 2019, p. 2), and there are White cultural norms and expectations around how workers should conduct themselves within these workplaces. In essence, the picture of the 'ideal worker' reflects the Whiteness of the organisation, and Whiteness is assumed to be the expected framework of workers and those in positions of authority (Ray, 2019; Rivera, 2012). Therefore, institutional racism reflects these privileges of Whiteness and manifests through the structure and governance of an organisation (Bourke et al., 2019) and expectations of who 'fits' within the workplace structure (Hobbs, 2018; Johnstone & Kanitsaki, 2010).

As I will note later in the analysis chapters, in the Australian aged care sector, privileges of Whiteness are enacted in micro-aggressions and institutional racism through key workplace practices: technical training, human resources training, staff induction processes, the use of assistive technologies and the complaints management system. These workplace practices in residential aged care facilities overlook and undermine the experiences of migrant workers. There are obvious differences in the cultural

backgrounds and types of knowledge of migrant workers, and it has been noted that migrant workers experience difficulties in understanding the training provided to them (King et al., 2013). Further, migrant workers and nurses in Australia and the UK have often described experiencing a lack of support for their institutional roles as personal care workers, as well as issues due to White privilege shown to their colleagues (inequities in shift allocation and opportunities for mentorship, with respect to work advancement and promotion) (Goel & Penman, 2015; Henry, 2007). I argue that institutions, and by extension the 'problems' associated with the workforce, have been organised around the 'White Anglo Celtic culture'. This has resulted in an emphasis on training migrant workers to fix an assumed skills deficit and overcome perceived cultural and communication challenges with clients and co-workers (Adebayo, Nichols, Albrecht, et al., 2020; Adebayo, Nichols, Heslop, et al., 2020; Khatutsky, Wiener, & Anderson, 2010; Nichols et al., 2015; Willis et al., 2018; Xiao, De Bellis, et al., 2017; Xiao et al., 2020; Xiao et al., 2018). I will discuss this in more detail in Chapter 6.

Whiteness is also reflected through the way White workers are seen and view themselves as the 'ideal carers', while migrant workers, and specifically African workers (personal care workers and nurses), are seen as 'different', are 'Othered', and 'constructed' as not being appropriate carers as a result of their skin colour, communication skills and bodily features (Nichols et al., 2015; Xiao et al., 2014). The Whiteness of institutional racism is also reflected through what an institution considers are work issues worth looking into, rather than just part of the job – i.e. workers' experiences of racism (Nichols et al., 2015).

3.5 Conclusion

My aim in this chapter was to critically conceptualise the possibilities and limits of the theory of micro-aggressions as a means of identifying interpersonal racism in aged care, and as a foundation for introducing theory on institutional racism to highlight the organisational logic of racism in aged care. The limitations of theories on micro-aggressions and institutional racism, in explaining why racism is expressed or embedded in specific ways, led me to the application of Stuart Hall's work on how colonial discourses construct particular groups of people as the 'Other'. In addition, theories of Whiteness also help to explain why particular groups are 'Othered' in the contemporary contexts of Australian aged care. These tools are useful for shedding light into the experiences of racism for Black women in nursing and aged care and in the workplace

more generally. I apply these in more detail in the chapters on my study findings and discussion, which are presented after an account of the methods and methodology I used for this research.

4 METHODS

In this chapter, I describe the methodology, sample characteristics, methods and ethical implications of my research. As discussed in Chapter 3, the theoretical tools guiding this study are the theory on micro-aggressions and on institutional racism, Hall's insights on colonial discourses, and the literature on Whiteness. These theoretical perspectives emphasise meaning making and lived experiences of racism, and inform the qualitative methodology and methods – specifically, in-depth interviews – used in this study.

4.1 Reflecting on my Position as a Researcher and an African Woman

My own identity as an African woman and my experiences of racism in Australia have informed my reflections and practice in this research. As Guba and Lincoln (2005) argue, reflexivity requires me to reflect on myself as a researcher and the multiple identities I might hold in the research setting. Doing this gives integrity to research procedures that use critical, feminist and race-based methodologies, which recognise relationality and power in the research process (Pillow, 2003).

I am a Black African woman interviewing other Black African women about their experiences of micro-aggressions and racialised 'Othering'. As other Black researchers affirm, my shared identity can help me to establish rapport with participants and develop deeper insights into their lived experiences (Atewologun, Sealy, & Vinnicombe, 2016; Mapedzahama, 2019). While recognising that African migrant women differ from each other across country of origin, biography, class and gender, as an African migrant woman, I wanted to give a voice to a marginalised group whose experiences of racism have not been consistently recognised in research or public debate. I was drawn to the aged care sector as a site for research because it is one of the major industries attracting African women migrants seeking employment in Australia. My choice was also informed by my connections and conversations with other African migrant women, sensitising me to the taken-for-granted expectation of this work as appropriate and available. Being an African migrant woman shaped the way I framed my interview questions with respect to participants' life experiences, as well as their experiences of racism in the workplace. Consequently, some of their narratives of racism resonated with me, and also the ways in which they made sense of their experiences.

As a researcher, I am positioned as a feature of the empirical data being collected and,

as such, I myself am a part of the meaning making process, in significant ways (Plummer, 2005). As Tracy (2010) writes, qualitative researchers must engage in self-reflexivity by being open to the ways in which they shape the research. My position as a Black woman and a Black African migrant shaped how I collected the data. For example, because I shared a racial background with the participants, I was able to build their trust when asking sensitive questions. When I asked participants about their experiences working in aged care, I believe they were able to freely share their experiences with me, encouraged by the similar migrant and racial positioning we shared. Because of this, when I asked these women about their relationships with clients, colleagues, and supervisors, they shared their experiences perhaps more openly than they would have with a researcher who was not visibly positioned as 'different' in the White Australian context. Our shared positioning also sensitised me to particular issues and themes that informed my interpretation and presentation of the findings; for example, issues around the marginalisation of Black workers, racist experiences and name calling, assumptions about incompetence, and accusations of criminality. More broadly, my own lived experience of 'small' or 'subtle' racism has sensitised me to the value of the theory on micro-aggressions as a tool for identifying and explaining participants' experiences of racism in aged care. However, I am also aware that I play a significant role in making meaning of the data through my interpretation of the voices and narratives of my participants. Ultimately, there are limits to our common position as African migrant women, as my relationship with the participants is a research relationship, rooted in institutional demands. Therefore, my voice and perspectives also shape the framing of the experiences that these African migrant women working in aged care choose to share with me.

4.2 Applying a Qualitative and Feminist Methodology

This study was informed by a qualitative research methodology. Qualitative research is strongly associated with an interpretive approach, and allows researchers to make sense of phenomena with reference to the meanings people bring to them and to the meanings that are co-constructed through the research process (Denzin & Lincoln, 2008; Warmbui, 2013). Qualitative methodologies are appropriate in studies that address topical issues such as experiences of racism for marginalised groups, and make meaning of data through the narratives of participants (Corbin & Strauss, 2008; Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017; Mohajan, 2018). As Mohajan (2018) also argues, these methodologies centre the knowledge and understanding of participants who come from

marginalised groups. They privilege the importance of attending to participants' experiences of their day-to-day life as expressed in their own words (Malterud, 2001; Walia, 2015). This was a particularly important consideration for me when undertaking the study presented in this thesis, as my participants are a group of women whose voices, experiences and interpretations are not consistently acknowledged and given weight in research or in their own workplaces.

My methodology is also inflected by feminist concerns. My feminist framework recognises women's lived experiences as valid evidence of their positioning, and aims to give women a voice with the purpose of pursuing – and ideally, achieving – social justice. Fonow and Cook (2005) put forward several guiding principles of feminist methodologies relevant to my research. First, they argue that there is the need for on-going reflexivity around the role of gender in social life, to ensure that the research process is inclusive. Second, they debunk the idea that researchers are 'separate' from the research process, as discussed above, and refute the belief that personal and grounded experiences are 'unscientific'. They also emphasise the importance of paying detailed attention to ethical considerations in feminist research, and avoiding exploitation of women as participants in the research process. In conducting my research, I endeavoured to apply these principles. I paid attention to the importance of relationship building between the researcher and participants; I abided by formal institutional and relational ethical considerations; and I amplified the experiences of African migrant women working in aged care, thereby giving them a voice – which was the overarching goal of my study.

4.3 Doing Ethical Research

My approach to ethical research recognised the importance of both institutional and relational ethics. My research fulfilled the requirements of Flinders University's ethics procedures. It was approved by the University's Social and Behavioural Research Ethics Committee on 20 June 2018 (project number 8007). The research was conducted in accordance with the approved research plan I submitted. The key ethical elements within this institutional framing included informed consent, confidentiality, and anonymity.

It was essential that my participants freely volunteered to participate in this research, and gave their informed consent. They were provided with all of the details pertaining to the research and were informed that they held the right to refuse to participate, in writing and/or through discussions with me. They were given assurances that their confidentiality would be maintained, and clear information about how the data obtained

from their participation would be used (for this thesis and, potentially, for publication in research papers) (Corti, Day, & Backhouse, 2000; Orb, Eisenhauer, & Wynaden, 2001).

In order to ensure the confidentiality and anonymity of participants, in the participant precis I present standardised information on their life history in their countries of origin; their professional roles and contexts; and length of work experience in the aged care sector. To maintain the women's anonymity, I have avoided providing details about the specific facilities or agencies where they work, and their countries of origin and languages spoken, both in the precis and where I introduce the participants in the chapters on my study findings. I gave the participants pseudonyms, and stored their raw data and transcribed interviews on computers locked by passwords, which only I can access. In instances where participants shared information about the facilities they worked and made negative comments about relationships with their supervisors and their managers – which could jeopardise their employment – I assured participants that any information I publish would be anonymised and would not endanger their jobs.

I managed the collection of participant consent in formal and informal ways. To ensure participants formally consented, I ensured they each signed a consent form, as required by Flinders University's Social and Behavioural Research Ethics Committee. However, I also understand consent to be an issue of ongoing negotiation – which is particularly important given the sensitivity of the matters discussed in the interviews. The need for on-going and negotiated consent across the interview process has been discussed in the literature (see Heath, Charles, Crow, & Wiles, 2004; Miller & Boulton, 2007). While the ethical principle of informed consent requires researchers to ensure participants indicate willingness to/or not to participate in a research study without any form of coercion or duress (Heath et al., 2004), the typical practice is that participants give their verbal consent before the commencement of an interview. However, researchers such as Miller and Boulton (2007) and Truman (2003) have questioned whether formal, informed consent measures can suffice for all the situations that could arise throughout the interview process. Miller and Boulton (2007) note that providing an information sheet, and collecting signed consent forms and informed consent, cannot manage all the experiences, sensitivities and vulnerabilities of participants that might emerge as a result of risk and the researcher's power in the research process. They assert that there is a need for a process of consent/negotiated consent that begins with the recruitment of participants to the study, and extends through the responses of participants; allowing them to negotiate the questions asked and the answers they provide, as well as

negotiate accessibility issues such as dates and times of their interviews (Miller & Boulton, 2007).

Keeping this in mind, in this study I endeavoured to continuously check and remain sensitive to the ease and comfort of my participants with the research process throughout the whole course of their interviews. For example, if I asked a participant a question relating to client racism or racial name-calling, and she was reluctant to answer or expand on my question, or her countenance changed – I respected her silence and implicit message of non-consent, and did not probe further.

The consideration of ongoing consent is a reminder of other, less formal institutional understandings of ethical research that are rooted in situational ethics, relational ethics and existing ethics (Tracy, 2010). *Situational ethics* deals with the context or specific situation in which the research takes place. To address this, I critically reflected on the research process, asking myself about the methods of data collection and whether the research promised more benefits to the participants than harm. The outcome of this reflection was a feeling of confidence that participants would benefit from sharing their narratives, because my study was giving them a voice.

Relational ethics refers to how researchers connect to and relate with participants during the research process, requiring a consciousness of their own character and its impact on participants (Tracy, 2010). This emphasises the importance of empathising with participants, being respectful and mindful of protecting their dignity, and maintaining an ethic of care (Christians, 2005; Ellis, 2007; González, 2000). My commitment to relational ethics in the research process emphasised not treating African migrant women as objects to be valued only for their part in my data collection. I worked to build trusting and respectful relationships with my participants, and listened to and acknowledged their narratives. I respected their decisions to answer or not answer, and the extent to which they answered the interview prompts. I acknowledged their concerns and challenges by expressing how I hoped the findings from this study might inform a change to their experiences of racism.

Existing ethics recognises that ethical considerations must extend beyond data collection into the ways in which data is presented (Tracy, 2010). Fine, Weis, Weseen, and Wong (2000) call attention to the risks of presenting data in ways that might cause more harm than good to participants. They note that this can be particularly true for marginalised groups and, as such, researchers need to be careful when discussing the experiences of

such groups (Fine et al., 2000). I was particularly sensitive to this, ensuring that in discussing the experiences of the African migrant women who participated, I did not describe or portray them as oppressed victims without any form of control; or as somehow deserving micro-aggressive attentions or the impacts of institutional racism, due to the different skills, communication practices or values they bring to aged care – compared to the normative White ideal that structures such care in the Australian context. I committed to recognising and presenting the responses of participants through which they were able to exercise agency.

4.4 Research Methods

Informed by the theoretical and methodological priorities discussed above, my approach to sampling and methods emphasised the importance of including in the study the voices of African women working in aged care, in order to generate and analyse pertinent data that provide insights on this under-researched group and the issue of racism in the sector.

4.4.1 Sample and recruitment

This research draws on interviews with 30 African women working in aged care in Adelaide. The women had migrated from six African countries: Nigeria (n=19), Kenya (n=7), Ghana (n=1), Liberia (n=1), Ethiopia (n=1) and Congo (n=1).

There are debates in academia about the appropriate number of participants for qualitative research (Alase, 2017; Creswell & Poth, 2016; Onwuegbuzie & Leech, 2007). Many of the responses to this debate have advocated interviewing participants until the point of data saturation, when no new themes are evident in data analysis (Baker, Edwards, & Doidge, 2012; Fugard & Potts, 2015). However, I designed my sample size on the basis of Tracey's (2007) recommendation to aim for quality, rigor and richness and detail in data analysis, rather than emphasise the number of participants in the research (Adler & Adler, 2011; Doucet & Mauthner, 2008; Tracy, 2007). While I cannot guarantee that no new themes would have emerged had I undertaken more interviews, I am confident that the data generated through my sample offers insights into the key experiences of African migrant women working in aged care.

I used purposive sampling as the sampling logic for this thesis research. Purposive sampling is an intentional mode of recruitment of participants on the basis of who can provide relevant and useful insights into the research (Etikan, Musa, & Alkassim, 2016;

Patton, 2002). Given this study's focus on African workers in aged care, the parameters of the purposive sample were African women who had migrated to Australia, were aged over 18 and working in aged care – either institutional aged care settings, or home care (and occasionally both). I chose to focus on women specifically, and not workers with a range of gender identities, because the aged care sector is a predominantly female occupation (Mavromaras et al., 2017). These empirical considerations aligned with my commitment to understanding women's lives through feminist and qualitative methodologies by making visible their experiences of racism (Makkonen, 2002). Including women who worked in different aged care contexts was important, as it would enable me to identify experiences of racism specific to each site and common across sites. I also sought to recruit women who worked in different roles such as personal care workers, support workers, community support workers and nurses.

Initially, I had sought to recruit participants by advertising in TAFE SA and recruiting through the Working Women's Centre in Adelaide (South Australia), but this was not successful. My decision to recruit participants from a religious organisation was based on the knowledge that it hosted aged care workers from a range of African countries. I ultimately recruited 20 women through this organisation. The other (n=10) women were recruited through the technique of snowballing. A network of friends from the African community referred me to participants (friends of friends), and participants I had interviewed earlier referred me to other African women working in aged care.

In my recruitment approach, I initially rang women and discussed my study with them. When they showed an interest in participating in the research, we decided upon a suitable location for the interview. For other women, I discussed the research face-to-face, and when they indicated willingness to participate in the study, we agreed on an interview date. All of the participants I approached were provided with an information sheet containing details of what my research entailed, possible risks they could be faced with, and the sensitivity of the research topic. I also gave them a consent form, which they read and signed to signify they were willing to participate in my research.

Recruiting through a church has meant that the sample is relatively homogenous in terms of religious beliefs, but diverse in terms of other socio-economic characteristics. My study does not centre religion as a focus of the research, nor as a category of analysis. As discussed in Chapter 7, religious beliefs did inform some women's responses to micro-aggressions and institutional racism – however, there was no indication that

their religious beliefs informed their understanding of and responses to racism directed toward them in their work more broadly.

The participants' biographies and current socio-economic circumstances are diverse (see Appendix 1). The women came from different work and life experiences in Africa. Two had migrated before working age; two had not yet been unable to secure employment before migrating; two had married and were not working; and two had just completed their undergraduate degrees before they migrated to Australia. Prior to migrating, other participants had worked in professional roles in finance (n=2), commercial enterprises (n=7) and the public service (n=2). Eight had worked as health care providers in their home country; two were teachers; and one had been employed in a small business. The women had lived in Australia between one year and 15 years. Most (n=22) had resided here for between one and five years; four women had lived in Australia 6–10 years and four women had lived in Australia for more than 10 years. The majority (n=22) of women were on temporary visas. Four women were Australian citizens, two were permanent residents and two were on a skilled migration visa.

The participants' educational qualifications ranged from a high school qualification to bachelor's and master's degrees. Twenty-three women had achieved a bachelor's degree in their home country and were currently pursuing a bachelor's degree in nursing in Australia, or were upgrading their initial nursing qualifications to a master's degree. Three women held nursing qualifications from their home countries and were not pursuing further studies. Two of the participants were enrolled here in a bachelor's degree in a health administration field. Two participants had a high school qualification in their home country and had no intentions of furthering their studies in Australia.

Twenty-two women worked only in institutional aged care settings, five worked in both institutional aged care settings and home care, and three women worked in home care only. The majority of participants worked as personal care staff, and others worked as support workers and community support workers. Two participants worked as nurses. With regards to their employment conditions: the majority of the women (n=24) had casual working conditions, one participant was contract staff, two women had part-time permanent positions, and three women had permanent full-time positions. Of the 24 casual workers, 18 worked only in institutional aged care facilities, while six women had casual employment with agencies. Most (n=23) of the women worked between 40 and 60 hours per fortnight; four worked more than 60 hours per fortnight; and three worked

between 10 and 40 hours per fortnight.

In terms of demographic characteristics: participants' ages ranged from 20 years to 65 years old. Twenty were aged between 20 and 35 years old, nine were aged between 35 and 65 years old, and one participant did not declare her age. With regards to their relationship status, 18 of the participants were married and had a family, 11 were single, and one was separated from her spouse.

My focus on African migrant women, and my use of a purposive sample, raises issues of generalisability, which is also referred to as transferability (Walsh, 2003). When qualitative researchers conduct studies on a group of respondents, it is often inappropriate to generalise their theories or conclusions beyond the sample (Auerbach & Silverstein, 2003; Furze, Savy, Brym, & Lie, 2011). Thus, it is not possible to determine if the experiences of the 30 participants in my study are generalisable to the broader population of African women migrants working in aged care. Nor can these findings on African migrants be generalised to other migrant groups (both men and women) working in aged care, as their experiences could also be different based on other intersectional variables such as class, gender, race and accent (Sue, 2010). However, generalisability is a concern that is more typically applied to quantitative studies (Furze et al., 2011). Rather than aiming to generalise the findings, my research seeks to explore the in-depth experiences and understandings of a particular group of aged care workers. Depth of understanding, rather than generalisability, is the driving concern of this thesis. This allows for more nuanced understandings of racism, as perpetrated by clients and colleagues and as experienced by these African care workers, and a more holistic and contextual analysis (Becker, 1970; Bradley, 1993).

4.4.2 The participants

Below, I present brief biographical précis of the 30 participants in my study. To avoid participants being identified through their biographical details, information has been standardised and personal information that could identify them (e.g. their country of origin and language spoken) has been removed.

Abi: left her country of origin as a teenager to escape conflict and persecution. This move put an end to her education, and she spent most of her adult life in Africa working in a low-skilled and low-paid occupation. She is now aged between 45 and 50 years old. She moved to Australia between 10 and 15 years ago, sponsored by a family member,

and is now an Australian citizen. Abi has been working in the aged care sector as a personal carer in residential care for approximately 10 years. She currently has a permanent position and works slightly less than full time.

Lisa: is aged between 30 and 35 years old. In her country of origin, she worked in the health sector. Lisa moved to Australia between one and five years ago and has a temporary permanent residence visa. In her home country, Lisa achieved a bachelor's degree in a health-related field. She has been employed in Australia as a personal care worker in a casual position for close to a year in an institutional aged care setting. She works 60–70 hours per fortnight.

Ola: has spent most of her adult life working in administrative positions. She is aged between 30 and 35 years old. She moved to Australia 5–10 years ago on a skilled migration visa. Ola studied a bachelor's degree in a discipline unrelated to health in Africa. She has been working in the aged care sector for approximately three years in a permanent part-time position, as a support worker in residential care. Ola works 50–60 hours per fortnight.

Venus: is aged between 25 and 30 years old. She left her country of origin after getting married, and moved to Australia to upgrade her studies in a field unrelated to health. Venus has lived in Australia between 5 and 10 years on a temporary visa. She has a permanent position in a residential care facility and works 40–60 hours fortnightly. She has been working in personal care in the aged care sector for approximately three years.

Cassy: left her home country as a teenager with her family and came to Australia 10–15 years ago; she is now a citizen. Aged between 20 and 25 years old, she is currently studying a bachelor's degree in a health-related field. Cassy has worked in the aged care sector as a personal care worker in residential care for less than a year. She holds a casual position and works about 20–40 hours per fortnight.

Bekes: left her country of origin 5–10 years ago to join her partner in Australia and is now a citizen. She is aged between 40 and 45 years old. She spent most of her adult life working in her home country in education. She has worked in the aged care sector for approximately five years, starting as a personal carer. Since graduating with a nursing degree in Australia, she has held a casual position as an enrolled nurse in an institutional aged care facility. She works 10–15 hours fortnightly.

May: achieved a bachelor's degree in a discipline unrelated to health in her home country. She migrated to Australia 1–5 years ago to further her studies in a health-related field. She is now aged between 30 and 35 years old. May is in Australia on a temporary visa. She has worked in the aged care sector for approximately two years as a personal care staff member in residential care. This is a casual role she holds with an agency. She typically works 40–50 hours in a fortnight.

Pauline: did not disclose her age. She is currently studying in a health-related discipline. Back in Africa, she completed a bachelor's degree in a different specialty area. Pauline has been in Australia between five and ten years on a temporary visa. She has worked in the aged care sector for three years as a personal care worker and is currently employed as a nurse in a casual position in residential care. She works 60–70 hours per fortnight.

Jumia: left her country of origin to escape persecution after her high school education, and decided not to further her studies. She is aged between 45 and 50 years old. She moved to Australia 5–10 years ago, sponsored by her partner, and is now an Australian citizen. Jumia has been working in the aged care sector for approximately three years as a community support worker in home care. A casual worker with an agency, on average she works between 15 and 20 hours in a fortnight.

Cecilia: is aged 30–35 years old. She spent most of her adult life working as a nurse, having completed a degree in nursing back in Africa. Cecilia moved into Australia to upgrade her nurse education and has lived here between one and five years on a temporary visa. She has worked in the aged care sector for less than a year in both residential and home care. She holds a casual agency staff position and works approximately 40–50 hours fortnightly.

Ella: migrated to Australia to pursue a master's degree in health services, having worked in a related field in Africa. She is aged between 30 and 35 years old, has lived in Australia 1–5 years and is on a temporary visa. Ella has been working in the aged care sector for approximately a year as a personal carer in a residential care facility. In this permanent position, she works 40–50 hours per fortnight.

Belinda: is aged between 30 and 35 years old. She is currently studying a bachelor's degree in nursing, upgrading a lower nursing qualification obtained in Africa. She has spent most of her adult life working as a nurse. She moved to Australia 1–5 years ago and is on a temporary visa. Belinda works in a personal care role in an institutional aged

care setting. She has worked for less than a year as a casual agency staff member, completing between 40 and 50 hours every fortnight.

Shade: spent most of her adult life working in an administrative support position. Back in Africa, she studied a bachelor's degree in a discipline unrelated to health; here in Australia, she is currently studying a diploma in a health field. She is aged between 35 and 40 years old. Shade has lived in Australia 5–10 years and is on a temporary visa. She has been working in the aged care sector as a personal care employee for three years in an institutional setting, has a casual position and works between 40 and 50 hours per fortnight.

Leila: is aged between 25 and 30 years old. She left her country of origin to join her partner in Australia. She moved to Australia 1–5 years ago and has a temporary visa. Leila has been working for close to a year in the residential care sector in a casual, personal care role. Every fortnight she works between 40 and 50 hours.

Funmi: moved to Australia 5–10 years ago and is a permanent resident. She left her country of origin with her partner after securing a better employment opportunity in Australia. She is aged 35–40 years old. Back in Africa, she studied a bachelor's degree in a health-related field and spent most of her adult life working in public health. Funmi has been working in the Australian aged care sector for a year as a community support worker in home care. Per fortnight she works 50–60 hours in a contract position.

Priscilia: is aged between 30 and 35 years old. She spent the majority of her adult life working as a nurse and left her country of origin to upgrade her nursing studies in Australia. She has lived in Australia 1–5 years on a temporary visa. Priscilia has been employed in residential care for a year as a personal care employee, in a casual position, working 40–50 hours fortnightly.

Tori: moved to Australia to pursue a master's degree in a field unrelated to health. Back in Africa, she worked mostly in health-related services. She is aged 30–35 years old. Tori has lived in Australia for 1–5 years on a temporary visa. She has worked both as a community support worker in home care and as a personal staff member in residential care for a year. She holds a casual agency position and works on average 40–50 hours fortnightly.

Esther: is aged 30–35 years old. She completed a master’s degree in Australia in a discipline related to health services. Esther has lived in Australia between one and five years and holds a skilled migration visa. She has been working in an institutional aged care setting for 2.5 years as a personal care worker. Esther has a casual position and works fortnightly between 60 and 70 hours.

Eddy: has spent the majority of her adult life working in education. She is aged between 30 and 35 years old. She left her country of origin 1–5 years ago to further her studies, and is here on a temporary visa. She works 40–50 hours in a fortnight in a casual position as a personal care staff member in residential care.

Muna: left her country of origin as a teenager to pursue her University education in a discipline unrelated to health care services. She is aged 20–25 years old. She moved to Australia 1–5 years ago and has a temporary visa. Muna is a personal care worker, holding casual and permanent positions across two institutional aged care facilities. She has worked in the aged care sector for two years, working on average between 40 and 50 hours in a fortnight.

Samantha: is aged between 30 and 35 years. She left her country of origin 1–5 years ago to further her studies. She currently holds a temporary visa. Samantha has been working in an institutional aged care facility and in-home care for close to a year, as a personal carer and community support worker. She holds a casual position with an agency and works between 40 and 50 hours in a fortnight.

Tracey: moved to Australia to pursue a master’s degree in a discipline unrelated to health care services. Back in Africa, she studied a bachelor’s degree in a specialty area outside of health sciences. She is aged 25–30 years old. She migrated into Australia 1–5 years ago on a temporary visa. Tracey has been working in a personal care role in residential care for less than a year. She has a casual position, working fortnightly about 40–50 hours.

Hannah: left her country of origin to undertake more study. She has spent most of her working life as a public servant. Aged between 40 and 45 years old, she moved to Australia 1–5 years ago on a temporary visa. Hannah has a casual position as a personal care worker and works 40–50 hours fortnightly. She has been working in aged care for around a year.

Sheni: has spent most of her adult life working in a volunteer role in health services. She is aged between 30 and 35 years old. She has lived in Australia 1–5 years on a temporary visa, and worked in the aged care sector for a year. She is employed in a personal care role in residential care on a casual basis. In a fortnight, she works between 40 and 50 hours.

Rachel: is aged between 30 and 35 years old. Back in her home country, she had spent most of her adult life working as a nurse. She moved to Australia between 1 and 5 years ago and holds a temporary visa. Rachel has worked for around one year in aged care as a support worker in residential and home care. She is on a casual working arrangement, and on an average in a fortnight works between 40–50 hours.

Nanna: spent most of her adult life in Africa working as a professional in private industry. She moved to Australia to pursue a master's degree related to health care services. Nanna's age is between 25 and 30 years old. She has lived in Australia between 1 and 5 years on a temporary visa, and worked for less than a year as a community support worker in home care. She holds a casual position, working 40–50 hours each fortnight.

Nike: has worked mostly in the health sector in Africa. Completing a bachelor's degree in a health-related field, she then moved into Australia to further her studies in the same discipline. She is aged between 20 and 25 years old. Nike has lived in Australia 1–5 years and has a temporary visa. She has worked in home care and residential care for less than a year. She is in a permanent part-time position with an agency, and each fortnight works between 40 and 50 hours.

Jenny: left her country of origin for greater education opportunities in a health-related discipline. She is currently aged between 25 and 30 years old. She has lived in Australia between 1 and 5 years on a temporary visa. Jenny has worked as a personal carer on a casual basis with an agency for less than a year. She works 40–50 hours every fortnight.

Anita: is aged between 35 and 40 years old. She studied education in Africa and has spent most of her adult life working as a teacher. She moved to Australia to further her studies in a discipline related to health care services, and has lived here for 1–5 years on a temporary visa. She has worked for a year as a personal carer in a casual position in residential care. Each fortnight, she works approximately 40–50 hours.

Nelly: spent most of her adult life working as a nurse. She came to Australia to further her education in health sciences. She is aged between 60 and 65 years old. Nelly has lived in Australia between 1 and 5 years on a temporary visa. She has worked in an institutional aged care setting for around a year as a personal carer. In this casual position, she works 40–50 hours fortnightly.

4.4.3 Conducting semi-structured, in-depth interviews

I conducted semi-structured, in-depth interviews with the participants to generate data. This form of data collection is particularly appropriate for exploring the lived experiences of African women working in the aged care sector. Semi-structured, in-depth interviews are useful tools for developing an understanding of sensitive matters such as experiences of racism (Warren & Karner, 2005). This type of interview allows participants to freely narrate their experiences of the topic area in ways that are meaningful to them. In listening and connecting to their narratives, the researcher is able to establish rapport with participants, which helps to foster trust, so that the interviewees give a fuller account of their experiences (Ardichvili, Page, & Wentling, 2003; Douglas, 1985; Rizzi, Pigeon, Rony, & Fort-Talabard, 2020). In-depth interviews give participants the space to discuss in detail the issues that matter to them, in ways they feel comfortable, enabling them to explore specific elements of their experiences (DiCicco-Bloom & Crabtree, 2006). Semi-structured, in-depth interviews can enable participants to freely discuss their views in relation to a topic, and potentially open up a discussion on issues that might otherwise remain unrecognised in relation to the topic. The use of semi-structured, in-depth interviews was particularly important for the current study because this format allowed the African migrant women to narrate their experiences using their own words, ideas and reference points, giving a voice to a group of women whose experiences and perspectives have been marginalised from research and from policy attention.

I began each participant interview with some pre-determined, open-ended questions, allowing new issues and questions to emerge from participants' responses (DiCicco-Bloom & Crabtree, 2006). This approach ensured that the discussion was focused on what was important to participants, while also capturing issues central to the conceptual and theoretical concerns of the thesis. The women were asked standardised questions regarding what they enjoyed about aged care work, and the challenges they faced in this work. At the beginning of their interview, participants were asked to provide socio-demographic information on their length of time in aged care work, their current role, work hours and conditions, age, relationship status, visa category and year of migration

into Australia. Each interview also explored participants' experiences of working in aged care, including the tasks they performed in their current job; how they began working in aged care; what it felt like; what they enjoyed, and what they considered difficult about this work; the strategies they used to meet client needs; and differences in the provision of aged care in their home country compared to in Australia. The key focus of the interviews centred around exploring the institutional context of care work. Participants were asked about the countries of origin of their co-workers; how they deal with co-workers, re. how they build positive relationships with colleagues, any points of tension or conflict; and how their managers address conflict.

The interviews also included discussions about racism. Participants were encouraged to describe how they understood racism and to narrate their experiences of racism with clients, co-workers, and managers. They reflected on the impacts of these experiences – how racism made them feel, and if/how it affected their relationships with clients, co-workers and managers. They were also asked to outline how they manage experiences of racism, and their experiences of their organisation's response to racism.

Throughout the interviews – and the analysis, discussed below – I have centred the participants' accounts and interpretations. This is partly as a challenge to critiques in the literature regarding micro-aggression studies which raise concerns about the limitations of participants self-reporting their experiences. It has been noted that micro-aggression measurement scales rely heavily on self-report and recall, which could introduce some form of bias when participants describe behaviour that was not 'meant' to be racist by the perpetrator, or lead them to focus heavily on negative experiences (see Nadal, Skolnik, & Wong, 2012; Sechrist, Swim, & Mark, 2003; Sue, 2010; Torres-Harding et al., 2012). However, intentionality is not the central concern of theory on micro-aggressions nor, for that matter, institutional racism. These acknowledge that individuals who are subject to racism are best placed to identify and define racist acts or processes, irrespective of the intentions of others. Thus, 'self-reporting' of racism is a key and valid element of my study. To further clarify, I understand the interview process as a means of encouraging participants to narrate – to make sense of, not simply report – their experiences of racism in aged care. I assert that the participants in my study are the individuals best placed to discuss 'small' acts of racism, and are likely to readily identify it after experiencing similar micro-aggressive acts.

4.4.4 Analysing the data

I made audio recordings of interviews using a password-protected recording device. Participants had been told at the time of recruitment that, during interviews, information shared with the researcher would be recorded, if they were agreeable for this to occur. After completing each interview, I transcribed the interviews verbatim, and then re-read the transcripts and removed superfluous words or clauses that were not essential for understanding the overall meaning of the data.

I used thematic analysis to interpret the data shared by the women I interviewed. Thematic analysis is a form of qualitative data analysis that systematically organises and makes meaning of data, by identifying and analysing recurring, important and patterned responses from the data set that align with the research question in a study (Braun & Clarke, 2006; 2012; 2020). Using this type of analysis, the researcher identifies and interprets different aspects of a topic and ultimately links these to theoretical and conceptual issues (Boyatzis, 1998).

My approach to analysis was data-driven: the patterns in the data informed my developing analysis – which was informed, but not primarily determined, by existing theory and concepts (Braun & Clarke, 2020; Braun, Clarke, & Weate, 2016). Through analysis, my aim was to generate an in-depth and abundant description and conceptualisation of the experiences of participants. As noted by Braun and Clarke (2012, p. 58), the process of coding and analysis embraces both data and theory, as “researchers always bring something to data when they analyse it and rarely completely ignore the semantic content of the data when coding”. Thus, my initial inductive approach was primarily concerned with systematically coding and understanding the voices and lived experiences of the participants. I then combined this with a deductive approach that explored these voices and experiences with reference to key theories, the relevance of which became apparent through the coding processes (Braun & Clarke, 2012).

In working with the data, I followed the six phases of thematic analysis described by Braun and Clarke (2006), which entailed:

1. Familiarising myself with the data through listening to audio recordings, transcribing and re-reading transcripts, making notes on the data and highlighting important content.

2. Generating initial codes by systematically coding experiences in, and interpretations of, the women's accounts.
3. Developing themes by categorising the initial codes.
4. Reviewing themes by constantly checking through them and seeing if they were meaningful across the sample. This involved going back to re-read the data, to ensure the themes I initially generated reflected the participants' interpretations and experiences in context.
5. Defining and naming themes. After reviewing themes, I began conceptualising what I meant by these themes, drawing on the literature on micro-aggressions and institutional racism, and empirical studies of aged care and nursing more generally.

This work then became the basis of the findings presented in the following chapters, which respectively focus on micro-aggressions, institutional racism and participants' responses to these racist processes.

4.5 Conclusion: Reflecting on the Rigor and Quality of the Research

Throughout the design, conduct and reporting of this research, I tried to remain sensitive to the contestations over what constitutes 'good' qualitative research. At the core of my definition of good research was a desire to develop a coherent and multi-dimensional account of my participants' experiences of working in aged care in ways that echoed their understandings, and to amplify these with theory. To achieve this aim, I used Tracy's (2010, p. 839) eight 'Big-Tent' criteria for good qualitative research to inform the design and conduct of my research:

1. worthy topic
2. rich rigor
3. sincerity
4. credibility
5. resonance
6. significant contribution
7. ethics
8. meaningful coherence. (Tracy, 2010)

In this final section of the chapter, I reflect on how these criteria informed my research,

so that readers can make their own assessments of the validity and rigour of the findings I present in the next chapters.

In relation to the first criterion, a *worthy topic*, good qualitative research should be educative and contemporarily relevant (Tracy, 2007). It should go beyond only restating issues already known, and interrogate topical or pressing issues in ways that are interesting and, ideally, present previously unrecognised experiences to readers. As I have noted already, scant research has been carried out on the topic of African migrants working in the aged care sector, internationally and in Australia. My research fills a gap by shifting the focus from the needs of the sector and an ageing population, which have been the dominant concerns in the policy literature, to the experiences of those working in aged care. Thus, my research has been designed to generate detailed data on an under-researched and vulnerable cohort of workers.

Tracy (2010) defines *rich rigour* as the process of applying a nuanced and detailed framework to the methods of data collection, the engagement of theoretical tools, and the process of data analysis when carrying out research. She specifies that rigor in research is reflected through the process of taking fieldnotes, the number and length of interviews, the types of questions asked and, overall, the process of converting raw data/interview transcripts into writing up the research findings. Weick (2007) notes that rich rigor emerges from the use of detailed theoretical perspectives, and a systematic and thorough analysis of the data set. Aligned with such perspectives, my study is more concerned with the quality and abundance of data per participant than specific numbers of participants. I centred the women's experiences in the data collection process through engaging them in semi-structured, in-depth interviews, asking them open-ended questions to encourage their reflection. I ensured transcript accuracy by replaying audio recordings in order to guard against omitting any important information. I edited the transcripts in order to remove/rewrite vague words and make meaningful use of the data. I also wrote field notes to reflect upon and contextualise the participants' interviews, particularly significant points, interactions and emergent themes.

Sincerity in research requires self-reflexivity, transparency and truthfulness (Richardson, 2000). Throughout the research, I reflected on my positioning as an African woman and how it shaped my rapport with participants and the co-construction of their experiences of racism. It is also important to raise the point that my research faced some unexpected challenges. I initially wanted to interview a sample of 60 African women, but I was

unable to gain access to this number due to the relatively small network of African women in Adelaide, and the reluctance of many women to participate in my research. Unable to recruit more women, I achieved a final sample of 30 African women for this study. This suggests that the position I shared with potential participants, as an African migrant woman, may not always have encouraged their trust and rapport, nor enabled me to overcome the barriers of time, disinterest, etc. necessary for more women to agree to participate in my study. Further, as I have already noted, my research focus on African women means that I am not able to contribute to the knowledge on other groups and contexts, including African men, other migrant groups, and industries in Australia outside of the aged care sector.

Credibility, Tracy's (2010) fourth criterion, requires the researcher to provide a detailed description of her or his research process and present the findings in ways that account for participants' cultural, social, and individual lived realities (Richardson, 2000). The fifth criterion of good research, *resonance*, which can be described as empathic validity (Dadds, 2008), refers to the ability to meaningfully impact those readers of the research and make them connect with the lived realities and experiences of participants. In the following chapters on the study findings, I bring to the forefront the different dimensions of participants' lived experiences through a detailed analysis, supported by multiple quotes from the interviews. In Chapter 5, I discuss the participants' experiences of racial micro-aggressions: how their cultural background and skin colour as African women shape their experiences of racism perpetrated by clients, co-workers and managers. Chapter 6 sheds light on their experiences of institutional racism. In Chapter 7, I discuss how women respond to and navigate racist experiences. Thus, with this thesis I extend empirical knowledge and theorising on the topic of racism but, just as importantly, I aim to encourage readers to attend to racism experienced by workers: experiences that are often ignored, denied, misrecognised or downplayed by their colleagues and the institutions in which they are employed.

Over the subsequent chapters and in my conclusion, I make a *significant contribution* with my research. When defining a significant contribution, Tracy (2010, p. 845) suggests that researchers engage with the following questions: "does the study extend knowledge; generate ongoing research? Does it liberate or empower?" I explore how racism is perpetrated interactionally and institutionally through an account of the micro-aggressions and institutional racism perpetrated by co-workers and clients against African migrant care workers in the aged care sector in Australia. I also consider how

workers respond to this racism, particularly through appropriating ideas of professionalism. Most importantly, my study aims to make a *significant contribution* to social justice, by challenging the existing tacit acceptance of racism in aged care and arguing for the legitimacy of African migrant women's experiences and needs. In putting forward their lived experiences in the literature, I give these women a voice. As I discuss in the conclusion, my findings suggest the importance of ongoing research on the different migrant groups working in the aged care sector – as victims and as perpetrators of racism – and a deeper understanding of how to meaningfully address racism in ways that institutionally embed anti-racist policies and practices.

5 MICRO-AGGRESSIONS PERPETRATED AGAINST AFRICAN MIGRANT CARERS

5.1 Introduction

The literature on ethnic minority workers in the aged care and nursing sector indicates that their experiences are rife with racism – although there are also some positive elements to their experiences. In this chapter, I present my study's findings on racism at the interpersonal or interactional level, building on existing research and using the theory of microaggressions as my analytic framework. Specifically, I focus on the women's experiences of micro-aggressions directed at them by clients, clients' families and their colleagues (including co-workers, supervisors and managers). My discussion is centred on micro-assaults and micro-insults, which were the predominant forms of microaggressions evident in the data.

This analysis is presented in four sections. I begin by discussing the micro-assaults and micro-insults as perpetrated by clients in nursing homes and home care. In the second section, I move to describe the micro-assaults and micro-insults perpetrated by clients' families. I then overview the micro-assaults and micro-insults as perpetrated by co-workers in nursing homes only; co-worker microaggressions did not occur in home care, because the women primarily worked alone in these contexts. Lastly, in the fourth section, I discuss micro-insults used by managers, supervisors and coordinators in nursing homes. Across this chapter, I argue that micro-aggressions emerge from racialised relationships of control and often from exploitation, because clients and their families pay for care services. These relationships have a long history of 'Othering' Black bodies, shaping and framing how micro-aggressions are enacted and experienced.

The implications of these microaggressions need to be contextualised in an understanding of care work as a set of activities engaged in to meet the needs of 'vulnerable' or 'dependent' people (Claassen, 2011; Stacey, 2011). This may include caring *for* and caring *about* clients. Caring for clients refers to assisting with the activities of daily living such as showering and toileting. Caring about clients, on the other hand, includes a caring motive and satisfying the emotional needs of clients (Dodds, 2007; Himmelweit, 1999). The findings suggest that micro-assaults and micro-insults perpetrated by clients and clients' families in nursing homes and home care served the purpose of defining carers as not 'real', 'ideal' or 'genuine' carers, and communicating

that to the women. Whenever clients believed carers did not have the qualities of caring for and caring about them (Claassen, 2011; Dodds, 2007), they judged them as not being 'real' carers. This judgement was intensified and made more complex when a carer's services were rejected by a client, denying her the opportunity to display her caring skills and prove her sense of self as an authentic carer.

5.2 Micro-Aggressions Perpetrated by Clients

5.2.1 Micro-assaults

Carers recounted experiences of racism expressed by clients through racist micro-assaults: outright verbal or non-verbal racial acts targeted towards people of colour that are synonymous with dominant cultural understandings of racism (Sue, Capodilupo, Torino, et al., 2007). These are typically expressed through name-calling or avoidant behaviour, and can also take the form of telling racist or gendered jokes (Sue, Capodilupo, et al., 2008; Sue, Capodilupo, Torino, et al., 2007). Micro-assaults are arguably the most easily identified type of micro-aggression (Dovidio & Gaertner, 2000).

In this study, micro-assaults were typically evident in obvious expressions of racism such as clients' rejection of care because workers were Black, along with harsh and racist statements about their physical characteristics. These micro-assaults expressed and in turn reinforced the cultural meanings associated with Black bodies as uncivilised, backward and primitive (Fanon, 1970; Hofstadter, 1992; McConnochie et al., 1988; Spurr, 1993).

When I asked participants about the challenges they experienced while undertaking aged care work, many referred to clients' discomfort or rejection of them as Black carers. They described instances of clients outright rejecting Black carers' services in nursing homes. They described verbal attacks and, through these attacks, clients' attempts to avoid Black carers. Rachel and Samantha illustrated clients' explicit rejection of Black carers when describing their work in nursing homes:

There are some clients that don't just want your colour – they are racist. They request for another carer, showing they don't just want your colour. Some would say, "You are Black, get out of my sight". For these ones, it's demoralising, you feel ---, you have gone there to help someone and he or she is yelling, "You Black get out of here". They want someone else and that person is a White carer. There's nothing you can do; they keep yelling like you are doing something bad to them. [Rachel]

Some clients don't want Black carers, they would say, "I don't want you bloody Black to shower me". That's racism. I'm here to care for you, I've signed up to care for you and I'm here introducing myself. Just because I'm Black, you don't want me to care for you and you call me a Black fool. [Samantha]

Rachel and Samantha made clear that such comments are 'racist' and that they believed race was a major factor for clients rejecting their care. Their experiences echo those of participants in the Canadian study undertaken by Sethi and Williams (2016, p. 368), who reported that clients expressly tell Black carers "they do not like Blacks". Similarly, Bourgeault et al. (2010, p. 114), also writing in the Canadian context, observed that "clients did not like Black women carers providing care services to them". The experiences of Rachel and Samantha also concur with UK studies, which found that clients explicitly stated they did not want Black workers attending to their care needs (Shutes & Walsh, 2012; Walsh & Shutes, 2013).

Carers working in clients' homes sometimes experienced micro-assaults in the form of clients rejecting the 'Black' carer and Black care. As noted in Chapter 2, while some clients in the UK and Ireland context may have the opportunity to veto or screen carers before coming to their homes, and so have an opportunity to reject Black carers (Shutes & Walsh, 2012; Timonen & Doyle, 2010), others do not – and so when Black carers are sent to them, they use explicitly racist micro-assaults instead. This was Rachel's experience, which she shared when I asked what the term discrimination meant to her. From Rachel's point of view, discrimination was a rejection based on her Black skin colour. When I asked her if she had been discriminated against in a client's home, she described the following experience:

It's a lot (laughs). When you go to their homes, just the other day I went to attend to a client and she told her brother, "The 'Black' one, I don't want the 'Black' one". So, the client went to sit outside until my shift was over and I would send the brother to give her drinks, because anytime I just try to go close, she says, "I don't want the 'Black' one". Some are a bit racist and the carer to relieve me was a White colleague and when she saw the White carer, she was very joyful and happy, like yay!

Rachel's anecdote illustrates how clients perpetrate micro-assaults through express reference to and rejection of racialised Black bodies, and explicit preferences for White carers. Clients can also be slightly less explicit in their perpetration of micro-assaults, however. For example, carers I interviewed described scenarios in which nursing home clients rejected their services because of supposed language difficulties, and specifically because the client said they did not understand their carer's spoken English. In an

interview with Shade, I asked what discrimination meant to her, and she responded by describing this experience:

I just knocked on a resident's room, and came in and before I said anything, she was saying, "I am not getting what you are saying, I don't understand you". She didn't give me the opportunity to speak, I was so disturbed and had to go out.

Extending her comments on discrimination, Shade described different forms of discrimination and how some played out based on perceptions of English language proficiency. She said:

Discrimination comes in many forms. Because English is my second language, someone does not want to understand me and is pretending that he or she does not understand what I am saying even before I talk: "What are you saying? I am not getting what you are saying". And I have not even started talking. I am speaking English and if you don't understand what I am saying, why don't you just tell me to repeat it rather than yelling. For me, I think you are discriminating against me because English is not my first language.

Similarly, Priscilia described what I conceptualise as a micro-assault from a client, expressed through dissatisfaction with her accent.

I walk into a client's room and I want to attend to them, but they do not understand me. I keep speaking slowly but they still don't understand and I'm wondering: if the Indian accent is worse than mine and they understand them, why can't they understand me?

Later in the interview, I asked Priscilia, "Do you really think clients don't understand your spoken English when you are caring for them?" and she responded:

Maybe clients are trying to make me feel bad. I just feel they don't want to do what I want them to. You just have to do what you have to do – your duty as a carer.

Key studies in the literature on the UK, US, Canadian and Australian aged care and nursing sectors reveal how communication barriers between carers, nurses and clients lead to rejection of care services based on stereotypes around workers' suitability as carers (Allan et al., 2009; Bourgeault et al., 2010; Duff et al., 2000; Nichols et al., 2015; Showers, 2015; Shutes & Walsh, 2012; Walsh & Shutes, 2013). Further, as noted in the introduction to this thesis, issues of communication have been defined as key challenges for a multicultural aged care sector (Gillham et al., 2018; Nichols et al., 2015; Xiao, De Bellis, et al., 2017; Xiao et al., 2020; Xiao, Willis, et al., 2017a; Xiao et al., 2018; Xiao, Willis, et al., 2017b). Indeed, in their UK study, Shutes and Walsh (2012) reported

clients' preference for carers who were proficient in the English language and consequently deemed suited for their care needs, because they felt they could establish trust in them. Clients believed communication barriers often resulted in misunderstandings, and improper care from carers (Shutes & Walsh, 2012). Shade and Priscilia, in my study, did not think that their language or accent caused problems of communication. They believed that clients' insistence on not understanding them was a reflection of racism. In their accounts, above, they describe clients pre-judging their capacity to communicate, or responding negatively to their use of accents associated with differently racialised groups, and they explicitly identify these interactions as attempts by clients to hurt them or discriminate against them.

Micro-assaults experienced by the participants in this study also drew upon the negative cultural meanings associated with Black bodies in ways that resonate with the arguments by Hall (1992) and Said (1978) that 'Black Others' have historically been viewed as savage, crude, dirty and backward. As noted in Chapter 3, Spurr (1983) argues that the trope of 'Debasement' continues to construct non-Western people as "filthy and abject". Commonly, the clients of my study participants inferred the African migrant carers were dirty; a similar experience to that reported in research on African nurses in Australia (Mapedzahama et al., 2012). When I asked if they faced challenges in their work, Eddy and May both relayed experiences of clients making racist, 'dirt-focused' micro-assaults towards them.

There was a client that asked me, "When last did you have a shower?" and I asked, "Why?". He said, "If you shower, you will not remain like this, your skin is 'Black'". I don't mind, I am proud of my colour. [Eddy]

A client I met with; he was Australian, had challenges with my colour. He was verbally abusive, talking about my skin colour, that my skin is sunburnt. I think I was working with another African man, and couple of days before, I had worked in that facility twice with another Australian, the client didn't say anything. So, I realised that it is discrimination. [May]

Similarly, in interviews with Bekes and Jenny, when I asked if they had experienced discrimination, they stated:

Some clients don't want Blacks to attend to them or touch them, they think Blacks can change their colour or make them dirty. [Bekes]

I and my Australian colleague were caring for a resident and she was like, "Can you tell this animal to get her hands off me". [Jenny]

Racism and rejection of carers' services, however, is not 'simply' matters of skin colour

or 'Blackness' or accent. There are meanings, values and identities attached to Black women working in care sectors which signify a "devaluation of their skills, ascriptions of less intelligence and a form of inferiorisation of their professional identity" (Mapedzahama et al., 2012, p. 155). These reflect the more widespread discourse of 'the West and the Rest', with a long history of constructing the 'Rest' as backward and less developed; incapable of reaching the standards of 'modern' societies (Hall, 1992). Indeed, as argued in Chapter 3, these forms of micro-assaults act to reinforce dominant discourses that have historically served as a "classification of humanity into races" (Spurr, 1993, p. 68); a "paradigm of comparison"; a "benchmark of assessment"; and a "yardstick for explaining differences" between those who come from societies classified as the 'West', and those who come from societies classified as the 'Rest' (Hall, 1992, p. 221).

This inferiorisation of carers' professional identities was another form of micro-assault perpetrated by clients towards participants in the current study. When I asked Pauline what it was like when she first started working in aged care, she linked her race and migrant identities to clients' assumptions that she could not adequately care for them:

When a carer talks, they just assume, especially being from the African continent, you are always being looked at as the inferior race. It's not a surprise to me, because continuously, you do a good job and you are still reminded, you are an immigrant.

Pauline's experiences speak to the insights of Mapedzahama and Kwansah-Aidoo (2017) who have noted how the 'Black' skin colour can be a burden for Black subjects, and impact negatively on their lived experiences in Australia. They argue that one element of this burden is racialised ascriptions of inferiority – including inferiority of the care offered – that attach to Black bodies in the Australian White space, reflecting constructions of the 'Rest' as inferior, backward, and less developed (Hall, 1992).

Micro-assaults were also frequently experienced by my participants in nursing homes in the forms of harsh, negative labels and stereotypes attached to their Black identities which implied that these workers could not care about clients. Ella shared the following experience when we discussed work situations in which she had been discriminated against:

It's just a client, who can be verbal, asking why you came here, government is allowing people to come in, and you came here just for the money.

Being labelled as working in the care sector only for financial gain has also been described by Zimbabwean carers working in the UK care sector (McGregor, 2007). These stereotypes echo other racialised assumptions about overseas/minority ethnic and Black migrant nurses: that they are incompetent, less intelligent, inferior professional workers lacking the necessary caring skills and knowledge (Alexis & Vydelingum, 2004; Allan et al., 2009; Mapedzahama et al., 2012).

As Webb (2015) notes, migrating for financial reasons is not intrinsically 'bad' or 'harmful' or illegal. Indeed, the Australian government has clear policies for promoting economic migration – albeit for specific classed and raced categories of people. Indeed, for those women who arrived in this country as refugees – and of course, for other types of migrants as well, aged care employment allows them to earn a living (Webb, 2015). However, suggesting that a carer is working in aged care solely for money, and implying this is an illegitimate reason for working, suggests that this client does not believe carers are 'genuine'. A genuine worker is someone who works primarily because they care about clients, as well as caring for them.

The implicit message that African migrant carers are unable to care about or care for their clients was also evident in clients' references to stereotypes that associate Black people with poverty and criminality (Hall, 1992). For example, when talking about the challenges she faced with clients in aged care, May described: "When you want to attend to some clients, they say their things have been stolen, someone wants to kill me, or someone wants to do nasty things to me, when you want to care for them". Nanna described a similar micro-assault by a client:

I went to an Australian client's house and at first, she was very comfortable, but the moment she asked which country I was from and I told her, she was, said we are all scammers there and she literally watched me like I was going to steal something all through the shift and I was not comfortable.

Other scholarly studies have also highlighted the association of theft with people from minority ethnic groups. Sue, Capodilupo, et al. (2008) have described this experience for Black migrants in the US, and it has also been reported in Canadian studies (England & Dyck, 2012; Sethi & Williams, 2016).

The context of in-home care presents more specific opportunities for clients to coerce workers than that of nursing home care. In the home setting, the employer-employee relationship is seemingly unmediated, although the relationship is in fact one between a

worker and the agency that employs her and allocates her work. Some clients pressured participants to undertake more work or different work from the work they were contracted to do; for example, coercing carers to work beyond their defined hours and threatening to report them to their agencies if the workers do not comply with their demands. I define such demands as a form of micro-assault because they are focused on exploiting carers; on taking advantage of their structural vulnerability based on their race and position in the labour market. This was the case for Jumia, who experienced many difficulties finding a job when she first arrived in Australia, and it had taken her three years before she was able to secure employment in home care. The challenges she faced in procuring the work provided the motivation behind Jumia's desire to please her clients beyond the hours of work for which she was paid.

Some clients want to boss you, around, but you don't want to go there and not do what they want you to do. You must do what they want. Some of them believe since you are Black, you must do certain things and they want to treat you anyhow ... A client I was working with in her home wanted me to go beyond my three hours of paid work. When I told her, it was time for me to go home, she insisted I should stay and threatened to call the agency and put me in trouble.

Jumia made explicit the racialised dimensions of this client's expectations and her presumed power to demand work based on their different raced and institutional positions. This form of micro-assault – racist and exploitative demands – is peculiar to home care because of the isolated and relatively unsupervised nature of the work.

In the current study, nursing homes are also sites for client, co-worker and managerial microaggressions, but offer arguably slightly greater protection through the expectations that employees only work specific, timetabled shifts. Jumia's experiences reflect the findings of other studies, which have reported issues with clients placing expectations on ethnic minority workers to provide care services beyond a contracted agreement, which the carers complied with out of compulsion or vulnerability resulting from their race, gender or social class (England & Dyck, 2012). Carers are aware of their vulnerability; their negotiating powers are limited by their need to maintain employment (Aronson, 2004a; Aronson & Neysmith, 2001; England & Dyck, 2012). Thus, the African migrant workers in my study felt obliged to please their clients and get commendations from them, to avoid clients making complaints or reports of dissatisfaction about their care services to their employing agencies.

For the carers in the current study, the power of clients' threats was intensified through

their own belief that their agencies supported the clients' interests over their own. They did not want their agency to terminate their employment contract. This expectation that agencies will side with clients has been borne out by the findings of previous studies (Datta et al., 2006; England & Dyck, 2012; Shutes & Walsh, 2012).

Jumia noted the trend of agencies believing clients when they made complaints about carers working in home care:

I was on a one-hour shift with an Australian client and after my shift was over, he insisted I take him for a doctor's appointment. When I noticed he was angry, I went with him, but he called the agency later and complained that I insulted him, and they believed. He must have been doing this before because he had told me sometimes earlier while working with him. He said, "There's this Black girl I complained about her", but I didn't try to understand what he said.

Later in the interview, when I asked Jumia if she is able to report problems to her agency, she replied:

The agency's first interest is the client, not you. They want to maintain the client; they don't want to lose the customer. It's all about the money.

Similarly, Tori shared an example of agencies believing clients' complaints about carers, and acting upon them.

An African friend who was a casual worker on a shift in a facility was complained about and reported to management, and subsequently the agency terminated his appointment without consulting with him and hearing his part of the story.

The client expectation that workers will offer or provide additional (unpaid) labour stands in contrast with earlier examples from the study data of clients sometimes rejecting the care of African migrant carers. In these situations, micro-aggressions do not constitute a judgement by clients regarding carers' capacity to care for and care about; but rather, they are a reflection of racist expectations by White clients that they have the authority to determine the conditions under which that care is demanded. In common with the results of previous aged care studies (Davidson, 2018; Henderson & Willis, 2020; Mares, 2016), these examples provide evidence that carers bear the brunt of poor working conditions in care work, such as being allocated insufficient time to care for clients properly (Doyle & Timonen, 2009; Shutes & Chiatti, 2012; Shutes & Walsh, 2012; Timonen & Doyle, 2010). This burden is particularly apparent in the provision of in-home care (England & Dyck, 2012). However, the findings also highlight how poor working

conditions can structure micro-assaults that express racist claims on carers' time. I suggest that the issue is not only that carers are working under tight timeframes – but that African migrant carers are particularly vulnerable to this form of micro-assault because of their raced identity and migrant position.

5.2.2 Micro-insults

Micro-insults are verbal, nonverbal or environmental behaviours that are hostile, insensitive or send humiliating messages to people from specific racial groups (Sue, Capodilupo, Torino, et al., 2007; Sue, Nadal, et al., 2008). Micro-insults directed by clients at the participants in this study typically communicated the belief that the African migrant carers were 'incompetent'; incapable of discharging care duties or providing appropriate care to clients. Micro-insults also expressed a 'feeling of fear' by clients towards the migrant carers attending to them.

Clients explicitly and implicitly questioned the women's care skills in the nursing home context. This devaluation or denial of the carers' professional capacities and training was also evident in my prior discussion of micro-assaults – but in the examples quoted here, clients are not explicitly linking an assumption of inferior care to the carer's race; rather, they are implying the inferiority of that care. For example, when May reflected in her interview on clients' discriminatory behaviours, she recalled her experience: "I was changing pad for a client and he was like, "Can you do it properly"? Because fixing an incontinence pad is a routine care practice and not difficult or technical work, this statement was a devaluation of May's skills.

When I asked Nike, "Do you think clients think you are incompetent?", she replied:

There are clients that think you don't know anything while undertaking aged care work, and they report you to management and you are interrogated. I tell them if the client didn't like what I did, they should have told me. I am a detailed and result-oriented person.

Another participant, Leila said:

They believe Africans are not smart or good in anything and my approach is speaking up and telling them it's not like that.

The experiences related by May, Nike and Leila of clients questioning their ability to do their jobs well and/or reporting them to management reflect assumptions that African migrant carers are lacking in knowledge and are in need of professional guidance, because they are from African countries. Here again, this constructs migrant workers

from African societies as inferior to their colleagues from 'Western' societies (Likupe, 2015; Likupe & Archibong, 2013; Mapedzahama, 2019; Mapedzahama et al., 2018).

Priscilia described experiencing a specific type of micro-insult that was manifested through a client's fear when she attempted to provide care:

I walked into a client's room to help with her shower and I could see she didn't want me to come close to her. What I could see was fear and trembling. Probably they have had strange experiences with 'Blacks'. This lady might associate Blacks with perceived behaviours, probably when she was younger or our appearance. Clients could be comfortable in their space and not want any change.

This was a micro-aggression of a different emotional tenor: fear, rather than the hostility more commonly displayed by clients. While not widespread, Priscilia's experience is interesting in that it suggests the co-existence of vulnerability and privilege. This client's fear reflects Fanon's comments in his essay 'The fact of Blackness': an expression of fear when the 'White' child sighted the 'Black man' and commented: "Mama, see the Negro! I'm frightened!" (Fanon, 1970, p. 16). Fanon argues that this fear emerges from discourses and historical ideas around 'Blackness', and is expressed by 'White men' towards 'Black' people through fright or avoidance. I suggest that older adults in nursing homes display fright towards carers because of historical and colonial frameworks portraying 'Black' people in negative ways – and indeed, Priscilia herself suggested a historical dimension to this response. This is not to justify such behaviours, but rather to highlight the value of using a micro-aggressions lens to interpret the expression and impact of these fears, rather than their motivation. In relation to the theme of 'caring for and caring about', I suggest that this fear, which suggests the existence of ill-will or a threat on Priscilia's part, can also be interpreted as the client's implicit conclusion that African migrant carers cannot care for her or about her.

In summary, this discussion on micro-assaults and micro-insults as expressed by clients and their families has highlighted the multiplicity of racist expressions at the level of client interaction. These are more or less explicit – hence my categorisation of them as either micro-assaults or micro-insults accordingly – and they include: clients' reference to and rejection of racialised Black bodies; claims of language 'problems'; negative stereotypes; questioning of carers' skills; inappropriate demands on carers' labour; and expressions of fear. Individually and cumulatively, these micro-aggressions query Black migrant carers' capacity to care for and care about their clients, and act to privilege clients' definitions of appropriate care.

5.3 Micro-Aggressions Perpetrated by Clients' Families

The behaviours of clients' families have been reported by only a few studies (Shutes & Walsh, 2012; Willis et al., 2018; Xiao, Willis, et al., 2017a), and this is particularly true with regard to micro-aggression behaviours, which are discussed primarily with reference to clients and co-workers. In my research, I found that clients' families also perpetrated micro-aggressions, although the examples offered by participants were not as extensive as those involving clients. Only a few of the women I spoke to in this study described micro-aggressions expressed by families, but those who did shared experiences in which they were rejected, accused of theft, and had their skills and training questioned. The language used by families, in these instances, mirrored the language of clients.

5.3.1 Micro-assaults

In nursing homes, some clients' families were well-recognised by carers and by management as racist, because of their ongoing racism towards African migrant carers, which they tended to express directly and in reporting dissatisfaction with the care services provided by African women. For example, when I asked Venus about her nursing home's approach to managing discrimination, she described a racist rejection of her services by a client's family.

There's this client I had in a facility, the husband and the wife were most times in the facility. The husband was the resident and the wife would say, "I don't want an African caring for him".

This is a clear example of a client's family expressing outright rejection and hostility towards a carer. The family member made an obvious connection between Venus' ascribed racial identity and the undesirability of her care, thus denying her capacity to care for the husband in ways I described in my earlier discussion of clients' micro-aggressions, as above.

Micro-assaults also occurred in the context of in-home care. Tori shared a story told to her by a friend: "The other day one of my friends went to a client's house and as soon as she got there, the client's mother was asking her if she found any money". The implication of theft echoed cultural constructions of Black people as untrustworthy (England & Dyck, 2012; Shutes & Walsh, 2012) and, at an individual level, left Tori's friend feeling that she was vulnerable to being formally accused, disciplined or losing her job.

Micro-assaults perpetrated by clients' families were not widely described by the participants in this study. Their significance lies more in the ways that they were expressed using language that echoed that of clients, highlighting the permeation of cultural discourses of 'the West and the Rest' in structuring families' racism towards, and interactions with, African migrant carers.

5.3.2 Micro-insults

The participants in this study more commonly described examples of family-perpetrated micro-insults. These interactions might be more common than micro-assaults, as they are more subtle. Micro-insults took the form of families ignoring African migrant carers and implicitly devaluing their training and skills, and were suggestive of contempt or disrespect rooted in taken-for-granted, and thus largely unspoken, racist expectations regarding the workers' caring capacities and skills.

When I asked Ella about her experiences of discrimination when working in aged care, she offered an example involving a client's family in a nursing home.

I've gone to a facility and a Black colleague told me the family of the resident was very racist and would never greet or say Hi to a carer who is African, who would even ask the employers why they are employing Africans. It does happen sometimes.

In specifically ignoring and disregarding African carers; in questioning the nursing home's recruitment of African migrant carers, thus devaluing these workers' skills and capacity to care for clients – this family was expressing micro-insults. Ella's experiences reflect those reported by the Black and migrant carer participants in a study by Shutes and Walsh (2012), who revealed experiencing similar racism from White clients' families.

Such micro-insults highlight the inter-relationship of protection and care with racism. A client's family may want to protect and care for their relative, and ensure she/he receives appropriate care, but hold racist assumptions about Africans that lead them to believe this can only be achieved by denying African migrant carers the opportunity to provide that care. The commodification of care and consequent positioning of clients as consumers/purchasers (Charlesworth & Isherwood, 2020; Davidson, 2018; Henderson & Willis, 2020; Mares, 2016) means that their families may feel they have the authority to require a nursing home or agency respond to their definitions of appropriate carers (Shutes & Walsh, 2012). Having been granted employment by an aged care facility or agency, African migrant carers have already been formally assessed on their capacity to

care for clients. Yet, in the minds of clients' relatives, these workers will never be able to offer the 'right' kind of care for their family member, by virtue of their own racist constructions of African workers as lacking the skills and capacity to care.

Racialised undervaluing of skills were the micro-insults most commonly reported by participants working in nursing homes. For example, upon asking Pauline about the discrimination she experienced at work in the past week, she described assumptions made by clients' families about her level of skills, training and authority.

Clients' parents come in once a month and they assume this 'Black' person is not who I should talk to. The assumption is you are not the nurse, maybe you are a personal care worker or a team leader. It's not very direct, you'd see it in their faces, and it takes a minute before they can come around. When they are dissatisfied, they look for the nurse or team leader and it takes a while before they realise, I am the person they should talk to or the person who has been taking care of the client.

Another participant, Bekes, described families' disregard of her care skills as one of the most challenging aspects of aged care work.

One of them is clients' family. As much as we try to satisfy them, they complain a lot. They believe we are incompetent and cannot take care of their family member.

These experiences reflect the disregard of carers' skills and capacity to care for clients. In assuming they are 'incompetent' and 'not the nurse', families are devaluing the workers' institutional position and authority. When families convey disregard in subtle ways – in implicit assumptions, rather than direct challenges to participants' care – it is difficult for workers to directly challenge this (for a detailed discussion of participants' responses to racism, see Chapter 7). Families make these assumptions without any evidence of participants' actual caring practices and skills or, as Bekes points out, despite the efforts and professional work of African migrant carers. This is rooted in colonial discourses that construct people from non-Western countries as less capable than people from Western countries; as only able to function in lower positions, and never able to reach the standards of 'modern' development (Hall, 1992; Said, 1978; Schech & Haggis, 2000; Spurr, 1993). In this way, non-Western groups are always set at the margins, viewed as 'outside' the capacities and capabilities of the West.

In summary, this discussion on micro-assaults and micro-insults as expressed by both clients and families has highlighted the multiplicity of racist expressions towards Black migrant care workers at the level of client interaction in Australian aged care contexts.

These expressions are more or less explicit (hence my categorisation of them as either micro-assaults or micro-insults), and include: clients' reference to and rejection of racialised Black bodies; complaints of language 'problems'; use of negative stereotypes; questioning of carers' skills; unreasonable demands on carers' labour; and expressions of fear. Individually and cumulatively, these micro-aggressions query Black migrant carers' capacity to care for and care about their clients, and privilege clients' definitions of appropriate care.

5.4 Micro-Aggressions Perpetrated by Co-Workers

In their interviews, the participants of this study most commonly emphasised racism directed at them by clients. However, they were also subjected to micro-aggressions, most commonly micro-insults, perpetrated by their colleagues. Their discussions revealed that these micro-aggressions were not explicitly racist, and so did not contravene any workplace policies – nonetheless, they left participants with the feeling that their capacity to care for clients was unrecognised, and that their presence in the workplace was unwelcome. The micro-aggressions reinforced a construction of African migrant carers as not 'real' carers.

5.4.1 Micro-assaults perpetrated in nursing homes

Carers reported only two cases of micro-assaults perpetrated by co-workers. While co-worker micro-assaults did not emerge as a strong theme in the data, I include them here because they indicate how racism permeates the participants' working conditions. Muna described micro-assaults in the form of racialised name-calling. She said:

Most staff are racist, there are unpleasant words they say to you and behind your back, and on an occasion one White colleague called us "Black carers", "Negros". I felt it was ridiculous to call us that. Someone that is educated or enlightened wouldn't say something like that.

Muna's experiences are a clear example of micro-assaults, and comparable with racist epithets related by participants in previous studies (Fanon, 1970, 2008; Sue, Capodilupo, Torino, et al., 2007; Sue, Nadal, et al., 2008). Sue, Capodilupo, Torino, et al. (2007) describe these kinds of micro-assaults as "old fashioned racism". The word 'Negro' in Muna's example – while rarely used, is a racist term with long historical roots. Muna was surprised that an Australian-born colleague would still call Black carers 'Negros', because micro-assaults are rarely expressed in such terms in modern-day Australia.

The other conceptual type of micro-assault came from Australian colleagues who made suggestions that African migrant carers were 'dirty' or 'filthy' and, for that reason, did not want to work with them. In my interview with Leila, she spoke about discrimination in the staffroom. Leila shared a friend's experience that resonated for her: "A friend of mine told me in her facility, her White co-workers complain that Blacks smell and for that reason they don't want to be associated with them". This reflects similar findings from studies on migrant care workers in the Irish context and in Australia, which have described racist remarks directed towards African and CALD carers by their colleagues (Nichols et al., 2015; Timonen & Doyle, 2010).

However, overall, micro-assaults from co-workers were not a common experience for participants, likely because of the institutional context. As Venus noted,

There's a lot of discrimination from clients, but from co-workers it is a bit tricky because there's a lot of awareness about discrimination and that it's not allowed in the facility. It is a highly sensitive matter. Even though, there are some cases, they do it in a very advanced way, they wouldn't show you they are discriminating, because they know there are repercussions against racism and stuff.

Cecilia made a similar point:

One thing the anti-discrimination policy has done is that co-workers don't discriminate openly, they know they don't have the right to do it openly, so they work with you, but they display the attitude they want towards you.

Institutional protections in the form of anti-discrimination policies guard against express racism towards co-workers in nursing homes. However, even with these policies in place, co-workers still perpetrate racism against carers, just in more subtle and indirect forms, i.e. as micro-insults, which are more difficult to articulate or report to management. These micro-insults were the most common and defining type of interpersonal racism perpetrated by co-workers that emerged in my data.

5.4.2 Micro-insults perpetrated in nursing homes

The micro-insults described by participants centred on co-workers not wanting to work with African carers, amounting to a devaluation of their care skills. For example, I asked Ola which workers she considered difficult to work with, and she answered as follows:

There was a time I went to work, and an Australian colleague said she did not want to work with me, and I asked why, she said she didn't want me. I felt discriminated against, she didn't respond but probably because of my colour.

Later in the interview, she added this anecdote:

Four workers are in a staff room, two Australians, one worker from Asia and I an African and the Australian colleague doesn't just want to talk to me, and I'm wondering, we are all talking together, so you really can't tell exactly why the attitude. I feel it's my colour.

Ola's experiences reflect the data of other researchers in the field. For example, Sethi and Williams (2016, p. 368) share this experience from one participant in their Canadian study on ethnic minority workers: "you go to the break table to have lunch and no one is having a conversation with you". Similarly, a participant in the study by Mapedzahama et al. (2012, p. 158) described this experience: "they might not say they don't like you coz you are black, but you can tell from what they are doing". Ola quoted above was also unsure if her experience was racism, but it felt different that her colleagues did not chat with her.

Ola's descriptions of avoidance by her co-worker suggest the subtleties of micro-insults and the difficulties in responding to them. In Ola's first example, the co-worker's statement that "she did not want to work with me" held no explicit indication that her reluctance was racially based. In the second quote, Ola could explain the conversational dynamics in a room but was less able to pinpoint exactly why her Australian colleague did not want to speak to her. However, she was sure that these behaviours were an expression of racism.

Ola's negotiation of these behaviours as racism reflects the argument of Sue, Capodilupo, Torino, et al. (2007) that people of colour often have to engage in 'guesswork' to identify subtle or 'disguised' forms of micro-aggressions, such as micro-insults (see also Deitch et al., 2003; Solorzano et al., 2000). Sue, Capodilupo, Torino, et al. (2007) explain that people of colour rely heavily on experiential reality and a long history of similar interactions to identify micro-insults. In the context of my study, Ola likely drew on experiences of micro-aggressions across her life to inform her interpretations.

Co-workers also expressed micro-insults through casting aspersions on a worker's ability to undertake care work. When I asked Shade what discrimination means to her, she described how co-workers could subtly demean her:

When you are working with co-workers, they tell the client, "I am really struggling now because I cannot even understand what my colleague is saying". Why is she telling the resident that I am tired of this shift; I am not

getting what my colleague is saying? Australian workers are difficult and insult you before clients.

Shade's example suggests a performative element to her colleague's demeaning statements, directed as they are towards a client. In claiming that Shade is not understandable, the co-worker implies that Shade has a fundamental inability to work as a carer and as part of a team; that she is not able to care for clients and is a barrier to others effectively caring for clients. And as noted above, the 'problem' of language and communication is presented as a problem generated by Shade's failures, not those of her co-worker (Bourgeault et al., 2010; Timonen & Doyle, 2010; Mapedzahama et al., 2012; Nichols et al., 2015; Showers, 2015; Shutes & Walsh, 2012; Walsh & Shutes, 2013).

Eddy and May described another expression of micro-insults by co-workers: a lack of belief in their caring skills. Eddy was less clear about whether there was any association between her co-workers' judgements and her identity as an African migrant carer:

For me, discrimination is workers looking down on you without even giving you a chance to get to know you or express yourself, a platform. They are quick to do away with you or make assumptions. I feel discrimination does not even mean race, but your skills – someone might just feel "I don't think you have the ability to do this based on inexperience", and the like, someone not confident in your skills or ability.

May shared this experience:

You feel it, they, co-workers, are always correcting us Africans: "You are not doing the right thing, and you don't know how to do this". You are working together, and they will keep calling someone else to come and help them. You are both to give care to a resident and they will keep pushing you to do something else and then call another person and you would be wondering why?

May's experiences were similar to those reported by participants in a study by Mapedzahama et al. (2012). They are a more explicit example of co-workers doubting her abilities to provide care to clients – a doubt that she links to her identity as an African care worker.

An associated form of micro-insult is evident when co-workers express surprise that African care workers can execute minor care tasks. Bekes says:

Some co-workers show some form of discrimination; little things that anyone can do, they'll be surprised that Blacks can do it.

Irrespective of whether, as Eddy suggested, an assumption that migrant carers lack skills is linked to perceived inexperience – a perception which is in itself racially inflected – or

is an expression of racism, the experiences described by Eddy, May and Bekes can be understood through Mapedzahama et al.'s (2018) argument that the practice of nursing in Australia privileges White knowledge and characterises African workers as inexperienced, lacking in appropriate training, skills or knowledge. While Mapedzahama and colleagues (2018) developed their argument on the basis of observations made in the nursing sector, I suggest it also holds for aged care work in Australia, as supported by the findings of studies conducted by Gillham et al. (2018) and Nichols et al. (2015). Bekes' example also illustrates how those classified as the 'Other' have been constructed in stereotypical ways as 'unknowing' and 'deficient', in terms of their capability to even carry out simple tasks (Mapedzahama et al., 2018, p. 52). Bekes' example also reflects Spurr's (1993, p. 68) conceptualisation of Surveillance which, as I argued earlier in Chapter 3, refers to the power of certain (dominant) groups to hold a privileged standpoint and entitlement to assess, command or view 'Others' in certain ways. While Mapedzahama et al. (2018; 2012) connect these constructions to White co-workers feeling the need to 'rescue' Black migrant nurses when undertaking care duties, the African migrant participants in the current study described a different response from co-workers, which focused on shaming them and denying their capacity to care. The micro-insults expressed by these co-workers, in implying that the participants were incompetent to execute care tasks, reflected their assumptions that these African women cannot be 'real' carers – carers who are capable of caring for clients.

Ola also described micro-insults that illustrate these processes, albeit inflected by still more assumptions: that African migrants are refugees, and refugees are 'not competent'. When I asked, "Do you think co-workers associate your colour with your competence?", Ola gave an anecdote about her friend's experience:

I can say that, yeah. There was a time that one of my African friends wanted to do something and the Australian asked that lady "Are you a refugee?". And she was like that, "Why would you think that of me? The fact that we are here doesn't mean that all of us are refugees". So, sometimes because you are just African, they already have some kind of mentality, some kind of thinking about you. They feel you are not competent to do some things or do not have some things because of that colour.

Although people from Africa have been coming to live in Australia in increasing numbers since the 1990s, some as refugees through the Australian government's humanitarian intake programs (Colic-Peisker, 2009; Colic-Peisker & Tilbury, 2007), of course not all African migrants – carers or otherwise – are refugees. There are assumptions in the broader Australian workforce that refugees who come into Australia do not possess 'the

required skills' or 'human capital' or professional qualifications for the labour market (Colic-Peisker, 2009). Ola's story suggests the Australian worker asked her friend if she was a refugee because that co-worker held the belief, on the basis of her skin colour, that she was 'less competent', 'less skilled', 'poor' and probably not qualified to come into Australia except through the humanitarian intake (Colic-Peisker, 2009).

A final form of micro-insult was evident in the surprise expressed by my participants' co-workers that these African migrant workers could speak English. For example, Ola recounted:

Sometimes when you go to occasions or social events and you are together with Australians, they would ask me questions like do I speak English? And I will respond "Of course, in my country I was born to speak English, it was the British that colonised us, so, I have been speaking English for a long time".

Similarly, Muna shared this:

It's a common question to me every day, how I speak good English and I say I have spoken English from childhood naturally and I even have to learn my native language – the one spoken in my country of origin. We speak English in my home county, it's our universal language.

Expressing surprise that African migrant carers can speak English – despite the fact that their training, and the care and services they provide to clients, are all conducted in English – suggests that co-workers believed these carers can only perform the basic activities of daily living (assisting with showers, toileting and feeding), but are not able to engage clients beyond the basics of care work, ultimately judging them as not 'real' carers. The assumption regarding language, along with the judgement that African migrant workers are not good at care, are 'powerful strategies' of Whiteness that are perpetuated in aged care contexts, and which serve the purpose of 'undermining' the background of 'Black' carers; communicating to workers who do not speak English like their Australian co-workers that they are 'different' or the 'Other' (Gillham et al., 2018; Nichols et al., 2015).

5.4.3 Micro-insults perpetrated by other ethnic minority workers

Participants' accounts of micro-aggressions focused heavily on the actions and omissions of White, non-migrant co-workers. However, they also shared experiences that align with those of participants in previous studies which illustrated that tensions and conflict can also exist between African, CALD workers and other migrant groups (Nichols et al., 2015; Timonen & Doyle, 2010).

For example, Priscilia, Nelly and Tracey described the following litany of micro-insults when I asked if they had experienced challenges with co-workers.

Asian co-workers give you an unwelcoming attitude in nursing homes like you are encroaching their territory. [Priscilia]

We have a problem with Asian, Indian and Nepalese co-workers sometimes, they have this attitude with us Black people – the attitude that we don't know what we are doing. They refuse to talk to you, you ask a question they refuse to give you an answer and others give you negative vibes – most times they won't refuse to work with you but they will give you negative attitudes – making you uncomfortable and not welcome in the facility. They have dominating attitudes. [Nelly]

I used to work with an Asian co-worker, they play on your intelligence and tell you what to do and touch while working in nursing homes. They want to try you because they see the Black race as inferior. It is our responsibility to let them know we are not inferior and not to boss us around. [Tracey]

Such remarks are illustrative of conflict that can occur between different cultural groups, which has previously been described by Nichols et al. (2015). Their Australian aged care study found a cultural bias perpetuated by workers from other migrant groups who felt threatened that African carers had come to take their jobs. The comments by Priscilia, Nelly and Tracey do not necessarily suggest that the ethnic minority workers they worked with are 'more or less' racist compared to their White colleagues, nor that they are more or less privileged, or themselves subjects to racism compared to the African migrant carers. Rather, they illustrate Hall's point that:

... all of us are composed of multiple social identities, not of one. That we are all complexly constructed through different categories, of different antagonisms, and these may have the effect of locating us socially in multiple positions of marginality and subordination. (Hall, 1999, p. 57)

This complexity accounts, in part, for the conflicts and tensions between these migrant groups.

While the social dynamics and cultural meanings driving ethnic minority workers to make micro-insults against their African migrant colleagues differed from those informing the microaggressions of White colleagues, they too contributed to the construction of African migrant workers as not real carers; as employees who lacked the capacity to care for their clients.

In summary, the language and behaviours used by co-workers of different ethnic minority groups through micro-insults echoed those employed by clients and their

families, similarly constructing a 'problem' with African workers' communication and language skills and devaluing their care skills. Again, the African migrant carers were being positioned as not 'real' carers – as unable and unwelcome to care for clients. An in-depth consideration of racism between ethnic minority workers, and towards ethnic minorities other than Africans, is beyond the scope of this thesis.

5.5 Micro-Aggressions Perpetrated by Managers and Supervisors

In the final section of this chapter, I discuss micro-aggressions perpetrated by those in a senior professional position to my participants, who had formal authority to shape their work conditions. The majority of the participants in my study described incidences of micro-insults by managers in the form of rudeness; deliberate non-payment of overtime hours; neglect to include them in social events outside of work; and non-acknowledgement of their contributions.

When I asked Bekes to discuss how her organisation managed conflict between workers, she jumped to a discussion of her own challenges with a manager around allocation of shifts:

Sometimes, I took a shift and later noticed that [I wasn't able to work then]. So, I wanted the shifts cancelled because of my children. You won't believe that my manager saw me during a shift, and she stood me up, while working and said, "Next time make sure you check before you pick a shift".

Later in the interview Bekes returned to the issue of swapping shifts:

I swap shifts with friends if it clashes with my family commitments and then the manager sends a mail to all workers that if you need to swap shifts, let me know. This mail was targeted towards me.

Bekes' understanding of the unfairness of this situation arose from her knowledge of the informal nursing home practices. Swapping shifts with co-workers was a common practice; one that was usually accepted by management. Bekes was treated differently to her colleagues, attracting a reprimand from her manager, which she interpreted as the motivation for later sending an email to all staff. Bekes' experiences of being subject to a reprimand for a minor issue – a non-issue – were also reflected in the following statement from Venus when I asked if she had met with difficult supervisors in aged care:

Yes, I have met difficult supervisors. They find petty issues to pick with you, some might be very irrelevant, and they'll make a big deal out of it, maybe to intimidate you, but you notice those issues, they wouldn't be picking with Australian co-workers. Yeah, because it's very easy to observe. They ask questions like, "Why did you leave that jug there? Why are you not wearing your name badge?"

Bekes reported other, illegal behaviours perpetrated against her by that manager:

I worked overtime and the manager deliberately did not pay me. We have another care manager in the nursing home who opened up to me that the manager asked her not to pay me.

Bekes' experiences highlight some of the challenges of defining racist micro-aggressions. As with other experiences described so far in this chapter, her account does not directly reference explicit racism, and nor did her manager behave in ways that are obviously racist. This is the challenge of interpreting microaggressions, particularly where one person's micro-insults express subtle disregard and contempt for another. However, it also illustrates the value of analysing discriminatory behaviour using a microaggression lens. In punishing Bekes for engaging in informal practices that are widely accepted in her workplace, and in withholding her additional pay, her manager indicated disregard for Bekes as a worker and a member of the team. Bekes' interpretation of her experiences support the argument by Sue and co-researchers (Sue, Capodilupo, Torino, et al., 2007; Sue, Nadal, et al., 2008) that victims of racial micro-aggressions understand their experiences with reference to a much longer history – as an individual and in their lives generally – of being disrespected, devalued or treated with contempt, often in subtle ways.

Another participant in my study, Tracey, also raised issues regarding a management practice, more explicitly linking specific patterns in shift allocation to racism. When I asked her about discrimination, she said:

Management could discriminate in terms of allocation of shifts. They tend to give some persons more shifts for reasons best known to them. Whoever employs you would not outrightly say you are Black or treat you Blackish – sometimes through the way shift is allocated you know this person does not like me and if you don't know me and you judge me, it's because I am Black and you have seen my colour. [Tracey]

Tracey suggests that unequal allocation of shifts among employees reflects a dislike for Black carers and a desire to withhold the benefits of increased work and increased pay from them. The experiences described by both Bekes and Tracey align with those of

Zimbabwean carers in the UK (McGregor, 2007) and immigrant carers in Australia (Nichols et al., 2015), who reported that management allocated them 'difficult' or 'lousy' shifts; 'different' to shifts they would give (non-immigrant) carers. In Goel and Penman's (2015) study on immigrant workers in aged care institutions in South Australia, participants described the unequal allocation of shifts as 'work politics' (Goel & Penman, 2015, p. 6). These biased management practices, which comparatively limit immigrant carers' opportunities to do care work, suggest these carers are not as welcome in Australian institutions.

Micro-insults directed at participants from supervisors and managers could also erode their sense of belonging to the workplace more generally. Venus explores these dynamics in depth:

I have seen discrimination with my supervisors when it comes to the working relationship – like, they won't engage you the same way they engage the other Australians workers or such – that's one way. I don't know, even when they have these social and end of year activities, most of them only engage the Australians, and we do not participate in suggesting ideas for the parties or anything. You are not given the opportunity to anchor any part of the program and even most of the ideas when we go to these meetings, when you make suggestions, they'll just sweep it under the carpet. And some of the complaints – I know some of my friends whose ideas have been dismissed, but with the Australian workers, they make use of their suggestions.

Ola also described an instance in which her contributions were minimised:

There was an incidence that happened in my facility, I worked with a colleague and an incident happened at work and this colleague, usually we do case notes, that's progress notes, we write the report of how the shift has been and we send it to our care coordinator. So, this colleague in his report made mention of one or two things about what happened, and he sent it through to the coordinator. When the coordinator responded, he accorded and acknowledged only my colleague, when he knew that he wasn't the only one that did the job, both of us did. So, I wondered why he referenced only my colleague in his response and left me out of it. ... I told my coordinator during the supervision, this is how I felt: they did not give me support, despite the fact that we worked together, and the coordinator responded that he didn't mean it that way, he just wanted to respond to the mail promptly. He apologised and I believe he was sorry. I had no regrets that I spoke up.

These experiences support findings in the literature that suggest migrant carers' contributions in aged care work in Australia are not properly recognised (Howe, 2009). Ignoring or not seeking out contributions may be accidental, or it may be deliberate – Venus suggests that supervisors actively seek out 'White' perspectives and ignore those of African migrant carers, and Ola says that the care coordinator apologised and claimed

he did not act deliberately. Lewis et al. (2013) also note that when Black women approach those who perpetrate micro-aggression acts towards them, the perpetrators claim it was an 'omission'. But irrespective of the deliberateness of the act, Venus' and Ola's comments show how micro-insults can have a symbolic impact beyond the financial and time-based implications of being denied shifts or allowed to swap shifts. Interacting with these African migrant carers in a different register, and marginalising and ignoring their suggestions for social and professional group activities, eroded their position as carers and as members of the worksite and work teams. While not directly constructing African carers' abilities to care for or about, the supervisors' micro-insults communicated to the carers that they are out of place and do not belong in these aged care facilities.

By virtue of their perpetrators' institutional positioning, micro-insults from managers and supervisors take a different form compared to those made by colleagues, clients and clients' families. The managers of the African carers in my study were not found to use micro-assaults, which might be understood as more directly and obviously damaging, hurtful and demeaning. However, they did use micro-insults, which are also corrosive. Rather than call into question the abilities of African migrant carers and their capacity to care for or about clients, managers' subtle expressions of disinterest, and their implicit distinctions between White and African migrant carers, had the effect of marginalising these women, and left them feeling unwelcome and undervalued.

5.6 Conclusion

The concept of micro-aggressions has been critiqued as overly sensitive to minor and subjectively interpreted infractions of civility (Embrick et al., 2017; Huber & Solorzano, 2015; Wong et al., 2014). However, in this study, participants' accounts highlight the widespread existence of these expressions of racism in an employment context that formally rejects and censures racism and discrimination. Some of the micro-aggressions described by participants were overtly racist – these were evident in the racist epithets and rejections of care that constituted the majority of micro-assaults. Micro-insults were also widespread, although these are arguably more difficult to recognise as such by those who have never been subject to them. Particularly when clients, their families and colleagues did not recognise participants' skills and training, this form of racism was not overt – however, it still effectively devalued the capacities of these professional African women, and was an expression of colonial constructions of 'Black identities' as uncivilised, uneducated and incapable.

Micro-assaults and micro-insults were experienced by the participants interpersonally, but they also drew upon and reinforced the wider, historical and contemporary colonial discourses of 'the West and the Rest'. These devalued and 'Othered' African migrant carers, classifying them into the much broader category of Black 'Others', as part of the historical development of racial hierarchies. Although the language of 'savages', 'brutes', 'illiterates' and 'inferior' (Fanon, 1970, p. 117) is now disguised, the racist thinking behind this colonial discourse is still evident in negative assumptions made by clients, co-workers and managers about the skills and characteristics of the African migrant carers, with regard to their 'belongingness' in the aged care sector.

Micro-aggressions and micro-insults not only expressed racism and unequal power relations in the moment, but they also positioned the African carers in ways that undermined their standing and position to care for their clients and to care about their clients. The rejection of the ability of African migrant carers to care for people was the most common microaggression across the sample. This was reflected in assumptions made by colleagues, clients and clients' families about their lack of skills or training; in their failure to recognise the carers' authority in the workplace; and in their emphasis on the 'problems' of communication with these carers. With regard to the commodification of care in care industries, scholars have argued that it is possible for carers to care for clients by simply fulfilling the basic requirements of paid work, without caring *about* the client, or without having a "caring disposition" (Himmelweit, 1999, p. 29) or a "caring motive" (Folbre & Weisskopf, 1998, pp. 172). Where clients and clients' families used micro-assaults and micro-insults accusing African migrant carers of theft from clients, this implied that the carers were working 'only for the money'. Managers' micro-insults focused less on denying the ability of participants to care for and care about clients, and more on positioning African migrant carers as unwelcome and 'different' in the workplace.

These micro-aggressions need to be understood with reference to the specific work of aged care. The experience of having people – people often defined as strangers – enter one's private spaces (domestic homes or personal rooms in aged care facilities) and personal space is a continuing and often discomfoting part of older people's lives (Buch, 2013). Bodywork is care work requiring skin-to-skin contact with clients (Twigg, 2000), including sensitive and intimate practices such as showering, assisting with toileting, fixing of incontinence pads and the like (Stacey, 2011). Bodywork can either sustain or erode a client's personhood, making her or him feel treated like a person who is cared

for and about, or feel like just one of the routines of the day (Taylor, 2010). Thus, bodywork demands client trust (Stacey, 2011). This becomes more complicated and racialised when White clients do not welcome bodywork, requiring intimacy and personal exposure, from African migrant carers, connecting their 'Blackness' with dirtiness or a threat, and rejecting their care. This response suggests that clients hold racist attitudes towards African migrant carers, and as such they cannot conceive of and do not want Black carers to care for them. In the context of aged care, micro-aggressions require a recognition of the personhood and desires of clients and the potential for personhood and desires to be rooted in racism, and therefore reinforce raced power dynamics at the individual level.

Power dynamics are also reinforced through the commodification of care that positions clients and, de facto, their families as consumers of care. This positioning legitimises their decisions to accept or reject care practices, standards and attitudes as they interpret them to be manifest in individual carers' work. The interviews with participants in this study show that these interpretations reflect racist and colonial discourses regarding the capacities of African people and the 'Other' to be gentle, to be educated or to learn how to appropriately care for clients. Anti-discrimination policies or compulsory training in a workplace will not necessarily protect African migrant carers from micro-insults that deny their capacity to care for clients. Rather, institutional practices that are informed by the commodification of care actually leave these workers vulnerable to racist judgements – a point I explore further in my consideration of institutional racism in Chapter 6.

6 INSTITUTIONAL RACISM

6.1 Introduction

As I argued in the previous chapter, micro-aggressions perpetrated by clients and their families, co-workers and managers expressed racism towards the study participants on an interpersonal level. These micro-assaults and micro-insults positioned the African carers as not 'real' carers. Through racist constructions of their skills, communication, and physical and personal characteristics, the perpetrators discursively and materially denied the capacity and legitimacy of these workers to care for and care about clients in the Australian aged care system. The women I interviewed were also 'Othered' by managers and supervisors who positioned them as unwelcome in aged care institutions, and unable to work in appropriate ways.

In this chapter, I shift my discussion from the interpersonal racism expressed through micro-aggressions to consider how the workplace practices in Australian aged care facilities reflect the structures and strategies of institutional racism, and in ways that reinforce Whiteness and White privilege. I argue that African migrant carers are 'Othered' through institutional racism that structures the logic of workplace practices, with regard to patterns of training, induction, equipment use and communication and language.

As discussed in Chapter 3, institutional racism is a process and set of relationships creating and reproducing structural constraints against subordinate or minority racial groups within organisations, with the result that they are controlled and subordinated (Carmichael, Ture, & Hamilton, 1992). This is evident in organisational culture, practices and expectations that overlook or deny the needs and experiences of people of colour (Bourke et al., 2019; Macpherson, 1999; Spangaro et al., 2016). I also argued that Whiteness and White privilege is the bedrock upon which institutional racism in organisations is built (Hobbs, 2018; Johnstone & Kanitsaki, 2010). As Lipsitz (2006) notes, Whiteness is commonly at the centre of organisations, often in invisible ways (see also Berwald & Houtstra, 2003; Carangio et al., 2020; Dyer, 2000; Moreton-Robinson, 2004; Nayak, 2007). Therefore, 'non-Whites' face challenges not only in fitting into a White organisational culture, but having their difference acknowledged, supported and unpunished through organisational processes (McLaren, 1997; McLaren, Leonardo, & Allen, 2000).

The experience of African migrant workers in Australian aged care can be contextualised with reference to prior studies on minority ethnic workers in health and in the public sector (Healy et al., 2011; Henry, 2007). These studies have demonstrated the influence of Whiteness and institutional racism on minority and migrant workers, with regard to: how their work is organised and disparities in opportunities for promotion (Johnstone & Kanitsaki, 2010; Nichols et al., 2015); formal skills training (Clayton et al., 2005); human resource practices (Healy et al., 2011); workplace training and induction (Nichols et al., 2015; Xiao et al., 2014); and the use of assistive technology (Soar, 2013; Sparrow & Sparrow, 2006; Vichitvanichphong et al., 2014). My research findings concur with many of the findings reported in these studies. In this chapter, I discuss five key institutional processes that on face value appear to be non-discriminatory and equally applicable to all workers: technical and skills training, human resources training, staff induction processes, the use of technology, and complaints processes. In relation to these processes, the participants described facing institutional barriers to their full engagement with the requirements, opportunities and worker protections of aged care institutions. Common to all was an institutional failure to acknowledge the raced position that shaped the skills and needs of African migrant carers. Issues with these key institutional processes left workers feeling that they were not well prepared or supported to care for clients, and reinforced their lack of belonging in their workplaces and the profession.

Before exploring these issues in more detail, I give an overview of participants' prior experiences of aged care work back in their home countries, to provide a context that highlights the institutional racism in their work lives in Australia.

6.2 African Migrant Carers' Experiences of Aged Care in Africa

The carers in this research described almost no formal or institutionalised aged care in their home countries, where caring for the elderly was a private matter, undertaken by family members. Given this experience back home, upon migration, carers reported an unfamiliarity with Australia's aged care practices and the logic of institutional and commercialised aged care.

In Africa, we take care of our elderly ourselves within the family. We don't have a lot of nursing homes in my country and even if we do, we don't have the technology. [Nike]

There's no aged care in Africa because traditionally, we are supposed to care for our elderly ones when they get old and frail but here, as soon as one is 65 in Australia, they retire, and they are looking at going to retirement homes because they don't want to be a burden. Whereas in Africa, there's no such thing as your grandma or grandpa being a burden – you take care of them. [Cassy]

Do we have aged care in my home country? (Laughs). I can't say that there are aged care facilities in my country. The only thing that happens is some non-for-profit organisations – like churches, organise some outreaches to take care of the elderly and displaced people. [Sheni]

It is our responsibility to look after our older people because we see that as a blessing to us. When they are sick, we take them to the hospital, and they care for them throughout. We have some rich people that private doctors can come and look after their old ones at home and sometimes they hire other people (maids) to help them do that. [Jumia]

These responses reflect other Australian studies in which CALD and African carers described caring for the elderly in their countries of origin as primarily the responsibility of each family (Nichols et al., 2015; Willis et al., 2018; Xiao et al., 2018).

Their lack of prior professional experience in, and cultural understanding of, institutional aged care meant that the women in my study lacked prior exposure to what in Australia are widely understood as practices and processes of aged care work. Also, I argue that the African migrant workers I interviewed were positioned as 'Others' in the Australian context, and this meant their understandings were not acknowledged, let alone embedded in institutionalised processes such as training or induction. These practices were designed for White aged care spaces, and therefore better aligned with non-migrant 'White' workers' understandings.

6.3 Key Workplace Processes Marginalising African Migrant Carers

In the next two sections I make a distinction between technical training for required skills to undertake care work (Clayton et al., 2005) and training in human resource processes. The latter are focused on developing workers' potential, improving their performance, assisting them to understand workplace processes, and ensuring they enjoy equal professional opportunities (Healy et al., 2011; Swanson, Holton, & Holton, 2001). Human resources training also helps orient workers towards the idea that aged care facilities should be respectful environments, where management and care workers value and treat each other with mutual respect and understanding, regardless of their country of origin, language, culture and beliefs (Adebayo, Nichols, Albrecht, et al., 2020;

Willis et al., 2018). I then discuss induction, which is closely linked to both technical and human resources training, albeit tailored to a specific workplace. Lastly, I address the use of technologies, which are again associated with technical training, before turning to the issue of unavailable and unresponsive complaints processes in aged care institutions.

6.3.1 Technical training

Before participants began working in aged care, they were required to participate in mandatory training, to prepare them to provide good care to clients. Training is widely understood as a tool for creating a workplace culture and promoting the acquisition of skills and knowledge that assist workers to provide quality services (Clayton et al., 2005; Goel & Penman, 2015; Nichols et al., 2015). Symbolically, the provision of training demonstrates to workers that they are valued and respected, and it emphasises the importance of workers' roles in these institutions (Clayton et al., 2005). Thus, training has both individual (skills) and institutional (shared practices, understandings and respect) meaning and significance.

The women I interviewed understood technical training as a formal requirement of their employment and as a means of building their skills. They had all undertaken technical training and had to acquire at least one of the following certifications to be employed: Certificate 3 in Aged Care, Certificate 3 in Disability and Individual Support, Certificate 3 in Individual Support, Certificate 3 in Individual Support and Home and Community Care, and Personal Care Work Stage 3 (PCW 3). They also participated in other training modules, similar to those described in prior studies (Clayton et al., 2005; Keevers & Outhwaite, 2002) and outlined in Table 1 below.

Table 1: Certification and Training Acquired by Participants for Aged Care Work

Participant	Certification	Training acquired
Abi	Certificate 3 in Aged Care	First aid, how to manage clients with dementia
Lisa	Certificate 3 in Individual Support	MAPA (managing the different attitudes of clients while working with them), fire training, cardiopulmonary resuscitation (CPR)

Ola	Certificate 3 in Aged Care	Manual handling, first aid, basic life support, hand hygiene, prevention of elder abuse
Venus	Certificate 3 in Aged Care	Manual handling, how to do documentation, how to manage clients with dementia and deal with aggressive behaviour
Cassy	Certificate 3 in Aged Care	Manual handling, first aid, feeding and showering
Bekes	Certificate 3 in Aged Care	Manual handling, first aid, how to manage clients with dementia
May	Certificate 3 in Individual Support	Manual handling, basic life support
Pauline	Certificate 3 in Aged Care	Manual handling, first aid, CPR, medication compliance, hand hygiene and food hygiene
Jumia	Certificate 3 in Individual Support and Disability	First aid, medication compliance
Cecilia	Certificate 3 in Aged Care and Disability	Medication care, how to manage aggressive behaviour
Ella	Certificate 3 in Aged Care	Manual handling, first aid, infection control
Belinda	Certificate 3 in Aged Care	Manual handling, first aid, infection control and hand hygiene
Shade	Certificate 3 in Individual Support and Disability	Medication training, prevention of elder abuse
Leila	Certificate 3 in Individual Support, Home and	Manual handling, first aid, medication competence

	Community Care	
Funmi	Certificate 3 in Aged Care	Manual handling, first aid, CPR, hand washing, food handling
Priscilia	Certificate 3 in Disability and Individual Support	Manual handling, first aid, CPR
Tori	Certificate 3 in Individual Support	Manual handling, behavioural management, bed making and showering
Esther	Certificate 3 in Individual Support and Disability	Manual handling, infection control, individual support
Eddy	Certificate 3 in Aged Care	Medication, seizure and behavioural prescriptive practice
Muna	Certificate 3 in Aged Care and Disability	First aid, basic life support
Samantha	Certificate 3 in Aged Care and Disability	Manual handling, first aid, prevention of elderly abuse
Tracey	Certificate 3 in Individual Support and Ageing	First aid, CPR, infection control, hand hygiene, palliative care, prevention of elderly abuse
Hannah	Certificate 3 in Aged Care	Manual handling, hand hygiene
Sheni	Certificate 3 in Aged Care	Manual handling, how to do documentation, how to manage challenging behaviours, health and safety
Rachael	Certificate 3 in Aged Care	Manual handling, first aid, CPR, medication compliance, hand hygiene, infection control, food hygiene, safety and disability
Nanna	Certificate 3 in Aged Care	Manual handling, first aid, CPR, medication compliance

Nike	Certificate 3 in Aged Care and Disability	Medication training, bowel care and peg training
Jenny	Certificate 3 in Aged Care and Community	Manual handling, first aid
Anita	Certificate 3 in Individual Support	Manual handling, first aid
Nelly	Personal Care Work Stage 3	Manual handling, first aid, CPR

However, participants typically described the value of their skills training as limited. For example, when I probed Bekes and Priscilia about their experiences of training, asking them to reflect on whether it had helped them meet clients' needs, they said:

Training is good but I think most of them come with experience, like if you ask me the training I got when I first started the job, did it help? Maybe not, because I've not actually put in what I've learnt, there was no relationship between what I was doing and what I learnt. Over time and even sometimes, I'll say, "Oh that's what I learnt", sometimes back. So, I think experience is key in aged care work, you'll see staff that have worked here for a while, you'll see the way they work better. [Bekes]

I think it's more of experience, training helps too. But even if we all get some training, when we get to the field, do we know what to expect? The more you work, the better you are at it, in aged care work. [Priscilia]

Bekes and Priscilia suggest that technical training may not be as useful as experience when it comes to actually doing care work. While some research suggests that CALD workers are unable to fully utilise what they learn from training sessions because of language problems (King et al., 2013), participants in my study did not explicitly talk about language difficulties as a key barrier to useful training. Rather, the limits to the usefulness of training were related to its theoretical or non-applied nature. Bekes suggested that experience was vital in the undertaking of aged care work, and Priscilia noted that while training does assist care workers, experience was more useful in helping carers to get better at doing aged care work.

Bekes' and Priscilia's comments suggest that participants had to learn on the job in aged care facilities in order to fully understand the work required. There was often no clear relationship between what they learnt in training and their work experience when they

began working in an aged care job. For those carers who did not find training relevant to actually undertaking care work, the need to develop skills through experience made them initially uncomfortable in undertaking their caring duties. They felt nervous, anxious and insecure, which eroded their confidence in their ability to care for clients. A sense of fear was evident when I asked Rachel, "What was it like when you first started working in aged care?". She said:

My first day was scary and I thought I would not make it because the environment. Where I did my placement was not very friendly because of dealing with people with dementia, sometimes we have behaviour problems, but then through practice and experience I know how to handle such people as I work in aged care.

When I asked what was scary about that first day, Rachel explained:

I was scared for my safety. I had the theory knowledge from trainings but the practical aspect of it was a bit challenging because at times, some clients are agitated, violent. Some throw things at you, some insult you.

Other studies have noted that a migrant worker's cultural background influences their understanding and perception of dementia as well as their approach to work in dementia care (Adebayo, Nichols, Heslop, et al., 2020; Brijnath, 2014). Rachel's background of very little formal practice of aged care and work in nursing homes had not exposed her to clients with dementia. Back home, there was no knowledge or experience of dementia, and the behaviour of aged people was characterised as 'baby-like' (Nichols et al., 2015, p. 25), and not labelled as dementia. Rachael's comments suggest that the knowledge she gained from institutional training did not equip her with the capacity to actually provide care for clients. While training is supposed to improve the skills of care workers and demonstrate the importance of providing quality care to clients (Clayton et al., 2005), for Rachel, and for other women I interviewed, the effect of this training was that it made them feel 'out of place', 'out of depth', and insecure when caring for clients.

Given that many participants described formalised skills training as unhelpful compared to on-the-job experience, the opportunity to work together with colleagues to build knowledge and confidence on the job became a particularly important source of training and support. However, as I now go on to discuss, this type of support was not reliable nor institutionally embedded, thus intensifying African migrant carers' sense of 'Otherness' and unbelonging, and making them feel they were not well supported by the institution in providing care for clients.

Bekes noted how some co-workers were welcoming in nursing homes, while other co-workers were aloof in terms of accommodating new carers. She shared some of the challenges she faced in her early days of work in aged care facilities:

It was very challenging, some Australian co-workers are nice, they'll take time to explain the job to you, some Australian co-workers would not work with you at all and if they do, they'll try to snub you while you're working together.

Other participants also described Australian co-workers not wanting to work with or accommodate them.

You would notice Australian workers smiling and laughing with themselves but when they are working with you, they would not do that, showing they don't want anything to do with you beyond work. [Cecilia]

Australian workers give us negative attitudes that they don't want to work with you. [Nelly]

Bekes' specific reference to 'Australian' co-workers suggests that she understood this unfriendliness to be racially referenced, and Cecilia and Nelly are explicit about the racial dimensions of their co-workers' attitudes. Such unfriendliness is a form of micro-insult, as discussed in Chapter 5. In addition, regardless of whether this unfriendliness was racially motivated, the impact was twofold: (1) it intensified the messages and feelings that arose through formal technical training, which made carers anxious in discharging their care duties; and (2) it left African migrant care workers feeling that they were not integrated into the White aged care space.

Given the prevalence of individual racism, offering training that in practice relied on co-worker support was a form of institutionalised racism, because it left the African migrant carers particularly vulnerable to missing opportunities to develop their skills and confidence on the job. African migrant carers were not supported in either technical training or in accessing the informal benefits of training – evidence that they were not valued in their roles in the institutions. These women felt they were not well supported to care for clients, and nor were they particularly welcome to do so.

6.3.2 Human resources training

In the above discussion, I referred to technical training as building carers' skills in providing quality care for clients. In the following quote, Bekes describes another dimension of training: training in human resource processes, with the formal aim of helping carers understand work processes and ensuring they enjoy equal opportunities.

When the African migrant carers were provided with this training in nursing homes, there were implicit organisational expectations that the training would be useful and that workers would use the knowledge. However, when I asked Bekes what opportunities were available to offer suggestions or feedback to managers, she stated:

There was a time I remember we were provided with a training on bullying and harassment, you won't believe staff had questions but could not say it. How do you ask a question about a manager that's bullying while working in the facility? Do you understand? I know it's a good thing that there's this training but it's complicated.

Bekes had experienced bullying from the manager and did not have the confidence to express her dissatisfaction or ask questions to her manager. In my interview with her, Bekes noted the implications of her skin colour and her supposed 'migrant' status despite being an Australian citizen:

I am looking for a means, to express myself but I don't want what I'll do that will backfire. Because whatever I do, I'm still a migrant, whether I'm a citizen or not and I'm still in 'Black' skin not 'White'. My registration is an important thing and I don't want anything that'll tarnish that, I suffered for it (laughs). That's why I'm even doing this job.

The training provided by Bekes' institution did not acknowledge likely disjunctions between workers' experiences of being racially bullied or discriminated against by a manager, and the unavailability of formal human resources processes that might address this. Because Whiteness is usually the mainstream culture of aged care organisations in Australia, it was not an 'expected' or a 'common situation' for workers to need to express their concerns about racial abuse at work, and there were no meaningful strategies in place to monitor and respond to such risks experienced by African migrant workers. As such, Bekes was subject to a form of institutional racism. Because of her raced/migrant background, she was fearful of expressing her dissatisfaction at work because she did not want to lose her job, with implications for her employment record, finances and sense of security as a migrant. Bekes' experiences reflect previous findings which showed that ethnic minority workers are more vulnerable to risks and racism in aged care workplaces, and find it hard to speak up about their experiences because of their migrant positioning (O'Keeffe, 2016; Sethi & Williams, 2016). As Acker (2006), and Healy et al. (2011) note, workers may not feel confident about the way management will address such cases, believing they will be judged in racialised and racist ways.

Regardless of the actions or inaction of any individual manager, institutionally racist

structures mean that even when management do not deliberately intend to offer irrelevant or unhelpful training, the failure to acknowledge racial, hierarchical differences means that training is developed and presented in ways that assume White experiences. Care sectors are structured in ways that overlook the experiences and implications of migrant status on people's ability to express dissatisfaction with their experiences of the training process in these institutions (Gillham et al., 2018; Omeri & Atkins, 2002).

6.3.3 Induction

Induction is a formal process designed to familiarise workers with a specific workplace. It is intended to help new workers to understand how things are done, what their role requires, and to understand their colleagues, with the aim of building knowledge and confidence so that those workers can discharge their duties (Hussein et al., 2011; Paré & Le Maistre, 2006). However, for the carers in my study, this was not the case. They described challenges with their induction, particularly in nursing homes, due to perceptions about communication and language barriers, a finding also reported in the literature (Goel & Penman, 2015; Nichols et al., 2015; Xiao et al., 2014).

Priscilia and Venus expressed concerns about language barriers when I asked them how they felt during induction training:

One of the things on my mind was language barrier, because it is one of the things we come across, because our accent most of the time really gives barriers in communication. Sometimes, they are like, "Sorry what did you say?", trying to tell them what you mean has also been a barrier. [Priscilia]

Some would be that you wouldn't communicate at the same level. Communication would be like a hurdle. They would feel they don't understand your English, even though you are speaking clearly, they'll be asking what you are saying because of your accent. Yeah, that would be a bigger part of it, because my pronunciation of some words is different. [Venus]

These experiences suggest that the message from co-workers with whom they were partnered during the induction program was that the African carers did not easily fit in with other carers in aged care facilities: their English 'accent' and pronunciation were not deemed good enough for the White space or environment. Their experiences in induction echo those reported in other findings on aged care and health work more generally, where communication challenges are a re-occurring theme (Allan & Larsen, 2003; Bourgeault et al., 2010; Likupe, 2006; Nichols et al., 2015; Showers, 2015; Shutes & Walsh, 2012; Walsh & Shutes, 2013; Xiao, De Bellis, et al., 2017; Xiao et al., 2018).

When being inducted into a facility, workers had the opportunity to work on a 'buddy shift' with co-workers where, again, they were positioned as the 'Other'. When I asked Leila and Venus about their experiences, they shared the following:

I felt a bit, how I would I put it, because then I was the only Black lady going through induction. I felt a bit [laughs] uncomfortable. My major fear then was communication, would they understand what I am going to say, will I understand them. Australians speak too fast. So, communication was a bit of a barrier then. But now I understand them. [Leila]

It was a bit challenging – feeling like you do not fit. It really felt different – like different, these people are looking at you but luckily enough, I wasn't the only Black person in that facility. That kept me going, like a bit normal but I felt intimidated in some instances. [Venus]

Unlike Priscilia and Venus, who were only concerned about clients and co-workers not understanding their spoken English, Leila was concerned about co-workers understanding her and how she would understand her co-workers, because "they talked too fast". However, all spoke about these experiences in ways that reflected the Whiteness of the institution. They felt "uncomfortable" (Leila), "different" and "like you do not fit" (Venus). Their experiences are similar to those reported by Cottingham, Johnson, and Erickson (2018), who noted a feeling of discomfort for women nurses of colour working in the US (Cottingham et al., 2018). The comments of Leila, Priscilia and Venus also support the argument that negative perceptions regarding English language proficiency is a key way through which Black people have been constructed as 'backward' and 'lagging' behind (Hall, 1992; Spurr, 1993).

For Venus, this sense of difference was diffused by the presence in the institution of other African migrants, who help her to feel 'normal'. Given the sense of being 'Other' from the majority of the workforce, it is perhaps not surprising that the carers described a preference for working with Black colleagues. Hannah and May indicated this preference when I asked whom they preferred to work with:

I prefer working with workers from my own part of the world, I just feel, maybe because of the colour of the skin, I don't know, I feel freer when I am working with people from Africa. [Hannah]

I prefer working with Africans, they are good and welcoming. [May]

For Hannah, May and the other women who participated in this study, workers with similar backgrounds did not perpetrate micro-aggressions and did not intensify the impacts of the institutional racism that made them partially dependent on colleagues for

their training. May described other African migrant workers as “good and welcoming” and Hannah felt “freer” – individualised responses that have larger implications for how participants felt they were positioned within their institutions.

Casual workers described a different experience of induction, compared to those who had permanent positions in aged care and did not have to move around to different facilities. Casual agency workers often did not have the opportunity to be inducted; they were sent to different nursing homes or client homes without any introductions or guidelines about rules and policies – a situation reported in other studies (Aronson & Neysmith, 2001; Bourgeault et al., 2010; Buch, 2013; England & Dyck, 2012). This was May’s experience:

As an agency worker, you don’t have any induction. You just go directly and work. It’s a little bit challenging, just from placement, you go directly and work. You are not given induction or extra staff – you just observe, you don’t have any responsibility but when you work with the agency, you go directly, and you are given work to do. You just work and cope.

Other agency workers, Cecilia and Tori, said their agency had given them an induction that informed them how they should behave and work in clients’ homes, but there was no opportunity to meet colleagues before they started working.

My agency had an induction for us but because I didn’t get the job with a facility, I was not introduced to clients and co-workers. [Cecilia]

Induction is to remind you some of the things you were trained about: how to introduce yourself the first time when you meet clients, it reminds you how the organisation wants you to work, it has embedded in it the personality of the company mixed with what you should do in the company but you do not get to meet clients and colleagues. [Tori]

The women I interviewed suggested that as casual and agency workers, being denied the opportunity to meet clients and co-workers before starting aged care work in nursing homes made it more difficult to integrate easily into the work culture of these facilities. They missed out on receiving initial support from co-workers in the form of being allocated on a ‘buddy shift’, as is common practice for new carers in nursing homes (although buddy shifts can come with their own challenges). Overall, the migrant care workers working in casual positions and employed by an agency were left with a sense of being unsupported. For these casual workers, the interaction of an absence of support and their vulnerability to individual racism, as described in Chapter 5, further highlights the impact of institutional racism. These women had to adapt to multiple policies and procedures in different facilities and, while learning on the job, they faced challenges

with racism from co-workers.

African migrant carers' experiences of induction suggest that while they often described their challenges with reference to interactions with individuals, these interactions reflected a systemic imposition and normalisation of 'White' subject positions and experiences as the ordering logic of induction processes. I argue that the carers' assumption that they would not be able to communicate effectively with Australian co-workers originates from a feeling of not fitting into the White mainstream culture (Lipsitz, 2006; McLaren et al., 2000), and not believing they can "make it" or be taken seriously (Hall, 1992; Mulholland, 2017; Schech & Haggis, 2000).

6.3.3.4 Assistive technologies

Assistive technologies in the aged care setting are diverse. They include lifters, electronic wheelchairs, GPS systems, sensor mats, remote pagers and personal amplifying devices to support dementia clients and older adults generally in nursing homes. Assistive technologies function in two ways. Firstly, they are items of equipment that increase or improve the functional capabilities of older adults, and allow care workers to provide care services and support the activities of elderly clients that they would otherwise be unable to do (Fleming & Sum, 2014; Vichitvanichphong et al., 2014). Second, they increase the ease and safety of care tasks, with the expectation of reducing carers' stress (see Kitano, 2005; Pineau, Montemerlo, Pollack, Roy, & Thrun, 2003; Soar, 2013; Sparrow & Sparrow, 2006; Sutherland, 1999).

I suggest that in prescribing the use of assistive technologies with older adults in aged care facilities, management make assumptions about carers' knowledge. The majority of the African migrant carers in this study had not seen these assistive technologies in their countries of origin – the exception being those few carers who worked as nurses in hospitals back home. While the technology is designed to make care work easier, most of the women I interviewed described feeling apprehensive and uncomfortable with using it.

One of the reasons for this apprehensiveness was because these African carers had not come across such equipment prior to their current work. When I asked Hannah if she had any challenges with technology, she said:

I was a bit apprehensive, because of the technology, the first thing that came to my mind and was a bit worrisome to me was to know how to use the technology that comes with taking care of the aged, like using the lifter, so many things that we did not have back home when taking care of our own

aged people, back home we will just take care of an old person not minding the safety rules, you just bend down and get up, but here in Australia, they will tell you things like manual handling, before you bend down to give any form of care, there is a level of bending you have to do and lifting and everything, so I was a bit not sure of you know, the whole process.

Jenny also described her lack of familiarity and the anxiety this caused her:

We don't have such equipment like manual handling. Those are things that are very new, because at the end of the day, if it's done in the family, you will not be having those equipment, even if these elderly clients are not mobile you will just lift them together with another person, you don't even bother about manual handling practice, basically we don't need equipment to do that.

Later in my interview with Jenny, she shared how scared she was seeing a client being put into the lifter:

It was scary. OH MY GOD!!! [laughs]. It was scary because we never used anything like that. Maybe a nurse could use that but personally, it was scary putting someone up in the lifter.

Bekes described similar challenges:

There was an instance that we had the lifter, and on the control, we had the button to open and close, go up and down, some machines have the control to swing or bring down. One of the experiences I had was, a co-worker was trying to tell me to close or open and I was like, "open what?" and everybody (co-workers) burst into laughter – and she was like on the control. It takes a while for you to get around and know how things operate.

I suggest that similar to training and induction processes described above, any training in the use of technology for these carers was not particularly effective in building their confidence and skills – even when there was an expectation by co-workers that this should be the case. Bekes' story does not necessarily suggest she was being stigmatised in this scenario – it is unclear if the laughter was kind or unkind – but, like Hannah's comments, it does highlight a feeling of worry around the use of this technology.

Belinda noted that things were more complicated for agency workers who were sent to multiple facilities that used different types of technologies, with limited induction or training in learning how to use them. She said:

For me as an agency worker, my challenge is the fact that I have to go to many facilities that I'm not used to. I'm not used to their daily policies. Each time I go to a facility, I have to learn how to cope and adapt to that facility, what they want for their residents, even some equipment are different for facilities – getting to know the usage of different equipment for facilities has been very challenging.

Belinda's comments highlight the more significant impact that absence of support has on migrant workers compared to their Australian colleagues, because they did not have the cultural exposure of using these technologies back in their home countries and, therefore, they needed to strive harder to fit into the workplace culture of different aged care facilities in Australia.

This section highlights how, for these women, requirements to use technology reinforced messages of inadequacies regarding their capacity to care for clients. The African migrant carers felt they were not able to care for clients in ways expected by their institution – another example of their professional standing being challenged because they did not have the required skills to care for clients. It is important, too, to be sensitive to the possibility that co-workers may have led the African nurses to feel inexperienced by emphasising the technological skills they did not have, rather than respecting their previous nursing specialisation (Likupe, 2015; Mapedzahama et al., 2018). I am not suggesting that training was intentionally withheld from the carers; but rather that institutional racism – which is not deliberate but manifests in taken-for-granted racial logics – was evident through issues in the management's design of workplace training and induction processes that failed to equip African migrant carers with the required skills to operate assistive technologies in providing care for their clients. This lack of procedural effectiveness had particular relevance in a context where African migrant carers were already disadvantaged through other failures in training and induction, and as the recipients of micro-aggressions, as described in Chapter 5.

6.3.3.5 Responding to complaints in nursing homes

African migrant carers described their feelings of being the 'Other' through anecdotes about their experiences with complaints processes – and specifically, co-workers' complaints about their performance. These experiences often involved micro-aggressions by managers, nurses and co-workers, but the processes by which these were heard, negotiated and responded to were a form of institutional racism. These processes effectively communicated to these women that they were not able to care for clients appropriately, and were unwelcome in their workplaces. For example, Bekes described how African migrant carers could be positioned as unwelcome both through individual complaints and the complaints process.

There's this African girl and a colleague in my nursing home. They always complain about her, that she's too slow. The co-worker reported her to management, I don't know what happened, but she said they took her off the

roster and gave her a memo to come and see the manager and when she came there was no resolve, she was not consulted and there was no enquiry to know what had gone wrong. She eventually resigned. I was sad about how management resolved the conflict. To me, it's unprofessional.

Belinda shared the following incidence of racism towards another migrant carer when I asked her how management resolves conflict between co-workers in her facility. She said:

My friend told me about discrimination from a co-worker who complained about her care provision to a client, but didn't come directly to her, because she's Black she didn't come to ask her. The co-worker just went to talk to the EN [Enrolled Nurse]. My friend felt if it was a co-worker of the same race or culture the Nurse would have come to ask her, this is what I heard, is it true? – confirm if it's true or not before reporting to the management, so she felt she was discriminated against.

When I prompted Belinda to talk a little more about how management addressed this report, she said:

Management eventually interrogated her, and she explained to the RN [Registered Nurse]. The RN concluded based on the narration of the co-worker and told the carer to meet with the client and resolve their differences. The carer did this and eventually the EN [Enrolled Nurse] and RN still wrote a bad report about her. That actually ended her job with that facility.

Bekes and Belinda describe experiences that differ in the particulars of the complaints processes, but share in common the underlying message that the complaint processes of their institutions were focused on reprimanding African migrant carers. These processes did not seem to acknowledge the carers' experiences, as conclusions were drawn without confirming or consulting with them. Belinda and the friend who was the subject of her story made it explicit that the complaints process, while likely conforming to institutional requirements, was discriminatory, reflecting an emphasis on White colleagues' and managers' interpretations of the problem.

6.4 Conclusion: Whiteness and Institutional Racism in Nursing Homes

African migrant carers' accounts of their own and other Black migrant carers' engagement with institutional processes in Australian aged care settings highlight how Whiteness is the foundation of institutional racism. This Whiteness is evident in the design and delivery of on-the-job training and human resources training and induction; the use of assistive technologies; and how complaints are managed in Australian aged

care facilities. The participants shared experiences of racism that did not qualify as interpersonal racism, as was evident in their accounts of what I have analysed to be institutional racism. Institutional racism was more subtle, reflecting organisational practices and expectations that were presented as normative – and often, as offering benefits to workers and clients – but did not align with the experiences and needs of African migrant carers. As is the case with micro-aggressions, the point of this analysis is not to argue that any process or outcome is deliberate: but rather, that the logic of organisational practices and expectations reflect “Whiteness as a standpoint” – a positioning from which White people look at themselves and others – and act or do not act accordingly (Frankenberg, 1993, p. 103). When Whiteness informs the development and implementation of institutional processes, this reproduces a privileged White norm and leaves African migrant carers unsupported in their roles, challenging their ability to care for clients and their sense of feeling welcome, valuable and capable in their roles. Here, I am not arguing that the women interviewed could not do their jobs but, rather, that institutional processes generated or intensified a feeling of difference and discomfort for African migrant workers in the aged care space.

The processes described in this chapter demand a sensitive and critical approach to issues of training and of formalised complaints processes, which are typically implemented as responses to workplace challenges. Some studies have recommended delivering cultural competency training – paying attention to the cultural background and needs of migrant workers, in order to bring out the best of these training services for workers (Davis & Smith, 2009; 2013; Renzaho et al., 2013; Sherman, 2007). This approach may create more appropriate training for migrant workers and, relatedly, a sense of greater welcome or belonging. Aged care researchers have advocated for in-service training on language and culture, cultural awareness and sensitivity, and vocational, occupation-specific communication training (Adebayo, Nichols, Albrecht, et al., 2020; Goel & Penman, 2015; Khatutsky et al., 2010; Nichols et al., 2015). While fostering greater understanding may assist in improving interactions with clients and co-worker relationships, I suggest that an explicit recognition of difference by institutions may not be helpful in dismantling the taken-for-granted assumptions of ‘sameness’ of workers in the aged care sector. Greater detail must be paid to workplace training that addresses comfort with assistive technologies in providing care to clients, which is often overlooked. Additionally, in-service training with a view to enhancing cultural sensitivity among workers can reinforce an emphasis on what ethnic minority workers ‘lack’.

The experiences of the African migrant carers in this study indicated that skills, human resources and technology training in nursing homes are usually developed with reference to Western and culturally specific definitions of what are necessary and valued skills. This training reflects institutional expectations but does not accommodate, promote and reward the skills and knowledges that African migrant carers may already hold. Consequently, the findings of my research agree with those of Mapedzahama et al. (2018), who found that African nurses in the Australian context feel unsure and insecure in terms of their skills and belonging in the care sector (Mapedzahama et al., 2018).

This chapter highlights the importance of understanding the interaction of institutional racism with interpersonal racism. The buddy system used in aged care institutions is designed to offer workers opportunities for teamwork and on-the-job training. This training was particularly important to the African workers in this study, given the knowledge and practice gaps left by the more theoretical or formal training they brought into the workforce. However, it also left these African migrant carers in a type of 'double-jeopardy', inadequately trained through the workings of institutional racism and yet unable to rely on their co-workers, who perpetrated micro-insults during teamwork and were reluctant to support their training. These disadvantages were further intensified when complaints processes privileged the accounts of White co-workers, resulting in formal and informal questioning and a denial of the African women's ability to care for clients.

There also needs to be sensitivity to the cultural context within which the aged care work and training occurs, and how this symbolically and materially positions African migrant carers. This was perhaps most evident in participants' awareness of differences in their use of English language, which at times was a barrier to understanding but, as noted in previous chapters, was also largely seen as the 'problem' of ethnic minority workers, rather than of the clients or colleagues of the women in nursing homes. English language expectations from clients and co-workers positioned African migrant carers in Australia as non-normative workers who did not have the capacity to care for clients. Even for workers who fulfil their required professional training and commitments, those marked as 'Other' in the colonial gaze are never viewed "as making it" – rather, they are constantly marked through difference (Hall, 1992).

In the following chapter I present a different aspect of African migrant carers' experiences of working in aged care. While this chapter and Chapter 5 focused on

interpersonal and institutional racism, in Chapter 7 I discuss participants' responses to racism. While many of the micro-aggressions and institutional processes experienced by participants served to deny their abilities to care for and care about clients, through their own responses to racism, these African care workers reaffirmed their identity and position as 'real' carers.

7 PROFESSIONAL PRIDE AS A RESPONSE TO RACISM

7.1 Introduction

In the previous chapters, I focused on micro-aggressions and institutional racism as key processes through which racism is perpetrated against African migrant carers in the Australian aged care sector. Microaggressions and institutional racism conveyed the message to the carers that they are not able to legitimately care for and care about clients, and as such reinforced the privileges of 'Whiteness', and positioned these carers as the 'Other'. In this chapter, I move to explore the ways in which carers respond to experiences of racism through claiming professionalism. It is important to reflect on how carers' respond to and manage their experiences of racism, because this acknowledges their agency in the context of institutions that ignore or silence their voices, experiences and abilities.

I define professionalism with regard to care work as the capacity and commitment to perform that work, along with possessing a duty of care to meet clients' needs. Professionalism in this context includes displaying a professional attitude, identity and responsibility, respecting clients' needs and relationships with colleagues, emphasising teamwork, communicating appropriately, and displaying a knowledge and understanding of the professional role. This definition of professionalism is supported by studies on professionalism in the health care sector, which identify a workplace ethic of being trustworthy, fulfilling the responsibilities and requirements of the job, and prioritising and respecting clients' and co-workers' interests (Evetts, 2014; Hafferty, 2006; McNair, 2005; Swick, 2000).

In the aged care and nursing literature on ethnic minority workers, there is some discussion of the role of professionalism in facing workplace challenges. In relation to their study of internationally recruited nurses in the UK, Allan and co-researchers interpret professionalism as the expressions of workers of being focused on the job, and their demand for respect and fair treatment while discharging caring duties to clients (Allan et al., 2009; Allan & Larsen, 2003). Goel and Penman (2015) discuss migrant workers' emphasis on hard work, and Larsen (2007) discusses overseas nurses' attempts in hospital settings to claim their knowledge and experience. However, none of these researchers have centred professionalism in interpreting the accounts of their participants' responses to racism in the workplace. My study goes further, making a

significant contribution to the literature by providing a more detailed examination of professionalism in African migrant carers' responses to micro-aggressions and institutional racism.

I argue that making claims to professionalism is the key mechanism through which African migrant carers respond to micro-aggressions and institutionally embedded racist workplace practices. Specifically, they draw on claims to professional pride and identity, and their capacity to symbolically challenge racism and assert their sense of self and their ability to care for and care about clients. To pursue this argument, I describe how professionalism is used in two ways. First, it is used in *indirect ways*. This refers to the ways in which the African migrant carers in this study deflected racism and claimed a professional identity by interpreting their clients' racism as the result of clients' individual circumstances or health conditions, and by drawing professional pride in the face of racist comments. Second, I move to explore how the African migrant carers used their professionalism in more *direct ways*. These include strategies such as: refusing to work with racist clients, leaving the work context, directly challenging racist clients and co-workers, and seeking redress via the institution to make it clear that they deserve to be treated better. Sometimes African women engaged only one form of professionalism, while at other times they intermingled direct and indirect approaches.

In the final section of this chapter, I explore how the women employed communal and collective responses, drawing on the professional insights of other carers, and those of some family and friends who have also worked in the sector and who serve as professional coaches and mentors to them. I also reflect on the significance of religion and spirituality in shaping participants' ability to respond to, cope with and challenge racist experiences. All of these responses were important in assisting the participants to symbolically and practically manage racism, and in limiting their exposure to racist clients and colleagues and the impact of racism. However, their responses also worked to simultaneously normalise racism in their workplace, and continue to place the responsibility for change on those who are vulnerable to and victims of such discrimination.

7.2 Indirect Responses

The African migrant carers' indirect responses to racism centred on re/interpreting the reason for and significance of racist micro-assaults from clients and micro-insults from colleagues. My analysis of their interview data highlighted two main indirect strategies

used by these workers: (1) they interpreted clients' racism as an expression of the health issues or past experiences of those clients; and (2) they centred their own professional identity when making sense of racism. Both of these strategies were informed by their strong sense of what was an appropriate professional response to and understanding of racism.

7.2.1 Interpreting clients' racism as the result of individual client characteristics

Here, I discuss the ways in which carers attributed clients' micro-aggressive racist behaviours to their health conditions and personal or past experiences. These interpretive responses were oriented to each carer's sense of self and understanding of the specific racist interaction. Carers focused on developing individualised explanations for the racist attitudes of clients, rather than attempting to explicitly confront or otherwise engage with the perpetrators of racism, or engage with sources of support. These responses indicate that the carers were concerned with managing how they felt about themselves in the context of clients' racism.

Carers attributed micro-aggressive acts to a client's mental state or the possibility of some past traumatic experience, creating a justification that interpreted a client's racism as an expression of that client's vulnerability. They worked to deflect and interpretively marginalise the relevance of these moments of racism in their professional lives. In this way, they were 'making a statement' about their professional pride and identity.

In the following excerpt, Hannah describes responding to clients' micro-aggressions by taking into account their health conditions:

These clients are aged, most of them are confused, let me use that word, they are agitated, if I am going to react based on what the client says to me, it means I am not doing it as a professional, and sometimes you just have to look at their situation. They are old, they are confused, she might not be saying that in her own frame of mind. You just have to make excuses for all these.

Hannah links clients' racism to their age and implies that as a professional she cannot react to racism from older people whose racism might originate from confusion. For Hannah, to react to racism from these clients would not be a professional thing to do. Therefore, Hannah draws on her professional skills to recognise clients' cognitive limitations. In this way, she attributes micro-aggressive acts to clients' illness more than to racism.

Lisa also decides to 'not judge' clients as a way to respond to micro-aggressions. She said:

With clients, yes, I experience discrimination, but I wouldn't judge them – their behaviour. Even if I felt that way – you just have to take it – like that's part of the job. The one I experienced was there is this client that said he doesn't like Blacks – in such a case they don't send Blacks there. The reason can be based on past experience that could make them traumatised. It could be based on this that he or she doesn't want a Black worker. So, you respect what clients want. We are being taught not to take anything personal – whatever they do, don't take it as discrimination. Though we are humans, sometimes I feel bad, but I don't take anything personal – it's part of the job that you experience a lot of things.

Lisa refrains from judging clients because "she is taught not to take clients' attitudes personally" in her professional role. She is clear that as a carer, as a professional, she needs to not react to clients' racism, but rather recognise that it might come from their past experiences; from their own vulnerabilities, victimisation or trauma. Claiming professionalism does not mean that racism does not hurt. For example, Lisa claimed her professionalism to build distance between herself and the racism, by arguing that racist comments did not define her. She implied that her professional identity was more important for dealing with micro-aggressions than her personal feelings. However, it is also important to note that this response could contribute to normalising racism because, as Lisa says, "she has to put up with racism". If that racism is taken for granted, it is not going to be otherwise addressed. Indeed, the message of feeling obliged to take racism for granted was evident through multiple women's accounts, which I present throughout this chapter, and which are littered with phrases such as "you just have to take it", "there is nothing much I can do", "it's normal" and "it's part of the job".

Similarly, Priscilia identified dementia as the possible reason why clients were explicitly racist towards her:

I experience discrimination from clients but there's nothing much you can do because most of them are not in their right state of mind – demented clients. Even those that are in the right state of mind, some of them are ill, have some conditions, you just have to put up with them, there's nothing much you can do.

Jenny also made a connection to a client's mental state, and age, in handling racism from that particular client:

Like the other day I went to work, and a resident called me an animal. Yeah, but there's nothing I can do about that. She's old and probably doesn't know

what she said. I didn't take it personally, its normal. I am there to make their lives okay. I just took it as normal, probably because of my skin colour. The client [she] is white. Maybe she has a problem with people of colour. I really can't tell because I was trying to assist her to go to her chair. I was holding her, and she told another carer who was Australian to tell this animal to get her hands off me. There was nothing I could do since she didn't want me and there was another carer. So, I just allowed the other carer to take care of her and I didn't take it personally.

In Priscilia's and Jenny's examples, the role of professionalism is less explicit, but nevertheless present. Supporting Evetts' (2014) argument that professionalism is evident in a worker's knowledge of the job, Priscilia also places an emphasis on taking into account her client's state of mind. She suggests that being professional means ignoring when clients express racism against her, and making allowances for them due to their elderly and infirm status. In communicating that she was "there to make clients' lives okay", irrespective of client racism, Jenny also expressed a professional attitude. This resonates with a finding by McNair (2005) that health care workers' focus is being responsive to the needs of clients in hospital settings.

In the following excerpt, Ola makes the decision to explicitly justify her professional status in the face of micro-aggressions:

Sometimes clients can be choosy because you are new, sometimes because they don't just know you, they don't know what they can expect from you and it's okay. It's okay, for instance, if you are new and the client doesn't know if he should talk to you. It's okay because you don't know that person. But the good thing is when you portray yourself to that client. Oh Ma, oh Sir, I know what I am doing, can you please trust me, can you please give me that opportunity to work with you, can you please give me the opportunity to do these things for you. So, with that approach you give them, hopefully they will change and then they will see that you really know what you are doing. And some of them can be choosy because of where you come from, because of your colour, background, culture, one experience or the other they might have had in the past. So many reasons can make people choosy. But it's okay, it's a free world, there is freedom of choice. All we do as people giving services is just to give them that appearance, attitude that they can trust you.

Here, Ola is simultaneously naming professional attributes (having knowledge, an ability to interact with and engage clients, a willingness to prioritise their needs), while also recognising a client's right to refuse. In this way, she draws on a form of professionalism that centres the client's right to be respected. These findings align with those reported by previous studies, which determined that ethnic minority workers tend to attribute clients' racism to their individual circumstances, on the understanding that those clients had not been exposed to or were not used to Black people caring for them (Sethi &

Williams, 2016); or they attribute clients' attitudes to mental or cognitive impairment (Nichols et al., 2015; Timonen & Doyle, 2010). These studies also found the same association of racism with dementia and ill health. However, for the African care workers in my study, these attributions have a strategic/symbolic role of foregrounding a different, less oppressive and more personally meaningful element of their identity: their professional identity.

7.2.2 Professional identity in the face of racist comments

In the previous section, I reported instances where participants ignored racism in the workplace by attempting to understand elderly clients' individual circumstances and past experiences. The second type of indirect responses these carers used involved emphasising their professional pride in the face of racist comments – their professional character, their personal strength to build on difficult experiences and make the most of opportunities, and their hard work. Larsen (2007) and Mapedzahama et al. (2012) have similarly described Black nurses claiming their professional status or competence to co-workers in hospital settings as an attempt to delegitimise racism they faced while on duty. In a study on coping with racial micro-aggression experiences, Holder et al. (2015, p. 172) found that Black women in corporate leadership reported that racial micro-aggressions also had 'positive' consequences, "making them stronger, tougher and enhancing their character".

In the following excerpt, May demonstrated her commitment to a client's needs in the face of racist micro-aggressions:

A client referred to my skin as sunburnt but it's about having that duty of care; you know you are there to assist that client and give them a sense of satisfaction.

May responded to the client's racist comment in this scenario by emphasising an alternative sense of self; one that referenced her (hard-won) role, her duty of care and the practices she associated with it. Here too, in response to co-workers' racism, Pauline drew on a sense of professional pride:

I would say discrimination happens almost every day at work, even when you are liaising with workers from other hospitals and dealing with paramedics. One way or another, someone will just look at you differently, but they come around when they see you know more than they do. So, I will not allow discrimination to overwhelm me or put me down. I even look at it as a positive thing because it makes me push myself, at times I feel there are opportunities that are available in Australia, these are not seen by locals, and migrants are

coming and realising these opportunities. Like an example, in my facility I have moved despite these experiences of discrimination from a personal care worker to higher positions in the nursing home I work.

Pauline suggested that rather than being overwhelmed by the attitudes of colleagues who look down on her, she has been able to prove her capability through her performance and achievements on the job. She claimed that emphasising professionalism and professional pride has helped migrant carers, including herself, to advance in their career in material terms, even in difficult circumstances. Her response to racism shows a denial – or marginalisation, at least – of its corrosive impacts, in exchange for an emphasis on professional development.

In another set of reflections, Priscilia also expressed a sense of professional pride, attributing the problem of racism to co-workers, rather than herself:

I think the key is I refuse to acknowledge discrimination. If the problem is with a co-worker, it shouldn't be an issue. If I have a co-worker that doesn't like me, as far as she does the job and assists me where she should, the maximum number of hours you can work with someone in a shift is 8 hours, once you do that you leave the job and forget about the co-worker.

Here, Priscilia is using professionalism in three ways: (1) she is using her professionalism to state that her co-worker is not just racist, but also unprofessional; (2) she displays a sense of confidence in suggesting her expertise and knowledge of the job are superior to those of her co-workers; and (3) she challenges the significance and legitimacy of her co-workers' racism by emphasising that it only strengthens her own sense of professionalism and pride on the job.

The study participants responded to racism by asserting an alternative account of their standing in the aged care sector that highlighted their ability to care for clients and – through emphasising their respect for the needs of clients, and their probable vulnerability – their commitment to care about those clients. These strategies are powerful as symbolic challenges to micro-aggressions. In using these, the African migrant carers asserted both a rejection of racism and their identities as 'real' carers. However, these strategies do not problematise the individual racism shown by clients, nor the negative cultural representations of Black workers and carers. To do so requires externally oriented strategies, to which I now turn.

7.3 Direct Responses

The African migrant carers in this study also described instances when they directly challenged racism. They did this in three key ways: (1) refusing to work with racist clients; (2) calling out racism; and (3) turning to the institution for redress. Not all of these strategies involved a confrontation with the perpetrator of racism, but all shared an express rejection of the racism as inappropriate, and sought to change the situation in order to limit the potential of future acts of racism by the specific perpetrators.

7.3.1 Refusing work with racist clients

When the study participants became intolerant of micro-aggressions from clients, they sometimes sought to remove themselves from the situation, either requesting employers change their clients or shifts or refusing to work with particular people. In the literature, this response strategy has been defined as avoidance, and involves ethnic minority workers staying away from perpetrators of micro-aggressions and situations that stir up bias and racism, either by changing clients or leaving the job (Sethi & Williams, 2016), or leaving the firm employing them (Shorter-Gooden, 2004). Nanna provided an example of asking to be allocated to new clients:

If I work with a client and I am not satisfied with the way they treat me, I let the agency know I don't want to work with them anymore and they assign me other new clients.

Funmi and Pauline also assert their professional identities by refusing to work with clients who treat them in ways they are not comfortable with:

I have seen clients behave like; I don't want this worker. The thing is once I work with a client and I don't feel comfortable, the next time the agency offers me the shift I turn it down. [Funmi]

At times, I become intolerant and say I don't want to work with that client in the nursing home. I would not tolerate discrimination from a resident, regardless of the fact that I am here for them. [Pauline]

Through their confidence and emphasis on their own expectations of work satisfaction, comfort and working free from discrimination, and their clear expectation of change, Nanna, Funmi and Pauline assert their professional identity and professional legitimacy. While prior studies emphasise that professionalism entails respecting the needs of clients and responding to these needs (Hafferty, 2006; Hilton & Slotnick, 2005; Swick, 2000), these carers enact a slightly different interpretation of professionalism: they demand to be respected as a professional in the client-carer relationship. Pauline describes the

tension between her professional commitment to be “here for them [clients]” and her sense of her own professional standing, which means that she will not tolerate discrimination. The expectations communicated by my participants echo those expressed by internationally recruited nurses in the UK health sector, who also demanded respect while caring for clients (Allan & Larsen, 2003).

In the above participant statements, Nanna and Pauline described presenting confidently to management in asking to be moved, and Funmi felt the confidence to turn down unwanted shifts allocated to her. The possibility to enact change and use a strategy of avoidance is more likely in agency home-based care, where workers can either avoid or request specific clients. In aged care facilities, carers are required to meet the needs of multiple clients and have less capacity to avoid individuals – although on one occasion, Pauline was able to ask to discontinue working with a racist client in the nursing home. Thus, agencies can provide some protection to carers from racism if they choose to do so. However, moving carers on to different clients does not actively challenge the racism of clients. This point was also made by Shutes and Walsh (2012) in their UK aged care study, who found that when migrant care workers reported their experiences to the agencies, the agencies sent another carer, a ‘White’ carer, to avoid further occurrences of racism, rather than addressing the racist act. That study also determined that when White clients did not like Black carers, the agency would agree to the clients’ terms. Thus, these circumstances were acting to create a “racial matching of care user and care worker” in managing racist clients (Shutes & Walsh, 2012, p. 94).

One participant in my study, Nike, used her professionalism slightly differently again. When she was dissatisfied with racism from her colleagues, she left her job altogether. Implicit in this decision was the desire to be treated with more respect.

I had to leave one of the jobs I had in a facility because of my co-workers’ attitude, they tend to treat you anyhow. They make you do all the work; they are rude, and you greet them they don’t answer you. I initially became quiet and didn’t greet them anymore but later I had to leave.

Through her response, Nike claimed some agency in her work conditions by refusing to countenance her colleagues’ micro-assaults and micro-insults. However, her phrasing at the end of this quote (“I had to leave”) suggests this agency was constrained. Ultimately, her choice was necessitated by the corrosive effects of ongoing racism, rather than a desire to pursue her work elsewhere. In common with Nanna, Pauline and Funmi (above), Nike’s avoidance solved the problem temporarily by removing herself from

racist people, but this did not confront the source of the problem. In leaving, Nike took on the responsibility of looking for a new job and the financial insecurity associated with being unemployed – while those who perpetrated the racism towards her got to retain their position (at least as far as Nike was aware). Further, Nike was likely to enter similar work circumstances in a new institution: she would still be at risk of micro-aggressions and institutionalised racism. Sethi and Williams' (2016) study uncovered a pertinent example of this: after a migrant ethnic minority worker quit her job because of racism, in another nursing home she experienced similar problems, and thus resolved to accept the experience as an everyday reality.

7.3.2 Challenging racist clients and co-workers

A second type of direct response used by African migrant carers in this study challenged racist behaviours and attitudes head-on. These carers explicitly named, called out and confronted clients, co-workers and supervisors who perpetrated micro-aggressions. This included speaking back against clients' racist comments, challenging supervisors about situations in which they felt they were not equally recognised for their contributions on the job, and directly addressing team leaders who did not allocate tasks equally among co-workers. In these ways, the women directly challenged stereotypes and assumptions about African migrant carers. In the literature, this form of response has been described as speaking up (Lewis et al., 2013), or directly addressing the perpetrator (Shorter-Gooden, 2004).

Shade relayed a moment in which she directly challenged a client's racist comments:

The other day we were chucking a whole lot of fruits because clients won't eat twice so we had watermelon and I was chucking it and this client behind me was saying, "Why are you chucking it, there are lots of people in Africa who need it". Do you know my response to her: "Africa is very far, yes, we know there is poverty there, but there are homeless people here walking around, they don't have anywhere to sleep, why would you transport all those things to Africa instead of you to walk to the city and help them?" So, you have to put clients in their right place, I have a response for everybody.

Here, Shade was able to directly address and challenge a client's stereotyped comments towards her and about 'Africa' in general (about poverty and homelessness). In doing so, Shade also spoke back against the long-standing colonial attitude underpinning this client's comment, that constructs 'Black Others' as 'backward', 'poor' and 'uncivilised' (Fanon, 1970; Hall, 1992; Spurr, 1993). In responding confidently, Shade actively asserted her professional identity in the face of a client's challenge to her behaviour and

her decision to throw out excess food. Again, this is evidence of a carer emphasising her professional standing and need for respect (“you have to put clients in their right place”), and prioritising these over a singular emphasis on client needs.

More commonly, participants described ‘speaking back’ against co-workers. Tracey, for example, foregrounds her professional pride and identity when confronting negative assumptions held about ‘Black’ carers:

I make co-workers who want to play on my intelligence see that the ‘Black’ race is not inferior. It's our responsibility to let them know we are not inferior and speak for ourselves when they are trying to play on our intelligence at work.

Tracey presents herself as reclaiming her identity and speaking for the ‘Black’ race, challenging negative assumptions that are expressed when people undermine or subtly challenge her skills (which she referred to as a “play on my intelligence”). Tracey understands speaking back as important: her comments may not change the broader context, but she sees value and impact in asserting a positive professional and racial identity, both in terms of challenging negative assumptions and in the process of speaking back against racism.

Ola also reported that she ‘speaks up’ against co-worker racism:

I try to make co-workers see that whatever thoughts they have about me, that is not who I am by speaking up. So, I speak up, I let them know this is who I am, I let them know the fact that I am a migrant doesn't mean they can disrespect me. As long as you speak up and make them see you know what you are doing, when they have that view of you, there will be mutual respect. If I am not comfortable with what any co-worker does at work or any action, attitude, I will speak up. So, speaking up helps me a lot.

Ola directly challenges assumptions that being a migrant automatically positions her as less deserving of professional respect. She claims a professional identity by expecting co-workers to realise her skills, and she demands respect for her professional abilities, in a way similar to the Black nurses in Allan and Larsen's (2003) study. Ola's insistence that co-workers see that she knows what she is doing suggests a desire that others recognise her capacity to care for clients, as noted in Larsen's study with Black nurses (Larsen, 2007). Like Tracey, Ola sees this confrontation as a means of effecting change. Demanding that co-workers acknowledge her ability to care for clients will, she believes, lead to mutual respect.

In another instance, Shade adopted a response that I am calling the ‘Strong African

Woman', inspired by accounts of confronting her team members and displaying strength and agency:

I don't even report my co-workers to management when they discriminate against me. I face them myself as a team leader. I am a strong African woman and I have zero tolerance for co-workers who are not respectful. When we are on the job, for co-workers who don't want to do the job and listen to me, I let them know bluntly we must do the tasks equally.

Shade makes it clear that she is firm and capable even in the face of micro-aggressions, and does not have to engage other institutional processes such as reporting to management. As I have noted earlier – and discuss in the next sub-section – a recourse to institutional processes is not always successful in changing racism in aged care, but Shade's refusal to use such processes is also symbolically important. It positions her as someone who is able to manage racism by herself. She asserts her institutional authority and professional identity as a senior worker (she is a team leader), which is the foundation of her claim to respect and obedience.

While Tracey, Ola and Shade used claims to professionalism to directly challenge co-workers who had stereotyped understandings of them, Rachael emphasised her professionalism by highlighting the importance of 'being firm' and assertive in rejecting co-workers who were rude and bossed her around. She said:

You have to be respectful when you are speaking to co-workers about their attitude, no shouting at them, be assertive when you are working with them because some would like to boss you around. You have to be firm and let them know you do not expect that attitude from them, but you do not want to strain your relationship with them because you might not be able to work together. Other co-workers like to be rude to you and if they are rude you just let them know that behaviour was rude.

Rachael differed in her approach by emphasising not "straining the professional relationship" and "maintaining a respectful stance" as important dimensions of professionalism (Evetts, 2014; Hilton & Slotnick, 2005). While Rachael also challenged her co-workers, her approach emphasised the importance of maintaining a civil working relationship, rather than the importance of demanding respect – two approaches that are related, but different in terms of where the emphasis lies.

Ola and Venus also spoke up to their supervisor to challenge issues related to the allocation of tasks and the lack of support at work. For example, Ola described an instance when her coordinator did not recognise her contributions. Although I presented

this example earlier in the thesis, in a discussion of supervisor micro-insults, here my focus lies on Ola's response.

There was an incidence at work when my colleague and I did a job and only my colleague was acknowledged by the coordinator. I told my coordinator during the supervision, this is how I felt they did not give me support, despite the fact that we worked together, and the coordinator responded that he didn't mean it that way, he just wanted to respond to the mail promptly. He apologised and I believe he was sorry. I had no regrets that I spoke up. I don't know if after that incidence he still likes me or not, but I have expressed myself. Sometimes we need to speak up, the colleague is an Australian and I am an African, so you understand.

Here, Ola noted that she was not acknowledged for the good job done; a behaviour that she understood to be racist and to reflect a devaluation of her work as an African migrant carer. It thus became important for Ola to challenge this devaluation and reassert her contributions and her professional identity as a carer who is capable and committed to her job. Ola recognised that there may be negative consequences as a result of her challenge ("I don't know if after that incidence he still likes me or not"), but she prioritised claiming her professional identity over any material or professional loss.

Venus also shared her experience when she argued for equal treatment from the team leader:

I had a situation with my team leader not sharing tasks equally between myself and an Australian co-worker and I spoke up to my team leader about it and when the situation did not change, I reported to my manager and the case was resolved. Even though the team leader later resigned, I don't know if he could not work with me in the team anymore.

Unlike the other examples offered by participants, in this instance Venus sought additional support when she could not change the situation. Like Ola, she was aware of the risks of raising an unequal and racist allocation of work, and she too prioritised the importance of asserting her claims to opportunities and demanding acknowledgement as a professional over those risks.

In all of these examples, participants described some change as a result of speaking back. In the interviews, I did not ask participants to reflect on the longer-term or systemic impacts of their challenges. As Shorter-Gooden (2004) notes, there are limits to the extent marginalised groups can use their agency and voice to challenge micro-aggressions: speaking up is directly instrumental to confronting racism, but this occurs in institutional contexts of pervasive and unequal racial power relations.

7.3.3 Seeking institutional responses to clients' racism

African migrant carers adopted a third form of direct action: reporting their experiences of micro-aggressions to the institution. They typically sought assistance from the institution in the face of clients' racism. This reinforced their claims to be treated as professionals, while also acknowledging the limits of their professional authority. This response reflects earlier studies that also found 'immigrant' or 'migrant' care workers formally report their experiences of racism from clients and managers (Sethi & Williams, 2016; Shutes & Walsh, 2012; Timonen & Doyle, 2010), as do Black nurses (Mapedzahama et al., 2012; Showers, 2015).

Ella described her response to clients who reject her care because of her race:

Basically, when a client is resistive to care, I don't force, I have to report to the supervisor who is usually a registered nurse. I don't force, if they prefer another carer helping, or if they don't want to be helped at that particular time, I just go by what they want.

Similarly, Ola described a decision to report client racism to the registered nurse:

What I did was to report to the nurse on floor, I told her this client does not want me, and the nurse said okay that is fine because clients have the right to choose who they want, it's part of their right, there is nothing we can do about it. All the nurse said was that if the client does not want me, she will just take me over somewhere else where I can work.

In common with participant reports from previous studies conducted on professionalism in the health care sector (Evetts, 2014; Hilton & Slotnick, 2005), Ella's and Ola's statements indicated that the ethics of respecting clients' wishes was important to their understanding of their professional identities. Institutional processes or the practicalities of covering their clients' care then required them to report the issues of racism. In both accounts, there is no indication that reporting would bring about changes to client behaviour or an explicit demand by an institutional representative that the carers be treated with respect. Indeed, Ola is explicit that the registered nurse's response precluded any change, because the nurse chose to prioritise the client's right to accept or reject care over Ola's claims to professional respect. Thus, Ola's and Ella's reporting were more effective as symbolic claims of their professional identity, oriented towards the institution, than as direct challenges to the perpetrators of racism.

Cassy also highlighted reporting her experience of clients' racism, hoping that her concerns would be taken seriously:

Client's discriminatory attitude makes you a bit sad, but you soak your emotions and keep on going with work. What I do is report to the nurse and hopefully the nurse will talk to the client – which is not always the case. You just have to go in, do whatever you can do and go.

In this example, Cassy is clear about responding as a professional, irrespective of a client's racism: "you have to keep on going with work". Like Ella and Ola, she reports racist behaviour from clients, with the hope that a worker with more authority will make a direct challenge on her behalf. However, Cassy also makes it clear that this does not always happen. Ultimately, Cassy chooses to maintain professionalism – "just going in and doing whatever she could do on the job", and walk away from a racist act if there is no institutional support. In this way, her attempts at a direct challenge become transformed into the more interpretive and indirect response of emphasising a professional identity, as described in the previous section of this chapter. This outcome reflects a key theme that emerged in the data: where support was sought from the institution, the perpetration of racism against African migrant carers was largely overlooked and not addressed. This lack of response amounted to a continuation of the institution to reproduce the racist structures and interactions that deny, overlook and diminish the experiences of African migrant carers.

7.4 Communal and Collective Responses

In the previous sections, I described how the carers employed a sense of professional pride and identity through direct and indirect responses that were largely oriented to their position as individual workers. Here, I discuss a different set of responses to racism that rest on communal and collective support. The African migrant carers reported that they draw on networks of friends and family who work in aged care and who provide them with professional coaching. The use of this strategy reflects the reports of Black women students in a study in a college setting in the US by Lewis et al. (2013). These women similarly described using collective responses, coming together to create an informal association as professionals in which they could discuss their challenges at work and share dissatisfactions. This type of response has been conceptualised as "leaning on shoulders", or leveraging the network of family members, friends and trusted co-workers. Black women in corporate leadership settings in the US also draw on this network of 'professionals' to verify if what they are experiencing are truly micro-

aggressions (Holder et al., 2015). Lewis et al. (2013) also observed instances of Black women students relying on this kind of network to seek support and advice when they experienced micro-aggressions in college settings. The participants in the present study described turning to close relationships that provided them with important communal reiteration of their professional identity and capacity, and a sense of support. As described by Ola:

When I experience discrimination at work or anything I'm not happy with at work I discuss it with my friends and husband to know what they think about it and this helps me.

Leila draws strength from her husband and friends to help navigate and process discriminatory experiences:

I would say my husband has been of great help because he also works in the aged care sector. He has given me a lot of orientation and whenever I come home with a particular experience of discrimination and I share with him, he has always been able to give me an advice that has helped me to overcome it and also I have met African friends like me working in the sector who have really helped me a lot and motivated me to strive to the peak of my career.

Here, Leila notes how relying on this network has provided her with some form of relief to deal with racism. Her network provides advice, which assists her in managing and overcoming individual acts of racism and motivates her to achieve greater things in her career. In so doing, they reiterate her position as a professional woman who not only has the capacity to care for clients, but effectively manages racism and achieves excellence in her career. In another instance, Samantha shared how a community of African migrant carers developed an informal professional community to forge ahead in the face of micro-aggressions:

There was a facility I was sent to work and African carers had an association that they gathered together, exchanged numbers, chatted on social media (Facebook) – and they had a platform they discussed their knowledge of care work and difficulties they faced on the job.

Samantha's support network has a similar role to the informal associations described by Lewis et al. (2013), supporting African carers to interact and collaborate as a means of carving out a space for themselves within the White aged care space. Despite their experiences of racial micro-aggressions and institutional racism, the migrant carers in my study found a way to form solidarity, as 'Black' migrants with a 'Black' identity, to discuss their challenges. Their individual professional identities were interwoven with and supported by a communal professional identity, which centred on problem solving by

addressing difficulties on the job and building and sharing knowledge. Thus, African migrant carers were supported to develop an identity and skills necessary to assert their claim to care for clients, to be 'real' carers in the aged care system.

These communal responses are reminiscent of Stuart Hall's reflections in his article 'Minimal selves', where he notes that despite Black people's experiences in London of being "marginalised, fragmented, unenfranchised, disadvantaged and dispersed" (Hall, 1987, p. 44), they were still able to create a feeling of ownership over some of the London territory, and support each other. My study reveals that the African migrant women had built support systems for themselves and their African colleagues as one strategy to help them grapple with racism in the predominantly White aged care sector. As Hall argues, establishing communities of 'Black' solidarity might ultimately help to fight against the politics of racism in the White society, and in this context, aged care facilities (Hall, 1987; Procter, 2004).

7.5 Religion and Spirituality

As I have noted so far in this chapter, claims to professionalism are a key mechanism through which African migrant carers respond to clients' and colleagues' racism. However, with only one exception, the carers also reported the use of an additional resource – religion and spirituality – to respond to racism perpetrated by co-workers.

I define the use of spirituality and religion as a response through which the carers drew strength, protection, and reliance on a sense of divinity to handle micro-aggressions, specifically from co-workers. Religion and spirituality served them as a form of encouragement to forge ahead despite racist co-workers. This finding agrees with the responses of participants in previous studies that have also explored people's use of prayer, spiritual beliefs and a relationship with God to manage the challenges of racial and gendered micro-aggressions (eg. Shorter-Gooden, 2004). Other researchers have described this response as offering a sense of empowerment, helping individuals to make sense of micro-aggressions and to forgive the perpetrators (Bacchus, 2008; Holder et al., 2015). Like the other types of individual and indirect responses, religion and spirituality offered the African migrant carers in this study a means of reinterpreting the meaning and significance of microaggressions. However, they were not useful for helping them to address the interpersonal, institutional, or wider cultural sources of the discrimination.

Priscilia's and Hannah's comments are representative of how participants used religion and spirituality to manage their experiences of micro-aggressions with co-workers.

Priscilia stated:

I pray to God about whomever will be assigned to work with me on the shift before going to work. This helps me a lot.

Hannah similarly emphasised the importance of prayer in the face of co-worker racism:

Interacting with co-workers can be very challenging but I am able to persevere through praying about my challenges with co-workers.

The use of spirituality and religion helped carers to reduce the impact of co-workers' racism on them by enabling them to develop a sense of solace and support. As with other indirect strategies, this response offered participants new ways of interpreting the significance of racism while leaving that racism unchallenged. They implicitly placed responsibility on themselves to engage their belief in God to help them minimise the negative impacts of micro-aggressions from co-workers.

7.6 Conclusion

My analysis shows that African migrant carers drew on their professional identity and pride in responding to racist micro-aggressions perpetrated by clients and co-workers. They used professionalism in three main ways: (1) as a means of reinterpreting the significance of racism (most common when dealing with client micro-aggressions); (2) as a means of directly responding to racism (typically colleague racism); and (3) as a means of drawing on collective experiences and strengthening a collective professional identity. The women's expressions of professional identity also changed across carers and contexts, highlighting a tension between working with and responding to client needs, and making claims for respect – two recognised elements of professionalism that sit in tension in the context of racist behaviours and work contexts. But at the core of these definitions and claims to professionalism was the need of these African migrant carers to develop a professional identity that was expressly referenced to racism. Thus, responding to racism was a foundational element of, and motivation for, their definitions and claims to professionalism.

These different expressions of professionalism served three purposes. Firstly, these expressions were a key means by which participants could reassert – directly or symbolically – that they were 'real' carers with the capacity to care for and care about

clients, and reassert their authority to practice that care. Secondly, these responses informed their agency to navigate and respond to racism. Thirdly, they enabled the African migrant carers to strategically claim a space for themselves and make known to the institution that they deserved to be treated better by clients and co-workers.

However, what was obvious through the indirect and direct responses was that these responses did not really change anything at an institutional level. Sometimes workplaces offered some protection to African migrant carers by removing them from contact with racist clients, but failed to actively challenge the racist acts of clients and other colleagues. Despite carers' claims to a legitimate professional identity of caring for and caring about clients in response to racism – and the institutions' attempts to resolve the discrimination – the context of the racism was rarely changed, even where specific expressions of it were successfully shut down. This confirms the observation of Shorter-Gooden (2004) that, while using one's voice and speaking up is directly instrumental to confronting racial bias and putting an end to racism, 'Black' women often do not have the power to change the racism they experience because of unequal power relations in institutions. And, I add, nor should they be expected to shoulder the burden of that change, particularly given their vulnerability and devaluation in these contexts. As racial micro-aggressions are a recurrent expression of social and cultural structures, there is limited effectiveness in confronting individuals (Forrest-Bank & Jenson, 2015; Shorter-Gooden, 2004). Thus, it is important to recognise that the African migrant carers' claims to professionalism are largely symbolic; and have limited power to effect change.

8 CONCLUSION

This study offers a unique contribution to our understanding of the need to consider racism in the working lives of African migrant women in aged care. Migrant workers, including African migrant women, have been identified in policy as a key solution to the care deficit and to meeting the needs of the vulnerable ageing population in Australia. This policy discourse has positioned migrant workers as both a solution to key problems in the aged care sector and a problem in itself. Challenges around language, client trust, and differing understandings of care practices have been raised as challenges of the multicultural workforce, but in fact are treated as deficiencies with regard to the migrant workforce. This thesis challenges this framing by centring and valuing the voices and experiences of 30 African migrant women carers – not as problems or policy solutions – but as a social and cultural group whose experiences offer insight and critique into the realities of aged care work.

8.1 Key Findings

The key finding of this thesis is that racism is a defining feature of African migrant workers' experiences of aged care. It indicates that in the largely White-dominated space of Australia, care workers' African bodies are racialised and they are labelled 'Black' (Mapedzahama & Kwansah-Aidoo, 2017), a form of racialisation into a 'Black category' or 'Black identity' (Mapedzahama et al., 2011, p. 159). I suggest that it was not only skin colour that conferred upon African migrant women such racialised categories and identities; clients and co-workers also referenced cultural, racialised meanings associated with Black bodies and wider social structures. As argued in this thesis, these meanings draw upon and align with historical and colonial frameworks and discourses of 'the West and the Rest' (Hall, 1992), and other theories of race and difference (Fanon, 1970; Hofstadter, 1992; Said, 1978; Spurr, 1993). These discourses denied the value and legitimacy of African carers' work and their identity as 'real' aged care workers, who cared for and cared about clients.

The following is a summary of the key findings with reference to the research questions guiding the thesis.

What are African migrant women's experiences of racism in the aged care sector?

The findings from this study revealed that racism in the aged care sector was perpetrated through micro-assaults and micro-insults directed at the Black African carers by clients, clients' families and co-workers, and also in the form of institutional racism. These carers reported experiencing micro-aggressions in the workplace, which highlighted the pervasiveness of interpersonal racism. Micro-aggressions perpetrated by clients took the form of explicit rejection of Black carers and racial name-calling (micro-assaults), and ascription of incompetence and a lack of knowledge on how to care for clients (micro-insults). The micro-assaults perpetrated by clients' families took a similar form, and included rejecting the care of the Black migrant workers, misrecognising and overlooking their care skills and experience, and – additionally in the context of in-home care – making assumptions or accusations of criminality. Micro-assaults perpetrated by the carers' colleagues were rare, which was likely an indication that their institutions had policies in place against discrimination. However, the Black carers' reported many instances of co-workers expressing micro-insults that assumed they were incompetent, had a poor command of the English language, and that communicated a generalised social rejection of the women. Perhaps unsurprisingly, given managers' and co-workers' expectations of their caring capacity, while there were no reports of micro-assaults from supervisors and managers, participants did describe experiencing micro-insults from those in senior positions to them. These micro-insults included: being talked to differently compared with White co-workers; disparities in shift allocation; and failure to recognise their work contributions.

The women I interviewed did not discuss witnessing behaviours in their workplace that would be conceptualised as micro-invalidations; the third type of microaggression under widely used typologies (Sue, Capodilupo, Torino, et al., 2007; Sue, Capodilupo, et al., 2008; Sue, Nadal, et al., 2008). Micro-invalidations imply that the particular lived experiences of racial groups are not real, are unfounded or can otherwise be ignored (Sue, Capodilupo, Torino, et al., 2007; Sue, Nadal, et al., 2008). I suggest this absence reflects the specificities of the women's work context, wherein clients, clients' families and co-workers were not primarily concerned with the lived experiences of the African migrant carers, and the carers were aware that sharing their experiences would be

unwelcome. As such, there were no opportunities for those parties to negate the carers' lived experiences. Additionally, most of the participants were very aware of the limits of manager responses and formal institutional processes in resolving overt racism; this awareness perhaps informed their decision to report only the most obvious expressions of racism by clients and co-workers, and thus limited the opportunities of management to act on racism.

In addition to micro-aggressions, participants' accounts also highlighted institutional racism. The cultural background and structural positioning of African migrant workers were not recognised in organisational induction programs and technical/skills and human resource training. While I cannot comment on the specific content and delivery of the training offered to participants, in their accounts it was clear that the array of training did not build their confidence in doing aged care work. When these deficits in formal training were combined with an expectation that carers participate in on-the-job training supported by colleagues who were often the perpetrators of micro-aggressions, African migrant carers felt further unsupported. Additionally, participants described formal complaints processes that failed to meaningfully address their experiences of racism, even when those experiences were acknowledged. In highlighting these processes, I am not arguing that organisations deliberately promoted racist policies or treatment; but rather, the logic of institutional aged care processes reflected White experiences, culture and expectations, which left the needs of the African workers marginalised and unaddressed.

While my thesis has primarily focused on the participants' experiences of racism, it is also important to acknowledge the ways in which African migrant carers respond, resist and reinterpret the racism of clients and colleagues. Recognising this agency informed my second research question, as follows.

Can African migrant women meaningfully challenge racism while undertaking aged care work?

This study's findings established that the primary way in which African migrant carers responded to racism, and specifically micro-aggressions from clients and workers, was through claims of their professional identity and status. This professionalism created the impetus and language for participants to indirectly and directly respond to racism. Their indirect responses were largely interpretive and symbolic, centred on explaining or redefining client racism as an expression of dementia, confusion or past experiences and

beliefs. This in turn allowed participants to foreground a more personally meaningful element of their work and identity: their professional identity. This focus enabled participants to position themselves as professionals who were committed to meeting the needs of clients irrespective of whether those clients expressed racism. The carers' direct responses to racism more explicitly challenged the legitimacy of racism, as mostly perpetrated by co-workers. African migrant carers emphasised their skills, authority and their expectations of respect from colleagues and managers/supervisors. These individualised responses were supplemented through seeking support from other African migrant care workers, with whom they collaborated to strengthen their personal and group identities as able and effective workers. The majority of participants also nominated their spirituality as a source of strength and support in facing – although not directly challenging – racism. If racist micro-aggressions and institutional racism challenged participants' standing as 'real' carers, then claims to professionalism allowed them to reassert their capacity and their authority to care for and care about clients.

The African migrant carers used a number of different strategies to respond to racism, but whether any of these had the potential to *meaningfully challenge* racism is not clear. Indirect and direct responses were largely symbolic, taking the form of the participants offering alternative accounts of their position and value as aged care workers to those who displayed racist behaviours towards them. And in the face of micro-insults, micro-assaults and institutional racism – which gave the African migrant carers strong messages that they were unskilled and unwelcome, and unable to care for and care about – this symbolism is important. In asserting their professional identities, these women were rejecting the definitions held by clients, colleagues and broader society of what it means to be Black (a point I return to below). The women I interviewed were clearly proud of their professional identities and saw value in claiming those identities and pushing back against racism in both small and more obvious ways. So, in this way, these challenges of racism were meaningful to the women who engaged in them.

However, there was less evidence that the carers' responses to racism in the workplace were effective in making lasting change at the interpersonal or institutional levels. Refusing to work with racist clients often meant that African migrant carers changed or lost shifts, or were simply removed from that particular care relationship. Thus, regardless of the women's capacity to care for or care about, they remained, in the eyes of many clients, unwelcome to provide care. Directly challenging racism from co-workers allowed the migrant carers to reassert their professional standing – but did not change

the lack of evident institutional processes in place to meaningfully discipline racist individuals or change racist culture. After analysing and reflecting upon the data from my interviews with participants, I confess I now feel slightly uncomfortable with my original focus on African migrant women's capacity to effect change in the aged care sector – because this places responsibility on the shoulders of the individuals who are subject to, rather than perpetrators or architects of, racism in aged care.

Ultimately, the women's experiences of racism, and their potential capacity to change racism in aged care, need to be understood in wider cultural contexts. As critical race and Whiteness theory indicate, expressions of racism at the interpersonal or institutional level are shaped by larger social and historical discourses that construct particular groups as 'Others' (Embrick et al., 2017; Frankenberg, 1993; Huber & Solorzano, 2015; Lipsitz, 2006; McIntosh, 1988; Wong et al., 2014). The long history of constructing racial hierarchies (civilised/uncivilised, progressive/backward, superior/inferior, developed/undeveloped) – hierarchies embedded in colonial discourses of 'the West and the Rest' (Fanon, 1970; Hall, 1992; Hofstadter, 1992; McConnochie et al., 1988; Said, 1978; Spurr, 1993) – are very much alive in contemporary contexts. These hierarchies, which construct the West as the epitome of human progress, underpin and explain the form and content of micro-aggressions towards the African participants in my study, as well how these migrants are defined through abject markers of difference: dirty, inferior, lacking in skills. In addition, the centring of White Western subjects at the heart of the Australian nation, and its institutions such as aged care, explains the processes and practices of institutional racism: i.e. whose experiences are prioritised, who gets listened to, and whose experiences are overlooked, denied and placed at the margins.

8.2 Key Contributions

This thesis expands upon existing knowledge about the Australian aged care sector. Specifically, it contributes to developing an understanding of racism as experienced and described by African migrant women working in this sector. This study extends other, scant, research in this and related fields. Many studies have explored the experiences of discrimination and racism for African nurses internationally (Alexis & Vydelingum, 2004; Allan et al., 2004; Allan et al., 2009; Larsen, 2007; Larsen et al., 2005; Likupe, 2006; 2013; 2015; Likupe & Archibong, 2013; Showers, 2015) and, to a lesser extent, in Australia (Mapedzahama et al., 2012; Mapedzahama et al., 2018; Omeri & Atkins, 2002; Willis et al., 2018; Xiao et al., 2014). Additionally, while there is a growing focus by

researchers on the broader category of 'migrant aged care workers' in Australia (Charlesworth & Isherwood, 2020; Fine & Mitchell, 2007; Howe, 2009; Hugo, 2007; 2009b; Negin et al., 2016), the research undertaken specifically on African aged care workers remains scarce. To date, the experiences of these workers have been analysed in conjunction with those of other migrant groups and ethnic minorities (Adebayo, Nichols, Albrecht, et al., 2020; Adebayo, Nichols, Heslop, et al., 2020; Gillham et al., 2018; Goel & Penman, 2015; Nichols et al., 2015; Willis et al., 2018).

Prior to this research thesis, no study had been carried out that focused specifically on African migrant aged care workers in Australia, nor on African migrant *women* in this context. I identified this as an important research gap to fill, given that migrant workers have recently been posited by policy documents and the literature as an important group in the aged care workforce in this nation, and there has been a rapid growth of African migrants working in this sector (Australian Government, 2016; Negin et al., 2016; Willis et al., 2018). For governments and institutions to take seriously the presence and value of this group of workers in aged care, they need to pay greater attention to the specific circumstances and experiences African migrant women bring to the sector. As this study has indicated, African migrant carers' experiences in the aged care workforce are marked by multiple dimensions and perpetrations of racism. I suggest then, that 'solving' the 'problem' of the aged care workforce requires solving – or at least as a first step, directly acknowledging – the problem of racism in that workforce.

My findings make clear that racism is a widespread element of African migrant workers' experiences in aged care, albeit one that tends to be easily ignored or mis-recognised in policy or management processes. As an analytical tool, the theory of micro-aggressions is valuable in identifying less obvious expressions of racism. The participants' accounts in this study indicated that outright forms of racism are rarely perpetrated by co-workers, and that institutional racism, by its nature, does not explicitly target particular groups. Thus, there is the risk that the extent of racism perpetrated against African migrant aged care workers can be underestimated if the focus of research lies on more obviously racist statements or practices. Micro-insults from co-workers in nursing homes were expressed as not wanting to work with or converse with African migrant carers, displaying negative attitudes towards them, not recognising the carers' skills and training, and defining their English as problematic. Managers, too, were not explicit in their racism towards the migrant carers, but perpetrated it through an array of micro-insults. These included: being rude and insensitive to their needs; not consulting with the carers in managing

conflict between them and their co-workers in nursing homes; not engaging them in social events; failing to recognise their ideas and contributions and; ultimately, failing to help carers feel a sense of belonging as employees in their aged care institution.

Institutional racism also sensitises us to the existence of otherwise unacknowledged racism. African migrant carers experienced institutional racism during processes that were open to all aged care employees (for example, training and induction) – but the seeming neutrality of these processes was built on White perspectives and privileges that were at odds with the position and experiences of African migrant carers, thereby disadvantaging them in subtle ways. Micro-aggressions and institutional racism made carers feel out of place and like the 'Other'; as unwelcome and unable to care for and about clients, especially when working in nursing homes. Many of the behaviours and processes flagged by participants did not explicitly reference race, and might be 'explained away' or go unnoticed by those who are not subject to them. Hence researchers need to look out for the often-hidden and difficult-to-recognise expressions of racism, in ways that acknowledge the experiences and interpretations of individuals and/or groups who are subject to them – a central concern and strategy of microaggression theories (Embrick et al., 2017; Essed, 1991; Holder et al., 2015; Huber & Solorzano, 2015; Lewis et al., 2013; Solorzano et al., 2000; Sue, Capodilupo, Torino, et al., 2007; Sue, Nadal, et al., 2008; Wong et al., 2014) and of approaches to studying institutional racism (Berard, 2008; Came, 2012; 2014; Carmichael & Hamilton, 1967; Carmichael et al., 1992; Hobbs, 2018; Macpherson, 1999; Spangaro et al., 2016).

My analytical strategy also deepens existing approaches to analysing micro-aggressions. While the findings of this thesis project concur with those of previous studies in aged care (Doyle & Timonen, 2009; Goel & Penman, 2015; Nichols et al., 2015; Sethi & Williams, 2016; Shutes & Walsh, 2012; Timonen & Doyle, 2010; Walsh & Shutes, 2013) – and relatedly, nursing (Allan et al., 2009; Allan & Larsen, 2003; Likupe & Archibong, 2013; Mapedzahama et al., 2012; Mapedzahama et al., 2018; Omeri & Atkins, 2002; Showers, 2015) – those studies did not engage theoretical tools and frameworks to create a more robust explanation of the sources of racist micro-aggressions. As I noted in the theory chapter, there is a real need to extend theorising on interpersonal racism by locating it in the wider social and structural drivers (Embrick et al., 2017; Huber & Solorzano, 2015; Wong et al., 2014). This study makes a relevant theoretical contribution by utilising a theoretical triangulation to explain the sources of racism perpetrated against African migrant women. I applied micro-aggression theories to

capture and analyse racism in interpersonal interactions; institutional racism frameworks to account for racism embedded in workplace policies and practices; and theoretical approaches to critical race and Whiteness to contextualise racist expressions with regard to colonial and global discourses that position Black people as 'Others' with specific characteristics associated with Blackness. In this way, I have developed a multi-dimensional account of racism as experienced by African migrant women working in Australian aged care.

8.3 Recommendations

The findings of thesis project reinforce the calls of other researchers for greater recognition of the significant contributions of migrant workers to aged care (Adebayo, Nichols, Heslop, et al., 2020; Charlesworth & Isherwood, 2020; Fine & Mitchell, 2007; Howe, 2009; Hugo, 2007, 2009a; King et al., 2013; Mavromaras et al., 2017). Such recognition should act as a motivation for institutional management, industry practice and policy makers to think carefully about how to work towards more positive experiences for migrant workers in general, and African migrants, in the aged care sector. However, it is also important from a social justice perspective to create better work conditions and experiences for African migrants, a group that is already marginalised and subjected to racism in the broader Australian society (Adebayo, Nichols, Albrecht, et al., 2020; Goel & Penman, 2015; Mapedzahama et al., 2018; Mapedzahama et al., 2012; Nichols et al., 2015; Omeri & Atkins, 2002). The following recommendations focus on acknowledging, challenging and reducing racism in the workplace. However, as I have noted throughout this thesis, interpersonal and institutional racism are expressions of widespread historical and contemporary colonial discourses which will likely persist, untouched, regardless of any changes made to aged care workplace practices. A detailed discussion on how to dismantle these is beyond the scope of this thesis.

There has been a lot of focus by Australian policy makers on diversity management and developing the migrant workforce in order to meet the high client demand for aged care services, and provide quality care. In doing so, the needs of clients have been prioritised, and the involvement of migrant carers in the aged care workforce has been constructed as problematic by policy documents and framings (Australian Government, 2018; Commonwealth of Australia, 2017; Parliament Australia, 2016; Royal Commission into Aged Care Quality & Safety, 2018). The negative experiences of migrant carers' have

been widely interpreted in the literature as a consequence of their cultural background, perceived poor command of English, and a lack of knowledge or ignorance of the workplace culture (Gillham et al., 2018; Goel & Penman, 2015; King et al., 2013; Nichols et al., 2015; Willis et al., 2018; Xiao et al., 2018; Xiao, Willis, et al., 2017b; 2017c). This thesis study shows that there is a need to focus on how wider policy discourses and specific workplace approaches can recognise the skills, capacities, commitment and valuable contributions of migrant workers irrespective of – or perhaps, because of – the fact that they do not ‘fit’ with dominant understandings of who are ‘real’ carers. Accommodating, making welcome and celebrating migrant workers in aged care organisations would constitute a very different approach to the current common practices of marginalising and undermining the professional competence of migrant workers, which are evident across a range of care contexts, including nursing (Goel & Penman, 2015; Mapedzahama et al., 2012; Nichols et al., 2015; Omeri & Atkins, 2002). Therefore, while it is just as important to train and build the skills of migrant workers as it is to train and build the skills of *all* aged care workers, policies must be in place at the governmental and organisational level to rethink what it means to help migrant workers fit into the Australian workplace culture.

All the women I spoke to mentioned the existence of anti-discrimination policies at the institution in which they worked. However, the majority of them still experienced racism from clients, co-workers and supervisors/managers. It is simply not enough for the management of aged care organisations to state that they embrace cultural diversity and have anti-discriminatory policies in place. Earlier aged care studies have noted a gap between policy and workplace practices (Nichols et al., 2015; Shutes & Walsh, 2012). Prior aged care and nursing studies, together with the findings from my study, make it clear that even managers can perpetrate racism against migrant workers. As determined by this thesis study and previous research, this racism is sometimes explicit (Nichols et al., 2015; Sethi & Williams, 2016; Shutes & Walsh, 2012; Timonen & Doyle, 2010), and at other times covert (Likupe, 2015; Likupe & Archibong, 2013; Mapedzahama et al., 2018; Mapedzahama et al., 2012).

Racism at the institutional level is also embedded (Goel & Penman, 2015), including in policies that on their surface appear neutral or to potentially assist all workers. This form of racism, too, cannot simply be managed by creating more policy. Chen et al. (2020, p. 1164) argue that meaningfully addressing racism requires the development of “human rights-based workplace policies”. For aged care organisations, these policies must be

designed to ensure staff from minority ethnic groups are protected from all forms of discrimination and racism. I also add that management in aged care institutions should work towards recognising the contribution of migrant workers in concrete ways, proactively incorporating and welcoming them into – and then hopefully changing – the Whiteman culture. Management should encourage the participation of these workers, recognising the significant role they could play as anchors in social and professional events; and seek and prioritise their input on organisational processes and conditions. There is also the need for aged care institutions to protect staff from clients' and co-workers' racism, by recognising the existence and impact of racial micro-aggressions directed at migrant carers from colleagues and clients, and directly addressing these as breaches of anti-discrimination policies and workplace practice. This should encompass challenging client racism and ensuring that, in instances where clients reject the professional care of African migrants, moving the carers on to different clients is desired by and in the best interests of those workers, rather than simply compliance to clients' racism.

Research by Willis et al. (2018, p. 696) observed that aged care homes in Australia use education, staff support mechanisms, multicultural events and activities to ensure that clients "get to know and understand CALD workers as people". While this may be useful in reducing client racism, institutions also need to put in place effective measures to address the perpetrators of racism, and not just leave clients and ethnic minority workers to negotiate racism without other supports – a position that leaves workers feeling alone in their experiences (Mapedzahama et al., 2012; Nichols et al., 2015; Shutes & Walsh, 2012).

Following this, there is a need for Australian-born workers and migrant workers to work together, share ideas, be aware of the cultural beliefs, practices and cultural knowledge of migrant workers, and see how both migrant and local-born workers can utilise their knowledge in aged care homes in providing quality care to clients (Adebayo, Nichols, Albrecht, et al., 2020; Chen et al., 2020; Goel & Penman, 2015; Xiao et al., 2020; Xiao et al., 2018; Xiao et al., 2014). It is essential to realise, however, that 'working together', such as sharing shifts or care duties, does not guarantee non-racist or anti-racist working relationships. Management need to provide on-going training and education sessions for employees that directly challenge prejudice, bias, racism and discrimination of migrant workers; and that actively promote respecting the presence, rights and contributions of those migrant workers in aged care organisations (Chen et

al., 2020; Douglas et al., 2011).

The findings from this study illustrate the need for aged care organisations, while ensuring migrant workers meet organisational goals, to also consider the cultural backgrounds of these workers. As noted by previous studies (Adebayo, Nichols, Heslop, et al., 2020; Nichols et al., 2015; Willis et al., 2018), migrant workers may enter the workforce with no prior knowledge of what dementia is, and with a limited understanding of the logic and processes of institutional aged care. Therefore, the initial period of beginning work in aged care is a learning phase for them. Aged care studies in Australia have also noted gaps in migrant carers' language, literacy and computer skills (Gillham et al., 2018; King et al., 2013) and therefore the need for institutions to provide more support in these areas for carers (Allan et al., 2004; Gillham et al., 2018; Likupe & Archibong, 2013; Nichols et al., 2015). However, centring the voices and experiences of some of the African migrant workers I spoke with, it is also pertinent to note that sometimes clients and colleagues construct English language barriers as a way of expressing racism towards these women, and do not want to accommodate their accent or spoken English.

The women I interviewed also described struggles with the skills and human resources training they received. Therefore, I suggest that the delivery of training to workers must take cognisance of their cultural backgrounds. Training should be tailored towards the education and literacy needs of migrant workers, and aimed at assisting them in understanding the norms and culture of their workplace (Goel & Penman, 2015), in addition to assisting them to develop specific skills. Xiao et al. (2018; 2020) reiterate the need for Australian aged care organisations to also establish support structures for migrant workers, through holding education sessions and organising access to mentors and coaching for CALD staff.

Ethnic minority workers who participated in earlier studies also flagged the need for institutions to offer face-to-face training and mentoring from senior colleagues and nurses in aged care organisations (Goel & Penman, 2015). This is in addition to the regular buddy shifts that migrant workers are allocated to support them when they initially begin working in aged care. However, Adebayo, Nichols, Albrecht, et al. (2020) extend these suggestions by stating there is a need for management to validate and assess the relevance of this training for migrant workers. I note that doing this will help to ascertain migrant workers' satisfaction on the job; and to determine how useful and

usable such training is in the actual delivery of care in aged care organisations, with regard to the use of assistive technologies and caring for the complex needs of clients with dementia. Ultimately: institutions should review the effectiveness of such training with regard to its effectiveness in assisting migrant care workers to 'catch up' with their Australian-born colleagues to deliver quality care to clients in the Australian aged care space. This assessment should also capture the on-the-ground experience of buddy and mentoring processes, in light of my participants' descriptions of co-worker micro-insults that left them feeling unwelcome and unsupported in buddy training.

Lastly, changes to policy and practice should be based on a critical interrogation of whether and how colonialist discourses, White privilege, and their manifestation in micro-aggressions, institutional processes and other racist expressions, can be challenged and prevented. These changes should privilege and support the abilities of ethnic minority care workers to care for and care about clients, and position them as 'real' carers who are welcome in aged care; rather than as substandard or not 'real' carers. Policy makers and aged care practitioners should decentre the taken-for-granted privileging of 'Whiteness' and the construction of ethnic minority carers as 'ignorant' or 'unknowing', which label them as incompetent (Mapedzahama et al., 2018). They should ensure ethnic minority carers are not symbolically or materially disadvantaged for their difference. There is a need to take seriously how 'Othering', which my study suggests is a defining experience of African migrant carers in aged care, contributes to these workers' feelings of discomfort; of not fitting into the White aged care space. Further, there is a need to recognise that such discomfort is not simply an individual emotional reaction, but reflects a discriminatory denial of the professional identities of ethnic minority workers by their clients, clients' families, co-workers and institutions.

8.4 Further Research

As a small-scale and tightly focused qualitative study, the findings of this thesis raise additional questions, and point to many additional opportunities for research.

My analysis focused on the racial/ethnic dimensions of African migrant women's experiences of working in aged care. I have not in my analysis developed an intersectional analysis which might offer additional insights into discrimination in aged care. The intersection of gender and race would be particularly pertinent, given the gendered dimensions of care as a social practice and as an employment opportunity. Such an analysis might ask: do the experiences discussed in this thesis also reflect those

of African migrant men working in aged care; and how might gender, and the intersection of gender and race, shape the similarities and differences? Migrant positioning may also be important: how do different migrant or citizenship statuses, their employment requirements and the stability they offer, shape how African migrant workers respond to racism? Finally, my sample was largely homogenous in terms of participants' roles and the care work they fulfilled. There is further scope to explore how different roles (nurses, personal care workers etc) interact with race and gender to shape micro-aggressions, institutional racism and workers' responses.

My chosen method of conducting a point-in-time, qualitative study limited my ability to consider longitudinal changes in the African carers' experiences and the generalisability of the research findings. A longitudinal study, revisiting participants over time, would offer insights into how their understandings of, and responses to racism, develop – especially if such research could also capture workers who gain increasing seniority or authority in the workplace. Such a study would also allow useful analyses of patterns with regard to workplace turnover and workers leaving the industry, and development of new skills and confidence etc. A longitudinal study would be particularly powerful if developed as a quantitative study that drew on a larger, representative sample. This would allow for generalisability across the wider population of African migrant aged care workers in Australia. Alternatively, a study could be designed to systematically capture and compare the experiences of different ethnic minority workers in the Australian aged care sector.

It is also worth noting that this study was not designed to be an intervention into the systemic problems of the aged care sector. Therefore, this thesis does not develop nor test an exhaustive strategy to limit client or co-worker racism. While a significant amount of work has been done to advocate for cultural competence and sensitivity training for migrant workers, to assist these workers to catch up with their Australian colleagues in delivering quality care for clients (Adebayo, Nichols, Albrecht, et al., 2020; Adebayo, Nichols, Heslop, et al., 2020; Davis & Smith, 2009, 2013; Khatutsky et al., 2010; Nichols et al., 2015; Renzaho et al., 2013; Willis et al., 2018; Xiao, De Bellis, et al., 2017; Xiao et al., 2020; Xiao et al., 2018), more policy and practice-focused resources need to be designed that centre a critical race approach to understanding how training and institutional processes can reinforce unequal racial positioning. I suggest that such research might also critically engage with the existence of less obvious forms of racism, especially micro-insults and institutional racism, in aged care, and consider

strategies that render such racism evident and a priority to those (managers and colleagues) who are in a position to change it.

8.5 Concluding Statement

This thesis offers important insights about racism and aged care. In this research, I strived to convey African migrant carers' voices authentically, as well as to present my own understanding of their experiences. However, I will conclude this thesis by stressing that studies like this one must be viewed as a starting point. It is vital that future academic and policy research provide adequate space – and give adequate attention to – the issues of race, migration and discrimination raised in this thesis with regard to care work. Indeed, given the sector's reliance on a multicultural and diverse workforce, further studies of this kind will ensure that diversity does not become 'tacked onto' institutional policies as a tick-box exercise. Significantly and connectedly, Australia's national commitment to provide quality aged care services will depend on workplace cultures and practices that support and validate all workers, thereby facilitating the ability of those workers to care for and about clients in sustaining and sustainable ways.

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APPENDICES

Appendix 1. Socio-economic Characteristics of Participants

Table 2

Participant	Length of time in Australia	Migrant status	Age range	Position	Aged care site
Abi	10–15 years	Citizen	45–50 years	Permanent	Residential care
Lisa	1–5 years	Temporary permanent resident	30–35 years	Casual	Residential care
Ola	5–10 years	Skilled migration visa	30–35 years	Permanent part-time	Residential care
Venus	5–10 years	Temporary resident	25–30 years	Permanent	Residential care
Cassy	10–15 years	Citizen	20–25 years	Casual	Residential care
Bekes	5–10 years	Citizen	40–45 years	Casual	Residential care
May	1-5 years	Temporary resident	30–35 years	Casual agency staff	Residential care
Pauline	5–10 years	Temporary resident	Did not disclose	Casual	Residential care

Jumia	5-10 years	Citizen	45-50 years	Casual	Home care
Cecilia	1-5 years	Temporary resident	30-35 years	Casual agency staff	Residential care and home care
Ella	1-5 years	Temporary resident	30-35 years	Permanent	Residential care
Belinda	1-5 years	Temporary resident	30-35 years	Casual agency staff	Residential care
Shade	5-10 years	Temporary resident	35-40 years	Casual	Residential care
Leila	1-5 years	Temporary resident	25-30 years	Casual	Residential care
Funmi	5-10 years	Permanent resident	35-40 years	Contract	Home care
Priscilia	1-5 years	Temporary resident	30-35 years	Casual	Residential care
Tori	1-5 years	Temporary resident	30-35 years	Casual agency	Residential care and home care
Esther	1-5 years	Skilled migration visa	30-35	Casual	Residential care
Eddy	1-5 years	Temporary resident	30-35 years	Casual	Residential care
Muna	1-5 years	Temporary	20-25	Casual and	Residential

		resident	years	permanent	care
Samantha	1-5 years	Temporary resident	30-35 years	Casual agency staff	Residential care and home care
Tracey	1-5 years	Temporary resident	25-30 years	Casual	Residential care
Hannah	1-5 years	Temporary resident	40-45 years	Casual	Residential care
Sheni	1-5 years	Temporary resident	30-35 years	Casual	Residential care
Rachael	1-5 years	Temporary resident	30-35 years	Casual	Residential care and home care
Nanna	1-5 years	Temporary resident	25-30 years	Casual	Home care
Nike	1-5 years	Temporary resident	20-25 years	Permanent part-time	Residential care and Home care
Jenny	1-5 years	Temporary resident	25-30 years	Casual agency staff	Residential care
Anita	1-5 years	Temporary resident	35-40 years	Casual	Residential care
Nelly	1-5 years	Temporary resident	60-65 years	Casual	Residential care