



RESETTING NORMAL:

WOMEN, DECENT WORK AND CANADA'S FRACTURED CARE ECONOMY



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Resetting Normal is a series of reports on gender equality and the COVID-19 pandemic in Canada. They explore risks to human rights exposed by the pandemic and propose new ways to build a gender-equal Canada in pandemic recovery efforts.

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INTRODUCTION

Women in Canada have been disproportionately impacted by the COVID-19 pandemic to an extent that threatens to roll back equality gains. Economic losses have fallen heavily on women and most dramatically on women living on low incomes who experience intersecting inequalities based on race, class, disability, education, and migration and immigration status. The pandemic crisis has highlighted the fragility of response systems and the urgent need for structural rethinking and systemic change.

Gender stereotypes position women as natural caregivers with an in-born ability to perform care work, and care work parallels traditional gender roles. In turn, care work is designated as women's work in the public sphere.ⁱ Intersecting with gender stereotypes, racist stereotypes and immigration policies serving Canada's "care deficit"ⁱⁱ position immigrant, Black, undocumented, and low-income women as best suited to perform care work. It is these women who are at the frontlines of the COVID-19 pandemic.¹

Care work and other women-majority occupations and industries are essential to containing the pandemic, reducing its impacts, and ensuring that essential services continue to function. These include direct care services such as childcare, long-term care, and gender-based violence services as well as cashiering and cleaning jobs. This is a global phenomenon: in 104 countries, women are at the frontline of pandemic care, comprising 70% of health and social care workers and earning 11% less than men.²

The COVID-19 pandemic has spawned national recognition that care work is essential, underpinning our daily lives and the economy. That recognition has brought the fractures in Canada's care infrastructure—which marginalized women bear the brunt of—to the forefront. As we enter the recovery planning phase, there is an opportunity to leverage this national recognition to gain and sustain decent work for care workers and high-quality care for communities. We can not only forestall loss of equality gains, we can reduce social and economic barriers and advance inclusion, gender equity, and gender equality.

The societal fault lines heightened by the pandemic slice differently through the daily lives of diverse and marginalized communities of women. Resetting normal requires effective recovery plans that centre those experiences with effective intersectional policy analysis.³ Failure to prioritize decent work for women in Canada's fractured care economy will extend and exacerbate the gendered impact of the pandemic for women doing care work and women who are prevented from rejoining the economy due to lack of access to the care services needed for their economic participation. Women's economic well-being must be prioritized in recovery plans. A post-pandemic economy and post-pandemic workplaces shaped without women's participation can only deepen structural barriers to equality.

i Another term used to describe this phenomenon is feminized labour.

ii "Care deficit" and "care gap" refer to Canada's longstanding labour shortage in home-based care, which has been addressed for decades through labour migration programs that import racialized women from the Global South. The "care gap" has been constructed through a combination of excluding these workers from basic employment standards, occupational health and safety, and collective bargaining rights, and immigration laws that tie them to individual employers putting them at high risk of exploitation.

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With the spread of COVID-19 levelling off in most of the country, debate has intensified about the optimal strategies for opening up the economy. Many provinces have moved or are now moving to expand the list of businesses allowed to operate taking new physical distancing guidelines into account.⁴

Garden centres, retail shops, car dealerships, selected manufacturing and construction and financial and insurance services are open again in much of the country, but many women won't have the option to return to work without the full re-opening of childcare centres and schools. This reality reveals, once again, how highly gendered the pandemic experience is. Issues of paid and unpaid care and the profound economic disparities that characterize our economy lie at the heart of the pandemic experience and the emerging response.

Women are at the forefront of the crisis

Women are at the forefront of the crisis in their work as primary caregivers and care workers in the public and private sectors. Not only are women more likely to contract the virus given their roles as caregivers, frontline healthcare workers, and those living in long-term care homes, they also have the least say in the policy response. Research shows that time and again, women's needs go unmet, even as actions exacerbate existing gender, social, and economic fault lines.

Over half of all female workers (56%)⁵ are employed in occupations involving the "5 Cs": caring, clerical, catering, cashiering, and cleaning. As noted, these are precisely the types of jobs that are directly involved in containing the pandemic and providing needed care and support—jobs that have been undervalued historically and systematically offloaded to women, particularly immigrant and racialized women.

Our primary care and long-term care systems are staffed largely by women.⁶ Over 90% of nurses are women, as are 75% of respiratory therapists and 80% of those working in medical labs. Up to 90% of the Personal Support Workers (PSWs), who do the lion's share of work in long-term care homes and home care work in the community, are women.

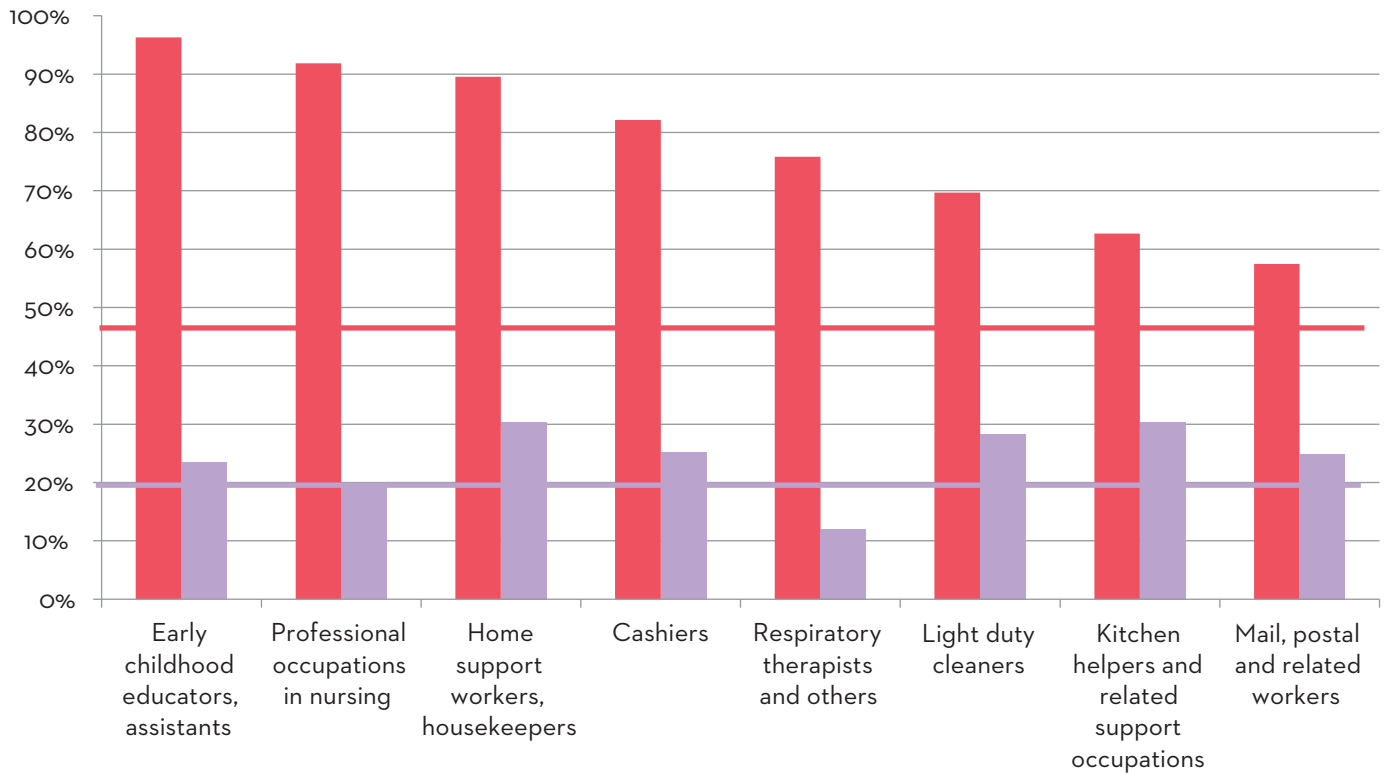
Over two-thirds of the people who clean and disinfect our hospitals, schools, and office buildings are women, undertaking work that is labelled "low skilled" yet is indispensable to our collective well-being.

Other women make up the majority of workers in sectors like accommodation and food; community, housing, and educational services; childcare; business administration; and retail trade⁷—a significant number in low-wage, precarious positions serving more affluent classes.⁸ All of these sectors have been hard hit by layoffs.

Many of the women working in these sectors are racialized, immigrant, migrant, and/or undocumented. They are concentrated in the lowest paying and most precarious of caring jobs—jobs that carry a high risk of exposure to coronavirus infection and are less likely to offer important protections such as paid sickness leave or health benefits.⁹ Only 21% of women workers in Canada are racialized women, yet they make up roughly 30% of home support workers and housekeepers, kitchen workers, and light duty cleaners.¹⁰ This is also true for Indigenous women who make up 4% of women workers and are over-represented in several low-wage service occupations.¹¹

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Women's and racialized women's share of the work force in caring occupations at frontlines of COVID-19



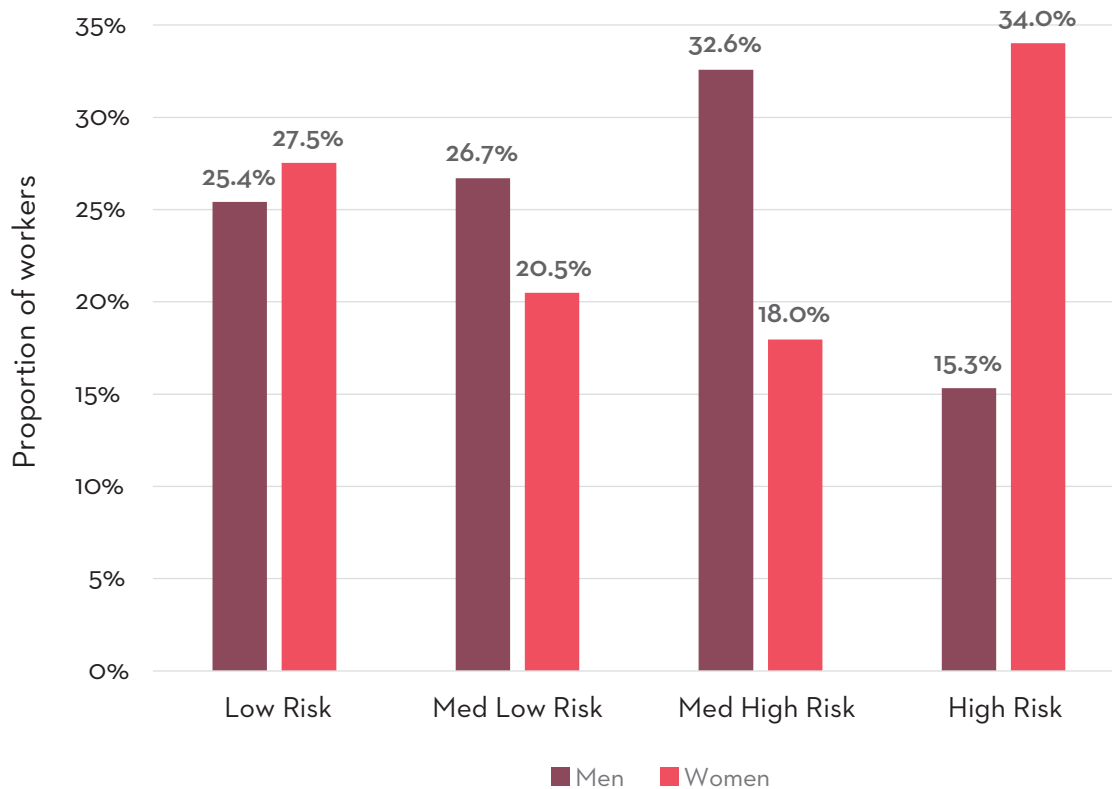
Share of total employment: **Women = 48%**
Racialized women = 21%

Source: Statistics Canada - 2016 Census. Catalogue number 98-400-X2016356.

Those at greatest risk are also those who earn the least. Fully one-third of all women workers (34%) work in “high risk” jobs—more than twice the rate of men (at 15%). The large majority are employed as PSWs, home childcare providers, cashiers, and retail workers. In February 2020, 43% of workers making \$14 per hour or less were in occupations at high risk of exposure to infection, compared to only 11% of workers in the top 10% making over \$48 per hour. These low-wage workers are also more likely to be women.

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Who can't physical distance at work?
Workers grouped by level of physical proximity in their work,
February 2020



Source: Statcan PUMF February, March 2020; O*NET and CCPA calculations

As restrictions lift, 1.2 million women in “high risk occupations”¹² - previously protected by government-enforced layoff - will face choosing between risk to their health and their income.

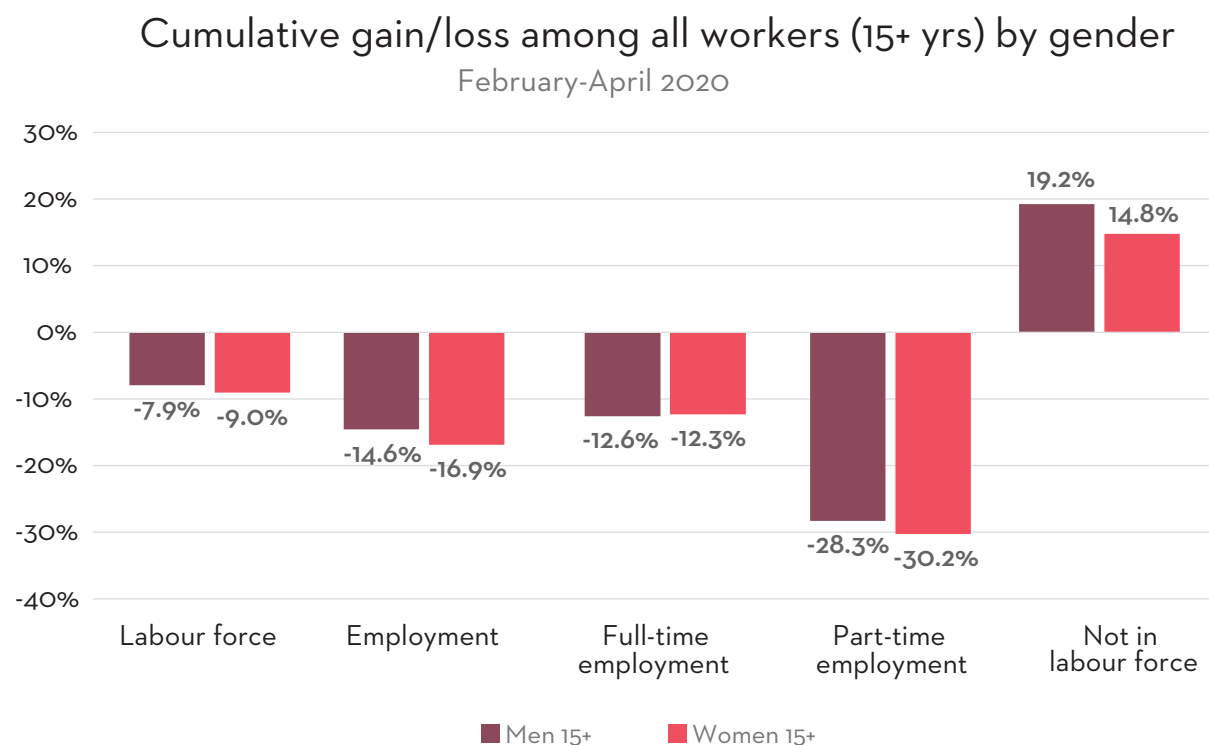
More women (54.3%) than men (45.7%) have died from the virus in Canada, even though more men than women have been hospitalized and admitted to the ICU.¹³ Currently, COVID-19 data on cases and deaths is disaggregated by sex, age, and geography, with some Public Health Units agreeing to collect race-based data. What is missing is data disaggregated by occupation. Such information can better highlight the health impacts on women working on the frontlines of the pandemic.

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The scale of women's job losses is enormous

The social distancing and lockdowns associated with the COVID-19 crisis have hit the women-majority service sector hard. Sectors whose activities involve social contact, such as retail, hospitality, childcare, and personal services, were the first to shut down.

In total, Canada's employment dropped by more than 1 million between late February and March, with women accounting for 63% of all losses.¹⁴ Among workers aged 25 to 54, women represented 70% of all job losses or 300,000 lost jobs. This is more than twice the decrease experienced by men the same age. Nearly half of these jobs - 144,000 - were held by women working part-time, many in low-paid service and care work and already living on the financial edge before the pandemic.



Source: Statistics Canada, Table 14-10-0287-01 Labour force characteristics, monthly, seasonally adjusted

April's employment numbers broke March's record losses with a decline of nearly 2 million jobs. All told, more than 3 million Canadians who had a job in February no longer had one in April,¹⁵ and another 2.5 million lost at least half of their hours, an unprecedented rise in economic hardship in such a short period of time.¹⁶ Effectively, all jobs created since October 2005, 15 years ago, were lost after a month of the necessary shutdown of much of Canada's economy, and many more workers lost the bulk of their hours.

As construction sites and manufacturing plants shut down in April, there was a sharp increase in men's unemployment, narrowing the gap with women. At month's end, 32% of women workers had lost their jobs or at least 50% of their employment hours, as had 29% of men.

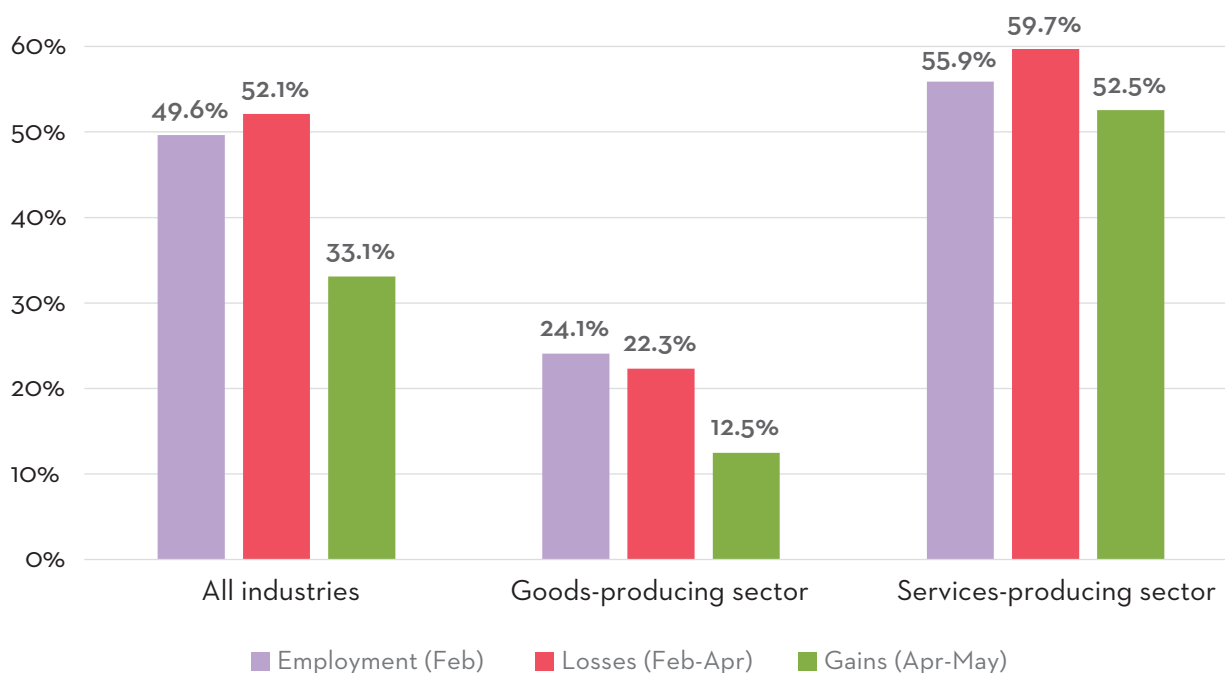
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May employment figures signal the start of a recovery - for men

The May jobs report hinted at a coming recovery in employment but, as feared, job creation among women lagged men by more than two to one. Women accounted for only 29% of the recovery in COVID-19-related job losses and absences posted in May.

The boost in women's employment—+1.1% or 84,000 jobs—was modest, to say the least. Taking these gains into account, cumulative job losses among women now stand at 1.5 million, and another 1.2 million women have lost the majority of their work hours. These losses are felt by more than one-quarter of all women workers (28%) in industrial sectors across the economy. Even in industries where women had lost a larger and disproportionate share of jobs, their share of employment gains was considerably lower.

Women's share of employment in February and employment losses / gains, by industrial sector
February-May 2020



Source: Statistics Canada, Table 14-10-0071-01 Job permanency by industry, monthly, unadjusted for seasonality

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Mothers experiencing disproportionate job loss

The May Jobs Report¹⁷ confirms again that mothers are bearing a disproportionate share of employment losses compared to fathers. Altogether, more than 900,000 parents have lost their jobs or more than 50% of their hours since February, with mothers accounting for well over half (56.7%) of these losses and only 40.7% of May's employment gains.

Tracking where and how the economy starts to open up—and the quality of employment on offer—will be essential to identifying barriers to women's employment and responding effectively to the challenges facing different groups, including those related to the unequal division of caring labour. The overall gender employment gap has already begun to widen. With the uptick in men's employment in May, it has now increased by 3.5 percentage points since February to 84.7%. Without decisive action, this key metric of gender equality signals significant economic stress ahead.

The most vulnerable have been hit the hardest

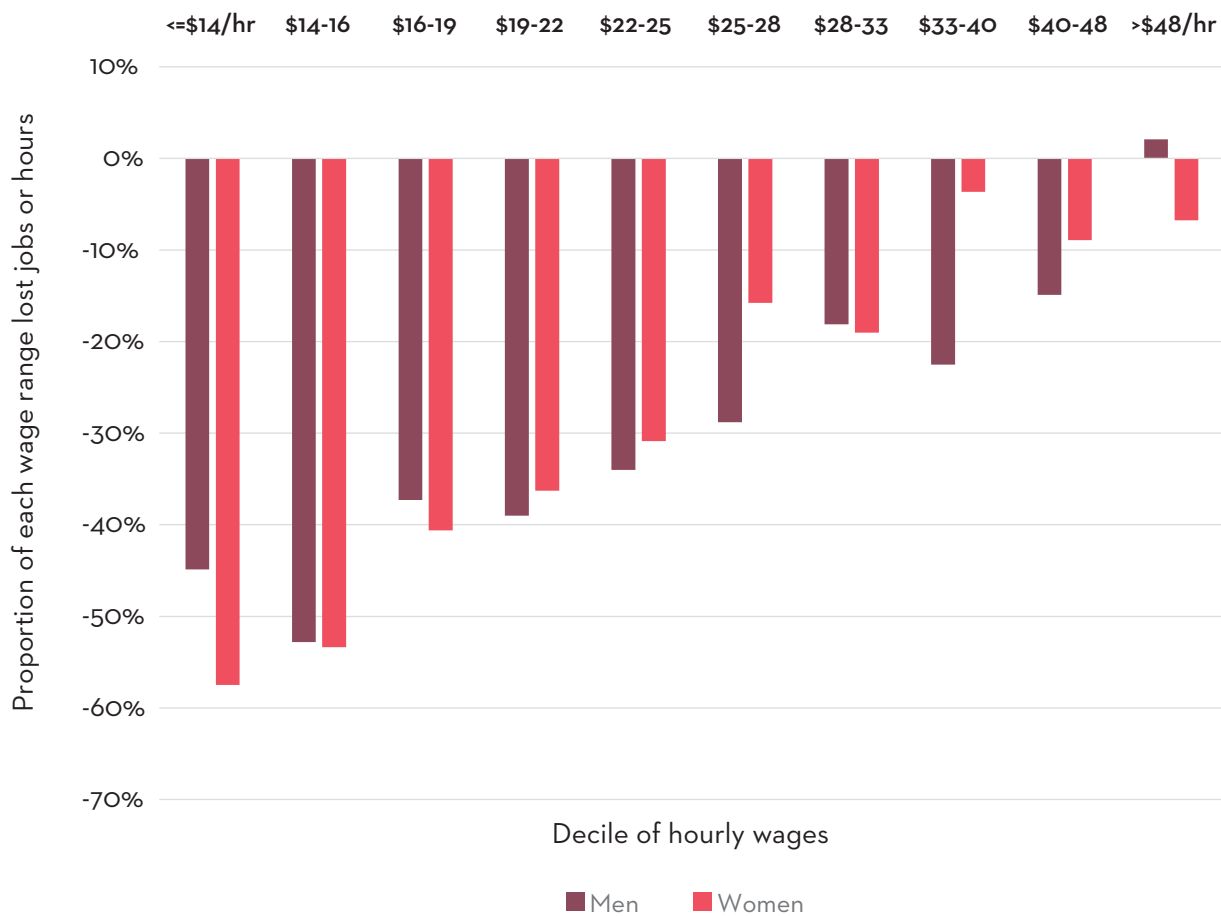
The impact of the pandemic lockdown has not been felt equally by all Canadian workers. Employment losses have been largest among those employed in precarious jobs¹⁸—the majority of whom are women¹⁹—and those in the lowest hourly wage bracket. Since February, job losses among temporary workers was -30.2%, almost double the average loss of -15.7%. Almost four out of 10 employees earning less than two-thirds of the 2019 median hourly wage lost work (38.1%), as did one in four of those who are paid by the hour (25.1%).

The lowest earning group is overwhelmingly women and highly racialized—Black, Indigenous, and women of colour—and the breakdown of job losses by hourly wage is hugely disparate. Almost six in 10 women (58%) earning \$14 per hour or less (the lowest 10% of earners), were laid off or lost the majority of their hours between February and April, as did 45% of men in the same earnings bracket. For those in the highest bracket, earning more than \$48 an hour, only 1% of jobs were lost or hours cut. The respective figures for women and men in the top 10% of workers were 7% job loss for women and a 2% increase in employment for men.²⁰

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Jobs or majority of hours lost by wage

February to April 2020



Source: February and April 2020 Labour Force Survey PUMF, excludes self employed.

Employment losses were particularly high among newcomers to Canada (those who have immigrated over the past decade). Almost half of recent immigrant women (-43.2%) who were employed in February lost their jobs or the majority of their hours by the end of April, 13 percentage points above the losses posted by Canadian-born women (-32.3%). In total, recent immigrants accounted for roughly one-tenth (10.5%) of all employment losses experienced by female workers over this period.

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Women are leaving the labour market and increasing care responsibilities at home

These are stark figures. Yet, the unemployment figures don't include those who have left the labour market altogether and are now at home caring for children or those who are ill, with no prospect of immediate return. There was a significant increase in the number of women "not in the labour market" between February and April. Among women aged 25-54, the number outside of the labour market increased by 424,500 or 34.1%. This includes those who didn't look for work because of the dire state of local labour markets as well as those who took up caring responsibilities. It is a number that bears watching.

Many of the women leaving the labour force are involved in childcare and home schooling, and others are caring for relatives who are ill. In all, we are seeing a considerable increase in hours of unpaid labour, notably among women, as new research from Oxfam Canada reveals.²¹ The burden is significant, especially for women living in poverty and those from marginalized communities. The strain is taking a considerable toll: 40% of women report feelings of stress, anxiety, and depression and 35% feel isolated or lonely. These impacts are most acute for essential workers and racialized women.²²

Loss of work, lack of childcare threaten women's economic security

The care crisis is particularly acute for the 2.25 million mothers of children under the age of 12 who were employed in February. Of this group, more than one-quarter—that's 615,000 mothers—had lost their jobs or more than 50% of their hours by April.

In the same group, single-parent mothers were more likely than mothers in two-parent families to have experienced job loss or reduced hours between February and April: -37.6% vs -25.7%. In April, 202,000 single mothers were in the paid labour market, juggling the demands of 24/7 childcare with little, if any, support. Another 122,000 were wondering if and how they could go back to work with the majority of childcare centres and schools still closed until the fall and little in the way of summer programs.²³

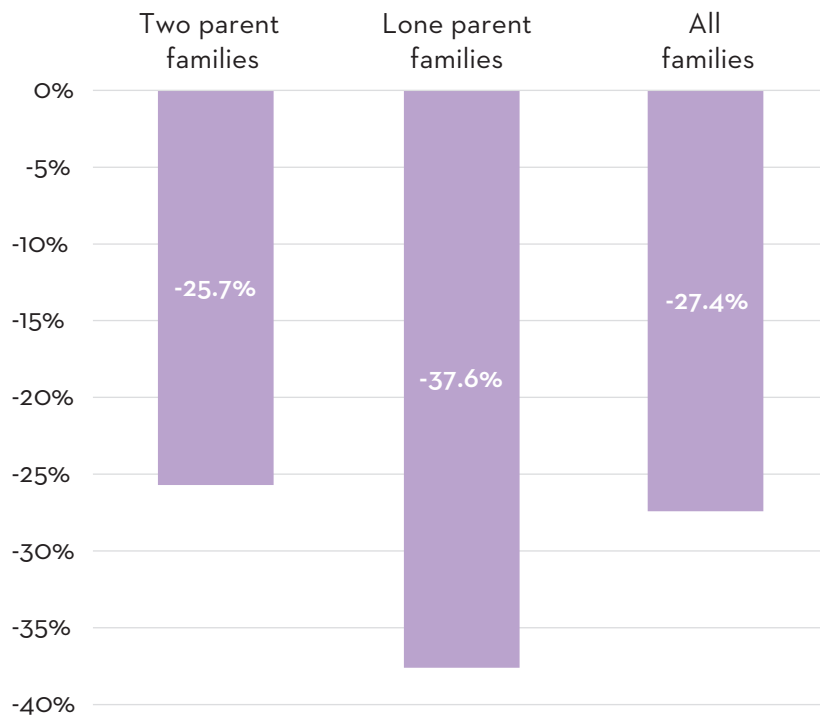
As businesses and workplaces reopen, will women who have been laid off be able to go back to work or increase their hours of employment? Will they feel comfortable sending their children back to childcare or to school? Will their local childcare centre even be open? In a recent survey of childcare centres,²⁴ only 64% indicated that they would "definitely" be reopening. The remaining 36% were either considering reopening or had definitely decided to close. Childcare providers will offer fewer spots²⁵ due to physical distancing measures, increasing already high costs for this vital service, often referred to as a ramp to women's equality.²⁶

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Scaling back paid work will significantly impact women's economic security. Decades of research²⁷ on the "motherhood penalty" shows that gaps in women's participation in paid work compounds the gender wage gap over their lifetimes. This is especially true for women from marginalized communities who face the highest barriers to employment and who are over-represented in low wage, precarious work, as noted. Without specific supports and accommodations, they can also be expected to have the greatest difficulty accessing jobs in the economic recovery.

Jobs or majority of hours lost among mothers with children <12 years by family type

February - April 2020



Source: February and April 2020 Labour Force Survey PUMF, excludes self employed.

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Will there be jobs to return to?

The economic security of many is hanging by a thread. The impact on household incomes and levels of poverty will be significant given the scale of economic losses among the lowest paid workers. There have already been increases in the number of single-earner and no-earner families,²⁸ including a 54% rise in the number of single parent families without employment (+126,000) between February and April. These are families on the brink, facing increased debt and higher levels of stress and related ill health.

In past recessions, women flooded into service sector jobs to stabilize family incomes devastated by losses in typically male-dominated goods-producing industries. With the shutdown of broad swaths of the service sector, this strategy isn't an option.

For a considerable number of women, the question may be, will there even be jobs to return to? Many businesses and nonprofits may be unable to weather this economic storm; others may take years to effectively adapt to the post-COVID world. Without accessible and affordable childcare on offer—and other health and housing supports—will women even have the choice?

An opportunity to tackle gender bias in economic public policy

This historic downturn is shaping up to be a disaster for women's economic security.²⁹ Those facing intersecting forms of systemic discrimination will suffer the largest and most profound losses and have the greatest difficulty emerging from the crisis. That describes many women – racialized and Black women, First Nation, Métis and Inuit women, migrant and undocumented women, women with disabilities and Deaf women - as well as many trans, Two-Spirit, and non-binary people.

Recovery planning provides an opportunity to tackle head on the gender bias in economic thinking and public policy that has neglected the value of social infrastructure, such as childcare and long-term care, and promoted austerity and deregulation as appropriate responses to the challenge of facilitating shared and sustainable prosperity. Transformative policies that support both paid and unpaid caring labour will be crucial to stopping the erosion of women's economic and social rights.

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Large numbers of precarious, low-wage, women workers, whose positions, up until recently, have had little public attention, are bearing the brunt of the economic crisis. Many women are working in care occupations. The disparities that characterize the economy and the gaps in our social safety net are glaringly apparent for all to see. The pandemic is both highlighting how important care work is to our health and well-being, including pandemic control, and exposing the low social value attached to care and women's work. The most poorly paid workers form the first line of defense against catastrophic illness and economic depression. Two decades of austerity measures in health care and community services have left Canada ill prepared to respond to the growing care deficit.

Defining care work

Care work is broadly defined by the International Labour Organization (ILO) as consisting of activities and relations involved in meeting the physical, psychological, and emotional needs of adults and children, old and young, frail and able-bodied.³⁰ Care work can be either paid or unpaid and can take place in public, private, and institutional settings. Feminist economists remind us that care work is the substance of what is involved in reproducing and maintaining our population on a daily and generational basis³¹ and is critical for the functioning of our economy and society. Care work in Canada covers a broad range of activities that take place across a range of settings, all of which have a profound impact on gender equality within families and households as well as on the ability of women—and parents of all genders—to engage in paid employment.

On one end of the spectrum are direct, face-to-face, caring or nurturing activities, such as looking after children or caring for the elderly, sick, or those with physical and mental disabilities and illnesses. At the other end of the spectrum are indirect caring or domestic labour activities that create the preconditions for reproducing and maintaining people and households, such as the provision of food, clothing, shelter, basic safety, and health care in addition to household maintenance and cleaning.

In the middle of the spectrum are other activities, both direct and indirect, that ensure the development and transmission of knowledge, social values, and cultural practices and the labour—including emotional labour—involved in sustaining relationships within families and among friends, colleagues, neighbours and the larger community. These connections are essential to individual and community well-being.³²

Who is responsible for direct care?

Care labour is essential in every society, but the ways in which these tasks and activities are organized can vary tremendously and change over time, reflecting differences in cultures as well as deep-seated ideas about gender, race, class, immigration, and the division of labour. In Canada, the state, market, community, and households are all involved in delivering care in some shape or form, making up Canada's formal and informal care economy.

For the purposes of this discussion, the state refers to federal, provincial, and municipal governments and school boards, all publicly owned and operated and democratically governed. Community refers to nonprofits and charities for public benefit, driven by a community purpose, consisting of members and supporters rather than shareholders, governed by an elected board of directors,

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and reinvesting revenue in services. For-profit or private market businesses are entities incorporated with the purpose of generating a profit for owners or shareholders through the provision of services and frequently sold to extract investment and profit. Further examination reveals a complex set of relationships in which the role of women is central.

Families have always played the central role in caring work, and within this context, women and girls have tended to shoulder a disproportionate share of this, often invisible, work. Even today, with very high rates of women participating in the workforce, on average, women spend 1.6 times the amount of time on unpaid work per day that men do: 3.9 hours vs 2.4 hours per day.^{iii,33} That's more than 28.6 million hours of unpaid labour every day, or the equivalent of 3.6 million people working 8 hours per day.^{iv}

Rise and fall of the post-war welfare state

Responsibility for care work has shifted over time. With the rise of the welfare state through the 20th century, governments took on a new set of responsibilities to help mitigate the risks and insecurities associated with market economies—such as unemployment, accidents, illness, and old age—and to reduce related inequalities through the provision of common public goods such as universal health care, public education, and other supports for care work. Access to care as a right of citizenship was particularly important for women, facilitating their economic independence through greater labour market participation and helping to address care needs among families with young children or relatives with disabilities.

The goal of social reformers in post-war Canada was to create a “safety net” for those who could not—for reasons deemed “acceptable”—generate the means to care for themselves. Individual families, headed by gainfully employed fathers, were expected to make their own way and ensure the welfare of their individual members by relying on “home-maker” mothers, drawing on available community supports and services if and when needed. The public and private domains were understood as clearly distinct. Yet, even during the economically buoyant post-war period, many Canadians fell through the social safety net.

iii The gap is even greater if we take unpaid work completed in conjunction with other tasks into account.

iv An OECD study estimates that the value of all unpaid work (undertaken by both women and men) is between 11.5% to 41.1% of GDP, depending on the method used to calculate the cost of labour (OECD, 2018).

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The expansion of public services was important for women in many ways, providing critical caring supports and serving as a source of good employment at a time when women were largely concentrated in low-level clerical and administrative work. For women, the public sector opened up better paying opportunities in professional and management occupations in largely unionized health, education, and social services—jobs that were characterized by lower levels of wage discrimination and access to key benefits such as paid parental leave, family leave, sick leave, and health benefits.³⁴

The era of rapid policy innovation and institution-building peaked in the mid-1970s. More recent decades have seen a shift toward “free markets,” decreased state regulation, and lower taxes. Cuts to welfare state programming and caring services at all levels of government was a fundamental plank of a neoliberal agenda, even as women were entering the labour market in greater numbers, generating much needed income to support their families in an increasingly challenging economy. In Canada, spending reductions by the federal, provincial, and municipal levels of government were significant.^v

Over the past 25 years, from health care and education to community services and public transit, Canada’s social infrastructure has been scaled back. As governments withdrew or devolved responsibility for care work, its distribution across the state-market-community-family nexus shifted.

The growing presence of for-profit business in Canada’s care economy

Government withdrawal has opened the door to the for-profit sector and the adoption of private sector managerial practices that have had a profound impact on the organization of care services within both private and public sectors.³⁵ Privatization and for-profit chains have proliferated in care work, promising efficiency of scale and choice in the marketplace for consumers/clients, both of which appeal to cost-cutting governments seeking to abandon direct service delivery and to attract more capital to build out needed physical infrastructure (e.g. hospitals).³⁶

Privatization is focused in care sectors that are “investment friendly,” where the market can derive profits and pay dividends to shareholders such as in childcare, home care, and long-term care. Private investors are attractive to government, because private “investors, always on the lookout for lucrative stable investments, have been actively offering to rescue governments from their cash shortages. The private sector can and will put up the capital to build the hospitals, drug treatment clinics, and nursing homes. In many instances the private investor also operates the facility with operating funds from the government.”³⁷ This pattern occurs across the country in various ways. For instance, before the pandemic, for-profit care homes were under scrutiny in British Columbia for delivering lower quality care with government funds, while Ontario’s current government is in the process of opening the door for further privatization of employment and training services and autism services—both on the spectrum of care work—as well as expanding the for-profit presence in childcare.

v Between 1992 and 2002, total Canadian government spending fell by 10 percentage points of GDP, compared to 4 points of GDP in the United Kingdom and 2 points in Italy, the only other OECD countries where program spending fell significantly. (See Jackson, 2009.)

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For-profit corporations in the care sector are in the business of generating profits to distribute to shareholders, which they accomplish by providing lower quality care, understaffing, and providing fewer benefits and protections for workers. Decades of research shows that for-profit service delivery is associated with substandard care, with negative consequences for those receiving care and for the highly gendered and racialized workforce in caregiving roles.³⁸

Community services on a precarious footing

The community sector continues to play a critical role in Canada's care economy on precarious financial terms that expose individuals and families relying on these services to significant risks. The current crisis has amply demonstrated this as well as how women and families struggle with a patchwork of underfunded services.

Many nonprofits and charities are part of the care economy in some way, particularly those with missions to care for the well-being of individuals, families, and communities. While childcare, long-term care, and home care are often cited as examples, nonprofits provide a wide range of human services. The women's sector is largely made up of nonprofits and charities offering counselling and referrals, employment programs, gender-based violence services, public health and trauma support, childcare, and legal aid to women and their families. These essential supports were fragile before the pandemic and came under acute stress as the pandemic began due to rising demand and chronic underfunding. Women make up 80% of the labour force of nonprofits and charities and over 90% of the women's sector.

While nonprofits and charities provide essential caring services, they are funded through an inadequate model consisting of unpredictable individual donations and gifts, earned income, and government service and project contracts. As we argue in *Resetting Normal: Funding a thriving women's sector*, this model "is not only very time-consuming, requiring constant renewal and contact, but also inefficient as agreements only last for twelve months to perhaps three years. As a result, groups are constantly searching for, applying for, requesting, and renewing funding, most of which is project-based and temporary."³⁹

The pandemic has elevated the pressure on this key sector exponentially. Many have taken steps to change their models of delivery in order to maintain services. But as the Ontario Nonprofit Network's flash survey of nonprofits found, 83% of respondents are experiencing or anticipate a disruption of services to clients and communities.⁴⁰ In the women's sector, 82% of organizations fear they will have to close their doors.⁴¹

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Households are struggling to fill the gaps

As a consequence of these developments, households, and in particular the women within them, pick up the caring labour that is no longer provided publicly or is priced beyond reach in the private market.⁴² The state encourages and supports individual responsibility for care through the provision of very modest, gender-biased tax credits, compassionate care benefits under Employment Insurance for those who qualify, and unpaid family responsibility leave.⁴³ Supports for caregivers are a patchwork of policies and programs across the country.

This situation reflects the status attached to unpaid care work, the monetary value of which has been pegged conservatively at \$10.8 trillion annually—three times the value of the world's tech industry.⁴⁴

Higher-income households have considerably more resources to take up this increased share of care labour through the purchase of services in the private market, including PSWs and nannies to work in their homes, roles often filled by migrant care workers. Like many other private sector service jobs, these caring jobs are typically low-paid and precarious, offering poor working conditions with scant labour protections and oversight, and for migrant care workers, subject to fluctuating immigration programs that fail to centre their safety or rights.

Care work as gendered, racialized migrant labour

Care work in Canada is also fragmented along public/private lines as a result of entrenched reliance on highly skilled but low-paid migrant care workers. As noted, gendered and racist stereotypes alongside immigration policies underpin who performs care work. On the one hand, low-waged, low-valued, and precarious care work is systematically offloaded onto migrant women, while on the other hand, the feminization and racialization of care work triggers further declines in wages, job security, and the social value of care work. In turn, the formal skills, education, and training required to take on care work are undermined.⁴⁵

To help fill the care gap, wealthy countries of the Global North have turned to workers from countries in the Global South where wages are lower. In recent decades, there has been a significant increase in women migrating to fulfill caring roles as maids, nannies, or attendant care providers in host countries. Women in the Global South are encouraged to emigrate and generate much needed remittances to send to their families at home. Yet, women who migrate to provide essential caring labour are not afforded the right to care for their own families and/or a clear, secure path to permanent residency in Canada and family reunification.

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Evolution of migrant care worker programs

Canada has imported (primarily) racialized women from the Global South as care workers with temporary migration status since the 1955 Caribbean Domestic Scheme. Migrant care work was originally restricted to live-in workers providing care for children in private homes. As austerity programs deepened and the “care deficit grew”, the scope of care that migrant workers provided expanded to include in-home care for people who are elderly or have high medical needs. Since 2014, migrant labour programs have expanded further to encompass registered nurses, registered psychiatric nurses, licensed practical nurses, childcare workers, attendants for persons with disabilities, home support workers, live-in caregivers, and personal care attendants.⁴⁶ As the scope of care has widened, migrant workers have been hired to deliver care in private homes and also in health care facilities.

Even as the range of care work for migrant workers has expanded, their possibility of securing permanent residence has narrowed. Prior to 2014, all migrant care workers who completed the equivalent of two years of full-time in-home care work within four years were eligible for permanent residence. Since 2014, successive time-limited “pilot projects” have restricted permanent residence to a maximum of 2,750 migrant care workers per year in each of two categories.^{vi}

Whether they are working on work permits that tie them to a specific employer,^{vii} or trying to complete the necessary work period to qualify for permanent residence, the precarious, temporary status of migrant care workers in Canada makes them targets for rights violations and exploitation and prevents them from being able to effectively enforce their rights.

Migrant care workers and COVID-19

Since the beginning of the pandemic, migrant care workers have faced increased precariousness even as they deliver frontline care to high risk populations. While the pandemic has brought increased care and cleaning responsibilities, migrant care workers have been left out of discussions about, and actual access to, personal protective equipment, danger pay, and emergency relief.

Some migrant care workers were dismissed when their employers began to work from home or were themselves laid off. These women were left without income while still needing to pay off recruitment fees and loans they needed to expend to get jobs in Canada. Others have been trapped in the private homes where they have been working by employers who fear that care workers may transmit the virus if they leave the house and have refused to let them go out. In those situations, care workers have been in lockdown with their employers 24/7 since the pandemic began. Other migrant care workers have lost their status and become undocumented because of delays in renewing work permits or processing permanent residency applications.

vi From 2014-2019 up to 2,750 in-home workers providing childcare and up to 2,750 in-home workers providing care to people with high medical needs could apply for permanent residence each year. Beginning in 2019, up to 2,750 care workers who provide in-home childcare and up to 2,750 workers who provide home support care can apply for permanent residence each year.

vii Migrant care workers who have arrived in Canada since 2019 under the new Home Childcare Provider or Home Support Worker pilot programs receive occupation-restricted work permits rather than employer-restricted work permits.

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Migrant workers have also encountered barriers in accessing the Canada Emergency Relief Benefit (CERB). Migrant workers' social insurance numbers are time limited in connection with their work permits. Workers with an expired social insurance number and without an individual tax number have faced exclusion from the CERB. At the same time, being in receipt of social assistance will normally disqualify a person from receiving permanent residence. As a result, migrant care workers who have a two-step path to permanent residence have feared that accessing the CERB may jeopardize their immigration applications.

Outside of discussions centred specifically on migrant workers, these essential migrant care workers are virtually invisible in system-wide policy discussions about care in Canada. This has obscured the significant role that privatized care based on precarious and exploited labour plays in Canada's care economy. It has also prevented meaningful policy discussion of how to build a sustainable care economy that is anchored in decent work for all workers.

A fractured care sector

Decades of neglect have undermined Canada's caring economy and compromised the rights and well-being of its workforce, which is overwhelmingly women, many of whom are navigating discriminatory systems both in Canada and globally. The pandemic has surfaced the serious consequences of this neglect. A precarious childcare sector, essential to economic recovery, is unable to reopen fully. Deadly outbreaks in long-term care facilities have required military personnel to address understaffing. Chronically underfunded gender-based violence services struggle to meet increased demand. At the same time, women's disproportionate share of unpaid care work in the household remains one of the largest barriers to participation in labour markets and a significant obstacle to accessing higher quality jobs, better working conditions, and higher earnings.

The pandemic has highlighted care work as an economic and social necessity and a core pillar of the social contract. Moving beyond a fragmented approach of underfunding, privatization, and exploitation propped up by systemic discrimination should be a priority for recovery planning. Like the best of the pandemic emergency response from public health leaders, many of whom are women, recovery planning for care sectors requires thorough analysis, clear evidence-supported outcome targets, a methodical approach to implementation, and responsible leadership with vision and heart.

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Pandemic measures and the virus itself have made visible the intrinsic role of care in sustaining human life and containing disease, as well as our reliance on care work to keep working. In particular, the experience of the pandemic has drawn attention to three care sectors crucial to women, gender equity, gender equality, and ultimately, to recovery: childcare, long-term care, and gender-based violence services. The slogan “everyone relies on someone who relies on childcare” was never truer than the moment when provincial governments that had announced wholesale closures of childcare centres pivoted to re-open spaces for children of essential workers. The epiphany of that moment needs to illuminate the issue until we have affordable national childcare for all families. A closer read of long-term care in Canada during the pandemic is a journey through preventable tragedy to the limits of market economics. The fragility and resilience of the sector providing violence against women and gender-based violence services underscore the breadth of that pandemic and the urgent need for a sustained and prioritized response, including where that response intersects with systemic discrimination by police.

Childcare

Childcare enables parents to work, is a significant source of employment, and ensures children are learning ready, which has positive impacts on their long term well-being. Even given this essential role, Canada’s childcare system is fragmented with patchwork solutions across the country that do not reflect the value of this care work.

During the pandemic, the already precarious childcare system was largely shut down with the expectation that it would be able to re-open along with the broader economy. This has not been the case. Caught in the crossfire are women who primarily rely on childcare as a critical support enabling them to work and women who work in early learning and childcare—a women-majority labour force. In both ways, childcare is crucial to gender equality and women’s economic prosperity.

Canadian childcare landscape

In 2017, the federal government used a Multilateral Early Learning and Childcare Framework, based on principles of accessibility, affordability, quality, inclusivity, and flexibility, to develop bilateral childcare agreements with provinces and territories (with the exception of Quebec).⁴⁷ The provinces and territories then created action plans on the use of the federal transfer funds in their jurisdictions. These action plans included setting and monitoring regulations that establish legal, facility, program, and health and safety

requirements and direct funding for some families or services.⁴⁸ Ontario is the only province where municipal governments are also involved as both childcare providers and sources of funding.

As of June 2017, the current federal government committed to providing \$7.5 billion over 11 years to the provinces and territories earmarked for childcare.⁴⁹ Bilateral agreements set in 2017 expired on March 31, 2020.

Of that \$7.5 billion, \$1.7 billion is allocated to an Indigenous Early Learning and Child Care (ELCC) framework co-created by the federal

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government and Indigenous communities in 2018.⁵⁰ The Indigenous ELCC framework addresses the importance and value of culturally rooted early learning and childcare for First Nations, Inuit, and Métis children and consists of a shared vision, principles, and pathways for a comprehensive and coordinated Indigenous-led and developed ELCC system in Canada. The allocation is in addition to funding for existing federally funded Indigenous ELCC programs.

Outside of Quebec, childcare is primarily funded by parent fees. The federal government and other provinces contribute limited operational funding (e.g. base funding or grants and wage enhancements) to reduce parent fees.⁵¹ According to the Canadian Centre for Policy Alternatives, childcare fees in Canada remain unaffordable in most cities.

Overall, the majority of childcare services in Canada are delivered by for-profits or nonprofits (e.g. Indigenous-led childcare provided by friendship centres) and parent groups rather than by the government (e.g. municipalities or school boards).⁵² In 2016, 30% of licensed centre-based childcare spaces in Canada were provided by for-profit businesses. There are considerable differences in the proportions of for-profit childcare in individual provinces and territories. Provincial and territorial legislation determines who provides childcare—the market and/or the community—and how much public money providers can access. For instance, 62% to 72% of spaces in New Brunswick, Yukon, and Newfoundland and Labrador are for-profit, while only 2% are for-profit in Saskatchewan, where only nonprofits are eligible for public funding of any kind.⁵³

Childcare advocates and researchers caution that, over the past decade, for-profit childcare has been

expanding at a greater rate than nonprofit early learning and childcare services and programs, increasing from 20% in 2004 to 30% in 2016.⁵⁴ Growth is not occurring through a rise in “mom-and-pop shop” for-profit childcare centres, but through big-box chains, which now make up a substantial portion of for-profit childcare centres.⁵⁵

Decent work and a community model are critical for high quality childcare

In Canada, 97% of childcare workers are women, and this is also a highly racialized workforce though there is a lack of data on the specific percentage. Similarly, Indigenous-led early learning and childcare is a critical source of employment for Indigenous women.⁵⁶ For this reason, poor working conditions and lack of decent work persist. Childcare worker wages do not reflect the value of childcare work or the level of education and experience required. Childcare workers earn less than workers in other women-majority sectors and in male class jobs that require the same level of education and skills. Their incomes also fall below the average income in Canada.⁵⁷ Based on the most recent data available, in 2011 early childhood educators earned a median annual wage of \$25,334 while truck drivers (97% male workers) earned \$45,417.⁵⁸ Childcare workers’ responsibilities, workload, and levels of education and skills have increased over the years, but wages have not. Low wages, coupled with a lack of health benefits, paid vacation, sick days, pension contributions, and little to no professional development create a highly precarious sector for the women concentrated in childcare services.

Who owns and delivers childcare services impacts decent work for the childcare labour force, which is linked to quality of care. This includes wages, working conditions, training, staff turnover,

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staff morale, staff/child ratios, and group size.⁵⁹ Numerous studies and policy analyses highlight that a community-based nonprofit model delivers higher quality, more affordable, and more equitable childcare in comparison to a market model.⁶⁰ Workers in nonprofits are relatively better off compared to those employed by for-profits.

The Indigenous ELCC framework recognizes the need for decent work for childcare workers, noting that wage equity and stability directly impact the well-being of childcare workers and their families. First Nations, Inuit, and Métis peoples' individual goals and strategies in the framework include the importance of well-funded programs for supporting human resources and thus delivering high quality care. In particular, they mention valuing childcare work, instituting equitable compensation practices and benefits, and pathways to professional development.⁶¹

Pandemic closures exacerbate a precarious system

Responding to the COVID-19 pandemic, provincial and territorial emergency orders across Canada forced closures of almost three-quarters (72%) of the country's 8,700 childcare centres.⁶² Childcare was declared an essential service to make emergency childcare available to essential frontline workers. Cost and accessibility varied across jurisdictions.

Closures brought childcare centres into a precarious situation: budgets decreased with loss of revenue from parent fees. Most jurisdictions banned collecting parent fees if childcare spaces were not being used. A lack of clarity and communication on how to use provincial and territorial funding during this time became a challenge. Many providers had difficulties

accessing federal supports to bridge financial losses. According to a national childcare survey, 68% of centres reported that their financial situation was worse than before the pandemic, 54% of centres were receiving less government funding than before the pandemic, and a minority of centres were accessing federal supports.⁶³

With this mass shutdown, women workers in the childcare sector face further economic insecurity. Seventy-one percent of centres laid off staff during the pandemic and over 90% of those workers reported having applied for a federal benefit program, most often the CERB at 87%.⁶⁴ Childcare workers providing emergency care are also at a high risk of COVID-19 exposure, as they come into contact with children from households at the frontlines of the pandemic.

Childcare is essential social infrastructure

The pandemic has revealed that Canada's childcare system is fragile yet essential for the economy to function and eventually recover. Governments, businesses, and nonprofits and charities—especially those organizations with a women-majority work force—will need childcare in order to reopen and move toward 100% productivity. There's no reopening or recovery without women, and women need accessible, affordable, safe, and high-quality childcare to work. For more than two decades, Canadian research has shown the benefits of childcare for children, mothers, families, and the economy.⁶⁵

Childcare is particularly important for women who, because of systemic inequities, already have lower rates of labour force participation (e.g. Indigenous women and women with disabilities who experience higher unemployment rates compared to non-Indigenous women and women without

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disabilities).⁶⁶ Submissions to the Indigenous ELCC framework from Indigenous communities noted that improved economic security of women has a direct impact on Indigenous communities and supports better outcomes for their children.

For childcare to reopen and eventually thrive, not simply function, a distinction must be drawn between what is needed immediately and in the near future for reopening and what is needed for pandemic recovery in the long term. To reopen, the childcare sector needs direct, adequate funding to address increased costs and needs as well as support for its women-majority workforce. National advocacy groups are calling on the federal government to take leadership on childcare. They are asking that at least \$2.5 billion

be allocated to childcare for stabilization out of the \$14 billion in federal funds announced for provinces/territories and Indigenous communities to safely reopen.⁶⁷

Such an investment would set the stage for a universal childcare system that reflects the crucial and essential role of childcare in our society.

Significant investments in physical infrastructure and human capital, ending privatization models, and broader policy mechanisms are part of “phase 2” recommendations to the federal government.⁶⁸ A national childcare secretariat, already included in federal mandate letters, will ensure that the federal government uses the opportunity the pandemic has provided to create a universal childcare system.

Long-Term Care

Canada has the highest reported national share of COVID-19 deaths for long-term care residents in the world, with 85% of total COVID-19 deaths occurring in long-term care facilities.⁶⁹ Where the virus has taken hold, the fatality rate in long-term care homes is as high as 29%, four times the national rate of 7%. The majority of deaths have occurred among women,⁷⁰ perhaps due to the predominance of women in the oldest age brackets living in long-term care facilities.

Long-term care residents and their predominantly women caregivers are caught in a terrible situation that has been years in the making. The virus is moving through facilities in the same way that it has around the world, preying on vulnerabilities that are well known: a growing reliance on a subcontracted labour force whose members work multiple jobs to make ends meet, and conditions of employment—fewer workers, more part-time hours, high turnover, heavy workloads, increasing levels of violence, poor wages and benefits—that work against quality care and recruitment.

Canada’s deeply flawed long-term care system

Health care workers paint a picture of a system that was already struggling before COVID-19 hit, drained and strained by austerity measures over the past two decades.⁷¹ Canada has actually seen a decline in the number of beds and long-term care facilities,⁷² despite the steady increase in the population of seniors. Governments intent

on containing health care costs and improving efficiencies have turned to private sector delivery and for-profit managerial strategies that have ended up delivering lower quality care at greater expense,⁷³ while shifting more of the costs and labour involved to seniors and their families.

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The pandemic is now exposing the graphic weaknesses of our current system and significant disparities in levels of quality care, both between and within provinces.⁷⁴ The failure over the years to provide enough beds to meet the growing need means that the majority of those now in long-term care homes have been diagnosed with dementia as well as a host of chronic illnesses. At the same time, few long-term care homes have been built to accommodate people with heavy health care needs, while regulations allow older facilities to continue with multiple beds in a room, making physical distancing all but impossible.

Many long-term care homes of all types have contracted out food, laundry, and housekeeping services, bringing in outsiders on a daily basis and limiting managerial control over the quality of this work. Some long-term care homes that receive public funding have unionized staff, which provides some protection against job loss and some sick leave benefits. But this is rarely the case for contract care workers and those employed in contracted services who, in many instances, are treated as self-employed contractors, responsible for their own training and protective equipment. Migrant and undocumented care workers may be caught in these unregulated jobs.

Low staffing levels have long been identified as a critical problem in the sector. For example, although there are requirements to have one registered nurse on staff or on call, only a few jurisdictions set minimum staffing levels, and those that do set them well below the recommended four hours of direct care per resident per day—a figure that is itself out of date and should be increased given the high needs of residents today.

Precarious conditions in long term care

Care work in nursing homes is overwhelmingly carried out by women, most employed as what are variously termed PSWs or care aides, many of whom are racialized, Black, and migrant and/or undocumented women. Hundreds of thousands of workers undertake this so-called “low skilled” work that is indispensable to our collective well-being and the well-being of vulnerable seniors.

Care workers are acutely aware of the impact of their working conditions on the quality of care offered. In a recent survey of Manitoba nurses working in long term care, only 26% rated the quality of care provided in their facility as “excellent”; 58% said they didn’t have enough time to properly care for their patients, and 56% said the staffing levels at their workplaces were inadequate.⁷⁵

Challenges are greater in for-profit facilities, which represent 37% of all residential care facilities⁷⁶ and approximately 60% of those in Ontario. Study after study shows that for-profits tend to have poorer quality of care than non-profits or municipal long-term care homes, as measured by lower hours of direct care per resident, number of verified complaints and deficiencies, and resident transfers to hospital.⁷⁷ With large private chains expanding across Canada to generate sizable profits through short staffing, lower wages, fewer benefits, and fewer pensions, nationally for-profit facilities have 34% fewer staff⁷⁸ and spend less on direct care than homes under public ownership. A recent report of British Columbia’s Office of the Seniors Advocate found that the for-profit sector spent an average of 17% less per worked hour compared to non-profit facilities, and the wages paid to care aides in particular were up to 28% below industry standard.⁷⁹

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Enter COVID-19. Emerging evidence from Ontario reveals that residents in for-profit homes are four times more likely to contract COVID-19 and die from the illness than those in publicly owned municipal homes.⁸⁰

Caring burden falls to women

With substandard staffing levels, the pressure is on relatives and volunteers to not just provide social support, but basic tasks such as helping residents to eat and dress. Increasingly, families with means hire privately paid companions, another precarious group of workers, to assist with these tasks, while families without struggle to provide needed assistance, living with constant anxiety and worry.

Paid or unpaid, these heavy demands fall largely on women, with often significantly negative consequences for their health as well as for their current and future employment.⁸¹ Almost 8 million Canadians are unpaid care providers, roughly half of whom provide support to a parent, in-law, or older relative with long term health conditions or age-related issues.⁸² Among all caregivers, 32% of women and 28% of men report unmet needs

related to their caregiving, including experiences of significant daily stress (36%) and fair or poor mental health (23%).⁸³ Many of these unpaid family caregivers provide care within long-term care homes.

In the wake of the pandemic, families are turning down placements in long-term care homes after waiting for months, or even years, for a bed to open up because of fear of infection and staffing challenges. At the same time, home care services and adult day programming are being cancelled or reduced in scale, increasing the demands on family caregivers. For those looking after an elderly spouse or relative on their own, as many older women do, the loss of home care will have a significant impact on their health and well-being.

COVID-19 demonstrates that many people, and the services they depend on, are economically and socially precarious. Allowing long-term care and home support to be structured as low-paid, precarious work provided by women who can't afford to stay home when they're ill has proven a disastrous choice as a society.

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Violence Against Women and Gender-based Violence Services

Although not yet commonly labelled care work, service responses to violence against women (VAW) and gender-based violence (GBV), such as women's shelters, transition houses, and sexual assault centres also fit the ILO's care work definition, as do service responses to poverty including homeless shelters, drop-in centres, and food banks, many of which are utilized by survivors of violence and trauma.

What now constitutes a broad national care sector working in response to, and for prevention of, VAW and GBV, began as community crisis responses initiated by young women. The first shelters for women escaping violent homes and the first rape crisis centres in Canada were founded in the 1970s as young women embraced feminist activism.⁸⁴ Almost five decades later, these, along with a host of other services from counselling to crisis phone lines to court support, comprise an autonomous, largely community-based VAW and GBV service sector funded mainly by provincial and territorial governments. This is a nonprofit sector, much of it characterized by the issues faced by women's sector nonprofits discussed above.

The COVID-19 pandemic and the emergency responses it has necessitated have shone a much-needed spotlight on VAW and GBV, while placing additional strain on already taxed anti-violence services. Government-mandated stay-at-home measures both heightened risk for women and children in abusive homes and reduced their ability to leave for the safety of a women's shelter. Closure of physical spaces and the shift to remote services brought unique access barriers to sexual assault centres,⁸⁵ with some centres experiencing an increase in contacts from youth looking to connect by text.⁸⁶

Need for services outstrips capacity

In the best of times, services are insufficient to meet needs. Demand for access to VAW shelters consistently exceeds capacity across the country, with 39% of shelters nationally almost always at capacity and another 22% often fully filled.⁸⁷ Almost three-quarters of VAW shelters extend women's stays beyond provincial and territorial guidelines, largely due to lack of affordable housing in the community, which stalls departures and bottlenecks admissions. In 2019, shelters and transition houses serving women and children leaving violence turned away 79% of potential residents on a typical single day.⁸⁸

Despite continuing expansion of services by VAW shelters and transition houses unsupported by equivalent funding increases,⁸⁹ significant gaps

persist in shelter services including for women with disabilities and Deaf women, women in rural and remote areas, and women in need of culturally specific services. Four out five VAW shelters across the country are accessed by First Nation, Métis, and/or Inuit women, yet only one in five is able to frequently provide culturally appropriate programs.⁹⁰

With the rise of #MeToo, police-reported sexual assaults increased over four consecutive years from 2015-2018, increasing by 13% in 2017 and another 15% in 2018, despite as few as 5% of sexual assaults being reported to police.⁹¹ Simultaneously, sexual assault centres saw much more significant increases in calls without matching increases in funding. As February 2020 ended, sexual assault survivors—some at high risk of suicide—were stuck on waiting lists for counselling across the country.⁹²

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A woman-dominated workforce providing care and support

Founded by women, the VAW and GBV services sector remains heavily women-dominated, “similar to other traditionally gendered professions such as teaching, nursing and social work”⁹³ and the care sector in general.

The small VAW shelter workforce of slightly over 5,500 people is over 97% women, and the few men working in shelters (fewer than 200) are concentrated in janitorial and maintenance work (63%).⁹⁴ VAW shelters are 24/7 residential crisis response services requiring shift work and casual and relief workers. Typical of care work, casual and relief staff make up a significant portion of the workforce (32%) and their employment is precarious.⁹⁵ Half (50%) of VAW shelter staff are full-time and 18% part-time.⁹⁶ VAW shelters identified low pay and lack of benefits in the sector—failing to match similar fields—as a major challenge to retaining high quality staff. More than one-third (38%) of VAW shelters in Canada are unionized, and the average minimum hourly rate in those shelters is 10% higher.⁹⁷ Staff turnover and burnout are major issues for a majority of shelters.

In the absence of detailed staffing information on sexual assault centres and broader GBV organizations, the profile of nonprofit organizations suggests that staff would be at least 80% women, and likely higher given their focus on violence against women.⁹⁸ As nonprofits, wages will be lower in comparison to public sector organizations, and as women-focused service non-profits, also lower than nonprofit organizations in general.⁹⁹ This is, unfortunately, entirely consistent with the care sectors discussed above.

Funding lags behind sector development and demand

The federal government’s early April announcement of \$50 million to assist GBV services with their pandemic response was welcome, but also highlighted the extent of underfunding. The executive director of one busy sexual assault centre described the impact of receiving \$25,000 in federal emergency funds and their shift to working remotely:

“COVID-19 has exposed the cracks of what years of lack of funding has done to the most vulnerable in our communities. Before the COVID-19 pandemic we had a 45% increase in all of our services, 10-week wait list, 35% increase in crisis line calls, 57% increase in demands of our therapeutic trauma-informed groups in our community.

We had to invest in a phone system as ours was a donation from 1980. We didn’t have funds for PPE for staff and volunteers accompanying women to hospitals, police, and doctors...As much as I’m grateful for the \$25k, I must be honest with you, it’s not enough...we need to invest in a web chat system for youth asking to text...we had to do home visits as we fear for some clients’ lives and despite reporting to police, nothing has been done. We are running out of PPE...Volunteers have begun to show signs of burnout and we are averaging 60-80 crisis calls a day...”¹⁰⁰

Started from scratch and receiving the greater share of funding from provincial and territorial governments, the sector remains underfunded. Almost three-quarters of VAW shelters (74%) report that insufficient funding is a major challenge.¹⁰¹ Community fundraising and project funding from foundations and other levels

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of government are sought to bridge service gaps, conduct action research, and pilot new approaches. More than half of VAW shelters must fundraise to fully cover operating expenses, and one in 10 can't cover operating expenses even with fundraising. Canadian Women's Foundation funding has been used in recent years to establish Sexual Assault Response Teams in rural and northern communities, in lieu of government funds for what is public health and public safety work. Capacity for knowledge mobilization is rare. Advocacy is a necessity to advance violence prevention, but is rarely funded and is conducted as an overtime activity due to lack of capacity.

Chronically insufficient government funding comes from a patchwork of provincial and territorial ministries and departments including community services, social development, social services, health, status of women, family services, justice, public safety, solicitors general, and victim services. The result is that programs and services "differ from one province/territory to the next" without coordination or standards.¹⁰²

While post-violence responses from the sector have advanced dramatically, a reduction in rates of violence has not followed.¹⁰³ Recognizing the vital role of this care sector and its impact on public health and gender equality with national leadership is essential to achieving that fundamental change. Violence prevention work is essential, as is national leadership on standards and coordination.

The COVID-19 pandemic has brought into focus the fragility and the resilience of VAW and GBV services. The recovery response must be sufficient to not only sustainably fund the sector and its continuing growth but also to foster violence prevention to induce the long-awaited reduction in rates of violence.

EMERGING INTO RECOVERY: EQUITY, EQUALITY, AND DECENT WORK

The pressure of any crisis reveals the fragility and inadequacy of supporting structures, and the current pandemic is no exception. COVID-19 and the imposition of emergency pandemic control measures have demonstrated how economically and socially precarious many people— and the services they depend on—are after 30 years of austerity and privatization. The pandemic has also exposed the systematic undervaluing of paid and unpaid care work. For long-term care, this is already clear. How true it is of childcare will be tested as re-opening unfolds. Violence against women always increases in a crisis, and already strained services have stretched to meet demand as safely as possible, with limited but very welcome emergency support.

The crisis has exposed the catastrophic inadequacy of employment for many, many women. On the frontline containing the pandemic, women are working in low-wage, precarious care positions at high risk of infection—jobs where intersecting inequalities and gender-biased public policy have concentrated racialized, Black, migrant, and undocumented women. Women who are least likely to have the financial means to weather unemployment have taken the greatest hit in months of job losses so severe that equality gains are under threat.

Pandemic emergency measures prioritized collective public good. Recovery planning can continue to do so by removing gender bias from economic and social policy and recognizing that what is good for all women is good for the country. Centring the experiences of diverse and marginalized communities of women in recovery planning with effective intersectional feminist policy analysis can rebuild our economy, enhancing justice, equity, and inclusion. Prioritization of decent work in women-dominated care and service sectors can ensure women re-enter the workforce and thrive at work, protect and advance equality gains, and boost the economy.

Recommendations

1. Revitalize social, not only physical, infrastructure through care sector investments

- Strengthen social policy in long-term care, childcare, and violence against women and gender-based violence, prioritizing investments in community and state models.
- Invest in quality care services, care policies, and care-relevant infrastructure to reduce social and economic barriers and advance inclusion, gender equity, and gender equality.
- Build a care economy centred on equity, equality, and shared prosperity working with care workers, including migrant care workers; care recipients; unpaid caregivers; and feminist economists.
- Increase capacity of public nonprofit care services and facilities through immediate creation of a sector stabilization fund to support direct operational costs.

EMERGING INTO RECOVERY: EQUITY, EQUALITY, AND DECENT WORK

- Set, monitor, and enforce national standards for quality care services based on evidence-based best practices covering staffing levels, training, service management and delivery, and protection of labour rights.
- Introduce care-friendly, gender-responsive policies and programs, including tax measures, targeting women living on low incomes and their families to assist with costs of caregiving.

2. Ensure care work is decent work

- Lead a meaningful policy discussion with all stakeholders to reimagine care and build a sustainable care economy anchored in decent work that ends the devaluation of care work.
- Develop a long-term care labour force strategy based on appropriate valuing of the skill, effort, responsibility, and working conditions and support for equitable, decent conditions.
- Raise federal, provincial, and territorial employment standards to a decent work floor for care workers and all workers, including minimum wages that reflect living wages, paid sick days, the right to refuse unsafe work, and stable full-time employment.
- Invest in women-majority care workforces through designated federal funding to the provinces and territories for the creation of high-quality jobs in the care economy that offer full-time work at better wages, improved working conditions, access to training, and robust employment protections.
- Modernize and strengthen social protections for workers, such as Employment Insurance, to reflect current and future labour realities.
- Ensure migrant care workers have decent work:
 - Grant permanent residence status to all migrant care workers who are currently in Canada, including migrant care workers who have become undocumented.
 - Ensure that in the future migrant care workers have secure permanent residency status on arrival in Canada.
 - Include migrant care workers in discussions that shape a sustainable care economy.
 - Ensure labour relations legislation provides real access to unionization and collective bargaining for in-home care workers, including through broader-based bargaining (sectoral bargaining).

EMERGING INTO RECOVERY: EQUITY, EQUALITY, AND DECENT WORK

3. Focus public investments to transform care sectors

- **Long-Term Care**

- Introduce federal legislation enshrining Canada's commitment to high quality long-term care, and related home care services for all in need, that sets out the principles, conditions, and accountability mechanisms for federal transfer payments to provinces/ territories.
- Increase federal and provincial public investment in long-term care and related community-based supports for seniors and others in need of care, including services, infrastructure, and facilities to meet increasing care needs.
- End privatization of long-term care and expand publicly managed non-profit long-term care facilities and home care services.
- Establish better integration/collaboration between health and social services to facilitate/ support increased access to appropriate services tailored to the needs of different communities.
- Report annually on the delivery and impact of long-term care services in provincial and federal legislatures in collaboration with all stakeholders.

- **Childcare**

- Increase public investment in childcare to ensure women and parents of all genders can return to work and to stimulate GDP recovery.
- Direct funding adequate to address increased costs and support the women-majority workforce for full re-opening in the short term.
- Meet the crucial long term social and economic role of childcare in Canada through redevelopment including:
 - significant investments in physical infrastructure: new centres, retrofits, supply chain inputs
 - significant investments in human capital: early childhood educators, cooks, cleaners
 - moving to community and state operating models and away from privatization
 - broader coordinating policy mechanisms and implementing a national secretariat.

EMERGING INTO RECOVERY: EQUITY, EQUALITY, AND DECENT WORK

- **Violence Against Women and Gender-Based Violence Services**
 - Co-develop and implement a long term National Action Plan on Violence Against Women and Gender-Based Violence with VAW and GBV services, including a timeline, financial transfers to the provinces and territories, and financial resources and standards sufficient to ensure national levels of service and protection for all women and decent work for the workforce.
 - Implement the Calls for Justice of the National Inquiry into Missing and Murdered Indigenous Women and Girls, including the National Action Plan to address violence against Indigenous women, girls, and 2SLGBTQQIA people.
 - Recognize the public health role of sexual assault centre work and stabilize funding at levels commensurate with growing demand while retaining autonomy and community governance.
 - Recognize the long-term role of the broader gender-based violence service sector in service response and violence prevention with stable permanent funding that supports decent work in the sector.

CO-AUTHORS

Canadian Centre for Policy Alternatives

The Canadian Centre for Policy Alternatives (CCPA) is an independent, non-partisan research institute concerned with issues of social, economic and environmental justice. Founded in 1980, the CCPA is one of Canada's leading progressive voices in public policy debates. Its Making Women Count program studies gender disparities and the solutions needed to advance a more gender equal and just society.

Canadian Women's Foundation

Launched in 1991 to address a critical need for philanthropy focused on women, the Canadian Women's Foundation is one of the largest women's foundations in the world. With the support of donors, the Foundation has raised more than \$100 million and funded over 2,000 programs throughout the country. These programs focus on addressing the root causes of the most critical issues and helping women and girls who face the greatest barriers.

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Ontario Nonprofit Network

ONN is the independent network for the 58,000 nonprofits and charities in Ontario, focused on policy, advocacy and services to strengthen the sector as a key pillar of our society and economy. We work to create a public policy environment that allows nonprofits to thrive. We engage our network of diverse nonprofit organizations across Ontario to work together on issues affecting the sector and channel the voices of our network to government, funders, and other stakeholders.

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