A STUDY INVESTIGATING COMMON EXPERIENCES AMONGST CHINESE, INDIAN AND FILIPINO MIGRANT HEALTH WORKERS IN AOTEAROA/NEW ZEALAND

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A thesis submitted in partial fulfilment of the requirements for the Degree of Master of Social Practice
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DECLARATION

This Thesis entitled: A Study Investigating Common Experiences Amongst Chinese, Indian and Filipino migrant health Workers in New Zealand is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Social Practice.

I confirm that:

- This Thesis Project represents my own work;
- The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies;
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Research Ethics Committee Approval Number: UREC 2009-1016

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4 August 2011

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- J.P.T.
DEDICATION

To the migrant health workers,

I hope that this piece of work will add inspiration

in making a significant difference

in your own lives and those of others

in this land we call our new home,

New Zealand;

To my beloved husband and friend, Osias,

and to my dear children,

Josiah, Darlene Joy and Esther Hope,

may our journey in the New Zealand experience

makes us more resilient

so we can be of better help to others and to each other.

- J.P.T.
THESIS ABSTRACT

This study sought to understand the experience of Chinese, Indian and Filipino migrant health workers in New Zealand. It explored the participants’ migration and employment experiences, including their perceived roles and motivations at work. It also gathered relevant information on the needs of and issues affecting these migrant health workers and their coping responses that helped increase their opportunities to achieve their potential in the New Zealand context. Consequently, the study aimed to promote transformative participation through seeking input on how the participants think other migrants could be best helped in relation to their experiences.

The general mode of inquiry is qualitative research design that involves a semi-structured interview method, supplemented with focus group discussions to generate the data, which are presented in themes. The themes were analysed generally through an interpretive approach, informed by a critical research paradigm.

The Chinese, Indian and Filipino migrant health workers are a special kind of migrants who form part of the growing majority of health workers in New Zealand. Linkages with family, friends and other networks, and the aspiration to have better opportunities in terms of lifestyle, education and profession were their common drivers for migration. The shortage of health workers, the easier access to New Zealand, and the impressive physical and social environments also attracted these participants to migrate.

The participants’ role in health work was one of change and accumulation. There were also patterns of under use/non-use of their professional skills in their current role; and patterns of skills use that were beyond the job description. While the participants’ core motivations for doing health work showed a strong sense of service and satisfaction, they also expect a fair return of their competence, hard work, perseverance, flexibility and willingness to try anything.

The employment experience was a straightforward series of steps into professional work for some; while the challenges were often considerable for others. Challenging issues were around personal/family concerns, work-related/professional factors and problems arising from agencies as well as from immigration agents/consultants. Their coping strategies include getting better access to available information and support in the migration process and employment; further study, re-training and/or continuing education; work-related actions such as volunteering, and focussing on competence and confidence, effective communication, cultural awareness and safety, and being able to work within a team. Cultivating personal qualities such as having positive attitude, working hard, holding hope, and having spiritual faith are also important coping responses for these participants.

A resilient nature had developed through the challenging experiences and the coping strategies that the participants employed. Their success factors include perceptiveness, establishing strong networks and positive social relationships, having a positive view of their personal future, flexibility and the willingness to try anything, as well as volunteering. Most went for further study/re-training and continuing education. They focused on becoming effective communicators, culturally aware and competent. They were self-motivated, and have maintained a positive attitude so they can persevere, work hard and hold hope for the future, coupled with their spiritual faith in God, which was described as the ‘foundation’ of their being resilient.

Key words:

Health workers, migration, employment, roles, motivations, issues and concerns, coping responses/solutions, resilience.
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CHAPTER I

INTRODUCTION

This chapter provides the background to the study of the experience of Chinese, Indian and Filipino migrant health and community workers in Aotearoa/New Zealand, its aims/objectives, and its significance. It also describes the nature and scope of the information sought, and presents the definition of terms, as well as the organization of subsequent chapters.

Background of the Study

New Zealand has a long history of international migration, with its changes and development, allowing the entry of diverse groups of people. Europeans make the majority of the population, and the other three main population groups are Maori, Pacific Islanders and Asians (Zodgekar, n.d. in Liu, McCreanor, McIntosh and Teaiwa, 2005) or other ethnicities (Statistics New Zealand, 2006). It is projected that the significant changes to the ethnic composition of New Zealand’s population will have an impact on both the services required and the workforce needed to provide those services. It is imperative then that ‘our future health and disability workforce reflects the population they support and care for’ (New Zealand Institute of Economic Research, 2004, p.6)

Immigration makes a significant contribution to the supply of health and community workers in New Zealand. In a case study on Asian migrants migration to New Zealand, it was found that ‘Asian migrants are a significant and increasing source of skilled labour, which New Zealand is in competition for’ (Badkar, Callister, Krishnan, Didham and Bedford, 2007,p. 126). In a report of the Ministry of Health (2006), ‘there is an overall lack of good data to profile the health workforce’ (p. vi). The 2006 New Zealand census, however, showed that 29% (10,500) of nurses were born overseas. Among the fifteen
main countries of birth of immigrant health professionals in New Zealand, Philippines is the fourth largest behind United Kingdom, Australia and South Africa, while China and India are also among the top fifteen.

In terms of gender, there is a large diversity by nationality from some Asian countries but men dominate the overall skilled/business stream and temporary categories (Badkar, et. al. 2007, p.127). However, in terms of the key working-age groups, there are significantly more Asian women than men who are living in New Zealand (Statistics New Zealand, 2006). This is probably why there are more women than men who were available for interview for the purposes of this study.

Since the researcher is a Filipino migrant health worker, and considering the importance of migrant health and community workers in the New Zealand society, as well as the apparent dearth of study among the growing population of Asian migrant health and community workers, particularly from the Philippines, China and India, these group were chosen to be studied. It is acknowledged that there are larger groups of migrant health and community workers coming from other continents of the world, but they may have other set of experience as they come from the first world or better off countries. They can be studied separately as time and accessibility do not warrant their inclusion in this research.

The population projections in the Organization for Economic Cooperation and Development (OECD) countries, including New Zealand, suggests an ageing population (Zurn and Dumont, 2008; Ridler, 1984), and a growing cultural diversity (Statistics New Zealand, 2006; International Organization for Migration [IOM], 2009) will contribute to growing health care needs and the rising cases of diseases and accidents. The OECD countries have an apparent shortage of health workers due to inadequate levels of training and in New Zealand’s case this is exacerbated by outflows of skilled New Zealanders to other OECD countries including Asia. Consequently, they rely on the supply of migrant health professionals and workers to maintain their health services (Khawaja and Thomson, 2009; WHO Media Centre, 2006; Bach, 2003; Bedford, 2002, cited by Human
The globalization in terms of the trade of the services of health workers is seen in Fiji, Jamaica, Mauritius and the Philippines where a significant number of nursing students pursue their education with the expressed intention of migrating (Statistics New Zealand, 2001, as cited in Stilwell, Diallo, Zurn, Vujicic, Adams and Poz; WHO Media Centre, 2006; Zurn and Dumont, 2008).

Migrant health workers are faced with challenging issues in their personal and occupational lives (Seton, 2004). How they respond to these challenges can influence their ability to contribute to the health as well as in the development of the country where they have settled, and perhaps extend help to their country of origin.

This research seeks to understand how migrant health and community workers from the three Asian nations (China, India and the Philippines) think they could be assisted in relation to their experiences of migration. The information gathered in this research can contribute to the review of human resource development programmes in health organizations, and to migration and employment policies. It may also serve as an inspiration or challenge to intending migrants or new Filipino, Indian and Chinese migrants who are still adapting to their new environment.

This study starts with a view that migrant health and community workers contribute in the economy of New Zealand through their ability to influence and create a healthy society now and in the future. Korten (1990) said:

“You and I have a special obligation to think and act as global citizens, to be a steward of whatever [relative] power we hold, to contribute to the transformation forces that are reshaping our world. The future of human society ... depends on each of us” (p. 216).

**Aims and objectives of the study**

This study aims to explore the migration and employment experiences of Chinese, Indian and Filipino health and community workers including their motivation for health work;
their roles (real and perceived); their needs and challenging issues; as well as their coping responses/solutions to these challenges.

Migrant health and community workers come to New Zealand with their rich resource of experiences and qualifications in many areas of health work, many of which are discounted by New Zealand employers and qualifications authorities. This research explores the outcomes of and solutions for the dichotomy between the competence of workers and the work that they find in New Zealand.

The objectives of the research project are as follows:

1. To explore and add to existing literature about the migrant health workers’ experiences including their motivation and perceived roles in health work;
2. To gather relevant information on the needs of and issues affecting Chinese, Indian and Filipino migrant health workers in migration, finding training and employment, and settling into a New Zealand way of life, and on the coping responses and solutions that may increase their opportunities to achieve their productive potential in the New Zealand context; and
3. To promote transformative participation, through seeking input on how the participants think people could be best helped in relation to their experiences.

**Significance of the study**

This study contributes to the needed expansion of research on the relationship between migration and occupation for Chinese, Indian and Filipino health and community workers in New Zealand. This study explores the following outcomes:

1. The research provides possible information for migration and employment policies, and guidelines so as to reduce the difficulties experienced by immigrants in the process of settlement and integration into New Zealand.
2. The research provides information for the review of human resource development programmes (or staff development) in health and social service organizations that have employed migrants.

3. The research promotes transformative participation through discovering how the participants solve their needs and issues, and how they think people could be best helped in relation to their experiences. This leads to recommendations on the relevant actions, services and support systems that can alleviate the negative impact of migration, and increase the benefits accruing to New Zealand and to migrant health and social practice workers.

4. This study can serve as a springboard to further and or related studies.

**Nature and scope of the study**

The nature of information sought in this research study is qualitative, based on a phenomenological approach. It focuses on understanding the ‘possible appearances, forms, and structures of the human experiences’ of the Chinese, Indian and Filipino migrant health and community workers. The information the ‘multiple, differing perspectives of the respondents’ self-worlds, based on their own hidden assumptions’ (Bridgman and Gremillion, 2009, p. 40) along with their reasons for migration to New Zealand, perceived roles and experiences, motivations for health and social services work, needs or challenging issues, and coping responses or solutions thereof.

This study is limited to Chinese, Indian and Filipino migrant health and community workers who had applied for New Zealand immigration on October 1995 onwards and who had worked for at least a year in New Zealand. This small group of participants represents a diversity of health roles (registered nurse, social worker, health care assistants, rehabilitation program workers, and community support workers), gender, age and culture.
**Definition of terms**

To establish a common understanding of this study, the following terms are defined:

*Coping.* This refers to the process of changing cognitive and behavioural efforts to manage specific demands that are considered as beyond the resources of the person. It refers to what the person actually thinks or does, would do or should do as the situation unfolds. Coping also refers to what the person actually thinks or does within a specific context or particular situation (Lazarus and Folkman, 1984 as cited in Eckenrode, 1991). In this study, coping involves the responses, solutions or recommendations of participants in terms of some factors as access to information and support, further study, re-training and/or continuing education, other work-related actions and cultivating personal qualities.

*Employment.* This refers to the work or occupation in which one is engaged and paid. It is an activity to which one devotes time (The American Heritage Dictionary of the English Language, 4th Ed., 2009). In this study, it includes the work or occupations of Registered Nurses (RN), Health Care Assistants (HCAs) or Nursing Assistants (NAs), Community Support Workers (CSWs), Social Workers (SW) and Rehabilitation Program Workers (PRWs). It refers to all types of work - either on a permanent, temporary, part-time or on casual basis with at least 20 hours work per week.

*Experience.* This refers to the observing, encountering, or undergoing of things generally as they occur in the course of time. It is the totality of a person’s perceptions, feelings and memories (World English Dictionary, 2011). This study refers to the experience of Chinese, Indian and Filipino migrant health and community workers in terms of their pre-migration and first experience, employment, challenging issues and concerns, as well as their coping responses/solutions and recommendations.

*Issues and concerns.* An issue is something that is put forth in any form. A concern is a matter that engages a person’s attention, interest or care, or that affects a person’s welfare
or happiness (World English Dictionary, 2011). In this study, the issues and concerns may include personal and family related, work/professional related and concerns arising from agencies.

_Migration_. This is the act or instance of migrating or movement. Immigration is the movement of non-native people into a country in order to settle there (World English Dictionary, 2011). This study refers to the immigration of Chinese, Indian and Filipino people to New Zealand.

_Migrant health and community workers_. Non-native people who are engaged across the spectrum of health services that do health work either in the hospital, resthome or rehabilitation centre. In this study, the term ‘migrant health and community worker’ is used interchangeably with ‘migrant health worker’. It is limited to the Chinese, Indian and Filipino migrants who are working either as a Registered Nurse (RN), Social Worker (SW), Health Care Assistant (HCA) or Nursing Assistant (NA), Community Support Worker (CSW) or Rehabilitation Program Worker (PRW).

_Motivation_. The process that arouses, sustains and regulates human behaviour (World English Dictionary, 2011). It is the driving force, incentive, reason or inspiration to do something. This study includes the exploration of the motivations of migrant health workers in New Zealand.

_Role_. This refers to the position, responsibility or duty and the expected social behaviour of an individual, which is associated with health work in this study.

**Organization of the chapters**

This thesis contains four subsequent chapters.

Chapter II provides a critical review of the literature in relation to migration demographics that includes the diversity of migrants in New Zealand, and the increase
and the settlement of Asian migrants in New Zealand. This chapter also provides a critical review on the drivers of migration, human motivations, roles of health workers, other migration experiences, and the challenge of multi-cultural society that involves cultural competence and the treaty of Waitangi in health work.

Chapter III shows the research design and methodology which guided the research process and its rationale. It presents the choice of paradigm and the general mode of inquiry. The methods of data collection and recruitment of participants are explained, and the methods of data analysis are described. Ethical issues associated with the research are also presented in this chapter.

Chapter IV reports the analysis and interpretation of the findings of the research study presented as the themes and sub-themes that arose from the data. The areas of exploration involved are: the pre-migration and first experience that includes the reasons of migration and positive first impressions of New Zealand, as well as the expectations and goals of the participants; the employment experience, including the motivations and perceived roles in health work; challenging issues and concerns; and the coping responses/solutions and recommendations as identified or implied by the participants.

Chapter V presents a discussion and integration of the findings across the areas of exploration and in relation to literature as well as the recommendations arising from the results of the study. Recommendations for further research in the future are also presented.

A reference list as well as the appendices complete the thesis.

The following chapter presents the review of related literature.
CHAPTER II

REVIEW OF RELATED LITERATURE

This chapter presents a review of literature for this study. It expands the background of this study, further defines the research problem, and helps in the interpretation of the results and implications of this study.

Migration demographics

Diversity of migrants in New Zealand

Recent migrant health workers came to New Zealand under the new immigration policies that were implemented as part of a broader program of social and economic deregulation. Hence, immigration in the 90s became more liberal, opening opportunities to a greater variety of people, eliminating a large element of discrimination in policy on the grounds of race, nationality or ethnic origin, colour, sex or marital status, and religious or ethical belief (Liu, McCreanor, McIntosh and Teaiwa, (Eds.), 2005). From 1995 new migrants were selected based on their potential contribution to New Zealand, either under various categories - skilled migrant category, family category, business category and others (NZIS, 2005a).

The skilled migrant category is a points system based on the ability to settle in skilled employment in New Zealand. Applicants must have a minimum total of 100 points in the following categories (NZIS, 2005a):

- recognized qualifications (variety of trade certificates, diplomas, bachelor’s degrees and post-graduate qualifications),
- work experience (at least two years previous experience in the same field for which one has skilled employment),
• job offer of skilled employment (from the list of skills shortage that includes health professions),
• age (55 years or younger), and
• having support from a close family who have residence or citizenship in New Zealand will also get points.

This skilled migrant category was used most by the Filipino and Indian participants who came to New Zealand as trained professionals, but they still had to do some retraining or bridging course in order to be registered in New Zealand.

Under the family migration category, a person may apply to come to New Zealand to live as a resident if he/she is sponsored by a family member who is already a New Zealand citizen and/or resident. If not opting for a family temporary visit, a person must be in one of the following groups of family residence: partner, dependent child, parent, parent retirement category, sibling or adult child (NZIS, 2005a). Most of the Filipino participants, though they applied first as a student (to do the nursing bridging course), and then applied through the skilled migrant category, have come to New Zealand due to the influence of a family member who is already in this country.

The business migration category is designed to contribute to the economic growth, attracting ‘smart’ capital and business expertise to New Zealand, and enabling experienced business people to buy or establish businesses in New Zealand (Department of Labour, 2006; NZIS, 2005a). There are three main elements of Business Migration: first, the Long Term Business Visa (LTBV), which is a three year work visa that aims to provide enough time for the applicant to move to New Zealand and set up their business before applying for New Zealand Residence. Second, is the entrepreneur (residence) who can apply for New Zealand residence under the Entrepreneur category if a person has been legitimately self employed in a business within New Zealand for at least two years. Third is the investor category that aims to encourage migrants who are able to invest in the New Zealand economy with at least $3.5 million to as high as NZ $25 million (Quilliam, 2009).
Although Chinese immigrants are concentrated in the business of accommodation, food and retail industries (NZ Statistics, 2006; Meares, Ho, Peace and Spoonley, 2010), and while a few of the Chinese participants of this study have initially worked as part time employees in this industry, some of them have come to New Zealand as students while their parents migrated through the business category.

*Increase of Asian migrants in New Zealand*

The New Zealand Asian population was historically limited to mainland Chinese and Indian migrants. Asian immigrants comprised fewer than 20% of the total immigration numbers until 1986. However, immigration figures for 1991 to 1996 show that there was a rise of 76% (to 173,000) in the size of Asian migration over that period. In October 1995, the points system was tightened so that professionals needed to be registered for practice in New Zealand before they received points for their qualifications. Moreover, a three-hour English-language test had to be passed by the principal applicant and adult dependants. Otherwise each dependant had to pay a bond of $NZ20,000 if not able to pass (Quilliam, 2009). Immigrants were carefully chosen under rigid and competitive criteria, and were invited to apply for residence permits based on the points that were awarded to them.

The 2006 Statistics New Zealand showed that the Asian ethnic group was New Zealand's fourth largest aggregated ethnic group after European, Māori, and Other Ethnicity, totalling 354,552 people (9.2%). There are two well established sub-groups with a long history of settlement: Indian ethnicities (23% born in New Zealand) and Chinese ethnicities (22% born in New Zealand). There are also people claiming Asian ethnicities who were born in a number of European and Pacific countries. The Asian population became diverse such that the sources of migration are no longer overwhelmingly Chinese (147,570) and Indian (104,583), with many other Asian countries like Korea (30,792), the Philippines (16,938), Japan (11,910), Sri Lanka (8,310), and Cambodia (6,918) making a contribution. These are the seven largest Asian migrant groups. The rest of the Asian
migrants come from Malaysia, Taiwan, Hong Kong, Thailand and Singapore (Statistics New Zealand, 2006).

**Settlement of Asian migrants in New Zealand**

Most Asian immigrants tend to settle initially in the major centres, primarily in Auckland but also significant numbers settle in Christchurch and Hamilton. Some made their home on the West Coast, Hawke’s Bay, Gisborne and Wellington. Two-thirds of the 234,222 people who identified with one or more Asian ethnic group/s live in the Auckland Region – particularly in Auckland City, followed by Manukau City, the North Shore and Waitakere, with a few in Papakura and Franklin districts. These migrants include a high proportion of young adults, with 31% people aged between 15 and 29 years, which can be possibly attributed to the number of Chinese students and the children moving with the families of Indian migrants. In the case of the Filipinos, most come as students or as a whole family under the skilled migrant category (Glowsky, 2002; Walrond, 2007; Statistics New Zealand, 2006). This study involves Chinese, Indian and Filipino migrant health workers in Auckland City, Waitakere and North Shore.

**The drivers of migration**

The drivers for migration are varied, and the decision to migrate is essentially a personal one, but it can be affected by societal circumstances that may overlap. In a review of dominant theories of international migration, Oishi (1992) suggested three approaches to migration analysis – the micro (individual desires and expectancies), the meso (collective forces and social networks), and the macro (national and international opportunity structures). These three approaches are to some extent aligned and interact with three other major approaches to migration theory: the socio-economic, systems and structural approaches.
Socio-economic migration (micro/macro)

The socio-economic perspective relates to the micro and macro socio-economic approaches of migration, which are evident among the participants of this study. The focus of the micro level is on the decision-making of the individual, which is affected by their ‘values or desires and expectancies of improving and securing survival, wealth status, comfort, stimulation, autonomy, affiliation and morality’ (Faist, 2000, p. 30). It is also characterized by ‘freedom’ or ‘choice’ to migrate, which is affected by the dynamics of migration such as ‘social networks - families, households, friendship and kinship circles, neighbourhoods, ethnic, religious and professional associations’ (Faist, 2000, p. 30; Oishi, 1992).

In a study of Italian migrant returnees from the United States, (Cerase, 1974, as cited in Cassarino, 2004) described the migrants’ aspirations, expectations and needs in terms of the financial and economic resources they bring back to their home country. Some migrants planned before migration to return home with enough money to buy land to ‘liberate’ themselves and their relatives from ‘loathsome’ landowners, while some migrants wanted to return to their home country just to acquire a piece of land and a home where they can retire. Cerase’s typology also suggests that there are ranges of social and economic long term goals, often innovative, that returning migrants are prepared to invest in that go beyond the purchase of land.

At the macro level, the macroeconomic approach analyses the ‘income and unemployment differentials’ of peripheral (traditional countries of migration origin) and core (modern countries receiving large net gains of migrants) countries that push and pull migrants (Faist, 2000, p. 30). The classic migration law (Ravenstein, 1885 as cited by Corbett, 2001) stresses economic opportunities as the key cause of migration from developing countries to developed or more developed countries. Economic migration is about the potential of the country of destination to offer suitable employment and more economic gains than the country of origin (Stilwell, Diallo, Zurn, Vujicic, Adams and Poz, 2003; Loewenson, 2008). Similarly, the economic perspective of migration is
related to the global interdependence of supply and demand for labour. Nations like the United States of America, United Kingdom and New Zealand with high demand for scarce health workers will have relatively high wage differentials that pull immigrants in from nations with a surplus of health workers like India and the Philippines (Kline, 2003; Todaro, 1969 cited in Danby, 2000; Oishi, 1992; Stilwell, et al., 2003; WHO, 2006).

In a study of Philippine migration of health workers, Lorenzo (2006) showed that economic reasons were often connected to social reasons for migration. In contrast to the economic reasons, the social reasons are to advance their professional development and careers on a global scale (Bach, 2003). In many less developed countries, opportunities for professional development are hindered by poor working conditions and economic policies that limit investment in public health care sector and reduce funds for health worker education. Also, it is argued that economic differentials have to be considerable as ‘a great majority of people want to stay near their families and loved ones, [and that] there may be a few adventurous individuals who wish to migrate, but most people will want to stay put if they can’ (Omaswa, 2007, cited in Kuehn, 2007, p. 3).

**Systems perspective of migration (meso)**

The systems perspective argues that the movement of people is not only due to economic reasons but is bi- or multi-directional in nature – migrants, their money and other assets return home, temporarily and permanently, or extended families migrate one by one. This systems perspective emphasises the individual, institutional and mass cultural links or linkages and networks between the place of origin and the place of destination (Cooke and Belanger, 2006; Cassarino, 2004; Martin and O’Connor, 1989; Scheyvens and Querton, 2007; Roel, 2007 All the migrant groups in this study (Filipino, Indian and Chinese ) rely extensively on their networks for advice and help of various sorts as they have limited non-migrant networks (Meares, et. al., 2010).

This systems perspective is akin to the meso level of migration (Faist, 2000) that emphasises community attitudes – the ‘ties people entertain with others’ that vary across
collectives and social networks. Meso level analysis focuses on the ‘social ties of family and households; symbolic ties of kin, ethnic, national and religious organizations; transaction ties as obligation, reciprocity and solidarity; and information, access and control to resources of others’ (pp.31-33) in both migrant-sending and receiving countries.

Networks are sets of interpersonal ties - cultural or social - that connect migrants, former migrants, and non-migrants in origin and destination areas through bonds of kinship, friendship, and shared community origin. They are a form of ‘social capital’ or resource that enables and inspires, on the one hand, people to migrate (de Haas, 2007, Oishi, 1992), and, on the other, greater efforts from people in the country of destination to reach across cultural and other divides (Putnam, 2007). This could be in terms of contributing to financing the relocation, helping to find a job or appropriate accommodation, or by giving information about education possibilities or access to social security abroad (De Haas, 2007). Migrant networks also create the potential for a chain of migration to occur. In the case of female migration in Asia, women tend to rely on their personal networks more than men do (Oishi, 1992).

A systems perspective adds the elements of social and political contexts to the economic contexts. In Wallis’ study (2006) of the settlement outcomes of skilled migrants in New Zealand, the social context includes other value-based dimensions of social development such as the desire for educational opportunities, career development and a good lifestyle such as being able to spend more time with family, recreation, and adventure. Similarly, in a survey of health-care workers’ reasons for migration in Cameroon, it was revealed that the lack of promotion opportunities, poor living conditions, and the desire to gain experience, ranked above poor wages as reasons why health-care professionals chose to migrate. However, in a study of other African countries (Uganda and Zimbabwe), the identified most important factor of migration is better remuneration (Awases, Gbary, Nyoni and Chatora, 2003, cited in Stilwell, et al., 2003), although social conditions such as overcrowding and understaffed health systems were also pushing migrants to find better working conditions elsewhere (Kuehn, 2007; Omaswa, 2008).
In a qualitative research study about the decision to emigrate with internationally recruited nurses from India and the Philippines in the United Kingdom, economic reasons were the main trigger for initial migration, but relocation to subsequent destinations revealed the importance of professional and social aspiration influences such as religious and gender issues, family support and migratory networks. The nurses from India go to the United Kingdom to stay, while Filipino nurses go as temporary migrants sending remittances to support their families in the Philippines (Alvaro and Maben, 2009) as an expression of their strong family and extended family oriented culture. According to the new economics of labour migration, these remittances have a positive impact on the economy of poor countries of origin (Jennissen, 2007).

Some individuals or families move with the influence of their ‘linkages’ such as family members or friends who are already overseas. Other drivers for migration suggest relationship motives, for example the ‘mail-order brides’ as in the case of the young Filipino women migrants in the early 1990s (Walrond, 2007) and elsewhere in the age of the internet. The reasons behind this again could be personal or as a way to better social or economic conditions.

The political context of migration includes the fundamental human right of people to enlarge their choices; and the universal aspirations of peace, personal development and a clean environment protected from destruction, and improving political and security conditions (Loewensen, 2008; Cox and Pawar, 2006).

**Structural approach to migration (macro)**

The structural approach to international migration is viewed in a dichotomy – the two worlds of the peripheral nations and the core nations within an international system (Cassarino, 2004; Oishi, 1992). Structural theory is similar to an extension of the world systems theory, which views migration as being affected by industrialization and capitalism in the sending/receiving countries; and the way that raw materials, including labour within peripheral countries, come under the influence of core countries (Massey,
Arango, Hugo, Kouaouci, Pellegrino and Taylor, 1993). International migration follows directly from the globalization of the market economy (Sasses 1988, cited in Massey, et.al., 1993). Thus, workers in developing countries are structurally pulled into the secondary labour markets of industrialized countries which are characterized by ‘low wages, [with] less preferable working conditions and lack of job security’ (Oishi, 1992, p5). In this study, both health and non-health workers, including students from the developing countries of the Philippines, China and India prefer to work in New Zealand due to better conditions as discussed in Chapter V.

Similarly, Faist (2000) presents a macro level approach to migration that refers to the structures of government policies that involve economics - income and unemployment differentials; politics - regulation of spatial mobility through nations and international regimes, political repression, ethnic, national and religious conflicts; cultural setting - dominant norms and discourses; demography and ecology - population growth, availability of arable land and level of technology (pp.31-33). In many studies of migration, the interpretation of the experience of migrants is drawn from all three aforementioned theoretical analyses (micro, meso and macro) of migration.

**Supply and demand of health and community workers**

The World Health Organization (2006) defines Health Workers as:

> All people whose main activities are aimed at enhancing health. They include the people who provide health services ... and management and support workers... Without them, prevention and treatment of disease and advances in health care cannot reach those in need. (p.1).

In a report of the Ministry of Health (2006) in New Zealand, ‘there is an overall lack of good data to profile the health workforce’ (p. vi). In an earlier report of the Health Workforce Advisory Committee (2002), there is an estimated 43,510 nurses and medical practitioners, making up 65% of the 67,000 registered practitioners. The rest include 30,000 support workers and 10,000 alternative and complementary health workers. There was an increased estimate of disability
workers in the community and residential care to approximately 45,000 Ministry of Health (2004). Another research estimated the total size of the health and disability workforce (registered and unregistered) as around 130,000 (New Zealand Institute of Economic Research, 2004). This same research revealed that there have been reported shortages in both regulated and unregulated workforce, particularly the medical practitioners, nurses in primary care, mental health professionals, allied and primary health professionals, Māori and Pacific practitioners, and community support workers.

New Zealand immigration has 27 categories of needed Health and Social Services migrants including social workers, speech and language therapists, psychiatrists, physiotherapists, osteopaths, occupational therapists and 15 sub-categories for registered nurses (Department of Labour, 2011). These positions are described as being in “extraordinarily high demand” (New Zealand Immigration Concepts, 2011). The New Zealand health workforce requires a significant number of immigrant health workers to meet its shortages.

The demand for health workers is influenced by the following trends that have recently emerged in the health workforce of the Organization for Economic Cooperation and Development (OECD) countries, including New Zealand (Ridler, 1984; Human Rights Commission, n.d.; MOH, 2002; Bach, 2003; New Zealand Institute of Economic Research, 2004; WHO Media Centre, 2006; Zurn and Dumont, 2008; Engeler, 2008; Khawaja, and Thomson, 2009):

- Our health work force is ageing (45 years is the average age for nurses and 44 for doctors, while many health care assistants are nearing retirement);
- Our ageing population requires more complex health care, with the rise of chronic illness like dementia, diabetes and heart disease;
- There is a shrinking work force due to an aging population and low birth rates, but an increasing demand for health care, domestic care and social service industries;
• Home care is becoming more frequent and specialised as overloaded hospitals discharge patients with high care needs early and more people wanting to look after high care family/whānau;

• The feminization of health workforce is limiting its focus. Nursing workforce is still quite gender biased with only about 6% male registered nurses and midwives. There is also a lack of workers in specific specialties since female doctors tend to concentrate more on primary care and to work more on part-time job than their male counterparts;

• Migration outflows from OECD countries cause shortages (Scheyves and Querton, 2007). The shortage of young people in OECD countries influences the flow of health workers throughout the world and in particular the strong migration outflows of New Zealand-born nurses to other OECD countries. Trans-national flows can also be related to the oversupply and active recruitment of health professionals in developing countries such as India and the Philippines (Stilwell et al., 2003; Bach, 2003; Scheyves and Querton, 2007). Health workers are more likely to migrate when they are reasonably sure that they will find suitable employment in a destination country (Stilwell et al., 2003).

• Health work is no longer a preferred occupation in OECD countries. Fewer young people are choosing nursing as a career due to the increase in career choices. Young people also perceive nursing as cleaning up people, with unsociable working hours and relatively poor pay for a demanding job (Wickett and McCutcheon, 2002, cited in Seton, 2004).

**Human motivations**

Behind the process of migration lie thousands of individual decisions directed by personal motivations about migration. Psychology textbooks show that motivation is a complex phenomenon that involves an internal state or condition - sometimes described as a need, desire, willingness or want that serves to activate or energize, to guide and sustain, and to drive people to achieve or accomplish personal and/or organizational goals.
Motivation is also defined as composed of psychological processes that describe why (for what purpose) a certain human behaviour is initiated; how (effort towards a goal) energy is directed and maintained or made persistent and intensified amidst obstacles to reach certain goals (Romando, 2007; Cherry, 2005).

**Intrinsic and extrinsic motivation**

Psychologists generally divide the sources of motivation into *intrinsic* or *extrinsic*. Intrinsic motivation is internally driven, thus it comes from the pleasure one gets from the task itself or from the sense of satisfaction of working and completing a task. Although some theorists argue that there is only a single kind of intrinsic motivation – one that enhances the self-concept (Combs, 1982; Purkey and Schmidt, 1987; Purkey and Stanley, 1991), most theorists have defined intrinsic motivation more broadly. Malone and Lepper (1987) included the factors of challenge (goals are challenging, but achievable), curiosity (stimulating interest to learn more), control (people understand the cause and effect relationship between an action and its result), fantasy (helping individuals imagine themselves in situations that are motivating), competition (comparing our performance to that of others) and cooperation (helping others achieve their goals).

Intrinsic sources of motivation have been sub-categorised into cognitive, affective, conative, social, biological and spiritual (Huitt, 2001). The cognitive motivation states that behaviour is an active result of the analysis and processing of available information to solve a problem or make a decision, to develop meaning or understanding or to figure something out, rather than an innate and mechanical set of rules that the mind uses to respond to situations. It is the power of positive thinking to minimise or eliminate threat or risk. The affective force is about maintaining levels of optimism and enthusiasm, increasing feeling good and decreasing feeling bad, feeling secure, and increasing self-esteem. The conative force is the will to achieve personal dream/s or goal/s, maintain self-efficiency and independence. The social force is about being part or a valued member of a group. The biological force refers to the activation of body senses (touch, taste, smell, etc.) and maintaining body homeostasis. The spiritual force relates to
understanding one’s life through connecting the self to divine or spiritual forces. Intrinsic motivation also includes motivations for growth, responsibility, advancement, recognition and job nature that occurs when people do something for their own pleasure, sense of importance or desire. Intrinsic motivation does not mean, however, that a person will not seek rewards, but such external rewards are not enough to keep a person motivated (Huit, 2001; Cherry, 2005; Romando, 2007).

On the other hand, extrinsic motivation comes from outside of the individual. It occurs when external factors or arbitrary rewards or threats that compel the person to do something such as earning money, performing unpleasant tasks to ensure job security, or taking on work or study options because of family pressure. It often involves tangible rewards received from work, which can be something as minor as a smiley face or simple ‘thank you’ to small acts of compensation, social recognition or praise through to something major like salary increases or promotion (Huit, 2001; Cherry, 2005; Romando, 2007). These rewards provide satisfaction and pleasure that the task itself may not provide. An extrinsically motivated health worker, for example, may dislike a certain task or may find it boring or have little interest in it, but will still work on the task because of the anticipated satisfaction they will get from some reward. It does not mean, that a person will not get any pleasure from working on or completing a task, but just that the pleasure they anticipate from some external reward will continue to be the greater motivator.

Psychologists generally argue that people perform better when they do something that they enjoy or want (intrinsic), and that certain levels of extrinsic rewards can sabotage natural desire. However, Reiss, cited in Grabmeier (2005) disagrees:

“There is not any way to reduce all of the desires to just two types...it’s a matter of individual differences because different people are motivated in different ways ... you can’t say some motivations, like money, are inherently inferior.” (p. 1)

In a study of Dieleman, Viet Cuong, Vu Anh and Martineau (2003) on the factors for job motivation of public health staff in Viet Nam, it was revealed that motivation is
influenced by both intrinsic and extrinsic incentives. The main motivating factors were appreciation by managers, colleagues and the community; a stable job, training and income; while the main discouraging factors were associated to low earnings and difficult working conditions.

More complex motivation theories include content theories that explain the possible reason/s of human behaviour, and the process theories which recognize variables that go into motivation, and their interrelationship.

**Content theories of motivation**

The content theory focuses on the internal factors that energize and direct human behaviour to determine and satisfy specific needs and goals. Some of the major content theories are Maslow's classical hierarchy of needs, (Maslow, 1971; Maslow and Lowery, 1998), which was reorganised into Alderfer’s Existence, Relatedness and Growth (ERG) needs-based theory (Alderfer, 1969, 1972). This ERG theory was argued to be more consistent with empirical findings. Other content theories include the dual factors theory of Herzberg, Mausner and Snydeman, (1962) and the three needs theory of McClelland (1962/1987).

The **hierarchy of needs theory** was developed by Maslow (1971; Maslow and Lowery,1998), a behavioural scientist who assumed that all individuals have a wide range of inter-dependent needs that are arranged into hierarchy, of which the lower level needs such as physiological needs must be satisfied before the other higher level needs of safety, social, esteem and self-actualization. These five basic categories are:

- **Physiological needs** - air, water, nourishment, sleep, shelter, lunch breaks, rest breaks, and wages that are sufficient to purchase the essentials of life;
- **Safety Needs** - safe living, social and working environments, retirement benefits, medical insurance, financial and job security;
- **Social Needs** - a sense of community through team-based projects and social events, needs for friends, for belonging and the need to give and receive love;
• Esteem Needs – self-respect, achievement, recognition, attention, reputation needs
• Self-Actualization - the challenge and the opportunity to reach one’s full potential, including needs of wisdom, meaning, justice, and truth (Daniels, 2001).

A critical appraisal on this theory, however, reveals that not all individuals have the same hierarchy of needs. For example, some people want to fulfil their self-actualization needs even though their primary needs may not have been fulfilled. Needs are not the only determinant of behaviour as there are other motivating factors that includes experiences, expectations, perceptions, that direct the behaviour of the individuals. Hence, Alderfer (1969, 1972) has re-grouped these needs into three categories: Existence, Relatedness and Growth (ERG) needs-based theory. The existence needs are similar to Maslow’s physiological and safety needs; the relatedness needs that are similar to the social needs; and the growth needs that refer to the desire to be productive, creative and to complete meaningful tasks are similar to Maslow’s internal esteem needs and self-actualization.

These needs were further categorized into two factors (Herzberg’s dual factor theory) relating to work based motivation: the need to avoid unpleasantness and discomfort (hygiene factors) and the need for personal improvement and development (job motivator factors). The ‘hygiene factors’ refer to the dynamics of job maintenance that include technical supervision, interpersonal relationship with peers and superiors/subordinates, salary/bonus and other incentives, safe working conditions, status, company policy and administration, job security and personal life (Herzberg, et. al., 1962; Chapman, 2009). These are closely related to the existence and relatedness needs of Alderfer. Although ‘hygiene factors’ must be met so as not to dissatisfy workers with the job, the presence of these hygiene factors is seldom considered as creating job satisfaction or motivators for better performance. Hence, the need of job motivator factors, sometimes termed as real or ‘true motivators’, such as achievement, advancement and career development, growth, work itself, recognition, appreciation and rewards, positive encouragement, increasing responsibilities and having challenging tasks (Herzberg, et. al., 1962; Chapman, 2009). These job motivator factors are associated with the growth needs of Alderfer, Maslow’s
esteem and self-actualization needs, as well as McClelland’s three need theory of motivation.

The three need theory (McClelland, 1962, 1987) is based on the assumption that experiences shape needs regarding achievement, affiliation and power. He proposed that a person's motivation and performance are influenced by these three needs. It uses a projective technique called the Thematic Aptitude Test (TAT) so as to evaluate people based on these three needs. McClelland (1962/1987) views that a person’s needs are acquired or learned over time and are influenced through one's early life experiences. This theory suggests that people with a high need for achievement will set challenging projects or ‘high goals, and usually try to do most things on their own than getting them done by others’. People with high need for affiliation perform best in a cooperative environment, and will reflect the desire to interact with people - ‘social relationship takes precedence over task accomplishment’, while people with high need for power work best in the opportunity to manage others (Goyal, n.d., p. 36).

Process theories of motivation

Process theories of motivation provide an opportunity to understand thought processes that influence behaviour (Ferguson, 2000). The major process theories of motivation include equity theory (Adams, 1965), expectancy theory (Vroom, 1964), goal-setting theory (Locke and Latham, 2002) and reinforcement theory (Skinner, 1953).

The equity theory was developed from Maslow’s Hierarchy of Needs and Herzberg's Two Factor Theory by the psychologist, John Adams (1965). The central idea of this equity theory is that workers expect a fair return for their contribution to their job, and will strive to balance what they put in to their jobs and what they get from them as they unconsciously assign values to each of their job contributions. Inputs usually involve effort, loyalty, hard work, commitment, skill, ability, adaptability, flexibility, tolerance, determination, enthusiasm, trust in superiors, support of colleagues, personal sacrifice, etc; while typical outputs include financial rewards (salary, benefits, bonuses, etc.),
intangibles that may consist of recognition, reputation, responsibility, sense of achievement, praise, stimulus, sense of advancement, growth and job security. Inequity (greater inputs than outputs) discourages workers in relation to their job and employer if a balance is not reached. Workers define what is equitable in comparison with what their peers in their workplace or in other workplaces receive, and will leave if they feel unfairly treated (Adams, 1965; Leventhal, 2000; Jones, George, Hill and Langton, 2002). It is argued, however, that equity emphasizes only the fairness of distribution, ignoring the fairness of procedure (Leventhal, 2000).

From the perspective of human rights and social development, fairness of procedure to equity theory is identified as one of the workers’ needs. Human rights include the values and principles of human basic needs, equality and non-discrimination. It also includes justice (dignity, security and integrity of members of the society) and solidarity (understanding, empathy and taking stand for others’ cause). Social development is about the well-being of people, giving them opportunities to enlarge their choices, always seeking to do better considering the multi-dimensional aspects of economic, social, political, cultural, legal and ecological (Human Rights Commission, n.d.; Cox and Pawar, 2006).

In relation to migration that leads to reduction in equality in the home country, Mckenzie and Rapoport (2006) said that the migration of middle class people tends to increase inequality but migration networks decrease the costs for future migrants. In a review of human resources management in health services, Martinez and Martineau (2002) pointed out that the reality for many health workers in developing countries is that they are ‘underpaid, poorly motivated and increasingly dissatisfied and sceptical’ (p.30). The relevance of motivation to migration is self-evident: there can be little doubt that for many health workers, an improvement in pay and conditions will act as incentives to stay in their country. Improved pensions, child care, educational opportunities and recognition are also known to be important incentives (Martinez and Martineau, 2002).
In contrast to the other content theories that focus on the needs of people to motivate themselves. Vroom (1964) developed the expectancy theory of motivation which assumes that people have different sets of individual goals (outcomes) or perceived probability of expectations, and can be motivated if they believe that there is positive correlation between effort and performance and rewards. As such, increased effort will basically lead to increased performance. Performance depends on individual factors such as gaining the appropriate skills, knowledge and experience to do the job and the necessary support of supervisors and having the right personality or attitude. This theory fits in the circumstances whereby the workers have the freedom to make their choice among alternative courses of action or behaviour.

Closely related to this expectancy theory but focusing on outcomes, is the goal-setting theory of motivation. Goals direct attention and effort toward goal-relevant activities. Goals have energizing functions that lead to greater effort and persistence, leading to the discovery, and/or use of task-relevant knowledge and strategies (Locke and Latham, 2002). This theory also states that goal setting leads to better performance, and that the willingness to achieve set goals is the main source of job motivation. As such, specific, clear and achievable goals set by the individual themselves will motivate them to meet higher performance levels (Waitley, 1996; Ferguson, 2000). Participation in goal-setting increases worker's commitment. While goal setting is a technique to complete work quickly, it is also used to improve feedback quality. However, there is no proof that goal setting improves job satisfaction, thus the need for positive reinforcement if achieving levels of performance (as targeted or above the goal) is to be achieved (Juneja and Juneja, 1998; Ferguson, 2000).

The reinforcement theory of motivation (Skinner, 1953) is based on the view that people are generally more strongly inclined to do things if they have had immediate, sincere and positive reinforcement rather than if they have been merely advised to do something. This theory states that behaviours that lead to positive outcomes will be repeated, and behaviours that lead to negative outcome will be avoided. Positive reinforcements may not be realistic at all times, and too much emphasis on negative consequences may be
detrimental. Hence, a delicate balance of both approach and avoidance motivation may lead to a more well-rounded and successful individual.

Roles of health and social workers

Roles are contributing elements of social institutions and social structures which are presented as two perspectives, ‘structural’ and ‘interactionist’ (Nye, 1976), that can accumulate and change overtime. The success of health and social worker migrants may be related to general forms of roles that are discussed below.

Structuralist, interactionist and accumulating and changing roles

The structuralist role perspective is concerned with culturally defined norms, duties, and expectations and standard job descriptions (Nye, 1976) that guide the performance of conduct. Job Bank USA (1995) offered the following structuralist job description, defining the role and responsibilities of registered nurses within the US health system:

‘Registered nurses (RNs), regardless of specialty or work setting, perform basic duties that include treating patients, educating patients and the public about various medical conditions, and providing advice and emotional support to patients’ family members. RNs record patients’ medical histories and symptoms help to perform diagnostic tests and analyse results, operate medical machinery, administer treatment and medications, and help with patient follow-up and rehabilitation’ (p.1).

Such roles have demanding access criteria and often migrants have to take on roles that do not require graduate qualifications such as Health Care Assistants (HCAs). In Spilsbury and Meyer’s (2004) study in the United Kingdom about the health care assistants’ role in the hospital, the HCA job descriptions clearly identified three key areas of work for HCAs — direct care, housekeeping and clerical duties but her findings revealed that the HCAs’ work were more on direct-client care, rather than housekeeping and clerical duties. Similarly, Coulshed and Orme (1998) identified caring and helping as a major part of the duties of health care workers. Structured roles may guide and
specify normative behaviour, but they do not entirely dictate conduct in the job itself as this is affected by individual skills, preferences and contexts. Roles can be informal, formal, and multiple (Reynolds and Kinney, 2003). Hence, at times, roles must be managed as they affect and are affected by the interactions with others.

The interactionist role perspective focuses on how people adopt and perform roles during interactions in social contexts. The focus is not on tasks, criteria, and standards, but on interactional processes (Goffman, 1959, 1961, cited by Reynolds and Kinney, 2003). For example, the rehabilitation program worker’s interactionist role is on understanding, assessing and communicating situations within a team. It is a relational role that involves listening; encouraging thinking, feelings and actions; giving reassurance, support and encouragement as well as understanding people and conveying hope. Coulshed and Orme (1998) and Barnard, Casella, Coffin, Hughes, Hurst, Rasey, Redding, Ribillard, St. James and Ullery (2001) said that at an advanced level, it can involve the supervision of others, coordination of care plans, oversight of facilities, negotiating, advocacy and networking or collaborating with other health professionals as well as with the patient’s Whanau. In this model, professional and non-professionals work as a team. They interact with patients and other staff such as the cleaners, ward clerks, doctors, social workers, and therapy workers to address specific conditions and issues and develop appropriate care plans. The interactionist model offers migrants greater access to responsible work than the more prescriptive structuralist model. Healthcare is becoming increasingly complex, thus the delegation of care from the nurses to the HCAs is part of that complexity (Gillen and Graffin, 2010).

People also accumulate and change roles at any given stage in life by taking on new roles, keeping some current ones, and leaving others behind (Spilsbury and Meyer, 2004). HCAs are sometimes used in ways that went beyond the expectations of formal policies resulting at times in the exploitation of the HCA role. On the other hand, HCAs can influence the shape of their work as they are challenged to do additional roles such as being more at the bedside of the patients, being able to gather more direct information about them (Spilsbury and Meyer, 2005). HCAs who have received appropriate training
and who have been assessed as competent may undertake greater responsibilities such as patient observations such as temperature, pulse, respirations, and weight (NHS, 2009, cited in Gillen and Graffin, 2010).

In a study of Spilsbury and Meyer (2004) at the United Kingdom, which includes England, Scotland, Wales, and Northern Ireland, some nursing activities were delegated to support workers or HCAs who assisted them in providing patient care, and the role of registered nurses was increased to carry out more highly technical care, sometimes taking on the work of junior doctors. HCAs had their duties as defined in their job description, but due to inadequate staffing at times, they undertook additional activities such as doing more of the delivery of bedside care, normally done by the nurses. HCAs also performed tasks like blood glucose monitoring without the proper qualification, although they may well have had experience of such tasks in their home country.

In another study at the United Kingdom, HCAs perceived little difference between their roles and those of qualified nurses, and they also experienced ambiguity as to their proper role. Because of this ambiguity, qualified nurses perceived the HCAs as a threat to their own roles. The HCAs are seen as deprived of their ‘real’ nursing role (O’Dowd, 2003) as they had some training, but were not qualified nurses, despite increasingly taking on the roles of nurses (Haworth and Shaw, 2003).

On the other hand, role accumulation can be reversed. HCAs who were trained as dieticians were told not to give dietary advice; and HCAs trained as phlebotomists were told not to take blood as part of their role as HCAs. Spilsbury and Meyer (2004) conclude that the miss-use of HCAs beyond policy boundaries, followed by a period of role restriction has made them feel de-skilled and frustrated and under-utilised.

**Roles of other non-professionalised staff**

Similar to Health Care Assistants (HCAs), Community Support Workers (CSWs), and Rehabilitation Program Workers (RPWs) are junior positions who assist the registered
nurses, social workers and other professionals in the health and disability sector. This study involves HCAs, CSWs and RPWs that already have related health professional experience and/or qualifications in their country of origin, and are in the process of re-training or registering in New Zealand.

The roles of RPWs are similar with the roles of CSWs in terms of working with a team to achieve best rehabilitation outcomes through encouraging independence and safe and sustainable services in all client therapy assistance, and promoting a quality of life and health and well being, as well as by just being people who the client could chat with or communicate effectively. Amongst these, supporting consumers includes respecting the dignity, rights, values and beliefs as well as supporting the personal and family goals of consumers. This is achieved through a positive work ethic in a collaborative team that has similar goals (Cavit ABI, 2007).

In a study of how the New Zealand community mental health support workers perceive their roles, Pace (2009) found their main role was seen as

> ‘developing and maintaining a therapeutic relationship, which was referred to as the philosophy behind their current practice ... working alongside the service users with a strong sense of partnership and collaborative practice, skill development and training’ (p.3).

Other roles described were teaching, skill development, community reintegration and administrative work, which are noted by support workers as a ‘necessary evil’ (Pace, 2009, p. 5). These roles are a mix of the structuralist and interactionist roles described above. Health care assistants, mental health workers and rehabilitation assistants support registered professionals by acting as a link in the communication chain between the patient/consumer and carers, and by taking on many of the tasks of those professionals in their work with the clients, and or completing tasks delegated to them.
The Migration experience

Why migrants chose New Zealand

In a study about the settlement outcomes of skilled migrants in New Zealand, it was found that a majority of the participants regarded lifestyle reasons, climate, natural beauty or a clean, green environment, friendly people or a relaxed way of life and safety from crime and violence as reasons why migrants have chosen New Zealand rather than another country; while a few participants also identified recreational opportunities, the small population, job opportunities, educational opportunities, favourable economic conditions, quality social services, political stability, freedom from corruption, and a lack of interracial, ethnic, or religious tensions (Wallis, 2006). Similarly, in a study of Meares, et.al. (2010) among Chinese employers and employees in Auckland, it was revealed that they migrated to New Zealand because of their dream for a better lifestyle that includes the appreciation of a clean, green and environment, as well as for a better future for their children, education and employment opportunities, and to have a new start in their business.

New Zealand Immigration Service (2005b) promotes New Zealand as needing ‘great people’ with skills to offer and make potential economic contribution, and as offering ‘a unique lifestyle’. It was recently ranked as the ‘third best country in the world to live in’ by the United Nations Human Development Index that measures income, health and education. All the participants in this study have implied if not expressed similar reasons why they have chosen New Zealand as their country of destination.

Cultural differences and culture shock

New Zealand has become increasingly culturally diverse (McLennan, Ryan and Spoonley, 2004; Statistics New Zealand, 2006; Hamilton, 1996). Likewise, the population of patients and other health consumers is also becoming multi-cultural (McDonald, 2001). The challenge of cultural differences are challenges of
understanding values (good-evil, right-wrong, natural-unnatural) that are considered the core of culture. It is also a challenge of recognising the symbols and valued cultural roles and models that are typically only recognised by cultural insiders; and of participating at some level in culturally important rituals (Hofstede, 1997). These rituals may include greetings to tangi and the adoption of Maori rituals such as the powhiri or welcoming ceremony (Phillips, 2009), as well as the general way of doing things as in health and other social services. Migrants face the prospect that a considerable portion of what they have learned about interpreting actions, or the assumptions that guided their understandings are no longer reliable (Brick 1991, cited by Seton, 2004: DeVito, 1991).

Differences of ethnicity, nationality and culture affect health beliefs, practices and behaviours. These may also influence the expectations that the patient and the provider have of each other. The lack of awareness about cultural differences can make it difficult to achieve the most appropriate care (DiversityRx, 2003).

Exposure with an entirely new and unfamiliar environment may lead to experiences of culture shock. Culture shock arises from the contrast between the reason for migration, and the realities of their new environment. It can include symptoms of depression (unexplained crying, difficulty in sleeping or excessive sleeping and a general feeling of malaise, loss of appetite, confusion, inability to make decisions, anger, lack of confidence, feeling inadequate); psycho-somatic symptoms (physical aches and pains or cramps, diarrhoea, constant fatigue), homesickness (idealizing their old country of residence, the desire to return home, longing for family and feelings of being lost, loss of identity), as well as frantically attempting to merge into the new culture (Brick, 1991, cited by Seton, 2004).

Culture shock is most connected to the second or crisis stage in the migration cycle. This cycle describes the following migration stages: first, the honeymoon stage where people are fascinated with the new culture and its people – there are feelings of joy, excitement and interest, however the honeymoon stage does not last forever. Second, the crisis stage where one finds the differences between his/her culture and the new one that creates problems. Problems emerge such as communication difficulties and professional and
personality issues that can affect the person’s integration to the new environment, which, in turn, may bring feelings of impatience, frustration and anger. Third is the recovery stage where one gains the skills necessary to function effectively; and fourth is the adjustment stage where periodic difficulties and strains may still occur but on the whole, the experience is pleasant (Oberg, 1960, cited in DeVito, 1991).

In a study of on the settlement of immigrants in New Zealand, Wallis (2006) revealed that during the first year, a great majority of skilled and business migrants were happy with their migration, and would even recommend New Zealand as a place to live. However, most of the participants have experienced unwelcome shocks on their first few months in New Zealand, including concerns about the high cost of health services, housing, lower than expected salaries and living generally, suggesting that the crisis might be early and short-lived. In another study about overseas registered nurses’ perspectives on transition to nursing practice in New Zealand, Seton (2004) found that there were various challenging and confusing experiences for the overseas nurses, and that the cultural shock experienced was both personal and professional. Particular influences included English language ability and communication difficulties, the presence or lack of support, perceived discrimination and prejudice in the workplace.

**Cultures of individualism and collectivism**

There are two general but related cultural orientations in cross-cultural psychology – individualism and collectivism - which have important implications in the processes of migration and employment. Trandis (1995) said that all individuals have a mixture of both individualist and collectivist values and response tendencies, but the response tendencies are determined by situation.

In collectivist societies (most typically tribal or village cultures), people are traditionalist and emphasize integrated, strong, cohesive in-groups, which throughout people's lifetimes continue to protect them in exchange for understanding, loyalty and respect for norms and directives of authorities (Hofstede, 1997/2001; Setiadi; Supratiknya; Bond and
Smith 1996b as cited in Trandis and Suh, 2002; Lonner and Poortinga, 2004). In vertical collectivist culture, individuals view personal goals and needs as subordinate to the goals and needs of in-groups (extended family, community, work organizations etc.) so they are more likely to favour promoting group harmony in their relationships by submitting to authorities and conventional norms (Trandis and Suh, 2002). Indians [and Filipinos] feel responsible and see it more as duty-based or obligation to help siblings or colleagues, while Americans consider it more as a matter of personal choice (Miller 1997 as cited in Trandis and Suh, 2002). In horizontal collectivist cultures, empathy, sociability, and cooperation are emphasized (Triandis & Gelfand 1998 as cited in Trandis and Suh, 2002).

In a study about culture, emotion, and well-being: good feelings in Japan and the United States, Americans reported more positive disengaged emotions as feeling superior, proud and on top of the world; whereas Japanese reported more interpersonally engaged emotions of being friendly, feeling close and having respect. Americans also reported more positive than negative emotions as compared to the Japanese (Kitayama, Markus Kurokawa, 2000). In collectivist cultures, people are motivated to change in order to “fit in” to the demands of the social environment. Collectivist cultures use indirect and face-saving communication more than people in individualist cultures (Holtgraves 1997 as cited in Trandis and Suh, 2002; Le Baron, 2003).

People in individualist cultures see themselves as more or less stable and have rights. For example, if they do not like their job, they can just change jobs (Chiu and Hong 1999, Hong et al. 2001 as cited in Trandis and Suh, 2002). Western urban cultures tend to be individualistic - ties between individuals are loose, everyone is expected to look after himself or herself and his or her immediate family, people are expected to speak up and express their personal opinions, even if they are contrary to those of the group, self-determination is regarded as freedom from group expectations, and self-reliance is regarded as a sign of strength (Corey and Corey, 2007). Individualistic approaches are seen as self centred and morally wrong (Setiadi et al., 2004).
With the strong influence of the Western world, collectivism is beginning to erode, although it is still alive and well in most settings (Galloway, 2009), and not necessarily in opposition to individualism as both are elements of a total system (Corey and Corey, 2007). Rather than thinking of cultural differences as barriers, we should learn to welcome the tensions between collectivism and individualism as something positive, recognizing that consciously dealing with this debate can make your job easier, not more difficult (Corey and Corey, 2007). Relative to the mainstream, individualistic Western-oriented culture of New Zealand, Chinese, Indian and Filipino cultures are much more collective.

**Difficulty of migrants in finding employment**

New Zealand immigration policy continues to target skilled and business immigrants that are hoped to successfully integrate and contribute to the socio-economic development of the country. However, immigrants, particularly those from ethnic minority backgrounds or from non-traditional sources like China, India, the Philippines and others face difficulties in finding employment in New Zealand (DIA, 1996; Henderson, 2004). Employment difficulties are related to factors that include miss-information and misunderstanding, denial of opportunities, a lack of recognition of overseas qualifications, an inability to access job and an inability to gain the training or experience necessary to meet the required standards to meet their trade or position (McGrath, Butcher, Pickering, and Smith, 2005). Sociologist Paul Spoonley said that ‘employers show a reluctance to employ new immigrants; particularly those who don't have a British surname, perhaps have an accent or do not have New Zealand experience’ (O’Hare, 2004, p.2).

Other identified barriers to employing immigrants are issues of cultural and organisational fit, fears that an immigrant might disrupt the workplace because of cultural differences; being over-qualified; and the perceived risk of an employee leaving for a better job (North, 2007). Those already in work can be dissatisfied because of the very
low pay, not being able to use their skills or experience, and their present job not aligned with their preferred occupation, among others (Badkar, 2008).

Other recent studies still reveal that skilled migrants have difficulty in finding jobs due primarily to the lack of recognition of overseas qualifications by New Zealand employers, the lack of New Zealand work experience and qualifications, lack of aptitude in the English language or communication proficiency, no suitable job opportunities and not knowing people in the industry, as well as employer attitudes (North, 2007; Badkar, 2008; Ward and Masgoret; 2008; Meares et. al., 2010). Studies revealed that the experience of racism by Asians in New Zealand is very common (Harris, Tobias, Jeffreys, Waldegrave, Karlsen and Nazroo, 2006). All these socio-cultural factors have relevant negative effect to the health and wellbeing of migrants, predominantly in terms of mental health (Asian Public Health Project Team, 2003). This mental health concern is rather termed as a ‘psychological and emotional injury’ since the effects emanate from the socio-cultural environment, and not from an abnormality that resides within the individual (Carter, Forsyth, Mazzula and Williams, 2004 as cited in Franklin, Boyd-Franklin and Kelly, 2006, p. 17). Moreover, the difficulty of skilled migrants in finding employment affects their general economic conditions and hinders their economic integration to the host country (Henderson, 2004).

**Educational qualifications not readily accepted**

Among the crises facing migrant communities is the non-recognition and acceptance of overseas qualifications by professional bodies, even where these qualifications were used to gain points in the immigration entry point system requirements. In a study of Lee (2003) as cited in Seton (2004), there were general indications that previous nursing background and knowledge were not always taken into account and appreciated when nurses migrated, and so some of them start to work as care-givers while processing their competency assessment program to register in New Zealand.
The New Zealand Association of Citizens Advice Bureaux (2000) reported considerable number of under-employment cases where overseas trained nurses, physiotherapists, occupational therapists, even physicians and dentists work as health care assistants, home care assistants, rehabilitation assistants and even cleaners or taxi drivers in some instances.

Inter-cultural communication and the English language

Collective/individual differences also show up in the language that one has learned to speak and in non-verbal messages used. Intercultural communication broadly refers to communication between people of different cultures (e.g. Chinese and Kiwi), sub-cultures (e.g. doctors and nurses or assistants), broad ethnic categories (e.g. Asian and European), nations (e.g. India and New Zealand), and sexes. Inter-cultural communication can be assisted by ‘enculturation’ - learning and ‘acculturation by modifying one’s culture through the direct contact with or exposure to another culture’ (DeVito, 1991, p.431).

Communication is affected by the context, personality and mood in interaction with a range of cultural influences including concepts of time and space, fate and personal responsibility, face and face-saving and nonverbal communication. The concept of time differs from culture to culture, and it affects the ways of doing things. In the West, ‘time is money’ and is always connected with ‘efficiency and success for economic endeavour’; while in the East, ‘time feels like it has unlimited continuity, an unravelling rather than a strict boundary’ (Le Baron, 2003, p.1).

In many cultures, maintaining face and face-saving that includes ideas of status, power, courtesy, insider and outsider relations, humour, and respect is important (Le Baron, 2003). However, ideas on how to do this differ as it relates to individualist and collectivist roles as discussed earlier. If there is conflict between individuals or within a group, direct confrontation is a solution for some, but others will prefer negotiations or mediation through a third party to save face and minimize potential damage to
relationships. Western individualistic achievement-oriented assertiveness may be considered by Asian cultures as being rude. Asian cultures communicate initially with only a few words, with an emphasis on politeness, and this may be construed as lack of character in Western cultures (Brick, 1991; Yi and Jezewski, 2000, cited in Seton, 2004).

In an inter-cultural society the relevant communication skills of initiating conversations or finding topics of mutual interest, active listening and non-verbal communication are important (McCaffery (1986). Active listening includes paraphrasing, summarizing, restating, reflecting feelings and testing of understanding. The cues of non-verbal communication are of paramount importance to verbal communication, more especially when the verbal communication is unclear or ambiguous. Non-verbal expressions include physical closeness, hand gestures, posture that implies willingness to enter into interaction, focus and eye contact, facial expressions, silence, spatial relations, emotional expression, touch, physical appearance, and other nonverbal cues (McCaffery, 1986; Le Baron, 2003) such as nod or smile instead of saying ‘yes’ or shrugging instead of saying ‘no’ (DeVito, 1991, p.216; Metge and Kinloch, 1978). Although some non-verbal communication such as the emotions of enjoyment, sadness, fear, anger, surprise and disgust are consistent across cultures, differences emerge with respect to which emotions are expressed in similar ways by people around the globe (Okun, 1999, cited in Le Baron, 2003). For example, the interpretation of facial expressions across cultures is difficult. In China and Japan, a facial expression that would be recognised around the world as conveying happiness may actually express anger or mask sadness, both of which are unacceptable to show overtly (Novinger, 2001, cited in Le Baron, 2003).

In New Zealand, intercultural communication between Maori, Pasifika, Asian and Pakeha involves appropriate eye contact, determination of when and where to sit and to stand; and ways of greeting and attitudes towards authorities (Arnold and Boggs, 1999; Metge and Kinloch, 1978; Durie, 1998/2001b). For example, many migrants come from a culture of respect, where they are likely to address senior nurses, managers, and academic staff as ‘sir’ or ma’am’ (Witchell and Ouch, 2002, cited in Seton, 2004). Added to the communication challenge is that of English pronunciation. With migrant nurses in
Australia, Gray and Pratt (1992) reported that being understood was difficult, particularly when word endings were not clearly enunciated, when consonants were not strongly sounded and when syllables in the words were not correctly stressed.

In Australia, the cross-cultural understanding for migrant nurses ‘requires both research knowledge and practical action’ on nursing and English skill components to reach an ‘adequate level of English to obtain the pre-registration and the work experience to gain a sufficiently adequate level of vocational language to operate effectively and therefore be acceptable to the health service’ (Menon, cited by Gray and Pratt, 1992, p. 232). Similarly in New Zealand, English language and nursing bridging course for nurses are designed to help migrant nurses to adapt in the multi-culture of colleagues and health consumers (NCNZ, 2005/2010; Seton, 2004).

Qualitative studies show that migrants with English as a second language recognize the importance of the acquisition, maintenance and proficiency in both the operational and the professional English language as a key element in successful integration (Barnard, 1996 as cited in McGrath et.al., 2005). Where English is not the first language, English language assessment is done either through the IELTS (International English Language Test System) or the OET (Occupational English Test) as a requirement to gain a recognized level in terms of language for entry into academic programmes (Unitec NZ, 2010; Waylink Direct Ltd, 2010), or as an additional qualification to be a registered nurse and work as such (Nursing Council of New Zealand, 2005). These English assessments test the competence of migrants in aspects of reading, writing, listening and speaking. High IELTS or OET scores are often cited as a reliable indicator of success in the transition to the health work in English speaking countries (Wickett and McCutcheon, 2002 as cited in Seton, 2004; Nursing Council of New Zealand, 2005/2010).

**Vulnerability of migrants**

Migrants have been identified as a vulnerable population in terms of adjusting to the new culture, difficulty in finding employment, educational qualifications not readily accepted,
in addition to what Derose, Escarce and Lurie (2007) identified as having inadequate health care and other socio economic factors as limited English proficiency, immigration status, little or no access to publicly funded health care, residential location, stigma and marginalization. Similarly, Lyons (1999,) viewed that “migrants are often the most likely people to experience the worst effects of limited, low-paid and insecure employment, poor housing conditions, strained health and education services and restrictive financial aid, should any be available” (p 123).

Swing (2008) posed the challenge that ‘migration can certainly be a manifestation of vulnerability, but it does not need to be’ when migration is linked to ‘logical and legitimate adaptation strategy of social development ... managed with feasible, accessible solutions through institutions, policies and resources’ (p.5). It was observed that government, and others often ‘consider it solely the immigrant’s responsibility to adjust to the New Zealand culture, perhaps reflecting a resistance seen in the wider society to the presences of immigrants’ (Spoonley, 2003, cited in Hunter, 2007, p. 21). However, Elsie Ho of Waikato University's Migration Research Group said that, "whether migrants adjust to a new environment is really a two-way process. It is not just themselves, it's everybody's reaction." (O'Hare, 2004, p.3).

**Adaptation and integration of migrants**

Part of this study explores how the participants think others in similar situation as theirs could be helped in the health and social practice contexts of valuing diversity, and strengthening disadvantaged individuals and minority groups Lyons (1999) such as possibly the migrants in this study. On the stages of migration adjustment, Coulshed and Orme (1998) said:

“Many immigrants go through a pattern of adaptation to an unfamiliar and probable discriminating environment. The loss of support networks together with a sense of emigrating through critical phases such as excitement-disenchantment-perception of discrimination-identification crisis and marginal acceptance.” (p.139)
McDonald’s (2001) study focused on facilitating adaptability through cultural competence in terms of collaboration among national agencies serving non-English speaking people; access to health care training for migrants with limited English; and developing research to better understand the migrant health workforce. Henderson’s (2004) study on the settlement experiences of immigrants in New Zealand revealed that immigrants’ responses to their challenging experiences include acceptance of underemployment, self-employment, frequent travels to Asia to work (astronauting), return migration, further education or retraining to gain New Zealand qualifications.

Adaptation efforts are geared towards integration to the new culture. Integration involves the concept of ‘assimilation’ or the adoption of the dominant culture; the ‘melting pot’ concept whereby diverse migrants participate in the formation of a new nation to produce a new society; and the more recent term of ‘cultural pluralism’, which assumes a mutual influence of multi-cultures that influence each other reciprocally, creating the ‘national space in which all migrants are citizens with equal rights and civic unity is promoted but not at the expense of ethnic diversity’ (McGrath, et.al, 2005, p.1).

Although integration is a long process that involves many processes from ‘legal protection to multicultural education that aims for the extremely difficult and improbable construction of a successful, well-functioning, multi-cultural or multi-racial society’ (Favell, 2001, p. 118), it creates practical steps by ‘projecting both social change and continuity between past and some idealised end-point’ (McGrath, et.al., 2005, p.1). It is argued that successful integration of migrants into a host society happens when citizenship and its corresponding rights are readily granted by the government, and new identify is accepted by the migrants; when labour market conditions are expanding, creating skill shortages that migrants can fill; when the host society respects the culture and values of the immigrant community (Weiner, 1996, cited in McGrath, et.al., 2005).

Furthermore, Gendall, Spoonley, and Trlin (2007) contend that successful immigrant settlement is a two-way process that depends on the adjustment of both immigrant and the host society, and that educational levels, contact and knowledge were considered as
impacting on the attitudes towards immigrants. It is further argued that the more educated the person was, the more tolerant he/she is likely to be; having contact helped contribute to positive attitudes; and knowledge about immigrants and immigration adds to positive attitudes.

The challenge of a multicultural society

Cultural competence

The multi-cultural nature of New Zealand creates a challenge for health providers and health and social practice workers to be able to work effectively with the different cultures, both of patients or consumers, their families, and of colleagues and employers. Cultural competence and cultural safety is thus an important element in the various services, such as health and social services, given to a culturally diverse society.

In the United States, the Department of Health and Human Services has promoted the development of cultural competence through numerous initiatives, and has offered the following definition cited by McDonald (2001):

“A set of attitudes, skills, behaviours and policies that enable organizations and staff to work effectively in cross-cultural situation. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competence also focuses its attention on population-specific issues including health-related beliefs and cultural values, disease prevalence, and treatment efficacy.” (p.46)

In New Zealand, Mason Durie defines cultural competence as ‘the acquisition of skills to better understand other cultures’ with the aim of achieving the ‘best possible health outcome’ or ‘better clinical results’ (Durie, 2001a, p.1). Cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context. The delivery of care in a culturally appropriate manner is an important
element in determining both the willingness of people to access services and the success of any treatment or care then delivered (Durie, 2001b).

The standards of cultural competence include the abilities to demonstrate cultural safety, which centres on the experiences of the consumer. It is a mechanism which allows the clients to say whether or not the service is safe for them. It involves continuing professional development in terms of maintaining/growing cultural competency; working towards being culturally competent in the broadest sense for improved health outcomes for all New Zealanders; and to apply the principles of the Treaty of Waitangi in nursing practice (Ramsden, 1992; Durie, 2001a; MOH, 2002; NCNZ, 2005/2010).

*The Treaty of Waitangi in health and community work*

The Treaty of Waitangi supports the bicultural policies and principles of *partnership, protection and participation*. Partnership focuses on the recognition of different cultural values and the sharing of power between two peoples - the indigenous Maori, and the immigrant Europeans who sought an ethnic identification as Pakeha in the 1980s (Rata, 1996, cited in Rata, 2003). The treaty recognizes Maori as tangata Whenua (people of the land), and that the Crown (government) is committed to fulfilling its obligations as a Treaty partner. This agreement has led to the “biculturalist” argument that New Zealand has to properly address the partnership between the treaty partners before it can address the wider issues of multiculturalism.

The principle of partnership rests on the premise that ‘each partner will act reasonably and in the utmost good faith towards the other’ (Waitangi Tribunal, 1987, p.150). Partnership also refers to the government working together with iwi, hapu, whanau and Maori communities to develop appropriate approaches for Maori gain in all aspects such as health care, education and other services (MOH, 2002). Kingi (2007) said:

“The principle of partnership places an obligation on the Crown to include Māori in the design of health legislation, policies, and strategies. It draws on the idea that Māori should play an active role in whatever plans for
Māori health are devised. Further, that these relationships extend beyond central government, to local government, and how interactions with local iwi can be improved.” (p. 8)

The principle of protection recognizes the government’s duty to actively promote and develop preventative strategies to ensure Maori enjoy at least the same level of health as non-Maori, while safeguarding Maori cultural concepts, values and practices (Kingi, 2007, HDC, 1996; Durie, 2001b). The principle of participation encourages ‘Maori involvement in the delivery of health services, in the planning and design of these and associated policies’ (Royal Commission on Social Policy, 1988, cited by Kingi, p.8). Kingi also notes that the ‘the Treaty is not about Maori privilege or a desire to erode non-Maori rights...[it] is about equality and balance, an expectation by Maori of equal access to health services and appropriate outcomes...’ (p. 7). The claims of privilege led Rata (2003) to caution that over-emphasis on biculturalism is ‘an inherently inward-looking and closed positioning that threatens New Zealand’s place in the international community and the global economy’ (pp. 12-13).

The application of the principles of the Treaty of Waitangi (with respect to health and other services and citizenship) can then be applied to all citizens of New Zealand, many of whom may feel challenged by the bicultural framework of the Treaty and want access to the ‘national identity available to all New Zealand citizens regardless of ethnic origin’ (Rata, 2003, p. 12).

On the level of application of this treaty, Kingi (2007) has this to say:

“The treaty may be applied in a variety of ways, at different levels, and in multiple settings... to guide both health policy and health legislation. At another level it can also be used to assist health service delivery and more focused interactions between health professionals and clients. Despite confusion as to how the Treaty may be applied (especially to health) it is clear that once all perspectives are considered it is essentially about promoting or providing the best possible outcomes.” (p.7)
The wide acceptance and application of Durie’s (1998, 2001a/b) Whare Tapa Wha model, (a ‘holistic perspective on body and mind that is both ancient and modern’, Morice, 2006, p.3) within health service is an example of how, through the use of a bicultural process, a model of health that has high relevance to migrant communities can be successfully introduced. This model compares hauora (health) to the four walls of a whare (house), each wall representing a different dimension necessary for strength and symmetry: taha wairua (spiritual side), taha hinengano (thoughts and feelings), taha Tinana (physical side), and taha Whanau (family) (Durie, 1998, 2001a/b; Morice, 2006). The application of this model is not ‘only to issues of Maori health but as an assessment tool for health professionals generally’ (Morice, 2006, p. 5). This supports the suggestion that the advancement of biculturalism has laid the foundation for the extension to multiculturalism (Ward and Lin, 2005 as cited by Ward and Masgoret, 2008).

This present study involves migrant health professionals and workers who work with diverse cultures of colleagues and clients. This study aims to explore the transformational change process from the perspective of migrant health workers. Perspective transformation considers how people interpret or reflect on their life experiences including dilemmas or crises, and make or revise their assumptions, opinions, attitudes, reactions and beliefs from reflective learning (Mezirow, 1991). The knowledge of the experiences, roles, motivations and needs of Chinese, Indian and Filipino Migrant health workers in New Zealand will be of greatest use when constructive life adaptations emerge from it.

The following chapter presents the research design and methodology.
CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

This chapter describes the research plan, process and rationale for the approach taken in this study. Our focus is on the experiences of Chinese, Indian and Filipino migrant health and community workers in New Zealand. It includes the participants’ major life event experiences of migration and employment in a foreign country. It also includes the roles, motivations, needs and challenging issues and concerns, as well as the responses they make towards solving them. The research perspective, paradigm and the general mode of inquiry are presented and discussed. The methods of data collection, the recruitment of participants, and the analysis of data are explained. A discussion of the trustworthiness, transparency and authenticity of the research process is presented. The issues on research ethics and social research relative to this study are also addressed.

Research Perspective and a Choice of Paradigm

The most common research perspectives are shown in the distinctions between qualitative and quantitative research. Myers (2011) presented the overview of these perspectives. Quantitative research methods advanced in the natural sciences to study natural phenomena. Quantitative methods include numerical methods, survey methods, laboratory experiments and other formal and scientific methods of research that seeks to prove or disprove hypothesis.

On the other hand, qualitative research broadly refers to any kind of research that generates findings without inferential statistical procedures (Strauss & Corbin, 1990 as cited in Myers, 2000). Qualitative methods were developed in the social sciences to facilitate the study or exploration of the depth, richness and complexity of people within their social and cultural phenomena. Qualitative research ultimately aims to offer a
perspective of the participant’s situation. It is not generalizable in the traditional sense but it has redeeming qualities that set it above that requirement - the richness and depth of explorations and descriptions that give the voice of participants (Myers, 2000).

The main ways of collecting qualitative data is through or a combination of interactive interviewing, written descriptions by participants or by observing the participants’ verbal and non-verbal behaviour. The main types of qualitative research are as follows (Myers, 2000):

- Case study that attempts to study a single case example of the phenomena;
- Grounded theory which is developed from an inductive body of data acquired by a participant-observer;
- Ethnographic study that focuses on the sociology of meaning through close fieldwork or community observation of socio-cultural phenomena;
- Historical study that refers to the systematic collection and objective evaluation of data related to past occurrences in order to test hypotheses concerning causes, effects, or trends of these events that may help to explain present events and anticipate future events; and
- Phenomenology that studies the structures of experience as they present themselves to consciousness, without resorting to theory, deduction, or assumptions from other disciplines.

Phenomenology seeks to identify the ‘essence’ of human experiences about a phenomenon, as described by the participants in a study (Creswell, 2003, p.15). This present study is more concerned with the interpretation and the meaning attached to the human experiences, situations or phenomena of the research participants in an interpretive paradigm, which will be discussed later in this section.

A paradigm is a set of research strategies, criteria and assumptions that scientists have of their discipline (Fossey, Harvey, McDermott and Davidson, 2002; Sarantakos, 2005). In a research milieu, a paradigm describes a structure of concepts, ideas or world views that
are used by researchers to influence their approach and interpretation of results (Bryman, 2004).

There are three principal research paradigms - the *positivist, critical theory* and the *interpretivist* - that embody different ways of looking at the world (Guba and Lincoln, 1994; Fossey, et. al, 2002; Neuman, 2003; Bryman, 2004; Cantrell, 2006, Myers, 2011). Doing research requires us to choose an appropriate approach to the observation and measurement or description of the phenomena being studied in relation to the purposes of the research and the nature of social reality, amongst other things.

The *positivist paradigm* is a product of natural science that originates from the dominant “hard“ or quantitative science methods which rely on deductive logic, cause and effect laws, and the testing of generalizations through formal methodological steps, including statistical analysis in an attempt to increase the predictive understanding of phenomena (Denzin and Lincoln, 2003a/b; Hoepfl, cited in Golafshani, 2003, Myers, 2011). It assumes that researchers can fully understand and generalize the findings through experiments and observations, and perceives the world as existing separately of our knowledge of it. Concepts and knowledge are held to be the product of straightforward experiences, confirmed by a rational deduction approach (Neuman, 2003, Guba and Lincoln, 1994; Fossey, et.al., 2002). The significance of this test is to ensure ‘replicability or repeatability’ of the result (Golafshani, 2003, p. 598).

The *critical theory* paradigm supports how our thinking is socially and historically constructed and how this limits our actions, and how we might operate in order to challenge these learned restrictions. The critical theory paradigm is used to explore the social world, to critique it, and to empower the individual to overcome the problems in the social world, and enable people to understand how society functions and how unsatisfactory aspects can be changed radically (Neuman, 2003; Guba and Lincoln, 1994; Fossey et. al, 2002, Myers, 2011). As such, the critical paradigm is more focussed on the outcomes of research than the process. Action Research methods draw from this paradigm, and it uses both qualitative and quantitative approaches.
In contrast to the positivist paradigm that involves quantitative science methods, the interpretive paradigm is qualitative in nature. Interpretive paradigm has no overarching framework on how it should be conducted; rather each type of interpretive research is guided by particular philosophical perspectives that are taken in relation to each phenomenon (O’Brien, n.d. as cited in Myers, 2011). Interpretive paradigm suggests that there are multiple realities of phenomena, and that these realities can differ across time and place. It focuses on understanding the meaning of human experiences and actions, taking people’s subjective experiences seriously as the essence of what is real for them, and assuming that people cannot separate themselves from what they know. Sense is made of people’s experiences by interacting with them and listening carefully to what they say. The researcher and the participant are linked such that who they are and how they understand the world is a central part of how they understand themselves and others (Neuman, 2003; Sarantakos, 2005, Myers, 2000). It is through interpretive methods such as interviewing that a more informed and complex understanding of the social world can be constructed (Guba and Lincoln, 1994; Fossey et.al, 2002; Bryman, 2004; Blanche, Durrheim and Painter, 2006; Cohen and Crabtree, 2006, Myers, 2000).

**General mode of inquiry**

The general mode of inquiry employed in this study is a qualitative interpretive research design. Insights are gained by discovering the meanings and implications of the participants’ phenomena through making sense of the gathered data. This research involves a semi-structured interview method, supplemented with focus group discussions to collect what is often described as ‘thick’ data. A qualitative approach is partially inductive or bottom up in nature as it seeks to generate themes from a rich description of experience and through more detailed analysis of these themes in relation to literature about the issues this research seeks to address (Stirling, 2001; Bryman, 2004; Braun and Clarke, 2006). A qualitative interpretive research design is considered appropriate for this study because it focuses on understanding the phenomenon and social realities of Chinese, Indian and Filipino migrants within their natural setting in the health workplace.
Gmelch (1980) as cited by Cooke and Belanger (2006) said that qualitative research is useful in understanding the motivations of migrants from their own perspectives, and to understand the social and economic context in which migration takes place.

The research design adopted in this study aims to develop context-relevant descriptive statements that can be compared to other contexts. It can be replicated to other settings or contexts; however it can not be generalized in the traditional sense because all interpretations are based in this particular context or situation and time. Sarantakos (2005) discussed that generalisability of qualitative findings can be improved with strategies such as conducting multi-site research. Research findings are also open to re-interpretation and negotiation through dialogue (Cohen and Crabtree, 2006).

**Methods of data collection**

The main method used to explore the research questions in this study is the use of a semi-structured, interactive interview process, supplemented with focus group discussions.

**The interview method**

Although the process of interview is time consuming and expensive, it is one of the best methods for data generation (Davidson and Tolich, 2003). It is useful for exploring and understanding both the subjective/personal and cultural perspectives of phenomenal experiences, including the perceptions, thoughts, beliefs, feelings and attitudes of individuals on a face-to-face basis (Barker, Pistang and Elliot, cited by Bridgman and Gremillion, 2009; Davidson and Tolich, 2003) with curious and facilitative stance. The interview process is flexible as the interviewer can follow up ideas, explore responses (Bell, 1993), and encourage participants to elaborate further to deepen meaning or dispel possible misunderstandings (Creswell, 2003).

In the interviews, eighteen participants were asked to verbally describe their experiences of phenomenon. The interview started with general or entry descriptive questions about
the participant’s migration, training and employment experiences and followed by simple evaluation questions then moving into more challenging areas of major evaluations, with solutions to complete the interview. Appropriate unfolding questions and prompts were used depending on the flow of the interview. Follow-up questions also built reflectively on the responses of the participants that widened their stories, sought other experiences that had different outcomes or other aspects that might have been left out, and ensured the key areas of inquiry were not left out.

Questions around the demographics of the participants, particularly on ethnicity (Filipino, Indian, Chinese), gender (male/female), age band (grouped into 18-25; 26-35; 36-45; 46-55; 56-65), educational attainment in original country, occupation in country of origin, education/re-training in New Zealand, and year of arrival in New Zealand were gathered at the end of the interview, if not already given during the interview. Each interview lasted between 35 to 45 minutes, and was digitally recorded as back up of the notes. An interview schedule (see appendix A), which was used to guide the data gathering, was prepared by the researcher and then reviewed by the thesis supervisor before it was used with the participants.

**The Focus Group method**

The researcher interacted with the same groups of respondents through focus group discussions. A focus group is a stimulating group interaction that serves as another useful exploratory method of data collection from the participants (Davidson and Tolich, 2003). In the focus group, participants can confirm or challenge the responses of other members and remind one another of certain phenomena (Axinn and Pearce, 2006) or add new insights to the data. The collated interview themes were presented back to the focus groups to allow for an interpretative validation and confirmation of themes that arose from the interviews. A guide for the focus group discussion process and a similar set of predetermined, sequenced, open-ended questions were prepared (see appendix B). Flexibility was considered in the entire process to allow adjustments in situations where discussions developed.
Recruitment of participants

*Locale of the study, participants and criteria of selection*

The participants recruited for the research are Asian migrant health and community workers from China, India and the Philippines living in Auckland, and are working in hospitals, resthomes, rehabilitation centres and from the mental health institutions.

Participants from China, India and the Philippines were chosen because they are among the top five source of Asian countries of registered nurses entering new Zealand (Immigration data in Badkar, Callister, and Didham, 2008). Both Indian and Chinese have active traditional health systems in New Zealand. They have major cultural community centres and organisations and major business interests serving the needs of their communities. Whilst Filipinos comprise the fourth largest migrant group in New Zealand (about half the size of the Korean group) over 60% of their female professional migrants are nurses or health and community work professionals (Statistics New Zealand, 2006) and the significance of the size their contribution to the health workforce in New Zealand is recognised by the New Zealand Nurses Association. The Chinese community has a relative disadvantage in terms of English language, however, Chinese participants were selected from those who are working in the mainstream and have good English language communication with clients and colleagues.

Table 3. 1 on the next page shows the intended diversity of participants. The sample aims to capture the three main migrant cultural communities involved in the health and community services of New Zealand and to provides a diverse range of occupations and skill level, as well as reflecting to some extent, the female gender bias in the health and community professions. Eighteen participants is a sufficient number for a qualitative research project where the aim is get a rich description of life experience across a diverse group within a specified area. I wanted six participants from each cultural community (Chinese, Indian and Filipino); nine professionally registered participants (Registered Nurses (RNs) and Social Workers (SWs) and nine support workers (Health Care
Assistants (HCAs), Community Support Workers (CSWs) or Rehabilitation Program Workers (RPWs); of which, twelve are females and six are males.

### Table 3.1

<table>
<thead>
<tr>
<th>Gender/job category</th>
<th>Chinese</th>
<th>Indian</th>
<th>Filipino</th>
<th>Sub-total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male Support work</strong></td>
<td>1 HCA, CSW or RPW</td>
<td>1 HCA, CSW or RPW</td>
<td>1 HCA, CSW or RPW</td>
<td>3</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>1 RN/SW</td>
<td>1 RN/SW</td>
<td>1 RN/SW</td>
<td>3</td>
</tr>
<tr>
<td><strong>Female Support work</strong></td>
<td>1 HCA, CSW or RPW</td>
<td>1 HCA, CSW or RPW</td>
<td>1 HCA, CSW or RPW</td>
<td>6</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>1 RN/SW</td>
<td>1 RN/SW</td>
<td>1 RN/SW</td>
<td>6</td>
</tr>
<tr>
<td><strong>Sub-totals</strong></td>
<td>4 females</td>
<td>4 females</td>
<td>4 females</td>
<td>12 females</td>
</tr>
<tr>
<td><strong>Grand totals</strong></td>
<td>6 Chinese</td>
<td>6 Indians</td>
<td>6 Filipinos</td>
<td>18 participants</td>
</tr>
</tbody>
</table>

Criteria for selection of the participants were:

- had applied for NZ immigration after October 1995 onwards, as this is when the immigration applied a more rigid point system in selecting migrants;
- had worked in the New Zealand health sector for at least one year;
- was currently working 20 hours or more per week;
- was eighteen years old or above;
- was working in a health care facility such as rest home, rehabilitation centre, hospital or community integrated health facility; and
• have reasonable command of English to be able to reasonably participate in both interview and focus group discussion.

**Method of recruitment for participants**

The participants in this research were recruited through a purposive quota sampling based on the above criteria and convenience sampling within each cell of table 3.1. For example, it was first-come, first-served within each cell. The recruitment of participants was done in part through an informal ‘reference group’ set up to guide and support the research and create networks through friends and acquaintances. These networks helped in the recruitment of research participants, and by giving out formal invitations consisting of the research information sheets (see appendix C) to their friends and acquaintances. Additionally, I requested permission to recruit research participants in health and community institutions (see appendix D for the generic request letter). These institutions also allowed the posting of the poster (see appendix E) recruiting research participants on their noticeboards, but no one volunteered through this. One health organization included the participant recruitment poster in their company newsletter, and this encouraged two of the participants to volunteer.

**Participants and the interview**

From twenty seven formal invitations, there were nineteen participants who consented to participate. The individual interviews were done in different places that were convenient and agreed upon with the participant. These places were either at their home or apartment, at the vacant Whanau centre of the hospital, at the Sunday school room in their church, at the discussion room of Unitec library, and at a convenient space at Albert Park.

One of the Filipino participants (support worker) had to be excluded because the desired number (six) was already filled, and though he consented for the interview, he had a hectic schedule so we were not able to do the actual interview. Of the other eight invited
people who declined the invitation, three were Indians and five were Chinese. Reasons included work commitments, being too busy with Chinese New Year celebrations, and being uneasy about the idea that the data taken from them will be stored for five years.

**Participants and the focus group discussion**

There were three focus groups (Chinese, Indian and Filipino) which composed of five people in each group who had participated in the interviews. One participant in each group was not able to come to the focus group discussion due to work commitments. Those who were not able to come for the focus group were given comment sheets to write on their opinions, to categorize/re-categorize and or to confirm results about the questions. Two participants handed in his comment sheet, and these were integrated in the data of the focus groups.

The focus group met once for approximately one hour from January to February 2010. The time and venue were arranged in consultation with the participants. Prior to the focus group meeting, each participant was given the opportunity to discuss matters concerning them. The focus group meeting started with a short introduction of the participants and the ground rules including the requirement to agree to maintain strict confidentiality of individual contributions to the focus group discussion. It was followed by the exploration questions that took most of the time then the relevant wrap up questions. Flexibility was allowed in the process, which made adjustments to situations. The group discussions were digitally recorded.

**Analysis of Data**

**Thematic analysis**

This study used a thematic analysis approach. Thematic analysis can handle the large quantity of data that can be obtained from a small number of participants (Myers, 2000), and is for identifying the themes within data. A theme is “something important about the
data in relation to the research question, and represents some level of patterned responses or meanings within the data set” (Braun and Clarke, 2006, p. 82). Thematic analysis is an inductive, detailed activity, which follows a cyclical and reflexive process (Coffey and Atkinson (1996), cited in Seton (2004)). It offers an accessible and theoretically flexible approach to analyzing qualitative data, and that it can potentially provide a “rich and detailed, yet complex” account of data (Braun and Clarke, 2006, p. 78) or “thick description” (Patton, 2002, p. 437) of data that provides a strong tool for the systematization and presentation of qualitative analyses (Stirling, 2001). The thematic data analysis here is analogous to the interpretative phenomenological analysis, which aims to offer insights into how the participants make sense of their personal phenomena such as the major life event of migrating to New Zealand and finding employment among others.

Figure 3.1 presents the model of data analysis was used.

**Figure 3.1**

**Research model of data analysis**

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
<th>Step 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Interview Transcripts</td>
<td>- Search for meaningful themes</td>
<td>- Check Interview themes with focus group transcripts to data set and repeat step 2</td>
<td>- Add focus group themes with data set</td>
<td>- Sorting out the themes into smaller sets</td>
<td>- Construct the outline of the narrative; identify outliers and re-code</td>
</tr>
</tbody>
</table>

(Adopted from Wainwright, 1997; Braun and Clarke, 2006; Sangasubana, 2009)

In steps 1 and 4, I with the help of my daughter (who is a second year university student that time) have transcribed the interviews and the focus group data. These were then checked against the digitally recorded material and, subsequently, with the participants for accuracy before they were deleted. These steps are akin to the ‘inventory of data’ collected that includes checking out the quality and completeness (Patton, 2002), and then making sense of the data as a whole (Davidson and Tolich, 2003) by using emerging codes/memos taken from the researcher’s process notes.
The researcher does not enter the situation with a blank mind, but comes with “a whole raft of assumptions, their own personal agenda and ideas that they have read about in their literature review” (Davidson and Tolich (2003, p.49). The researcher reflected on her own preconceptions about the data but deferred these in order to understand the participants’ experience.

This model of analysis includes the processes of becoming familiar with the data (step 2) in relation to the issues raised in the literature review. Step 2 involves the development of themes that were given descriptive labels or codes for assigning units of meaning to the descriptive or inferential information compiled during the study (Neuman 2003). These rough themes were then presented back to the participants in Step 3 for confirmation, addition or deletion, and the focus group data added to the data from the interviews, and step 2 repeated with a greater emphasis on comparing, contrasting to identify patterns and a sense of possible connections between the information (Sangasubana, 2009; Davidson and Tolich, 2003).

In steps 4 and 5, the themes were identified and refined not only at their explicit level but were driven beyond the surface meanings of the data, identifying the underlying meanings, assumptions, conceptualizations and ideologies that shaped the content of the data. The data coding continued to develop and then defined as themes throughout the process. Memos (insights or ideas about the data) were written to keep track of assumptions or opinions that need clarification/s throughout the whole process (Sangasubana, 2009). In steps 4 and 5 the coded data were literally cut up and pasted into matrices according to their prevalent themes using Microsoft Excel. Where there were situations that were not consistent with the first data coding, these were re-grouped or re-sequenced with other more fitting data set. They were re-ordered or segmented into meaningful groups that reflect the key themes that were derived from the data itself. These themes were reviewed and refined, defined, named, and discussed with the research supervisor. These were then re-sequenced to form the outline of the study. All relevant extracts or illustrative quotations from the participants for each identified theme were collated (Braun and Clarke, 2006).
In step 6, this type of analysis reads more like a novel or biography than mathematical proof, and considers a depth of explorations and rich detailed descriptions of people’s experiences (Myers, 2000; Neuman, 2003) as found in this qualitative study. The descriptive narrative and analytic method was used in the final research write up. This method involves describing, recording, analyzing, interpreting and counting conditions that are perceived to exist, and determining and reporting the way things are (Gay and Airasian, 1992). The findings are related to theories and the review of related literature in order to make sense of the rich and complex data collected, and are presented in chapter IV of this study.

**Triangulation**

Triangulation is a tried and tested means of addressing qualitative/quantitative differences to demonstrate confirmability, completeness and acceptability across paradigms (Tobin and Begley, 2004). Various types of triangulation are intended in this study: the use of a mixture of adequate sources of information in the literature review (Janesick, 1994, cited in Blanche, Durrheim and Painter, 2006; Morse, Barrett, Mayan, Olson and Spiers, 2002; Bridgman and Gremillion, 2009); and the use of mixed methods such as reflexive interviews and collaborative focus group discussions to generate a variety of data (Davidson and Tolich, 1999; Guba and Lincoln, 1994; Denzin and Lincoln, 2003a/b; Bryman, 2004). In the discussion, the triangulation of relevant patterns, concepts or perspectives (Janesick 1994, cited in Blanche, et. al, 2006) included findings from literature, including findings of other disciplines that interpret the data (Bridgman, Gremillion, 2009; Blanche, et. al, 2006).

Collaborative triangulation (Tobin and Begley, 2004) was also done with the transdisciplinary informal reference group whose members represent the disciplines of social work, health and education. In two separate occasions, the rough summary of themes gathered from the collated interview data (without the participants’ names to maintain confidentiality) was discussed with this group. A few additional inputs on the shaping of the themes (but more encouragements) were gathered. This transdisciplinary
approach (Hadorn, 2008) can help in finding ways in which the narratives of cultural diverse participants become shared knowledge and shared understanding, and the outcomes of the study could benefit the whole system of health migration.

**Validity: Trustworthiness, transparency and authenticity of data**

A great deal of existing discourse has focused on the difficulty of determining validity criteria in qualitative research because of the challenging process to incorporate subjectivity and creativity of qualitative research into the scientific process of quantitative research (Whittemore, Chase and Mandle, 2001). Although an exacting translation is inappropriate and inadequate (Hammersely, 1992; Bailey, 1996, cited in Whittemore, Chase and Mandle, 2001), the terms of trustworthiness and authenticity replace the traditional positivists criteria of internal and external validity in qualitative research (Denzin and Lincoln, 2003a/b). Thus internal validity was translated to credibility; external validity to transferability; reliability to dependability; and objectivity to confirmability (Guba and Lincoln, 1994).

The verification strategies for establishing the *reliability* and *validity* of qualitative research were used to shape and direct this research during its development (Morse, Barrett, Mayan, Olson and Spiers, 2002). Techniques of verification included investigating, checking, questioning and theorizing (Kvale, 1989, as cited in Morse, et.al., 2002), and taking into account the various perspectives intrinsic in qualitative research. The strategies used were specific to, and inherent in, each methodological approach of interview and focus group.

Whitmore et. al (2001) states that reliability of findings referred to its *stability*, whereas validity represented the *truthfulness, credibility* and *explicitness* of the findings. The research design allows ample personal interaction thereby giving the chance to confirm data with the participants, thus promoting more accuracy and reliability of the research (Creswell, 2003; Bridgman and Gremillion, 2009). Additionally, the transcripts were returned to the participants so that they were able to confirm that the transcription was an
authentic description of their individual perspective. The participants were invited to make any corrections and to confirm whether the accounts were accurate. All of the participants confirmed their transcripts with a few minor corrections and additions. Trustworthiness and authenticity of the research are also established in the narrative through examples and extracts that were directly drawn from the transcript that exemplify the experience of research participants (Denzin and Lincoln, 2003a/b).

A further authenticity challenge is to capture the meanings as expressed by the participants while acknowledging and appropriately positioning my own personal perspective as a Filipino health worker in New Zealand. Since this study employed the interpretivist paradigm, my own values are inherent in all phases of the research process. My personal bias (while never absent, and useful as a touchstone for this research) was managed through the process of respondent confirmation of the meanings and perspectives of the interviewees and triangulation of sources and methods across different perspectives (Bridgman and Gremillion, 2009).

**Ethics issues and social research**

Ethics is the science of morality, and social research is the scientific study of society that explores people’s reality, knowledge, attitudes, assumptions, cultures, beliefs and the like. Collecting information about people raises potentially intense ethical issues about the focus of research, the methods and procedures adopted, and the form and use of the findings (David and Sutton, 2004; Cohen and Minion, 1994; Denzin and Lincoln, 2003a/b). The approval of thesis proposal (see appendix F) was obtained from the programme director of the Department of Social Practice. Application for ethical approval (see appendix G) for this research was sought from the Unitec Research Ethics Committee, and then the corresponding ethics approval (see appendix H) was received before any interviews and focus group meetings began.
The following principles were considered in the research at all stages (Bridgman and Gremillion, 2009; Trochim, 2006; Miles and Huberman, 1994 as cited in Punch, 2005; Flick, 2009):

**Voluntary participation and informed consent**

Voluntary participation is the requirement of informed consent (Trochim, 2006). Participants were fully informed about the procedures and risks involved in the research through the information sheet and the consent form which were supplemented by personal explanations about the research. An information sheet and a consent form (see appendix I) were used. Those who gave their consent were only the ones who participated in the research. Participants were also informed that they have the right to withdraw from the research within a period of time after the interview and or focus group discussion. This is consistent with the principle of informed consent that arises from the subject’s right to freedom and self-determination, which also implies informed refusal (Cohen and Manion, 1994).

**Respect for rights and confidentiality**

Possible risks of involvement in the research include concern about confidentiality and anonymity of disclosed information. Considerable efforts were made to preserve confidentiality and anonymity to safeguard participants against any potential harm. All information collected from the individual interviews and from the focus group discussions, including consent forms, were treated with strict confidentiality - identifying information were not and will not be made available to anyone who is not directly involved in the study (Trochim, 2006) other than the focus group members (focus group information only), the researcher and the supervisor. Pseudonyms were assigned in the transcripts of both interview and focus group discussions and possible identifying features removed (e.g. sources of referral, places of work, and names of colleagues or managers). All recordings were erased after the transcription and the participants’
affirmation of its contents. The transcripts of all information collected were stored on a password protected file at Unitec for a period of five years.

**Harm minimisation**

The principles of research ethics require researchers “to avoid harming participants involved in the process by respecting and taking into account their needs and interests” (Flick, 2009, p. 36). The interviews or focus groups involved discussing personal issues which may cause uneasiness to the participant. However, I have spent considerable effort in establishing good rapport with the participants, and ensuring that there were no distressing situations that arose in the process. I have been prepared to stop or redirect the interview in case a participant becomes distressed, and to provide names of suitable support people. This is akin to the principle of cultural sensitivity which involves the use of a social work value-base of respect, and being non-oppressive and non-discriminatory. The relationship with the participants was collaborative of engaging with honesty and trust. A transdisciplinary and trans-cultural informal reference group was also used for advice on such matters as recruitment and the management of the interview and focus group process.

**Summary of Research Design and Methodology**

This is a qualitative descriptive research study that is influenced by the interpretive paradigm, which seeks to make sense or understand the phenomenal experience or situation as described by the participants of the study. The data were gathered through the face-to-face interactive interviewing of sixteen participants and through the conduct of focus group discussions among the Chinese, Indian and Filipino groups. These participants all work at the health sector of the Auckland region, and were selected on the basis of set criteria through purposive sampling. Thematic analysis of data and triangulation were done. The validity and the ethical issues of social research were considered in the conduct of the research.
The following chapter presents the findings of this research as regards the participants’ migration and first experience; employment experience that includes their perceived roles and motivations; their challenging issues and concerns; and their coping strategies/solutions and recommendations.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

This chapter presents the profile of the participants and the analysis of the transcripts of this research. The data contained here are the thick description and analysis of the Chinese, Indian and Filipino migrant health and community workers’ experience in New Zealand. The data are presented as themes and sub-themes around pre-migration and first experience, employment experience, as well as the issues and concerns of the respondents. The participants’ coping responses and solutions to their challenging issues, together with their other recommendations were also thematically presented.

Profile of Participants

Table 4.1 on the next page shows the profile of the participants of this study. Not all the criteria set in chapter 3 were fully met. There were eighteen participants - six came from each of the Chinese, Indian and Filipino culture. Despite wanting to get a balance of male and female participants, there was a difficulty in finding male participants who fit the criteria, particularly from the Chinese group. Hence, there were only four male participants (two from the Indian and two from the Filipino group). The balance of three registered professionals versus three support workers in each cultural group was not met for the Indian (2 professional versus 4 support workers) and Filipino (4 professionals versus 2 support workers) groups. However, there were equal numbers of professionals versus support workers, and the objectives of diversity and consistency set in Chapter 3 were met overall.

Pseudonyms from each ethnicity were used in order to protect the participants and to address the issue of confidentiality. More than one third (8) of the participants are within 26-35 age band; one third are within 35-45 age band; and the remaining participants are within 18-25 (2) and 46-55 (2) age band.

A majority of the participants (all Filipino participants, four of the Indian participants and only one Chinese participant) had graduate level health qualification with some at
## Table 4.1
### Profile of Participants

<table>
<thead>
<tr>
<th>Culture and pseudonym</th>
<th>Gender</th>
<th>Age bracket</th>
<th>Educational attainment in original country</th>
<th>Occupation in original country</th>
<th>Education/re-training in New Zealand</th>
<th>Health occupation In NZ</th>
<th>Years in NZ health work</th>
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<tbody>
<tr>
<td><strong>Chinese Group</strong></td>
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<td>Ah Cy</td>
<td>F</td>
<td>36-45</td>
<td>BS Teaching</td>
<td>Univ. lecturer</td>
<td>MA in Language teaching; PG cert. in Social Practice</td>
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<td>36-45</td>
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<td>35-45</td>
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<td>Cert. in Computer prog.; Cert. in MH; BSW (on going)</td>
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<td>Nurse</td>
<td>HCA course</td>
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<tr>
<td>Danilo</td>
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<td>46-55</td>
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<td>Nurse</td>
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<tr>
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<td>Dentist and business prop.</td>
<td>MA in Social Work</td>
<td>Community Support Worker, Social worker</td>
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</tr>
</tbody>
</table>
post-graduate level before they migrated to New Zealand. Another four participants had two post-graduate levels before they migrated to New Zealand. Another four participants (two Indians and two Chinese) came with non-health degree or diploma qualifications, and half of the Chinese came to New Zealand with high school qualifications. The work that the participants were doing in their home country reflected the qualifications they had achieved with 11 of the 18 participants working in health areas, and 7 of the 18 participants in the non-health areas. All of these participants have undergone health-related education or re-training in the New Zealand context. This is either through the nursing bridging course in the case of nurses, pursuing nursing degrees in the case of Chinese high school students, or retraining entirely in another health related programme or merely attending vital in-service trainings.

The Filipino group included the oldest participants, those with the most experience of health and community work in New Zealand (14 and 15 years), and the youngest participant who had the least experience (two years) of health and community work in New Zealand. The Chinese group had also one of the youngest participants and corresponding least health and community work experience (two years) in New Zealand. The Indian group also had a participant with the least (one year) New Zealand health and community work experience.

The following sections focus on the responses to the research questions (see appendix D). Section A focuses on the responses to question 1; section B addresses questions 2, 3 and 4 questions; section C focuses on question 5; and section D focuses on questions 6, 7 and 8.

**A. PRE-MIGRATION AND FIRST EXPERIENCE OF NEW ZEALAND**

The majority of the women, those over 35 years old, and those with bachelors degree and post graduate degree have organized their migration through an agent or consultant. While some, particularly the men have migrated to New Zealand through a family member, wife, aunt, sister, and sponsorship. The Chinese high school students, who are under 35 years old, have organized their international student
migration through the support of their parents, who are either in China or here in New Zealand doing business. The following sections present the participants’ reasons for migration, their first impressions of New Zealand, and their expectations and goals.

**Reasons of migration to New Zealand**

*Linkages with family and friends*

The given most important reason for migration had to do with linkages with family and friends. Three out of the four men participants identified a linkage influence as their reason for migration to New Zealand. Carlo came to New Zealand to follow his wife who is working as a physiotherapy assistant. Likewise, Hamid came to New Zealand to join his wife who came for the nursing bridging course, then after two months, [he] started preparing... to come here. Danilo was working as a registered nurse in the Philippines and his friend came to visit, and told about New Zealand. That made him interested in coming to New Zealand, and so the friend sponsored... [him] to come here.

A majority of the Filipino participants identified that they had migrated because of the influence of their aunt, sister, friend, or spouse. One third of the Chinese and Indian respondents also identified that they had migrated to join a member of their family or the person sponsoring them. Ligaya said I came to New Zealand because I have an aunt here. I also have a friend who wanted to come to New Zealand. That’s where it started.

Valencia is a dentist practitioner who never thought of migrating to New Zealand at first, but was encouraged by her sister to migrate:

First and foremost, my sister was here. She came ahead so of course, she encouraged us. I never thought I would be migrating in this country. I never thought I would be migrating, because I thought that it is only nurses who can work overseas.
Ajita came to New Zealand in a partnership work visa that was *like a traditional arranged marriage*, but where the partners may not have intended to remain together. The linkages that brought people to New Zealand appear to be enduring, but in Ajita’s case, the linkage collapsed.

_After one year or even at the start, we had so many problems between us, and according to New Zealand immigration law, like after husband and wife living together for one year, and I can apply for the residency but he didn’t sign the paper for me, so I renewed my visa again with a small workplace._

**Change of lifestyle**

The second biggest reason for migration was change of lifestyle. Four of the Chinese participants want to escape from *overcrowding* and *from being controlled or wanting to be independent*. Ah Cy came to study a master’s degree in New Zealand, and later decided to stay. She said _I want to change my lifestyle, because in China . . . [there is] too much competition for the job, for everything. For the house, [it is] overcrowded, and in New Zealand, [it is] not overcrowded._ Similarly, Chao Xing was impressed with the good environment and weather of New Zealand. She said, _I was in Finland before, but it's too cold, and cannot go anywhere. New Zealand has a good weather. It’s good weather... better than in a crowded or very cold environment._ Lihwa revealed that she migrated to New Zealand because she _wants to see or know how to live ... to change lifestyle and be independent._ Similarly, Jingfie said _you know everyone wants to see the world and do something different, to be independent. I came here [for reasons] not related to work at all [in the beginning]._

A female Indian participant said in New Zealand _you can live a very peaceful life._ Three of the Filipino participants were attracted to migrate to New Zealand because it would be a better environment for their families. Amelia found _from the internet that New Zealand is family oriented_ as compared to other countries. Four of the six Filipinos talked of the advantages for families in New Zealand - Ligaya said _we migrated here because of our family. We want to give them a good future._ For me, I’m, working because of my family, actually my priority is my family, that’s why I’m working. Carlo mentioned the *big challenge...to come to another country and work, but just think of your family._ Even though Valencia was a practicing dentist, was
running a restaurant business in the Philippines, and was married to a lawyer, she was attracted to New Zealand because she thought it would provide a better future for her children - *I think the number one motivating factor why we migrated here in New Zealand. It is for the future of our children.* Amelia, however, migrated to improve the life circumstances of her extended family in the Philippines:

... because I am the eldest, I am expected to help my younger sisters, but I married early. Now that I’m here, I am supporting my sister who is also taking up nursing in the Philippines. I also want to bring my third sister here in New Zealand to study.

**Study or pursue education**

Also important as a reason for migration was the pursuit of educational opportunities. One third of the participants, including four Chinese indicated that they came to New Zealand to study. High school students Mei, Jingfei and Jia, as well as Lihwa from secretarial college came to New Zealand to pursue their education with their parent’s support, with the intention of becoming permanent residents in New Zealand. Ligaya came here... to do two months bridging course in nursing then she got her registration from the Nursing Council of New Zealand.

In contrast, Ah Cy (already a university lecturer) initially intended to go back to China after her studies, *because in China, people value the high qualifications... [and] can get promoted to associate professor.* However, after she completed her studies and paid high international tuition fees, her initial plan of going back to China was changed. She began to *like* the idea of staying here, and became concerned about how difficult it would be to pay back the money she owed to her parents:

> Because I paid too high tuition fee, too high, and if I go back to China, the university teacher didn’t earn too much. I have not much savings or much money. I borrowed from my parents ...it will be hard for me to earn lots of money [and] to return [it] to my parents.

Likewise, Rajh earlier planned to go back to India to serve his own people after his studies, but he is still here in New Zealand working for his permanent residency:
Actually, the plan of coming to New Zealand is to do a course on cognitive behavioural therapy. My earlier plan is to finish the course and go back to India and do something ... to work for your own society, but I'm still here until now.

Other reasons for migration

Less frequent reasons for migration included better professional opportunities (four participants), easier access to New Zealand (four participants) and better pay of work (two participants).

Indian and Filipino participants migrated for better professional opportunities. Aashi believed that she can use her nursing background. Sara said that nursing is a shortage in New Zealand so we come here... that is actually a big motivation for nurses back in India... that New Zealand is really good for nurses. Sofia came to New Zealand not only to visit but also to find a better nursing job. However, she had to undergo a basic health course in New Zealand at the start:

The job situation in the Philippines made me think of going overseas. There are more graduates but there is no job available for us. I migrated to look for a greener pasture, and I arrived here with lots of hopes – that I was also really interested to look for a job, but I was here on visitor’s visa. I studied for 3 months, doing health care assistant course at Unitec.

Whilst Ligaya migrated for better professional opportunity as a nurse, she also thought that it is easier to migrate to New Zealand than to other countries:

The first thing that I thought of abroad is that I want to work as a nurse anywhere aside from New Zealand....but because New Zealand is the easiest to process my papers, and it was going smoothly, it was very fast, no problem, so I think I was really in for New Zealand rather than other countries.

Sofia was also preparing to migrate to the United States as a nurse, but there was a freezing of nursing employment there at that time. New Zealand then became her alternative option:

Friends talked about NZ to me, but my first priority after graduation is to work in the Philippines, to do my MA and review for NCLEX to apply for
USA. I came to NZ because it is easier. The US is not getting anymore nurses that time, so NZ is a different option. When I heard of NZ, it gave new hope to work. My wish is granted by God. I never knew that the expenses to come here would be like Php350,000 - Php500,000. Dad is good in business, so he helped me.

Amelia also planned to go to the United States but was hindered. She said New Zealand was not my first choice, it was USA but I had problems with my English exam. and CGFNS. Plus the migration process is taking long - for about two years. Likewise, Hamid said actually, frankly speaking, we were planning to go to Australia in the first place. We already paid some money but they need more points, the IELTS and all – so we changed our mind.

Better pay for work was mentioned by Sara who said they give higher pay than in India. Ligaya also indicated that nursing in New Zealand has better pay. She said nursing was just very hard work, you need to work a lot but the pay is not worth it. You get like [an equivalent of] $500-600 only per month in the Philippines. Well, it’s good money here [in New Zealand].

Positive first impressions of New Zealand

Two thirds of the participants (five Filipinos, five Chinese and two Indians), and almost three quarters of the women respondents were impressed with the positive physical environment of New Zealand as beautiful, with lots of places that are good to see, fresh, pollution free, quiet place and really clean and green, with good weather, with good lawns and gardens. Lihwa said:

First time I come to New Zealand, the environment is very good. The sky is blue, and because I come from China, the air pollution is no good, and here [it] is very good. New Zealand is a beautiful country.

In addition, Sofia expressed her good impression about the image of Auckland city in the world: It [Auckland] is also one of the top ten cities of the world, which is good. Aside from the impressive physical environment, some of the respondents revealed that they were impressed through the internet with New Zealand’s family oriented
culture, low crime rate where you can live a peaceful life, and being one of the least corrupt countries. Danilo had this impression:

New Zealand is very easy-going country... the stress is not really as bad as the other countries. It’s not that I have been to different countries then, but the way they are described to me and everything, looks like New Zealand is not really that bad as compared to lifestyle, compared to work and finding employment.

In addition to the physical environment, seven participants identified a positive social environment. Amelia has ... been hoping that it is a good country to raise my family. Moreover, Carlo learned that it is the least corrupt country in the world and that the health system is also good. Manika thought you can live a very peaceful life. Ligaya reckons that New Zealand is family oriented. She said:

... I never experienced my family being so close, because my husband has so many friends in the Philippines... we don’t spend much time together when we are still in the Philippines, but here, our world is just revolving within our family and close friends, which is really, really good.

A few participants were impressed with the cultural tolerance and the friendly people of New Zealand. Sara said, it’s really multi-cultural; there are a lot of cultures represented here, good and vibrant. Manika further described that this [New Zealand] country is very friendly, and it has got all cultural things and understands the person’s point of view, like if you can’t do, because of cultural things, they don’t insist on that. Lihwa found that the people are kind... that people are good, while Ligaya said:

I heard from my cousin that New Zealanders are friendly. If they are really New Zealanders, it’s very spontaneous for them, Kiwis, to say “hello”, “how are you?”... I also heard that they are not racist that’s why I thought that they are friendly because they are a multi-cultural country so they accept any culture throughout the world to live in their country.

Another aspect of the social environment that was commented on was New Zealand’s helpful institutions. Sara felt that the New Zealand Immigration Service was helpful in facilitating her permanent residency:
Oh, it was really, really good. Actually my family was back in India when I came so I was emotionally upset, but when they came here, they really like the way New Zealand treat us. We applied for residency and we were given...Yeah the moment I came, I think I can merge with New Zealand lifestyle. It’s really vibrant and nice and supportive to migrants.

Chao-Xing described her first impression with New Zealand immigration as amazing. She said my immigration experience is so wonderful. I came with my whole family, invited by the New Zealand immigration.

Expectations and goals

Two thirds of the participants expected to settle in New Zealand and get a job. For example, Amelia’s goal was to settle and bring her family [in New Zealand] and she also wants to buy a house. Aashi and Sara expected to meet new people, get a job, and settle here to continue [their] practice as registered nurses. Ligaya came to New Zealand to do her nursing bridging course in order to be registered in New Zealand. She had her priorities in place:

My first goal was to do my two months bridging course, get my registration from the Nursing Council of New Zealand, and then look for a job to be able to get a work permit, and work as a nurse, and then my ultimate goal that time was to get my family.

Similarly, Ajita’s goal was to re-train in the New Zealand to get more knowledge about treating clients, in terms of social work in New Zealand, to enhance her knowledge in line with her present job as a support worker in the drug and alcohol area. Some other participants, especially registered nurses, have implied that they want to help people with their professional skills and knowledge. Mei expected to use her nursing career to help people because she wanted to put more patience in [her] work and hopefully help the people who need it. Valencia expected to go for re-training in social work as New Zealand was very hospitable, so the first thought is “how can I give back to the country that hosted and welcomed us?”
However, five of the participants (one Indian and four Chinese) had no strong expectations of settling in New Zealand at the start of their migration. Two did initially plan to go back to their own countries after training, but later changed their mind to settle in New Zealand. The three Chinese high school students who came to New Zealand as international students have finished their studies, and one of them (Jingfie) said *I do not have any expectations actually...I never have any plan for the future but I’m quite happy with my current situation.* They all now have their degrees in nursing and are New Zealand residents, and continue to have few positive expectations to continue working in their professions.

**Summary and additional focus group information**

The majority of the participants had organized their migration through agents or consultants, while some have organized their migration through the help of their personal linkages. All Filipinos (six), almost all of the Indian (four) and one Chinese had health related qualification before they migrated to New Zealand. Those that did not have health related qualifications (two Indians and one Chinese) and those who came to New Zealand as high school students (four Chinese), underwent health related re-training in New Zealand in order to get into the New Zealand health and community work industry. They are quite happy in their professions despite some related challenging issues and concerns to be discussed later in part C of this chapter.

The participants’ reasons for migration are varied yet related. Half of the participants have indicated that they migrated to New Zealand due to a family or friend linkage influence. In all the focus groups, the participants confirmed the importance of their personal linkage. The Chinese high school students came to New Zealand with student visas, while most of the Filipino and Indian nurses said that they initially arrived in New Zealand with an international student visa to do the bridging course or competency course. Most availed of the services of immigration agents or consultants. Some of them applied for work visa after their re-training/studies, while a few nurses claimed to have applied for work visa even while they were doing their bridging course.
For the Chinese group, a change of lifestyle was an important reason for migration, so was study, and a better pay for work. Better future for their children and family, better professional opportunities, better pay for work and ease of access to New Zealand was evident for the Filipino group. The Indian focus group also emphasized better professional opportunities and study. The Filipino and Indian focus groups indicated an average of one year to process migration applications for New Zealand, and that the migration fee is generally cheaper than in other countries like USA, UK and Australia.

For the three focus groups, the most common first impression of New Zealand was of its beautiful, clean and green natural environment. Another first impression (of the Filipino group) on New Zealand is that it is family oriented and has a relatively good social and political image. Despite the participants’ relative issues and concerns (discussed in part C), the Filipino and Indian focus groups confirmed the impression of New Zealanders as a culturally tolerant and friendly people with helpful institutions. The Filipino and Indian focus groups added that while New Zealand may not be the safest place, participants mostly believed that it is a good place to raise a family.

Most participants expected to settle in New Zealand, to retrain, and to take pride in their skills in the helping professions. All the focus groups confirmed the participant’s expectations around getting a better job with better pay and to continue working in their profession or in the health sector. Filipino participants were concerned to support their extended families back in the Philippines. This could include inviting family members to visit or migrate here after getting their New Zealand qualifications.

B. EMPLOYMENT EXPERIENCE

This section presents the employment experience including the factors that made employment difficult or easy. It also covers the participants’ reasons or motivations for being a health or community worker in New Zealand, as well as their perceived roles in health and community work.
Experience of difficult or challenging employment

All the non-student participants struggled because of their lack of New Zealand work experience. Ah Cy said it’s hard to find a job at the beginning because they always ask for New Zealand experience...The employers always emphasize New Zealand experience, and the catch is that new migrants are not given a chance in the first place. Aashi expressed similar predicament as Ah Cy. A related challenge is finding a good local referee. Ah Cy further argued that it’s hard to find a job because of no referee. I didn’t know too many people. How can I find a referee? Referee is an issue... Often New Zealand employment is obtained “through the grapevine”. Manika complained that any job that is advertised, as a migrant it is very difficult to get [that] job because by time you see the job, it will be too late. Ajita had a similar experience sensing that with small organizations, they will have already found a social worker or support worker even before she applied.

Some participants have expressed difficulty in finding jobs that are directly related to their overseas qualifications. The men and non-nurses particularly claimed that the limited or non-transferability of overseas qualifications made their search of employment rather hard. Not only was New Zealand experience a pre-requisite, but also a New Zealand qualification. Rajh worked as a counsellor in India but when he wanted to practice as a counsellor in New Zealand, they asked [him] to do a course and have a good experience here before [he] can get into that line. Hamid came to New Zealand and re-trained in computing in order to get a New Zealand qualification, but he still could not find a job related to this. He said it was a very tough time because [he] worked there [Saudi Arabia] for seventeen years in computers, and coming to this place [he is still] desperately looking for a job. Chao Xing cannot find any job directly related to... [her] qualification as a dentist. Carlo felt overwhelmed with the guidelines for registering in his profession as physiotherapist in New Zealand, because of the regional differences in practice:

Well, I’m currently working on my registration now as a physiotherapist, and I consider this as a long term goal, because when I read the instruction on the guidelines for foreign trained physiotherapist to become
registered in New Zealand, I believe that it’s like a mountain to climb. It’s really difficult. One of the problems is that there is a regional difference in practice.

Participants experienced a limited or complete non-transferability of overseas qualification. In the social work field, Ajita applied so many places related to social work or any mental health and community work but ended up with a support worker job. She was concerned that she has to find a job according to [her] qualification in applying for residency. Manika was a corporate manager in India, and has arrived in New Zealand with a permanent resident visa, however she experienced that they [employers] only consider New Zealand qualifications and experience...It is very disappointing...It is pretty hard...our qualifications are not considered, and they put pressure on us to work on our [New Zealand] qualification.

**Experience of discrimination in gaining employment**

For the non-nursing migrants, one of the greatest challenges around gaining employment is the experience of discrimination. Valencia retrained as a social worker in New Zealand applied for a full time job which was advertised in her workplace, She was given four reasons why [she] didn’t get the job. One is that [she is] small, not from New Zealand, [she has] English as [her] second language and of course, [she is] not a Maori or Pacific Islander, Valencia felt this fits into discrimination. You know, no one should be discriminated [against].

Moreover, Valencia felt discriminated against when she applied for a full time job, which was given to someone who has no qualification instead:

> Even where I am working now, it was advertised that they need a social worker with B qualification... I was offered a casual job only. I was the only qualified applicant, but they got the one who has no qualification as a social worker but had the New Zealand experience. It was contrary to their advertisement.

Rajh was a counsellor in India, re-trained on health care in New Zealand yet sensed a sort of discrimination in his job search. He said that after doing the course... [he] tried
so many places to get a job ... but couldn’t find any, because.... [he] doesn’t know why. Danilo felt racial discrimination from some employers. He said, still there are issues on your race or where you come from...some employers are very supportive of you. Some employers think that you’re not good enough for that position. Likewise, Ah Cy said that Chinese immigrants are much more discriminated by mainstream than any other ethnic groups, [and she] finds it very hard.

Sara was concerned about her husband who:

had a very good experience in the Middle East, but cannot get any job for five to six months, and the main reason is that he doesn’t have a permanent residency...that was a real pain...that was a sort of discrimination.

Similarly, Lihwa who was a New Zealand registered nurse was told when applying for a hospital job that she should have a permanent residence. Part of the issue here from Ah Cy's perspective is the double jeopardy of not being able to get work or a benefit until you are permanent resident. She notes that:

Migrants need to have two years before they will have [access to the] benefit so it’s very very hard for a new immigrant to start a new life. During the two years, they have not any benefit, and no chance to get a [suitable] job so they have to get a cleaning job and that is a cheap labour job.

Experience of easy/facilitated employment

On the other hand, some participants indicated an easier route to employment through training, being more flexible about the work that they were prepared to undertake, being recruited form their home country, and using networks and job placement services

Health-related study/training in New Zealand

All the high school Chinese students who completed their training in New Zealand, most of the registered respondents, and some of the non-registered respondents considered health-related training in New Zealand as an option that enhanced their
chances of getting an employment. Jingfei found it quite easy to find a job here as a nurse...when [she] graduated [she] only applied to three hospitals, and all hospitals gave job offers. Ligaya got work permit and a job right away. She said:

Also when all the Filipino nurses are in their bridging course, when they have placement in rest homes, they will offer you a job even without your registration, and offer cash out from the payroll as long as you work. Even though you are not yet finished, they will ask you to work for them.

Manika and Hamid do not have prior health-related qualifications, but they found their niche in mental health by studying for a mental health certificate while doing a relieving job, and that gave [them] the ability to work in that industry as community support professionals. [They] did not have any difficulty. Mei said that she just needed to pass the nursing state exam, and then finally applied in the vocation that we [New Zealand] need and which [she] likes most. Carlo also thought that having a “rich” credential, having a rich experience both in the academe as well as in the clinical setting would help in finding a job in New Zealand.

Flexibility and willingness to try anything

A majority of participants with bachelor’s and post graduate degrees (all five women and three out of four men) and those non-registered and who are above 35 years old, showed the flexibility and willingness to try anything in their job search.

Many are able to get work which is related to their career aspirations even if their qualifications were not fully recognized. Before being able to have a full time RN role, Danilo had to accept a part-time RN and part-time caregiver role depending on what’s the available shift as they [employers] don’t have any full time shifts. He exemplified what he called determination and personal follow up of applications. Jia has to accept unsociable working hours as her charge nurse said to [her] that that’s a part of nursing. Sacrifices have to be made:

Since I’m working on weekends or always on public holidays, I don’t know what to do, to be honest. Like when other people enjoy the weekend, and other people say, “You should come with us”, but I can’t because I have work.
Aashi opted for an on call job with a nursing bureau, which means that she does not have a regular schedule and place to work, but she managed to adjust to its nature.

Some participants, mostly non-registered, have accepted under-employment/on-call work/part-time job. Chao Xing cannot find any job directly related to... [her] qualification as a dentist so... [she] ended up working as a health care assistant. Sofia doesn’t have a choice to the situation... [she] had to start as a caregiver, which she considers as better than [being] without work, while working on [her] NZ registration. Carlo conditioned himself not to be choosy in searching for a job, but to take whatever job that comes in. He felt fortunate for being accepted as a physiotherapy assistant in one of the rest homes in West Auckland. Carlo further said:

...while still working on my papers to become a registered Physiotherapist here, I am just happy that I have work although it is really a challenge for me. They said that ‘if you’re already wet, you need to take a shower’. We are here already, so we might as well do what is best or what is needed. I have to work in settings that I would consider as under-employment or something. I would work below my qualification.

Mei and Lihwa had part time jobs as health care assistants while they were studying nursing. This experience had apparently provided a plus factor in their curriculum vitae as well as it added to their work experience and employment contacts. Lihwa said:

I worked as a health care assistant, part time. I think it’s easy, it's good because that gives you chance to learn more. You can understand the health system. So it’s a good chance. Yes, after the first semester of my second year, I applied as health care assistant.

Some people had to shift town to get work. Rajh finished his health care assistant course, but he could not find a job in Auckland, so he moved from Auckland to Hastings. Similarly, Danilo was registered nurse in the Philippines but he still had a hard time finding work in Auckland [fourteen years ago] so he had to go up north, in a farm to be a caregiver to an old man then, while...[he] worked on ...[his] registration.
However, there are some who could not work in an area that is closely related to their profession but were prepared to take on a wider range of work. Amelia proposed that if you are not picky, you can always get a job. Valencia was a dentist in the Philippines but she started as a store assistant at the Sky City before she studied social work before, and eventually employed in a mental health rehabilitation centre. Chao Xing was also a dentist in China but she can not practice in New Zealand unless she will study again, but she is not prepared to do that so she settled for a health care assistant job. She thought that migrants should not be picky. Whatever kind of job, just pick it up so that you will have a job. You can then go further from there... Ah Cy also knew that some of her fellow Chinese migrants have to get a cleaning job, which is a cheap labour job. Ajita also thought:

_The people who are migrating to New Zealand have to have in mind to do any job, like to do job even not related to their course or qualification – they have to do any job, even cleaning or working in a café as a start, because, now a days, it is difficult to find a job._

**Other influencing factors of easy or facilitated employment**

Almost half of the Indian and Filipino respondents were aware of the highly publicized need for health and community workers, particularly nurses in New Zealand. Jingfie and Danilo knew that there is a shortage of nurses...heaps of jobs for nurses in New Zealand, so one can find a job anywhere. Sara admitted that there are things which are different in New Zealand, but her relevant work experience back home [India] on the neuro-surgery helped in obtaining her desired job more easily. Besides, she doesn't have difficulty finding a job because at that time, there was an acute need, and at the same time they were not asking for too much demands. Hamid also believed that nursing is in demand so his wife got a job easily. Similarly, Ligaya knew from the start that there are heaps of jobs here for nurses, so it wasn’t really that bad to look for a job. Amelia thought that there is always a way to get a job as a nurse. Sometimes they [rest homes] will even give a contract to work for them even while you are schooling.

Some participants implied that part of their positive employment experience was attributed to their existing contacts and links into the New Zealand setting. Jia and
Mei said that they were hired by their placement agency. Mei argued that because she had a clinical placement...in the three years nursing practice in university... [she] doesn’t need a separate work experience. Hamid completed a national certificate in mental health, but while doing the course... [he] had to work a minimum of 16 hours per week... got more than that and was offered a casual job. He was then hired full time while pursuing his further studies in the Bachelor of Social work. Apparently, they had established their credibility in their work placement so they were readily considered when there was a job vacancy.

Sofia’s expectation about her agent’s promise for Unitec [where she trained as an HCA] to invite employers did not happen. However, she made use of other referrals like her landlord and classmates, aside from placing her applications on line. Similarly, Ligaya had her aunt and uncle help in finding places of work. On the other hand, Amelia said that finding employment as a nurse is easy because she had a contract for two years with her first employer.

It is not always that easy, Lihwa trained and registered as a nurse here in New Zealand, but she was hired as a registered nurse only when her permanent residency was approved:

I just had my registration lately, and when I was applying at the hospital, they tell me that I should have my PR. I also just received my PR but now I want to work in the community in primary health care. I found out that it’s not easy to get there. I just applied now in the rest home. I will start next week actually.

Motivations for being a health or community worker in New Zealand

Part of understanding the employment experience of the participants is exploring their motivations for being a health or community worker. The participants revealed that they are in health or community work primarily because it is related with their qualification and experience, and as a chosen profession that gives them sense of service and satisfaction. It is also for economic reasons to support themselves and their families.
Related with qualification and experience, and as a chosen profession

A majority of the participants, mostly Filipinos with degrees and all the three Chinese who came specifically to study in New Zealand, registered and those less than 35 years old claimed that they are in the health and community work because it is their choice, and they have been trained for it. Nursing is the profession that they want/love and are respected for it. All participants with health-related qualification in their country of origin knew the need of health and community workers in New Zealand, while a few other participants who have no health related qualification before migrating to New Zealand recognized the need of health and community workers, so they decided to re-train in line with it. All of them are now working either as registered nurses or social workers, health care assistants, rehabilitation program workers or community support workers. The participants’ profile on page 65 shows the educational qualifications/trainings and work experiences, among others.

Sense of service and satisfaction

Most of the participants across all cultures indicated a sense of service and satisfaction as their reason for doing health and community work. Almost all the participants have a sense of service and satisfaction as their motivation in doing health and community work including all those in registered professions and those with graduate or post graduate qualifications.

Rajh knew very well that [he is] a service-oriented person so that decided [him] to be in the same line. I consider that this is my correct path... Carlo said that health and community work is the best job in the world. He has this guiding principle:

... you touch people’s lives. You don’t deal with machines, you don’t deal with many papers but you touch the human soul, which is very noble. I have been actually guided by the principles of Socrates when he said, “individuals who are inclined in the restoration of health is above all great men on earth, since to restore and renew is as noble as to create”. I wasn’t really motivated to work as a health and community worker just to go to New Zealand but I believe that is already innate that I want to be a health and community worker.
Ah Cy was a teacher-counsellor in her home country and is now working as a support worker in mental health in New Zealand because [she] got same experience in counselling skill... talking therapy...empathy...can use my past working experience...[and the] health area is her love.

Chao Xing is happy with the process of helping: when you see them happy with how you are helping them, it makes you happy also. Mei and Lihwa are happy to be able to help people as a nurse. Jingfei took pride being a nurse and saw the opportunity for adventure: I feel the good thing. I think I am very useful. Sometimes, I feel like I’m saving lives. In New Zealand, nurse – your job, they respect you. Ajita considers it’s a very good experience to work with different people... because they come from more problems.

Other participants expressed their satisfaction with the results of their work. Ligaya took a sense of satisfaction in dealing with people... seeing them improve in a way, you know they’re back to their normal life – it’s very uplifting. Aashi said, you know when you see the patients getting better, it gives you a feeling of satisfaction. Amelia commented that salary wise, NZ is not that much [more] but the rapport built with clients is fulfilling...I like my present job... it makes me feel satisfied to see bed-ridden clients able to recover and become better.

For some, the sense of satisfaction reflects the pleasure of being engaged with the cultures in New Zealand, being part of a team, giving something back to New Zealand and being part of community. Danilo likes listening to the stories of his rest home clients because:

……..it gives me some satisfaction that it’s just like looking after my parents or my grandparents. It gives me the passion - oh I think it’s quite nice looking after them...talk to them, and oh they also give you their experiences when they were still young... It’s quite entertaining...that gives me some form of satisfaction that I’m making them happy.

Sara likes the very good teamwork in the ward. It gives satisfaction to be of help to other people. Manika says it’s what we have given to the people that give a lot of
satisfaction...at the end of the day. Valencia, a social worker, likes her work especially when going out to the community...dealing with and relating to her clients. However, for Carlo while he happy helping people in his job, it is not enough:

You know for us humans, we always want to take our achievements to higher levels. We are not contented with simple jobs. We want something that will boost our self-esteem...it is satisfying to see clients become better in their rehab. But we still would want a job that is suited to what we are qualified for.

Economic motivations

Some of the participants, mostly registered women under 35 years old, have economic motivations. The cost of studying and living in New Zealand is high. Lihwa, Mei and Jia reasoned out that because [they] finished nursing as international students, [they] ... have to work to pay our very high expenses...the weekly rent...and of course to pay our international student fees. Similarly, Ajita said that other people come to New Zealand to study, and they don’t go back to India because they have to work and pay their high tuition fee. For Jingfei the first thing is money, we need to earn as a human beings; while Aashi, Ah Cy and Sara noted you need to pay everything, we have to work to pay the bills, pay everything.

However, many did not raise economic concerns. Ligaya reckoned that she really had a good experience ... even if you’re not in a high position, even if you are an ordinary employee...at the minimum wage, you can buy what the rich can buy as compared to the situation in her home country.

Family reasons

While family influence is one of the key reasons for migration, it is evident that family is also an important reason as to why some participants are in the health and community workforce of New Zealand. Lihwa studied nursing because she wanted to be able to help... [her] diabetic father and other people. For Amelia and Ligaya family
is the actual priority – [they are] working to support [their] families. The flexible working hours in their particular health and community workplaces, are good for their families as they have kids to take care of. Coming to live in New Zealand is a big challenge, but all you have to do to find the motivation, says Carlo, is to think of your family.

Perceived roles in health and community work

The participants described their perceived roles in health and community work, and these were grouped into use of skills commensurate with their job role, under use/non use of their skills in their current role and an expectation of the use of skills beyond the job role given.

Use of skills commensurate with their job role

Caring, helping and supporting

All the participants identified that a huge part of their role is about caring and helping their sick or disadvantaged clients. All registered nurses, health care assistants and rehabilitation program workers were aware of their role in direct client care, such as client assessment and observation (taking temperature, pulse rate and respiration rate as well as observing any physical changes in the skin colour, eating and drinking patterns), administering medications (oral, ointment, drops), showering, wound dressing, giving bed wash or washing client in bed if they cannot yet get up, assisting with oral care, feeding, dressing, toileting and attending to behavioural care, if any. These roles could be challenging [with] a lot of learning outcomes (Sara) or simple such as in working in rest homes where it’s was just like looking after my parents or my grandparents (Danilo) or nursing without complicated procedures like IV injections (Amelia). Changing bed sheets, making beds and tidying up client’s room were also identified as part of their expected activities.

The support workers (CSWs and RPWs) also identified their role as giving medications, supporting their clients by talking to them, encouraging them to have their medications, do their chores, as well as helping them in ways so that they can re-
integrate to their families or to the community. Rajh described his role in mental health as mostly watching and observing the patients. Being a driver/chaperone/companion is one of their tasks - bringing or driving clients to their activities, appointments, places of interest or to outings/picnics, or bringing them home as well as fetching them back to the facility. Carlo considered that there is always a risk when they go out of the facility because they drive clients.

**Communicating, Educating and Advocating**

A majority of the respondents both male and female, most of the registered and over half of the non-registered mentioned that communicating, educating and advocating was part of their roles as health and community workers. The registered nurses, caregivers and support workers interact or talk to clients and their whanau and other health and community workers. Chao Xing talks to [her] clients while doing [her] chores or while feeding them. Ajita also claimed that she is supporting them [clients] while talking, discussing about all their problems - like family problems, work problems, and if it is possible to help them... Hamid also explained that part of his role as a support worker is talking and helping them plan their [clients’] activities. Correspondingly, Jingfei identified that part of her role is to provide health education to patients, explain what the procedure is going to be like and its result, its benefit and risk factor.

Jia identified communicating with the patient and the family as part of her role. Moreover, Mei saw the registered nurse’ role as more encompassing, and she confidently said:

> Sometimes you do not only look after the patients, you have to look after the family as well... If we have a (Chinese) patient who cannot speak English...I am a bilingual speaker so I can be a translator... I can pass on information to my patient... Our responsibility is much bigger.

Registered nurses and support staff record client’s notes, convey messages through handovers and clinical meetings. They also collaborate with other health professionals like the therapists, coordinators, key workers, doctors, managers as well as other support staff. Ligaya said that she has to call the person on-call if anything
happens beyond delegated decision making practice. Sara also realized that part of her work as RN is advocacy, and that nurses have a holistic overview:

We act as family advocate as well. For example if a patient is going even for a minor procedure like a CT scan, and the families are not aware, we have to discuss it with them because it can become very a very sensitive issue for them. They don’t know what is going on and we have to talk to them. Yeah, we also act as client advocate especially for clients whose needs must be coordinated with the doctor, the physiotherapist, the occupational therapist and so on.

Managing and supervising

Most female, registered workers have identified managing or supervision, control and overseeing as one of their roles. Mei saw her role as at a professional level with bigger responsibility. This includes working with a team that requires some overseeing role, coordinating with others and organizing things with clients and whanau as well as with the other health care professionals. Lihwa thought that she has to control all the things... to arrange the health care assistants’ work or how they will help. It’s kind of a different level. Jingfei also considered her role has a very professional responsibility that includes coordinating with the doctors and other health care ...organizing the health part, the social part of patients while they are in the hospital.

Aashi identified decision-making as one of her roles, because she has to decide about what to do with a certain patient, and with what work to give to the caregivers who help. Carlo also observed that nurses also...[coordinate], like with admin, because they do the catch up notes with RPWs. In a sense, they are doing part of the manager’s work of assessing the staff. Amelia said that working in NZ rest homes required decision-making skills because there are no doctors around most of the time. She also implied that part of her role is to relate with the team that is working with her, to bridge between... to be like a glue - to sort out misunderstandings in the team.

Ligaya described her role in making decisions regarding the clients as well as on administrative issues during her shift:
...being in charge of all the clients in the house. It’s like totally accountable for everything. If something goes wrong, it boomerangs to you, it will always be accountable for nurses...especially during weekends, and you have to do also the admin job and other decision-making, because there are no doctor or admin people around.

Valencia is a senior social worker that supervises student/intern social workers in her workplace:

I have the duty of supervising students who are doing social work internship. I want to see them being competent – that they be able to do their assessment, case planning and follow ups for their clients’ issues. So while they’re with us for 3 months, I usually sit with them, and if there are issues, we discuss about it, and make sure that they that after their internship, they are able to register with their professional body and work as social workers.

**Encouraging, giving hope and as a friend**

The role of encouraging and giving hope is identified by a few female respondents of over 35 years old, who have degrees and are working as support staff. Manika said that she supports the clients basically by encouraging them in their daily activities...just encouraging them to do things actually. Ah Cy also claimed that part of her basic role is supporting the clients [to] discover their strengths and have hope:

In the hard times they experience, the most important for recovery is to discover their strength and get hope. Hope is very important. No hope, they have no any motive to change...In the community support work, we encourage them in their journey of recovery. We stress their strengths and we help them have hope for a good future.

Chao Xing said that she also acts as a friend to residents in the rest home because most of them are alone and lonely. Similarly, Jingfei said that sometimes you can be a friend, because especially like after operation, their [clients] emotions are low, so you need to bring them a hot drink and make them relax.

**Under use/non use of their skills in their current role**

All Filipino participants and a few Indian and Chinese, those with a post graduate degree, but not registered professionals in New Zealand, male and female alike have
identified with doing work that they felt overqualified for. Chao Xing is a practicing dentist in China but cannot find any job that is directly related to her qualification so she ended up working as a health care assistant. Rajh completed his MA in Psychology in India but is doing a healthcare assistant work, helping the nurse to do the basic needs of the patients.

Likewise, Sofia is a registered nurse in the Philippines but while still working on her papers to become a registered nurse in New Zealand, she is working as a caregiver. Carlo is also a Physical Therapist in the Philippines, but while still working on his papers to become a registered Physiotherapist in New Zealand, he is just happy to work as a rehabilitation program worker doing the rehab activities that are in the timetable of clients. Amelia also observed that in the rest home, she only gives medications and there are no complicated procedures like ivy injections.

**Use of skills beyond the job role given**

A few post graduate and degree professionals from the Philippines and India claimed that they are doing work that is beyond their job description, but commensurate with their experience. This is either on a voluntary basis or as requested as the case of support worker Ajita, who uses some techniques of counselling to help her clients with their recovery. Sofia is working as a caregiver but is sometimes asked to take the observations, even the BSL [blood sugar level] and change the catheter bags of patients because she was a nurse back home.

Ligaya also observed that there is abuse in the miss-use of Carlo’s role:

*I can see that there is also abuse, like they know that he is a PT in the Philippines, but unfortunately not yet registered here, so they give him like more obligations, more job. He is an RPW but they look at it like, he can do that...it’s not too much of a task for him. It’s not right, at the end of the day, he is responsible for it but still paid like an ordinary RPW.*
Summary and additional focus group information

The migrant health and community workers who participated in this study have a combination of difficult and relatively straightforward employment experiences. Factors that made employment hard are the lack of New Zealand work experience, coupled with the difficulty in finding a good local referee, late timing in finding jobs, no jobs or limited jobs directly related to overseas qualification or non-transferability of overseas qualification due to regional difference in practice, discrimination in terms of ethnicity/race, language and having no permanent residency. The focus groups affirmed that all these factors contributed to their difficult employment experiences, and that they were at the mercy of employers who took the courage to employ them even when they have no New Zealand experience or no permanent residency at the start. While only two participants did not yet take the IELTS (International English Language Test System) or the OET (Occupational English Test) in order to be registered in New Zealand, language proficiency was a general concern in terms of diction or way of speaking, but it is being addressed in time or as they work and speak to people.

On the other hand, the facilitating factors for employment are health-related training or study in New Zealand that includes passing the state examination for nurses and subsequent registration; having good credentials, getting the theory and practical experience; being flexible and willing to try anything by looking a wide range of work options, including accepting unwanted night shifts and other on call jobs, as well as working outside Auckland and shifting to a town where one can find a job. Other influencing factors contributing to straightforward employment include the shortage of health and community workers, having contract with employers before coming to New Zealand, complying with all the requirements, and having a permanent residency in New Zealand. The focus groups raised the issue on conflicting requirements between employers and New Zealand Immigration Service (NZIS) – employers prefer workers with New Zealand permanent residency, while NZIS requires a job offer and New Zealand experience, which is related to one’s qualification before granting permanent residency.

Some of the participants’ reasons for being in the health and community work resemble their reasons for migration. All of the participants implied that they are in
health or community work because it is related to their qualification and work experience, while a majority said it is their chosen profession. A majority of the participants also work in health or community work because it gives them a sense of service and satisfaction. Some identified economic reasons such as working to pay the high international tuition fee. Others identified family reasons (e.g. flexible working hours) as their motivation in working with the health and community workforce of New Zealand. All these reasons were concurred by the focus groups with more emphasis on health or community work as a chosen profession, as a way of service and as a way of supporting their family.

Most participants felt they were using their skills that commensurate with their job role. All identified caring, helping and supporting roles, and a majority identified communicating, educating and advocating roles. Most of the registered participants have also identified managing and supervision as part of their roles. A few female participants have implied that encouraging, giving hope and being a friend are part of their role. A few of the non-registered participants have also implied that housekeeping or being a driver/chaperone/companion is part of their role. However, some were also aware of under use/non use of their skills in their current role because despite their qualification and experience, they work in junior positions as assistants or support workers in New Zealand. Others faced expectations of the use of skills beyond the job role given due to short staffing or because they are willing to do it.

The focus group participants, particularly the registered nurses, were aware of their own and others’ experience on having to start at some stage with junior positions while waiting for their registration. The non-nurses experienced significant under-use/non use of their skills in their current role, while a few others use their skills beyond the job role given when called for, but this is not always given due credit. There is always part of a job that may not be pleasant, but overall the participants’ migration has been successful, with them relatively enjoying their work, life in New Zealand, and making good progress on the goals around work and family.
C. CHALLENGING ISSUES AND CONCERNS

The issues and concerns expressed by the respondents were grouped into personal and family concerns, work-related/professional concerns and concerns arising from agencies.

Personal and family concerns/issues

Personal and family concerns named by more than half the participants include being homesick, worrying about children and culture shock. A few of the participants from all cultures have identified being homesick and lonely. Lihwa said, you get lonely. Sometimes, you get depressed and sometimes it’s hard. Jingfei also faced similar but more intense personal issue being away from family and living alone, particularly as she had just broken up with her boyfriend. Sofia was also homesick. She said it is not that easy to migrate, away from the family. Sometimes I get lonely... missed the family, really wanted to go home but had to work. For Rajh, cold weather added to homesickness:

...the first thing that affected me is that at the beginning I didn’t know the cause and effect around my ill health after landing here. I was not happy of being here that time. I didn’t know that I was homesick. Another thing is because of the cold weather that affected me a lot.

Child care concerns were mentioned by a few Indian and Filipino female registered nurses. Ligaya was concerned about the cost of kids getting sick without any support [from family carers]... to look after them... you have to bring your kid unless you get a nanny, but it’s very expensive. Amelia did not like giving her baby to stranger: Sometimes [she] had to give her baby to a trusted baby sitter... [and she] doesn’t really know them in a personal basis, but [she] had no choice.

Similarly, Sara worries about giving her children over to their new environment and the different values in New Zealand.

The freedom issue... when our children will grow up here, their values will be different. Even in terms of food, even going out late at night, they think “all my friends are doing it”... very hard.
A few Filipino participants identified accommodation/housing concerns. Sofia’s agent arranged for a place for her to stay, but Sofia was not happy about the restrictions in what to cook in that house due to cultural differences. [She] is not allowed to cook pork in that house. Amelia had a contract with her agent, who promised to provide her accommodation. However, she said:

*The day I arrived, a Filipino friend’s situation – her living conditions, made me depressed, and I want to go home... There is no heater, and it was very cold. No washing machine. The $800.00 [which was quoted by agent as allowance] was not enough for our food and transportation costs. I was scared.*

There are some Indian and Filipino women degree holders who said they did not access nor had no access to vital information in relation to their migration. Consequently, they had culture shock when they arrived in New Zealand. Sofia doesn’t have any idea about the environment, the people, and [she] was even shocked that New Zealand is a multi-cultural place. Sara apparently did not know about Citizen’s Advice Bureaus, and Aashi said I was just by myself and a few friends. We all have the same problem, so we just share our problems, just talking, but there was nobody to help us. I didn’t know anything that time, but now I know.

**Work-related/professional concerns/issues**

*Racism, discrimination, unfair treatment and/or bullying*

All Filipino respondents, half of the Chinese respondents and one Indian, all with degrees and/or post graduate qualifications, registered and non-registered, males and females perceived that they have experienced racism, discrimination, unfair treatment and/or bullying at work. Jia reported that just recently, one of her colleagues in the other ward [of the hospital] happened to be quite racist. Danilo agrees, going much further in asserting some general trends.

[There is an issue] *I don’t know whether to call it “racism” or what...... but my impression is that New Zealand is not yet ready to accept new migrants, especially skilled ones... I think that they may think that we are a threat to their job... They look at you just you’re a migrant trying to take their job away from them... they think that you cannot contribute to the New Zealand economy or the New Zealand health system. That’s the thing that upsets me sometimes.*
Sofia and Ah Cy argue for a different construction of racism, saying some co-workers just look at us, see our colour and then they think that we cannot do a proper work. This attitude led to her being a victim of a false accusation. She was mistakenly accused, in writing, of not shaving her client. She explained:

I know when I work, I really work hard and I don’t even leave the room unarranged. I don’t want to go to work [after that incident], I was depressed, down, but I am a professional so I have to go to work anyway.

Amelia had a similar experience of working hard and another worker wanting to pull [her] down... [through] gossiping or complaining:

I had this incident where a new staff worked for the first time with me on a weekend, and she wrote an incident report about me to the manager that I am going to other houses and using the phone most of the time. [It is] part of my job to answer calls because some staff are calling sick, and I have to get replacements from the bureau and things like that. The reception is closed, phone calls were directed directly to the main house where I’m working. I also need to go to other houses to do my job as only two RNs were on for the whole shift. If you work hard, and just one new staff comes in and makes judgments.

In contrast to migrants who work hard and are competent, some participants from the Chinese and Filipino cultures felt some New Zealand and migrant staff from other cultures staff are lazy and bossy. Jia said, well in the first time, the sr. nurse tried to be bossy. Chao Xing was annoyed with her co-worker:

She just talks about her personal issues. She enjoys talking about her personal life at work, instead of working. I don’t like her attitude. She is also bossy, like mother or teacher, talking, talking, and just doing paper works, not really helping us [on the floor].

While Jia linked bossiness to outright racism, Ah Cy thought that the main challenging issue is discrimination, an issue she has already raised in relation to getting work in section B within work, she felt belittled because of her ethnicity and English proficiency:

Their attitude is very, how to say, judging you as a Chinese. Sometimes from their tone, I feel, they devalue me. So I don’t like this attitude. Yeah,
for example, some very simple words, “Do you know this word? This is uh...what does it mean? Bla bla bla”... They always talk to me like I’m a child or whatever. They let us feel very oh, like we don’t know anything at all. I don’t like this attitude.

Carlo felt discrimination in the inconsistent application of practice standards at work. On the one hand, we have previously seen, he is asked to work beyond his RPW role, but when he:

volunteered in the gym as a PT assistant, and I think I know what I’m doing because I was a PT also in the Philippines. When I performed the same exercise to the client, it was rather easy, I was told not to do so, but they allow us to do some physio exercises in the houses, as per [clients’] timetable... It was a horrible experience, like limiting what you can do. I just stopped volunteering and concentrated on my RPW duties only.

Sometimes the discrimination is difficult to detect as with the organisation of rosters, but still powerful in effect, Amelia felt that some people are being favoured in terms of assigning staff:

In New Zealand, it’s a multi-cultural country, and sometimes there are cultures who would like to be above the rest... and sometimes, if they are on for the shift, they make sure they’ve got the right number of HCAs, while if us Filipinos, [it’s] as if they don’t care or maybe they overlook [things] but it is becoming more regular...Many times, I have to work in a shift that is understaffed or full of bureau staff, even there are specials [1:1 clients]. Yeah, it’s really difficult during those times, but we managed to survived, although it’s really difficult.

Others felt that they were given too much administrative work ... without additional compensation. Amelia said I have to do the catch up with other staffs - that is not my job. The manager [can] catch up with me, but [I’m] doing it [catch up administration work] for her.

Felt discrimination intensifies when participants experience unfair treatment around wages and employment opportunities. Amelia did not have any pay rise after a year of working with the rest home. When she approached the rest home manager, she felt that:

...the rest home manager was very discriminating..."you accepted $19.00/hr, you just wanted more money!" The manager was even
mentioning, seems like threatening me, about my husband’s coming to New Zealand...

She left the rest home at a personal cost of $3000. Ligaya also resigned from a rest home because of wage issues. She discovered that a nurse who was just hired... much later than me... was receiving $3.00 per hour... higher than me. Her new employer promised ... the same salary, but when I got my contract, it was even $1.00 less than my former job and I cannot go back to that because I already resigned. Oh it was terrible. I cannot believe it.

One of the most damaging examples of discrimination is workplace bullying. Chao Xing was not personally bullied, but she was aware of an environment of staff bullying the patients or bullying other staff. Ligaya, a relatively new RN in a rest home, felt its full force.

There was a client in the rest home who was very constipated, and that the guy who is in charge of the rest home side came to me, calling me with his one finger. He and a lady caregiver were very intimidating, telling me what to do. He told me “come here and do the manual extraction!” I got so upset with that. Of course, I’m going to do it but the way he treated me was like he is very discriminating. I felt I was so small, so what I told him is that “I’m going to do it if you have tried it but not successfully, but I’m not going to do it if you did not try to do it”. I felt it was very intimidating, and they both started laughing.

Cultural and communication differences

The feeling that Asian migrants are hard workers and suffer for it may represent a difference in cultural perceptions around what constitutes a reasonable level of work output. Almost all Chinese and half of the Indian respondents have named cultural differences as part of their general concerns at work. Manika said, as a migrant, we have to pass so many things like as a cultural thing; we have many differences of our country from this country. Chao Xing said that Asian people sometimes use non-verbal communication... I think this is culture different. Rajh has a master’s degree in counselling in India, but admitted that he is not good at understanding the cultural
factors of New Zealand, so [he] wants to do something with that. He just does that [counselling] only to [his cultural] cell group.

Aashi’s migration experience is not too bad, but there are challenges –

one is the language and the other is culture. They expect you to know everything. Everything is different from my place, like the food and so many things that are different. When you come from a different culture, it is very hard... I have so many things going on.

For Jingfei, trying to manage the cultural isolation and cultural differences is distressing:

In Palmerston North, .. in the hospital, I feel I am the only Asian there so automatically I’m isolated because I’m different from other people..... When I was a student nurse, I feel it so hard to understand the culture, their living habits, like their way of drinking coffee, simple things like that.

Such differences are painful when patients refuse care because of cultural differences. The following example reflects (as does Valencia’s in the section above) the complexity of cultural communication in bi-cultural and multicultural New Zealand. Lihwa was dismayed for herself and her patient when her Maori patient refused her help, and wanted someone else’s instead:

Ah I think it’s the culture issues. For example my patients are Maori people, and like one Maori patient, she doesn’t like Asian people. She likes Maori people to look after her, so she just got angry and she said “go out!”, so I got out. You sometimes feel it’s very hard. There is no Maori caregiver so a kiwi nurse helped her. Ah, it’s hard.

At the centre of above example is the culture of worker-consumer power relations. Rajh finds the system here is different from India... in New Zealand, we give more importance to the human rights and all [and] too much freedom. The consequence for Rajh is that he has to focus more on how to control [his] feelings.

That’s the major challenging thing I had. In the past two years, I was too much upset of the person’s behaviour here, because. It’s not easy in [getting] them [under] control. We have to go according to their wish on how to solve their problem. This is a new trend for me after coming to
New Zealand – so that was really a challenging factor, to change my approach.

Communication issues are at the heart of intercultural challenges, particularly for the Indian and Chinese participants. Ah Cy said (in addition to colour) that people judge us by our language. Added to this is the challenge, as Rajh acknowledged that of New Zealand as a multi-cultural society. He further argued that:

..our language is totally re-structured to England’s system, but when we talk to this people, even the kiwis, their accent is different, Maoris have different accent, Samoan have different accent – it is different, so it is really difficult to manage that language. So that itself, took me a long time to mingle with this society properly.

On the same line, Aashi claimed that the language barrier is very huge. She said:

Even now, the nurses are suffering a lot with this language problem. Even if they are good in English, but they really have difficulty understanding this language... Even though I can understand English but when I came here, I didn’t understand a word, like New Zealand slang. It’s really hard to understand.

Similarly, Carlo said that sometimes there are communication barriers... because of the diction. Sometimes they speak fast and ... [he is] really struggling to understand it. During Sara’s competency training she had difficulty in understanding phone calls. She said when we talk to them [face-to-face], we can learn how they talk because we see their lip movement.

In terms of the ordinary meaning of words, Lihwa knows the words but doesn’t know the meaning when used here in New Zealand before. For example, they say “what’s for tea?”, [she] now understands that it means “what’s for dinner? As Rajh has suggested, these problems are temporary. Ajita found difficulties about [her] language because it’s different here than in India, but now [it’s] fine.

**Working with challenging clients and systems**

A few participants from all cultures identified challenging clients, particularly those with mental health issues, as one of their concerns. Nurses Jia and Mei working on a
neuropsychiatric ward and in a rest home find clients are confused and abusive at times and they can become agitated, and they become angry or rude. In community mental health settings, Hamid and Rajh also have challenging experience with clients who are abusive and difficult to manage in the mental health facilities, as does Ajita working for an alcohol and drug detoxification unit. She recalls intimidating experiences... every job got its own risk. We don’t know what they’re going to do.

The families of clients can also be very demanding as Sarah discovered:

wanting to stay with the patient even after visiting hours...they want to listen when the doctors do their rounds, but it goes against the privacy and confidentiality because we have like 8-10 patients in the ward... Sometimes it is difficult for them [family] to understand.

Adding to Sarah’s stress is the equipment and the protocols are quite different from what... [they] have and what [they] learned back home... [She] had to face a lot of challenges especially in times of emergency. These system issues are compounded for Filipino and Indian participants working through employment bureaux and particularly on shift work. Sofia and Ligaya, feel the roster is chaotic and there are many erasures and changes. The shifts are irregular. Rajh didn’t get enough jobs from his bureau work because they lost some contracts. Danilo had to endure working shift arrangement both as a registered nurse and as a caregiver before getting a full time registered nurse job.

The consequences of semi-chaotic shift work with its unsociable working hours, is that, as Jia says I lost my social life. Add constantly changing places of work to this mix of shift work, new systems, discrimination and cultural and communication misunderstandings and you have the conditions for burnout. Aashi, who has experienced most of these problems, describes her role:

I do not work every day with particular clients or workmates. I find it challenging to adjust to a new place that I go. Although I know my duty as a nurse and things like that, but because the clients are new to me, even the staff that I work with and the whole facility is new.

How Aashi manages to survive, I will leave to section D.
Concerns arising from agencies

In the background are the immigration and accreditation agencies that set the criteria for employment and the consultants that supposedly help migrants work their way through the bureaucracies.

Waiting for New Zealand Immigration Service (NZIS) to respond can be an expensive process. When Rajh could not find a job in Auckland, he moved to Hastings where he found a job as a support worker. When he was there, he did not receive his notice from NZIS on time. Although he was a little bit late in responding to their requirements...they made it a very big issue. For Ajita the most stressful time [was] waiting for my PR [permanent residence] approval. With her masters in social work she could get work, but not without a work permit. She thinks that if you got permanent job like what [she has] now, they should approve it. The stress is intense when, as Amelia states:

...you’ve got only two days and your working visa will expire, and then the work permit didn’t yet arrive, you will be thinking, “Oh my God...” it’s very scary to think that you won’t be able to work and have no money to pay to survive in a foreign country.

Immigration consultants that are based overseas are beyond New Zealand legislation. They often charge large amount of money for their services. However, these consultants are still found wanting by their clients. Sofia, Aashi and Amelia had this experience of not being informed fully (by their immigration agents/consultants) of the realities in New Zealand. Amelia said:

I am grateful with my agency, but I am not happy with the way they informed us about the reality of coming here - that you need to have more or much more money to come here actually. They inform only about 15% so that we will not be dismayed. My friend told me that they have emailed the agency in the Philippines about the realities in New Zealand, but they did not fully inform us. They don’t want to discourage their clients.
The New Zealand Nursing Council (NZNC) acts as the gatekeeper for New Zealand nursing qualifications, Sofia apparently only got piece-meal information of the additional requirements and timeframes from NZNC. She said:

I have given all the requirements. I have done my IELTS and passed it... They [NZNC] questioned the Statistics subject that I enrolled for in the Commerce Department, but that is just in addition to my nursing course to help me with the research [course]. They questioned that, but it was alright now. [Then] just another requirement again – a certificate of the number of hours that I worked or volunteered as a registered nurse in the Philippines.

Will she get through? She said I just pray about it. Meanwhile, Sofia had also requested her parents to secure this needed certificate from where she worked before.

Sara also observed that NZNC is getting stricter in the registration of overseas nurses:

... but now they [NZNC] are asking for specialization. If you are applying for a surgical ward, they ask for related experience, whether how much is your fluency or trying to pinpoint any flaw in us.

If things don’t go well, Sara said, we may be referred to a rest home to work.

Summary and additional focus group information

The challenging issues and concerns of participants involve both personal and family, work-related/professional matters, as well as concerns arising from agencies such as the New Zealand Immigration Service (NZIS), Immigration agent/consultant and the New Zealand Nursing Council (NZNC). Personal and family concerns/issues include being homesick, away from family, alone and lonely; concerns on childcare and integration of children to the new environment; high cost of living and accommodation/housing concerns; and the non-access to vital immigration information. The focus group discussions revealed that nearly all participants, men and women alike, but more particularly among the younger participants and those who have no families in New Zealand, have suffered from homesickness. The focus group discussions also affirmed that the participants’ concerns on their expensive tuition fees they have to pay as international students.
Work-related/professional concerns/issues included racism, discrimination, unfair treatment and bullying, which were also factors as to why getting employment is a difficult experience. Other issues identified are the challenges cultural differences and communication differences, and the difficulty with working with challenging clients and systems. Discussions in the focus groups confirmed that the issue of discrimination is more prevalent among the Filipino and Chinese groups, while cultural difference, English language and inter-cultural communication difficulty is more of a concern for the Indian and Chinese groups.

Some participants were earlier impressed with helpful New Zealand agencies. However, others expressed their concerns arising from NZIS on the delayed renewal of work permits and approval of permanent residence. Other participants had issues on not being fully informed of their migration by their highly paid migration agent/consultant. Overseas registered nurses who are seeking registration through the NZNC experienced piece-meal information of additional requirements and increasingly strict requirements for their registration. The non-provision of government benefits to new skilled migrants, who are still looking for jobs to start a new life in New Zealand, has been a concern as well.

The focus groups confirmed the concern on obtaining a work permit, permanent residency and professional registration. The difficulty of obtaining permanent residence if one is not given the chance to work in line with his/her qualification is still a paradox for some participants and their spouses. The focus groups also brought out the concern for other overseas trained nurses who are working as caregivers because of the lack of English proficiency. The focus groups posed the issue on how these people can be helped to review and pass their IELTS or OET without necessarily spending too much.

**D. COPING STRATEGIES, SOLUTIONS AND RECOMMENDATIONS**

In this section we look at the participant’s coping strategies, solutions and recommendations to the concerns raised so far in this chapter. The general themes
that emerge are as follows: access to available information and support, further study, re-training and/or continuing education, work-related actions, and personal actions.

**Access to available information and support**

**Information and support in the migration process**

Be prepared for New Zealand. Nearly a third of the participants recommended that migrants be better informed about what they are going to experience. Mei, Aashi, Sofia and Rajh felt that migrants have to know more information, and that it’s really important to read first and get legal advice from others who have very good experience. Sofia said if migrants were more aware they will not be victimized, and have a culture shock, have loneliness. She recommends go to the internet first to check the lifestyle – like the housing, transport, the environment, the people. Go beyond the limited and favourable information given by immigration agents. She did not do this, she just heard from her agent that it’s nice here. They didn’t even say that it’s a multi-cultural country. Aashi agreed: ask someone who knows before you migrate. Try to find someone, a friend or a relative who can give you some advice.

Make sure you know what the professional requirements are. Nurses need to work with the New Zealand Nursing Council and comply (says Sofia) to all the requirements until they [NZNC] will be satisfied...They should work on their qualifications, like passing the IELTS or OET [requirements].

Many of recommendations made in relation to information and support relate to the agencies controlling the migration process. Sofia wants those assessing the immigration requirements at NZIS need to be more consistent with their assessment, more prompt in releasing their decisions, and allow opportunities of appeal if warranted. She said:

_The people who assess the papers or requirements should have the same standards, because some applications were approved and others were denied but the applicants come from the same school, the same batch, the same workplace and their qualifications are almost the same. They [NZIS] said they can’t change their decision if they have denied the other._
Hamid thought that the requirement on working in a related job before having a permanent residency should become more lenient, so that qualified migrants can work in any field that is available, and then go forward from that. On Immigration procedure, Sara believed that overseas qualified migrants will have more chances of employment when they are given permanent residency while in their original country because it’s difficult coming here and trying to apply but they don’t give you a chance until you have permanent residency.

For immigration agents/consultants, Amelia felt that they should be more professional, honest, able to give complete information and act with transparency:

*The recruiting agency should be investigated. They [agents/consultants] should tell their applicants all the necessary information needed like, how much will be the indemnity insurance and all that. They say it is so easy but when we arrive in New Zealand, it is not that easy...*

For New Zealand employers, Carlo appreciated the system where other employers hire skilled migrants even in junior positions as occupational therapy assistants, physiotherapy assistants or health care assistants, and then help them get their NZ registration. Danilo suggested:

*Everybody should be given a chance to prove their worth for as long as they have qualifications and related experience. That’s for me then. If you think this kind of person can put their work in, then give them a chance, if you think that they are helping to the New Zealand economy, well, give them a chance then... I mean all migrants really work hard.*

**Information and support in employment**

Once in work in New Zealand, a majority of the respondents and most of those under 35 years old, recommend getting information and support from managers, senior staff or from their colleagues, as part of their coping strategies. Sometimes this should be just part of the management procedure as with Hamid who phones the crisis person or team leader anything happens beyond his scope. Jia talked about her concerns about
racism and being bossed around to the nurse manager and to people who are in charge, and Ligaya went further to both her former manager and to her current general manager when she was not happy about how she was treated by her co-workers.

Chao Xing recommends that we need to ask the senior staff and try to find the best way to sort out...and seek the help of the hospital management. Ajita had had difficulties in her employment but is now fine because everyone encouraged and supported [her]. Sara had few challenging issues, possibly because she was positive at the outset about getting help from colleagues and senior nurses, and despite Carlo’s skills being unrecognised by some, he got inspiration from a senior physiotherapist, who told him that “if there is one in your country to be registered [in New Zealand], it should be you”. Aashi works as a bureau nurse, and goes to many different health facilities. She gave this practical recommendation:

I ask the staff there about things that I’m not familiar with. I get the hand-over from the previous shift...know more about the places I have to go...get as much information as you can before you come to a new place.

Some participants, both registered and non-registered suggest that access to support people is important in coping with their issues. Rajh said: I keep on contacting my own community people. That helped me to continue further. Ajita said that she found help from her cousins, mum, family, the church. And I’ve got my workplace that helped me a lot. That’s the turning point in my life. Jia talked to the charge nurse about it [her concern on unwanted time of work shifts], she said to me that “that’s a part of nursing so I have to accept it”. I always request, because I wanted to go to church, but I can’t. I just joined the Bible study on the week day.

On the other hand, Hamid suggested that if somebody comes in from other country, [he/she can] always find some support group. Like each migrant group, they have support group. They have to find out from Citizens’ Advice Bureau, and they can get support from that. Lihwa thinks that:

Social activity is also important ... and maybe go to church – because we come here and only you, you get lonely. Sometimes, you get depressed and sometimes it’s hard, but if you have friends, and it makes it easy.
Amelia commented that:

...the ones who cope here in New Zealand are those who reach out. I know a lot of Filipinos who just keep their struggles to themselves and they just go back to the Philippines. They don’t realize that it’s already too much for them. They need to share it to others so they can cope.

She also suggested, in general, that migrants should assertively seek help from both private and government services like Plunket, even [for] small things... it will add up, and speak out if need be. Other participants stressed the importance of socializing with other cultures. Rajh coped through mingling with the society and talking to other cultures... Lihwa said, if you have friends, it makes it easy. Similarly, Jingfei coped through socializing with others, and developing her English language:

The good thing I found in Auckland hospital...it is very multi-cultural...I can talk to my colleagues...you don’t feel you are different anymore, especially my colleagues, we go to watch movies, we go to barbecues, we go to beach. The more we socialize, the more we develop our language. So the way I’m coping is that I meet a lot of friends.

**Further study/re-training and/or /continuing education**

A majority of the participants from all cultures with post graduate, degrees and high school qualifications, and both registered and non-registered have recommended further study or retraining in New Zealand. Manika said that migrants have to start studying in the local [New Zealand]...working part-time with related course until...[they] can get a job...do anything to be able to work. I’m glad I did that certificate in mental health support work. She and Ah Cy recommended study programmes with placements or on-the-job trainings as a means to get a professional job.

When Hamid could not get a job in computer programming, he retrained in mental health and then continued to Bachelor of Social Work while doing his job in mental health. Ajita is a Master of Social Work in India, and is now working as a support worker in New Zealand. She is planning to go for specialized study related to her present job:
I’m using my qualification [from] back home, but I think I have to get more knowledge about treating clients in terms of social work in New Zealand so I’m just planning to go for any course like drug and alcohol to improve my knowledge and to implement to the clients.

Valencia came to New Zealand fifteen years ago. She worked in many menial odd jobs for the first two years then decided to study Master in Social Work. She strongly recommends re-training and doing something about the difficulty of having a job:

*I think all I can say is if you qualified overseas, it is very, very important to re-train ... so I will tell people, ‘look, just accept it and be challenged, and if you need training, just be humble enough to be re-trained. Once you are trained, you’ll get the job.*

Some participants also recommended in-service or ongoing education and training. Rajh suggested that a continuous good quality of education is best. Jingfie and Jia supported in-service education through attending staff development trainings and other teaching sessions as scheduled at work. Jingfie said:

*Learn some more... Attend to staff development trainings. There is what we call ‘teaching session’ about everything. Sometimes they just come and introduce the new products... Sometimes, they teach about a particular disease like Parkinson’s disease, how to take care of patients from the nurses’ point of view. It’s increasing our knowledge.*

Mei recommended more study, more readings and sharing of experience...always de-brief, because people come across different things, and we get different and new ideas. Aashi is already seven years RN in New Zealand but acknowledged that she still needs to increase her knowledge about nursing in New Zealand. Danilo was a registered nurse for more than ten years in New Zealand, but he still recommended that health and community workers get as much training as possible to update them. In addition, he recommended further learning about the different cultures in New Zealand, and how to integrate to the New Zealand society. Related to this, Mei sensed that migrants have to know how to deliver appropriate health care for different cultures. She strongly feels [that] the [New Zealand] way of treating patients as a health professional is very important.
Rajh said that once he learned the [New Zealand’s] system then he was able to manage. Valencia who has been a social worker for thirteen years in New Zealand asserted the importance of studying the diverse culture of New Zealand, and the principles of the treaty of Waitangi as a general basis of service delivery:

They [migrants] need to study the culture and how the family dynamics are working. I know that it’s totally different...One important thing is the treaty of Waitangi. They should really fully understand it as it relates to their work. Treaty of Waitangi is really important because it is our basis of dealing with our clients.

**Work-related actions**

**Volunteering**
Do the obvious like submitting CVs or applying for jobs (Sara), but if migrants are unable to get paid work, some participants recommended volunteering in order to get a relevant job experience. Sofia was a registered nurse in the Philippines, but she had to volunteer there for one year as a nurse, because there were no available jobs. Manika was a corporate manager in India and volunteered in an orphanage. That experience led her to working and studying mental health support work in New Zealand. Danilo suggested that volunteering will make migrants more interesting to employers. Hamid agreed because most [prospective employers] will be happy if somebody has done a voluntary job. Much of the value of volunteering is in acculturation, where there is some kind of involving with the public so you can go to the mainstream of working with people later on. From that volunteer job said Ah Cy, people will get that important referee for another or better job.

**Being competent**

When in work and faced with issue of discrimination most participants say the solution is doing a good job, having confidence and being competent. In section C, Ah Cy and Amelia noted the importance of doing hard work. Chao Xing, Rajh and Aashi concentrated on doing a good job. Ah Cy and Lihwa stressed having self-confidence in this area. Ligaya recommended set your goal and prove to them that
they are wrong... one should always be competent ... Carlo went further. Being competent is not enough so you have to be above average... to show your employer you are a world class professional. It’s the survival of the fittest and the elimination of the unfit. To survive you have to document what you have done otherwise they won’t recognize it. You have to be very vocal to your boss. This process of self promotion is uncomfortable for Carlo because in [his] culture, it is just like lifting your own chair, ‘nakakahiya’ - that is to say it is shameful.

**Effective communication**

Communication in general will help say some participants, and using particular communication may help more. Mei would like to make people more comfortable so [she] always communicates, while Jingfei believed that the practice of basic English communication in different workplaces has helped. Ah Cy noted that communication skills are very necessary to show yourself, to show that our people can still cope, can communicate, and can show our ability, particularly verbal communication and talking openly. Ligaya and Valencia add that one should always be honest, while Jingfei uses honesty and openness within a much more subtle and rich communication framework that also involves careful listening - a skill generally conspicuous because of its absence in the transcripts.

*I personally just talk to the charge nurse. I share most of my life with my charge nurse and tell her what exactly [problems] I am having, even they are just personal, I just share with her, and she understands me. If I just tell her, “I want a holiday”, she might just get grumpy, but if I tell her “see, this is my problem bla bla bla, and why I need a time away”. She can give you time off, and if you come back feeling better [it’s all good].*

While ‘listening’ gets no mention, observing and putting yourself to other’s shoes (Mei) does. Lihwa watches other nurses working too long losing their patience and losing hope.

*They think everything is like that – like dying. They think, no more. Sometimes they don’t care. Maybe they worked too long, maybe they worked too hard, I don’t know but sometimes, some nurses give you a feeling like they don’t care.*
While having confidence is Lihwa’s first piece of advice, the second one is to really care.

While Lihwa extends this ‘listening’ advice to client’s and families (giving time for the client’s family to show their feelings is important), communication with clients who are confused, abusive or non-compliant is an area of significant challenge for migrants. Jia tells her difficult clients straight away and quietly seriously that [their behaviour] is not acceptable, but in more complex cases such where the patient’s whanau do not accept hospital rules regarding visitors, getting help from more senior staff is needed. Sara gives this example:

...because like the whole family is there, they bring their priest or someone from their church [to] do something, [and] they bring their own food... it’s difficult for them to understand. Sometimes it’s quite a clash, so we have to get the coordinator to talk to them. We tell the coordinator or the main charge nurse to talk to them, because such patient really needs close monitoring, and this is the case, so she will be the one to talk with them.

Under conditions of risk Ajita always wears the panic alarm. So if anything happens, [she] just press[es] the alarm to get help from colleagues. Similarly, Rajh emphasized, we always have to be vigilant, anything can happen. Hamid said:

Sometimes the clients are very agitated, they can turn abusive, and could do physical attacks, it’s hard but we just have to cope with it. We phone the crises team for help. We also have to be vigilant, and work together.

**Cultural Awareness**

Awareness and particularly cultural awareness is another way that some participants practised sensitive observation in their new environments. Aashi said that we need to be more aware [in order] to understand. Sara emphasized that we have to apply the bi-cultural approach; we have to deal with the Maori culture and those of others. We should treat them [patients] with cultural safety. Ah Cy believed that we need to adjust to their [New Zealanders] culture, while Rajh acknowledged that he is still trying to adjust to the New Zealand culture, he believed that accepting others’ culture is an achievement in his life. Mei stressed about being aware of the cultural difference
not only between migrant cultures and ‘New Zealand’, culture, but between the different cultural contexts in New Zealand:

...so you have to pick up good stuff and leave the bad stuff. So cultural awareness like having eye contact is really important for Asian people, but for Maori people I think they don’t like eye contact – it’s like uhm rude for them.

Lihwa believed that respecting each other is very good... do not make any assumption... you always ask them [clients]. That’s the best thing. Danilo agreed that there are times when we need to ask how they [clients] want it done here.

**Team work**

Being part of team helps. Mei said that although some people have bad experience, they have to work together. Jia’s experience of teamwork is quite good. The senior nurse are happy to teach...they give you chance to learn nursing skills. Despite Jia working difficult and unsociable working, she loves the teamwork in her ward, and because this ward is a lovely ward [with] good teamwork, I just stay. But if I find some better shifts then... (laughs).

A good basis for teamwork is the buddy systems that some services use to orient new staff. Aashi liked being buddied with another Indian because although she could understand English, when [she] came here, [she] didn’t understand a word, like New Zealand slang. Other friends who were buddied with nurses of different cultures had a hard time. Sara felt that the non-culturally linked buddy system increased her practical knowledge about nursing in New Zealand. She said:

The senior staff will buddy us for the first six weeks. Sometimes there are things that are different back home. Even when we have a patient from the theatre, and they may not be safe to go back to the wards, they are not yet stable, the sr. nurse will have to be with us, and we can learn from them.
Cultivate personal qualities

Positive attitude – working hard and holding hope

Almost all the participants (six Chinese, six Filipinos and four Indians) suggested that having a positive attitude helped in managing their migration and employment challenges. Mei and Chao Xing thought that having a good attitude is important. Being positive, say Chao Xing, Lihwa and Mei, can mean that we have to be patient in working. Valencia is now a full time senior social worker in Auckland City, but not without experiencing four years of having to persevere as a casual employee. You’ll just be hurt Valencia said if you accept discrimination, [and], you’ll just be self-pitying. If you don’t get the job, do something about it. Ligaya emphasized that there are ups and downs but you just have to deal with it really. You have to deal with those kinds of problems which you are not used [to].

Danilo arrived in New Zealand fourteen years ago as an overseas registered nurse but still had difficulties in getting a job that time. He says:

There’s job in New Zealand, as long as you persevere. Try to show your worth to your employer. It’s not always an easy task but oh, in the end, you’ll get there. Just be patient, persevere in doing what you’re trying to do.

Carlo agrees that health workers [and community workers] who are planning to come to New Zealand have to be strong and determined, with lots of patience. Danilo points out that not every migrant who comes to New Zealand can cope and that other people come here, and they just maybe after one month or two, they give up in New Zealand. However, in coming to New Zealand, some migrants toughen up. Sofia said:

I also think that when we come here, our attitudes change. We become like strong minded, because here we have to survive, learn to stand up for ourselves and to decide. If you feel sick in the Philippines [you can be sick] - here you become strong because you have to survive.

More specifically being positive means working hard. We have already mentioned the participant’s experience of hard work. Amelia and Carlo recommend that health and
community workers be willing to work hard and Aashi adds we have to just keep on working hard. It is ongoing. Ligaya said:

*Others may think that when you go to other countries, your life is better, but without hard work, it will still be the same... you can’t reach your goal, if you are not hard working, [so] just work well and work hard.*

Some employers and colleagues, says Carlo, are sweet people and some are hard people who always find fault or flaw in others. The hard people make it harder but you just [have to] do your best. For Carlo, ‘hardness’ is an individual quality (as is perseverance for Danilo, above), but Valencia names the ability to work hard as cultural quality.

*Filipino people are hardworking and honest people. We just do the best we can. We are not trying to please the people or your boss, but just be honest with what you do... remember, you are getting paid to do the job. Just give the best you can.*

Generally, the advice from the participants particularly those with post graduate and bachelor’s degrees who felt forced by circumstances to accept under-employment, is accept the reality of migrating to New Zealand, work hard, and to be humble enough to go back and re-train.

More than a touch of bitterness can accompany this advice. Ah Cy was a university lecturer in China, and has a New Zealand MA in Language Teaching. In China you may be, she says, an associate professor.... here [you] are just cleaner. This is reality. If you cannot accept it then it’s a big issue, so just accept it. Don’t compare to your past. You start from zero here. However, Ah Cy, also calls for migrants to go beyond their usual markers of power and status, pointing out that you’ll never ever feel balanced in your heart, if you do not accept this different status. Lihwa puts it more succinctly: if you’re happy to help the people, you’re happy to work in that environment. Otherwise, it’s hard.

Holding hope is the second major aspect of positive attitude. It is expressed by nearly half the participants across all the three cultures. Danilo who at one stage, when he could not find work said, he was *pretty much losing hope because nobody gives me a*
chance. He now encourages migrants to see the positive side and not to lose hope as there is always something for them if they persevere. Ah Cy in her mental health and community work, supports Chinese migrants. She says the most important for recovery is to discover their strength and get hope. Hope is very important. No hope, they have no any motive to change. Ajita revealed that she learned a lot of things, became more positive, more stable, changed a lot in life, and just keep hope for everything. Similarly, Hamid said:

> Each person will have a different situation, so we have to be always optimistic. Don’t give up hope. Because once we come to a new country, we have so many challenges and we have to face it. If we feel upset and down, we can’t move forward, so let us be positive and never give up hope, because that is from my own experience.

Sarah simply says we have to hope. The key to hope is that things do get better over time. Jingfie said, I think as you stay here, you learn more, you get used to it and you feel better. Hamid who used to work with computers for such a long time overseas had demonstrated that he learned to love his present job in a matter of time… after 6 years, I am getting friendlier and I am getting into the work. As for me, I have learned to love this job after making adjustments.

Finally there are suggestions for holding that positive balance. Jia said, the way I am coping is that I meet a lot of friends, do some exercise, learn some more… Chao Xing uses techniques of emotional self management when other workmates are rather annoying, and Carlo encourages other migrant health and community workers to set their goals so that they can give a better future for their family, especially their children, and be of help to some other overseas health workers – that they might have a good life here also.

**Spiritual Faith**

Hope and faith are closely connected. A majority of the participants (four Chinese, four Filipinos and two Indians), mostly females and one male, suggested that their spiritual faith had helped them cope with their challenging situations. Most of these expressions of faith are mentioned in passing as part of the participants’ coping
responses and covered going to church (Lihwa, Chao Xing and Mei), hoping and praying for a better future (Sofia, Amelia, Sara and Ajita) and joining Bible study group for support (Jia).

Amelia and others were more expansive about the positive value of faith:

*Have faith in God, because if only by yourself without God’s help, you’ll be nothing. Without God we can’t achieve all those hard work, we will be fruitless. Not only here but anywhere in the world, you know, the foundation - our faith.*

Sofia believed that her faith in God made her strong, and that enables her to live *one day at a time.* Carlo believed that Divine intervention resolved one of his difficult situations. Ajita said, *believe in God, that’s the main thing, because in my belief, God will not give a sad moment without good, so we pray and hope.* Likewise, Valencia believes that being a Christian enabled her to do her best and take things rather easy when she was discriminated against in her earlier job searches:

*It (job situation challenge) actually came easy, because I’m thinking to myself as a Christian. I believe that they are not my real boss, they are just employees like me, and so I believe that we just do the best we can. We are not trying to please the people or our boss, but just be honest with what you do...*

**Summary and additional focus group information**

The participants’ coping strategies/solutions and recommendations with regard to their challenging issues and concerns include the following active coping strategies. Access available information and support about migration process and settlement in New Zealand, including vital information about the employment and cultural conditions and migration requirements of New Zealand. Ensure that you get support from work colleagues, senior staff and managers, and from support groups and individuals and agencies such as the Citizen’s Advice Bureau and Work and Income. This will prevent the worst effects of culture shock and hasten adjustment to the new environment.
Further re-training and/or continuing education in both formal and informal settings are important. This involves learning about New Zealand cultures including the principles of the Treaty of Waitangi as applied in health and community work, as well as the use of English language in New Zealand. Another way to get experience of New Zealand systems and cultures is volunteering. Volunteering provides local experience and referees that will make one more interesting to prospective employers.

To address the issue of discrimination, demonstrate competence - do a good job, be confident, show self-confidence and be hard-working. Another work related action is the practice of effective communication that includes the use of basic New Zealand English (in all its guises) in the workplace, using assertive communication, being honest, and to really care about your clients. Part of this includes culturally awareness of the multi-cultural nature of New Zealand and accepting and respecting other cultures.

Cultivate personal and professional qualities that include teamwork, developing and maintaining a positive attitude, the prowess to work hard and to hold hope. Team work includes mentoring of and supporting other migrants. Having a positive attitude entails patience, strength, perseverance and determination, as well as the willingness to work hard and being happy to do the job, observing self-control, acceptance of reality and the clients. It also involves having hope, not giving up, maintaining physical fitness and helping others. The participants’ spiritual beliefs and practices played a major part in sustaining hope and energy for the future. Other participants also thought that the passage of time helped them cope with their situation, whilst others consider that coping is helped by having a family lifestyle.

In all the three focus groups, these aforementioned coping responses/solutions and recommendations were all strongly affirmed by all of the participants except for one Indian participant, who had the thought that having faith in God might be part of his coping solutions to his issues.
Summary of the Chapter

The participants migrated to New Zealand due to the influence of their linkages with family and friends, their desire to change lifestyle and to study, among others. Their pre-migration and first experience of New Zealand is that of a generally positive one despite of the challenging issues and concerns of personal and family, work-related/professional as well as concerns arising from agencies. Their experience of difficult or challenging employment is compounded by the lack of New Zealand work experience, difficulty in finding jobs that are directly related to their overseas qualification or the non-transferability of overseas experience, discrimination in terms of race or ethnicity, having English as a second language and having no permanent residency status yet from the immigration office. Their employment concerns were facilitated through health-related study or re-training in New Zealand; through their flexibility and willingness to try anything such as accepting under-employment/on-call work/part time job and willingness to find job outside the Auckland region to gain a New Zealand experience before coming back to Auckland. The need of health and community workers and the help of existing linkages in New Zealand also facilitated their employment. Their motivations for being a health and community worker include sense of service and satisfaction, related work with experience and chosen profession, as well as for economic and family reasons. Perceived roles in health and community work include the use of skills that commensurate with their job role; under use/non-use of skills in current role; and use of skills beyond the job role given.

Coping responses/solutions and recommendation from the participants includes but not limited to accessing available information and support both in the migration process and in employment; further study, re-training and/or continuing education; work-related actions as volunteering, being competent to include effective communication, cultural awareness and teamwork; and cultivating positive personal qualities such as working hard, holding hope and maintaining spiritual faith.

The following chapter presents the discussion of the findings and implications of this study.
CHAPTER V

DISCUSSION

This chapter discusses the themes of the study across different sections of the findings and in relation to literature. This study explored the experience of Chinese, Indian and Filipino migrant health and community workers who have worked in the frontline of New Zealand health sector for at least one year. The focus of the research was to discover the participants’ migration and employment experiences, including their motivations and perceived roles in health work. The study also focused on how they think other migrants could be helped in relation to their experiences, and how their opportunities could be increased to achieve productive potential in the New Zealand context. Implications of the research findings are included in the chapter. These are followed by brief discussions on the limitations of the study, the recommendations, the suggestions for further research, and the conclusions of the study.

Differences between the groups

Before starting on the discussion proper, it is important to see what extent the analysis has shown in the differences between the groups of participants. While this study is not able to provide a statistical analysis between the various ways of grouping the participants, the percentage of participants in one group that picked up on a theme was often quite different from that of a contrasting group. This section summarises the most important differences.

Registered professionals (9) versus support workers (9). Registered professionals were more likely to have come as students or with a job in nursing or health care already secured, to seek registration and to settle in New Zealand. As such they were more likely to come on a student visa and with parental financial support. This may have lead to their much more positive first impressions of New Zealand. While the support workers commented on the helpfulness of New Zealand institutions, getting a job was much tougher for them, particularly in relation to the recognition of their overseas qualifications and experiences. They were much more likely to have to
retrain, be flexible about the jobs they took, which were more menial in nature, and do volunteer work. They experienced things getting better over time, and that focussing on demonstrating competence on their jobs had better employment outcomes.

**Females (14) versus Males (4).** 75% males were in support worker roles whereas only 29% of the females were. The men’s experience mirrors that of support workers, which is generally a tougher migration experience, particularly around the issue of transferability of qualifications. Other areas where males stood out related to less family involvement, more struggles with NZIS, more difficult work conditions, and possibly being less likely to communicate their problems. On the positive side, the males were much more likely to have joined a support group. The female participants were more positively impressed with New Zealand, and wanted to have a change of lifestyle, work for their families and for the future of their children. They have more personal and family concerns/issues but they have a generally easier employment experience. They are more inclined to express themselves and communicate/ask, as well as expressing that belief in God is an important part of their coping responses.

**Older (36 years old and above = 8) versus younger (under 36 years old = 10).** Only one of the younger groups was male and 70% were registered professionals in New Zealand as compared with only 38% in the older group. Consequently, the migration experience of the male support workers (older group) is more reflective of the generally tougher and more protracted migration experience. Other things that stand out for the older group are a greater desire for a change in lifestyle, and their stronger recommendations on doing a good job and being competent, being strong and determined, with patience and perseverance. This is coupled with more cultural awareness and their faith in God as a personal resource in times of stress.

**Chinese (6) versus Indian (6) versus Filipino (6).** These three groups are not balanced with respect to the above variables. The Indian group has half the number of registered professionals compared with the Chinese and Filipino groups; and the Chinese group have one less over 35 year olds and no male participants. It would seem that the younger, female and more professionalised Chinese group had the easiest of transitions. The older participants, partly males, and less professionalised
Indian group had the most difficult introduction to New Zealand, and the Filipino group being somewhere in the middle. Certainly, the Indian group experienced many more employment difficulties than the other two groups, but once in work they raised less concerns than other groups. The Filipino group seemed the most focused on becoming a recognised New Zealand professional, which may have accentuated their sensitivity to discrimination. They were much more likely to name discrimination as an issue and feel they were being asked to perform beyond their job role as defined in their job description. The Chinese group had the least employment difficulties as most of them earned their qualification in New Zealand, and were consequently registered. They were more concerned about managing cultural differences and having good communication strategies.

While these differences as discussed above are noteworthy, they are multi-factorial and would not necessarily be significant in a larger cohort. However, these differences give us access to some of the flavours in the narrative and add depth to the picture as a whole that follows.

**Migrant health workers' drivers for migration to New Zealand**

We normally require significant reasons before we make important decisions such as migrating to another country. As to the possible drivers of migration identified in chapter II, the participants suggested the following drivers for migration to New Zealand (in order of frequency of occurrence):

- Linkages with family and friends;
- Change of lifestyle;
- Study or pursue education;
- Others: Shortage of health workers in New Zealand; better professional opportunities; easier access to New Zealand; and income differentials.
Linkages with family and friends

The first most frequently named driver overall for migration among the majority of participants (five Filipinos and three Indians) is linkages with family and friends or some other links that connected them to a migration resource network. These networks relate to the social ties of family and friends as well as with other linkages, based on personal, cultural, and/or other social ties such as church affiliation and regional origin. These networks often inspire migration or help others to find accommodation, jobs, and adjust to the new environment. Hence, linkages reduce the costs and trauma of migration for new migrants, and further encourage probable migrants to move out from their countries.

The driver of linkage with family and friends who are already in New Zealand aligns with Filipino cultural values of love of family, selflessness or willingness to sacrifice, (such as giving up one’s job in the Philippines) just to be with one’s wife and or family in New Zealand as was the case of two participants in this study. This driver is also congruent with the intrinsic motivational needs identified as social needs in Maslow’s hierarchy. This involves things such as love, affection, belonging and support, which are consistent with the need for emotional relationships that motivated these migrants to follow their family abroad. The linkage driver also ties in with issues of the human right of migrants and their families to reunification with families left behind. Likewise, this linkage driver aligns to the human right of developing social and cultural capital in the new country through religious groups/churches, community groups, sports teams, private or cultural organizations and voluntary organizations that assist in migration, cultural maintenance and settlement. All of which were identified by participants in this study.

Change of lifestyle

The second most frequent driver for migration is change of lifestyle, which was named by a majority of the participants. Most (four) of the Chinese migrated for a change of lifestyle in terms of the physical environment - good weather, not polluted and not over crowded population, as well as for social opportunities of being independent and free from too much competition (at least two participants). This is
aligned to the right of freedom from the state repression in China, as well as the universal aspirations of personal and professional development and a personal feeling of independence.

Most (five) Filipino participants mentioned a *better future of their children/family* as their reason of migration. Better future implies better and more relevant education, as well as better opportunities of employment and overall a better quality of life for their children and extended families. Participants with children (Filipinos and Indians) confirmed in the focus group discussion that they came to New Zealand for the better future of their children and family.

The term *better future* was related to education and a good standard of living, but does not necessarily refer to the unrealistic accumulation of wealth. There is however, the concern from a few participants that their children might be too relaxed in pursuing their education, and would want to go on a *'gap year'* (a year of not studying) and end up marrying early before finishing their studies, all because of *'too much freedom'* here. It appears that the freedom of choice and availability of opportunities in New Zealand have become a toxic ground for some children who did not have to undergo what their parents have struggled with. One participant’s vicarious experience is that the notion of working hard in order to achieve something is fading for a few young people due to the availability of student allowances and student loans to help support their education. However, this support for education is a powerful tool to encourage the pursuit of education, knowledge and skills. If this support for education is not taken for granted then the whole aspiration of a better future will likely be realised.

Across all three participant groups, *change of lifestyle* also relates to the pursuit of interconnected and interdependent human rights such as the right to a steady job and the right to receive wages that contribute to an adequate standard of living. Two Filipino participants felt the obligation of their culture to send remittances to help in the tuition fees of their siblings or their extended families back home. They are not only being concerned about making improvement to their lifestyle, but to that of their extended families as well.
New Zealand was seen by some (two Indian, two Filipinos and one Chinese) as a country where there was greater respect for human rights. Participants were impressed with the positive social environment of New Zealand as being safe for their family, and a place where they can live a peaceful life due to low crime rate and corruption compared to other countries. They were also impressed with the relatively good health system, and services that helped some of them in their first few weeks in New Zealand. Services that were identified included the Citizen’s Advice Bureau, libraries with free computer use, Plunket and Studylink after two years of stay in New Zealand. Most of all, they were impressed with the friendly people and the cultural tolerance of New Zealand.

Others appreciated the lifestyle of New Zealand in general. Even though they might not be working in their ideal jobs, they were still happy to be helping other people in their capacity as health professionals or health and community workers while they are in the process of pursuing a New Zealand qualification to improve their position in the health industry.

The emphasis on linkages and lifestyle suggest that in the minds of the participants, a meso/systems perspective (see chapter II) that includes collective forces and social networks, bi- or multi-directional influences and ties and development of social capital best explain the drivers for migration of these participants. (Cooke and Belanger, 2006; Cassarino, 2004; Martin and O’Connor, 1989; Scheyvens and Querton, 2007; Roel, 2007; Oishi, 2002).

**Study or pursue education**

The third most frequent driver for migration to New Zealand is education, which was mentioned directly by six participants, and indirectly by another five participants who did the nursing competency assessment programme, which is more commonly referred by the participants as a bridging course. This drive to study is associated with the majority (five) of Chinese participants who had no health/welfare qualification, and came to New Zealand to study English language courses before moving into health training. The Chinese students had no strong expectations at the beginning other than to enjoy life. It is possible that this is a consequence of China’s
one child policy. As an only child, there are less family obligations other than following their parent’s wishes. Some of the Chinese participants came to New Zealand with their parents on a business migration category while they were in high school.

However, the profiles of most participants (all Filipinos and Indians and two Chinese) show that they are well educated and have worked in their own country so are less affected by the micro socio-economic drivers of migration (Faist, 2000, Corbett, 2001 and others in chapter II). This was evident as none talked about being exposed to deprivation of food, housing, health services, basic security or freedom of movement in their own country. Their commitment to take on further and often long-term training in New Zealand, in order to get New Zealand registration or qualify to work in the health sector, further suggests that economic drivers are not that significant. The pursuit of education in New Zealand seems to have more to do with career development, self esteem, personal worth and the sense of being able to make a valued contribution to the society than the push from micro or macro economic and structural forces

Those who came to New Zealand to pursue postgraduate studies, initially planned to go back to their own countries, but have had to stay and work in New Zealand to pay back their high international tuition fees.

While macro socio-economic forces or structural changes (see Cassarino, 2004; Oishi, 2002 and others in chapter II) such as health worker shortages in developed countries serve as a driver for migration, others such as the high growth rates of the Asian economies have created more opportunities for health professionals in their own countries.

**Other drivers for migration**

Finally, there are other drivers of migration identified by the participants that involve the national and international macro-economic and structure forces. Five Filipino and two Indian participants, who were already in health work as nurses or physiotherapists in their countries of origin, named better professional opportunities as their reason for
migration. They expected to continue working in their chosen profession in health work, because there is a shortage of workers in New Zealand. This driver of migration or moving in search of better professional opportunities, particularly for education and employment confirms to the findings of Wallis (2006).

In addition, two Filipino participants claimed that there are more graduates [in the Philippines] but there are no jobs available. Certainly, the growing importance of remittances to the Philippines economy ($US17 billion) makes it likely that the export of health workers is a deliberate economic strategy (Adriano, 2009).

The shortage of health workers as part of the significant reasons for immigration is found in other studies (WHO Media Centre, 2006; Zurn and Dumont, 2008; Khawaja and Thomson, 2009). Likewise in this study, some participants (three Filipinos and one Indian) were aware of the demand for their skills due to the shortage of health workers in New Zealand at the time they were applying for migration. This shortage of health workers is also considered as a facilitating factor in the employment of some participants.

Three Filipino participants believed that there is easier to access to New Zealand in terms of migration fees and waiting period than in other countries like USA, Canada and United Kingdom; while at least one Indian participant claimed that New Zealand is an alternative option to Australia which has more stringent migration requirements.

Finally micro-economic reasons are important to some. Two Indian and two Filipino participants who were already working as health workers or nurses in their respective countries felt that incomes would be higher in New Zealand. However, some participants questioned whether migrants were financially better off, an issue to be discussed later on in this chapter.

There are other quality of life drivers for migration that are important, and it is likely that internal motivations and the notions of role will play a significant part in both the causes and success of migration.
Motivations of migrant health workers in New Zealand

While discussions on the drivers of migration thus far have focussed on extrinsic factors of networks, environments, rights and professionalism, in this section the discussion predominantly focuses on the motivations of participants in terms of intrinsic factors. In chapter II, a number of motivation theories were presented. Some of which seem better aligned with our participants’ responses than others.

In this study, the participants’ motivations for being in the New Zealand health work closely aligns to the drivers for migration but also gave considerable weight to personal factors. The primary motivations of migrant health workers show the following in order of frequency of response:

- Chosen profession/related to qualifications and experience;
- Sense of service and satisfaction;
- Economic motivations; and
- Family reasons.

**Chosen profession/related to qualification and experience**

Migrant health workers came from a background where they were willing to input effort and hard work, determination and commitment to study, to retrain and up skill themselves in order to be competent and eligible to work in their chosen profession as health workers.

All of the Filipino participants and majority (four) of the Indian participants had past experience and educational qualification/training in health or community work in their home countries. All the nurses went through the bridging course to qualify for registration and subsequent nursing practice in New Zealand. One Chinese had an educational qualification in health work (as a dentist), but could not get a job closely related to that, and so she had to work as a care giver and attend to in-service care giving trainings. The rest (five) of the Chinese participants gained their health related training (Bachelor of Nursing) in New Zealand after studying in high school or studying English as their second language. Those who were not in health or
community work prior to coming to New Zealand were flexible enough to start with junior positions while adapting and re-training for the New Zealand context.

This whole process is captured in Vroom’s (1964) expectancy and goal-setting theories that centre on the belief that people can be motivated if they associate effort to performance that leads to valued rewards which could be extrinsic or intrinsic in nature. A majority of participants came to New Zealand with high expectations to settle, get a job and bring a family. Most expected to continue working in their health or social work or profession, and were willing to put effort and commitment into this; to work hard, to deal with challenging situations, and to study or retrain to get relevant New Zealand qualifications and experience. This purposeful and personal sacrifice to train or retrain, as well as the acquisition of related knowledge, adjusting attitudes and skills-building is the means to get into the health and community work force.

It is important to reflect on why these goals are important. For many other migrants economic opportunities are uppermost in their thoughts. For health and community workers, their profession comes first. It is their choice, an innate interest or their love or enjoy-to-do work. The academic accomplishments and professional activities play a role in fulfilling their esteem and personal needs, which are intrinsic in nature. An intrinsically motivated health and community worker will work in a hospital, rest home, rehabilitation centre or in the community, for example, because it makes them feel good, useful and respected. Or an intrinsically motivated person will go back to study or retrain because the challenge of being able to register and/or work as a health professional in New Zealand provides a sense of satisfaction. This is because he/she can better fulfil his/her potential in the sense of self-esteem and self-actualisation (Maslow and Lowery, 1998).

On the other hand, one Chinese participant considered her health work as an experience for future opportunities of travelling around the world someday. While this appears to be both a goal and an extrinsic motivation, Ferguson (2000) said that having a dream or a goal allows a person to be motivated in meeting higher personal or professional performance levels.
Sense of service and satisfaction

Whilst most participants regarded their health work as a chosen profession, more than a majority of the participants from all cultures have implied that their primary reason for being a health worker in New Zealand is having a sense of service and satisfaction: to be of help to other people, seeing them improve/getting better is very uplifting... fulfilling, and one feels like she is saving lives...and they respect you as a nurse. Despite how other people might see the job of health and community workers as cleaning up after people, these migrant health workers take pride in their work or profession, and have already expected to continue working in the health field because they view that there is something that they are giving to the people.

This sense of service and satisfaction is an intrinsic motivation that is also viewed as a social need relating to the need for a sense of community or affiliation in health and community work, and the need to give quality service and receive respect in one’s profession. This implies that the participants felt valued by others as well as have a sense of making a contribution to the world and therefore being satisfied as a contributor of something good and important. These intrinsic senses of service and job satisfaction are regarded as ‘real or true motivators’. These are likely related to responsibility and work itself, advancement in career development, and increased and/or challenging tasks and responsibilities, which are all associated with ‘growth needs’, which suggest a pattern of satisfaction progression. Growth need relates to the intrinsic motivation of esteem needs that include the desire to achieve or complete meaningful tasks and be recognized or respected or gain reputation. This also includes the desire to be productive and useful, which is described as self-actualization needs that provide challenge and opportunity for people to reach their potential in serving as competent health workers or professionals in this context. The sense of service and satisfaction here does not mean that the health and community workers do not expect external rewards such as good or better pay and other rewards. It just means that the latter are not enough to keep them motivated.

The participants intrinsic motivations reflect Huitt’s (2001) social (being part or a valued member of a group) and conative forces (the will to achieve personal dream/s or goal/s, maintain self-efficiency and independence). In Alderfer’s (1972) update on
Maslow’s theory, the needs of relatedness and growth best fit the data. In McClelland’s (1962/1987) *three need theory*, affiliation and achievement rather than power are the better fit.

**Economic motivation**

A few participants, however, refer to extrinsic sources. The individual decision or choice to migrate with the expectation to improve one’s economic status were implied by some participants: *to look for a greener pasture, to get a job, that salary is better, and that it is easier to access New Zealand* due to lesser immigration fees. Also, some participants mentioned that part of the reasons why they work (in the health and community sector) is to meet the economic demands of daily living. Although most of the participants implied that they are motivated to work in the health and community sector with a sense of service and satisfaction, half of them (four Indians, three Filipinos and two Chinese) indicated economic considerations as part of the reasons why they work: *to pay their high expenses on international tuition fees, to pay the weekly rent and to pay all the bills.* A few more ambitious participants expressed their desire *to settle in New Zealand, buy a house, get a job and bring family.* These participants have more clearly defined goals or reinforcers, and to the extent that their efforts and persistence are focused on their goal/s as suggested by Locke and Latham’s (2002) goal oriented theory or Skinner’s (1953) theories of reinforcement. These can be powerful motivators.

**Family Reasons**

The strongest goal for all participants with children (most Filipino and some Indian participants) was the desire for a better future of their children and family. This is why they have sacrificed so much even at mid life. The Filipino participants mentioned *family* as their main reason why they are working: *it is for the future of our children as the number one motivating factor,* and for this reason, *flexibility of working hours* around family and around the needs of family is important. With this arrangement, they do not need to take their children to the day care centre every day, thus they save money for other important purposes as well as bonding well with their children.
This feeling for family injects meaning into their work that goes well beyond the extrinsic. This aligns with positive thinking (Huitt, 2001) to help others achieve their goals (Malone and Lepper, 1987). It also includes the aspirations for growth and advancement in doing something with a sense of service and satisfaction as being part of the health workforce.

A Chinese participant mentioned that she became a nurse because she wanted to know more on how to take care of her diabetic father and a Filipino participant said that looking after the old people gives some satisfaction... it’s just like looking after parents or grandparents. This is akin to the familism construct, a view of society that emphasises the importance of cooperation, trust and loyalty where care giving becomes a source of emotional fulfilment (Andrew, Scharlach, Kellam, Ong, Baskin, Goldstein and Fox, 2006). This is an intrinsic affective force of enthusiasm for caring work.

Perhaps the theoretical position that best sums up the motivations of migrants is Cox and Pawar’s (2006) update of equity theory which draws Maslow’s ideas and goes beyond wage and resource equity issues into a strong support of human rights and social and personal development. Understanding the motivations of the migrant health workers could be one of the most common challenges facing employers, but it is necessary because these migrant health and community workers hold significant roles and influence in helping to meet the growing health concerns of the general and the ageing population of New Zealand.

**Perceived roles in health work**

The roles of health and community workers differ depending on what institution they are working for. The nurses and social workers have registrations regulated by their professional bodies, while support workers generally receive training on entering the job, but their role is unregulated or not covered by legislation. This study included the exploration of the experiences of migrant health and community workers as to their perceived roles, which were grouped as follows:
• Use of structured and interactionist roles
• Under use/non use of skills in current role
• Use of accumulating and changing roles

Use of structured and interactionist roles

Structured roles are defined by cultural norms, duties, expectations and by standard job descriptions (Nye, 1976), while the interactionist roles focus on how people adopt and perform roles during interactions in social contexts. Structured roles (duties, etc) in health work necessarily interact as it always involves different people (client and staff) from different backgrounds and roles. This development of relationships and a sense of partnership with staff, clients and their families aligns with the model of accumulating roles (Spilsbury and Meyer, 2004) as discussed in chapter II.

All the participants (nurses, nurse aids/health care assistants, and community support and rehabilitation workers) in this study have described their role in relation to caring, helping and supporting. Support work includes watching and observing clients, being a driver/chaperone/companion as part of their unwritten role; and housekeeping work like tidying up the patient’s room and making beds. Most, but not all of these roles, are included in the job descriptions and/or work protocols (structured roles).

A significant majority of the participants indicated that their health and community work role includes the interactional roles of communicating, educating and advocating as well as encouraging hope and just being there as a friend. All these go alongside the caring, helping and supporting roles. These roles build on requirements of the job description, policies and protocols of their employment, but are further developed through interaction between the health workers and with the clients and their families. They see their role as holistic to interact, talk, discuss or convey messages to other health workers through written form (writing in the client contact notes or diary writing/reporting) and/or verbal communications through staff meetings and handovers. It also includes the promotion of formal or informal health education, and encouraging client and families to set their goals and plan their activities in relation to their health care. Health and social practitioners also empower
their clients by educating them on certain aspects that help them gain independence as much as possible. They also help encourage realistic hope to clients by stressing their strengths, or by just being there as a person or friend to talk to.

What is interesting here and later in the section on effective communication is that despite the efforts that these migrants appear to be effective communicators, the word “listen or listening” is not used by any participant. Active and reflective listening (Lang, Floyd and Biene, 2000) have long been a staple of Western communication skills teaching. The participants do note that as part of their roles, the processes that take place in interactive meetings, handovers, and goal settings, and the fact that they consider themselves as a person or friend to confide in, suggests that listening is part of their many important roles. However, the absence of “listening” as a named part of the participants’ role may imply a restricted ability on their part to reflect on what has been said, thus the need to ask or clarify matters with others.

The registered nurses and the social worker in this study were also aware of their managing or supervising role. Registered nurses do a lot of coordinating, organizing and collaborating things with a medical team - doctors, therapists, colleagues or other staff and with the clients and their whanaus, as well as team up with the support or rehabilitation workers or health care assistants. They (RNs) see it as a very professional responsibility … being in charged, accountable … in a different level that required decision-making skills. The senior social worker in this study supervises the student social workers, and makes sure that they do their assessment, care planning and follow ups for their clients’ issues.

**Under use/non use of skills in current roles**

This study found some patterns of under use/non-use of skills in current roles. Overseas trained professionals accepted under-employment when they cannot find their right fit job. Nurse participants that met the requirements were registered in New Zealand, while a few others, including a physiotherapist, are still in the process of applying for registration with their professional bodies, and are working as health care assistants (HCAs), rehabilitation program workers (RPWs) or support workers. HCAs and RPWs are guided by their job descriptions and other policies in the
exercise of their roles. Although many expressed some kind of work satisfaction, they felt under used or not being used on their past training as registered nurses or physiotherapists. They want to take their achievements to higher levels...not contented with simple job...want something that will boost their self-esteem...a job that is suited to their qualification.

The under use/non-use of their perceived roles made them feel de-valued, de-skilled and frustrated, confirming the findings of Spilsbury and Meyer (2004) on health care assistants who were not allowed to do what they were trained for. In this study, they also felt that there is an under use/non-use of their roles as for example the situation of a then newly registered nurse who was hired as a part-time nurse and a part-time HCA, and the Philippine trained physiotherapist who is not even allowed to do very simple exercises with the clients in the gym.

A rest home nurse said that she only gives medications, and there are no complicated procedures like intravenous injections. This may imply a lesser challenge for her as she had been a nurse in a very busy emergency department for some time in her country of origin. On the other hand, a health care assistant staff member complained about a participant who was a registered nurse in a rest home, saying that she (RN) was only doing the medications, and was not helping with the clients’ personal care needs, despite the fact that she also had to write reports, attend meetings and liaise with other health care professionals. There is an expectation here that the registered nurse’s role should include, as much as possible, the important caring, helping and supporting roles directly with patients or clients.

Use of accumulating and changing roles

People accumulate and change roles at any given stage in life by taking some, keeping some, leaving others behind, and beginning or making new roles (Spilsbury and Meyer, 2004). The roles of HCAs, RPWs and CSWs are more likely accumulating and changing based on their limited opportunities of health work in New Zealand. This is because as health professionals (physiotherapists, occupational therapists, social workers, nurses and dentists, doctors) they find when they migrate to New Zealand that the only jobs they can get in health care are of lower responsibility and
skill. Because of the high skill base of these migrant health workers, they often informally add other roles, particularly interactionist roles, to the structuralist roles that they are employed for.

When there is inadequate staffing, HCAs and RPWs were asked to do some additional duties that are beyond what is defined in their job description or beyond the expectations of formal policies. Some participants who trained and worked as nurses or physiotherapists in their country of origin have to work as assistants while working on their professional registrations. They are motivated to have more responsibilities and accumulating roles or do some challenging jobs, which sometimes become a source of misunderstanding under the scope of practice. They undertake delegated additional activities such as taking the observations (blood pressure, pulse rate and temperature) of the clients. Other additional activities include wound dressing, BSL (blood sugar level) monitoring, administering medications and doing some physiotherapy exercises with the clients. Although these HCAs and RPWs take the challenge of doing these activities, since these add some variety, depth and satisfaction to their work, these are still outside their job description, and in some instances, the legal limits of their role. This can result in the exploitation of their roles as HCAs and RPWs, and the possibility of risk to clients should mistakes be made.

Overall the analysis of roles confirms the findings of overseas research cited in chapter II about the tendency for health and social practice migrants to have interactionist and accumulating roles, to experience both under- and over-use of roles. An example here is the case of the overseas registered physiotherapist who was initially allowed and then prevented from doing exercise training, a restriction of an existing role.

**The migration experience**

The discussions on the drivers for migration and motivations for health work, as well as the perceived roles have given a partial and generally positive perspective on the migration experience of participants. There are other experiences that the migrants have had. The migrant health workers had initial positive impressions on the physical
and social environment of New Zealand; they had strong goals and aspirations for themselves and their families. This relates to the ‘honeymoon stage’ of migration where migrants are fascinated, excited and interested in the new culture and its people. However, many participants experienced a ‘crisis stage’ or culture shock at the reality of living in New Zealand. This crisis or shock caused stress, unhappiness, frustration, desperation, disappointment and feelings of inadequacy, which need to be understood and addressed by co-workers, employers and others.

New Zealand environments for health services may not be the most conducive places, thus adding to migrant stress. A collaborative research study by Auckland, Massey and Waikato universities revealed that employees in health and education sectors are most likely to suffer or experience bullying (including intimidation and behaviour that offends or makes fun), undermining and exclusion. Furthermore, part of the reason why bullying is huge in New Zealand is that managers do not invest in management development (Olsen, 2010, cited by Tapaleao in NZ Herald 15 April, 2010, p. A3). In Seton’s (2004) study, some overseas registered nurses experienced feelings of prejudice and discrimination in terms of having less chance in getting placement for Asians and in some other health care contexts.

In this study, a majority of the participants have experienced discrimination in gaining employment and in the workplace. Discrimination in gaining employment includes not being hired due to ethnicity/race – one participant was told that she is small... and not a Maori or Pacific Islander. It also includes not being given a full time job that gave at least two participants the notion that employers think that they [migrants] are not good enough for a position. Discrimination was also evident in not being considered for a job because of poor English proficiency; that English is not their first language; because of they do not have permanent residency; or because they are not from New Zealand.

The work related concerns on discrimination include racism, unfair treatment and/or bullying in the workplace. Examples of discrimination are shown in a number of constructions as being mistakenly accused of incompetence due to colour of skin, being the subject of gossip, being bossed around and belittled because of ethnicity and English proficiency. Another form of discrimination is felt in the inconsistent
application of practice standards at work, and overloading with work (additional nursing roles for health care assistants and additional administrative work or often with other menial tasks for registered nurses) without additional compensation. Sometimes, discrimination is observed with the organization of staff rosters, such that some groups appear to be given easier shifts and with full staffing, while some groups were given the harder ones or with short staffing. At least two nurses experienced unfair treatment around wages and employment opportunities, while one health care assistant observed other staff bullying the patients or bullying other staff.

Migrating to other places can make migrants vulnerable in all aspects of life. However, it does not need to be if it is linked to accessible solutions and adaptation of legitimate social development (Swing, 2008). Psychologists have identified the major coping strategies into two types, namely: the problem-focused strategies directed at changing the situation that is creating the problem through confrontation and planning; and the emotion-focused strategies, which are directed at managing the distress through either distancing one’s self, self-controlling, seeking social support, accepting responsibility, escape-avoidance or positive re-appraisal (Folkman and Lazarus, 1989, cited in Banyard, 1999, pg. 33-34). These relate to the ‘recovery stage’ and the consequent ‘adjustment stage’ as presented in chapter II, and discussed as follows.

In this study, the migrant health and social practice workers adopted a problem solving approach such as acquiring the necessary qualification to re-engage with their professions, being prepared to take on jobs that they were overqualified for, or moving to other parts of the country to seek work. In doing this, they managed personal and family challenges, as well as concerns arising from the offices of the New Zealand Immigration Service, Nursing Council and from their immigration agents or consultants. At times these were clearly very emotional experiences requiring a resilient nature in terms of their attitudes of commitment, control and challenge that helped them transform their difficulties to their advantage. Commitment involves keeping on being involved and not detaching yourself when things get difficult. Control means continuing to try to have a positive influence on
your desired end result/s and challenge refers to finding out how you can develop through pressures (Chapman, 2011).

The health and welfare system of New Zealand strongly affirms the right to support for clients/consumers. Similarly, health and community workers have the right to access available support when they need it, both personally and professionally. In this study, the participants cope with their challenging concerns/issues by being committed to doing something (control) about their situation or dealing with it (challenge) through a combination of cognitive and behavioural-focused coping responses. The following are the attributes/success factors of migrant health workers in relation to their experiences.

**Attributes/success factors of migrant health workers’ migration**

**Perceptiveness**

New Zealand presented good options in terms of access and migration costs as perceived by the migrant health and social practice workers. They have a realistic understanding of their situation. They studied to improve their English and their professional skills. They also took pleasure using their skills in caring, helping and supporting, as well as encouraging and giving hope to their clients. While they had high expectations and positive impressions of New Zealand, they were aware of their challenges in finding employment, and were keen to respond to them. There were struggles in the total migration process (personal and professional), but they maintained a realistic lifestyle, alongside sensible use of credit cards and careful budgeting, which helped them cope with their challenges.

**Networks and positive social relationships**

A lot of the personal and work-related concerns of the participants were met through their networks and positive social relationships. Networks with family, friends, colleagues and support agencies helped in the flow of information and support regarding the migration and employment processes. Positive social relationships with families and friends also provided caring and support. One participant’s relationship
with her partner ended, and she focused on building positive relationships with her mother, church and work.

The Chinese and Filipino groups and at least two from the Indian group joined their cultural group, a church or Bible study group. Most of the young single Chinese met with other/new people and went out with friends, joined barbeque parties and all other meetings at work so that they were not bored or isolated and lonely.

In the health workplace, the need for teamwork is indispensable. The support of a work supervisor/manager and having the right attitude contributed to the participants’ success in migration. Some RNs noted good teamwork in their ward, and some support workers suggested the importance of teamwork in dealing with clients. One of the RNs, working on unsociable working shifts (night shifts and weekends), found comfort in the good teamwork in her ward. Many felt working together was a key part of being in a positive workplace. The buddy system is a two-person team which was helpful for two RNs who had the same migrant language. Everyone needs the skills of respecting, listening, helping, sharing information and resources, persuading and questioning or participating or working together to create a positive and more effective team.

**Positive view of personal future**

What and how we think determines our experience. Despite the many challenges of migration and employment, the participants of this study depicted a positive view of their personal future through their optimistic goals for migration. Most Chinese participants expected to change their lifestyle in of terms escaping from their overcrowded cities, pollution, poor weather, too much competition, and the lack of independence. Most Filipinos migrated for a better future for their children, as well as for their extended family as was the case of two participants. Some Filipinos and Indians see New Zealand as having a low level of crime and corruption, social services that support a family oriented system, good health systems and helpful institutions. New Zealand is perceived as having a culture of tolerance, where people can raise their families safely, continue their health or social practice work and have better professional opportunities and income. Added to this is the general
participants’ desire to develop a greater sense of job satisfaction through service to the people who, in distress, need their empathetic support and their professional skills

*Flexibility and willingness to try anything*

The participants have high expectations for success, and generally believe in their ability to accomplish their goals, despite the difficulties they encounter along the way. They strive for progress so they are willing to try anything that they believe will realise their expectations.

For migrants, the chances of finding a right fit job can prove to be tough at the beginning, so it’s more likely that one is forced to settle for an entry level job that is outside one’s field of expertise. Although some were disappointed to not be in a job that recognised their skills and training, all have learned to adjust to the present reality of migration and employment requirements and to be flexible by being willing to try most things and not being too choosy about the jobs they take. This has meant under-employment, accepting positions with low responsibility and remuneration, doing unpopular night shifts, and on call or part-time jobs.

Coming from families and environments, humble beginnings where hard work and sacrifice are expected, participants seem to effectively manage the emotional and financial hardships of under-employment. However, in this study it was evident that an increased length of residence in New Zealand and a greater competence in English improved the migrants’ possibility of finding employment that either partly or fully made use of their qualifications.

The findings of this study are related to the study of Henderson (2004) which indicated that immigrants respond to discrimination in the labour market with the acceptance of under-employment, self-employment, and further education or retraining to gain New Zealand qualifications that may lead to suitable or paid employment. In the case of nurses, many authors regard initial preparation courses, ongoing professional development courses/trainings, and access to social support are vital to support their integration and professional adaptation into a new country of migration (NCNZ, 2005/2010; Witchell and Ousch, 2002; Seton, 2004).
Volunteer work

Volunteering is viewed as a stepping stone to integration in the host country (Handy and Greenspan, 2009). A third of the participants in this study had experience volunteering and recommended it if one cannot get a paid job at the beginning. Volunteering provides local experience, further develops skills, improving what can be put in a resume, and sometimes directly leading to regular or paid employment in the process. Volunteering can also widen understanding of new cultures and environments, thus allowing more chances of adjustment and integration of the cultures, as well as regaining self-confidence that can be lost in the experience of numerous rejection letters and emails. Although this sort of volunteerism appears to be self-serving, it is also underpinned by a strong desire to give back to the community that welcomed us through the use of their skills and services with mutual benefits in opening opportunities for meaningful participation and usefulness of life.

Further study/re-training/continuing education

Half of the participants in this study felt that they were discriminated against in gaining employment due to culture, their English language and inter-cultural communication difficulty, as well as with the notion that employers think that they are not sufficiently equipped to work in their chosen profession in New Zealand. They cope with this in a long-term process. They go back for retraining/study in the New Zealand context, including studying English and New Zealand culture so that they can be more competent. As mentioned earlier, all participants had done basic training or re-training in New Zealand as a preparation to their goal of registering and working in New Zealand. Thirty-nine percent (7 participants) had no health or community work related background (they were students, or had jobs in general business) and opted to train/re-train in nursing, health and in social work, which gave them the opportunity to be employed in those fields eventually. They said that their job search was made rather easy because of the shortage of health workers, and that they gained practical and related health and community work experience while they were training or studying. Moreover, the participants were aware that employment would be easier when they have passed the state examination for nurses or gained the relevant qualification in mental health or social work.
In-service Education was also important for both professional and support work as part of understanding the rights of consumers to services of an appropriate standard. Moreover, some participants have acknowledged that it is important to learn the New Zealand English for more effective communication, as well as to learn the New Zealand culture for competent and safe practice.

Effective communication

Effective communication is a part of interpersonal skills, which are important in the delivery of health care services and in our daily interactions with other people. Virtually all of the Chinese and Indian and two Filipino participants talked about communication issues both as a challenge or a solution, and as part of the most frequent recommendations for coping with their given challenges.

Other useful ways of communicating effectively with consumers include listening (to what others have to say in order to understand), rephrasing, speaking positively, clearly and directly on one idea at a time and in specific terms, being mindful of the appropriate tone of voice and vocal volume, body language and physical closeness, appropriateness of touching and use of sense of humour, as well as encouraging and reassuring the patient or client (DeVito, 1991; Barnard, Casella, Coffin, Hughes, Hurst, Rasey, Redding, Ribillard, St. James and Ullery, 2001).

The participants described or referred to many components of effective inter-cultural communication that were discussed in Chapter II including respect for clients, asking and not assuming, explaining, learning their speaking habits, as well as the proper use of non verbal communication such as eye contact, and being mindful of the appropriate tone of voice so as not to appear as if one is talking down to others. While not one of the participants mentioned about ‘listening’ or “active listening” (paraphrasing, summarizing, re-stating, reflecting feelings and testing of understanding - McCaffery, 1986) as part of his/her roles, most of them implied roles in two-way interactions as communicating, educating, advocating, supervising (for registered nurses), and being a chaperone or companion and just being there as a friend or person to talk to.
Most often, people judge others based on their communication skills, however, Barnard et. al (2001) argued that patients rarely refer friends or relatives to health care providers because the staff are ‘the most talented medical professionals,’ but they do refer patients to providers because the staff are ‘helpful and friendly’ (p. 250). A survey of the US National Association of Colleges and Employers (2007) identified that communication skill is important for job seekers. However, this skill is eroded if negative factors like arrogance, rudeness, meanness accompany this confidence (Sinha, 2008). So while intercultural communication is an issue for this group (although possibly less so for Filipino migrants), the solutions as well as problems are recognised and the focus on relationships, particularly with clients suggest that two key features of good intercultural relationships - competence and genuine warmth – have been incorporated into the participant’s professional practice.

*Cultural awareness and Competence*

Fourteen of the 18 participants (78%) evenly spread across the participant groups made reference to the importance of cultural issues. Some 28 statements were made using the root word culture- across all sections of the interview covering such things as follows:

- surprise and pleasure at the tolerance, vibrancy and size of New Zealand’s multicultural society;
- the frustrations of trying to understand English as it is spoken by New Zealand cultures such as Maori, Samoan, etc., and the minutiae of local conventions such as *what’s their way of drinking coffee?*;
- the cultural dimensions of discrimination experienced not only from the Pākehā population (colleagues and potential employers), but at times from Māori (patients);
- the feelings of cultural isolation in small town New Zealand or culture shock in the suburbs of Auckland; or an unexpected tide of home sicknesses;
- the relief that comes from being an apprentice to someone of your own culture;
• the connections that unfold when you recognise someone from your own family in a client from another culture that you are supporting;
• the pleasure of finding that you can fit in, that New Zealand cultures can have many echoes of home, that you can change and still hold onto a vibrant cultural connection with home; and
• the need to do additional cultural training, be assertive, adapt and take on training about role of Maori (two participants talked of bi-culturalism or the Treaty of Waitangi, both affirming importance of learning in this area).

There is a rich, varied and essential positive engagement with New Zealand cultures. The participants are aware of and sometimes surprised by the strength of multi-cultural society of New Zealand, hence, their recommendations around cultural awareness and competence. This aligns with McDonald’s (2001) study that focused on facilitating adaptability of non-English speaking people through cultural competence.

The humanistic view of motivation assumes that people intrinsically strive to fulfil basic needs for competence and autonomy (Brown, 2007). Some participants said that they just have to do a good job and to work hard; and another participant believed that having confidence on the job is of foremost importance. They take care of their role as a health or community worker or professional. They are friendly, kind, patient and personable, but professional with their clients by paying close attention to details at work as for example in giving medications, in communicating effectively with others, and in working together as a team.

All of the participants in this study have adapted or are in the process of adapting (retaining a home identity while aligning with the new) to the New Zealand culture in terms of undergoing re-training/study both in the academe and in the practical health work in New Zealand in order to be competent. Since all of the participants have undergone formal and/or informal training in New Zealand, they have been oriented on the principles of the Treaty of Waitangi that supports the code of health and disability services consumers’ rights (HDC, 2006) that also includes the number one right of consumers/clients - to be treated with respect and taking into account the
needs, values and beliefs of the different cultural, religious, social and ethnic groups of the consumers. They have increased their self-confidence and sharpened their life skills, knowledge, experience and abilities to do the right job among the challenging clients and systems that they are exposed to. They seem to be managing across the complex cultural interfaces of work and community.

However, some participants acknowledged the need to have more training exposures to different environments, and do some learning as to other practical applications of the principles of the Treaty. This also includes understanding how bicultural attitudes and behaviours were translated into formal policies, protocols or directives which enable both health providers and workers to work successfully in a multi-cultural group of people. This aligns with the ability to acquire and use knowledge and skills about cultural differences in order to better understand other cultures and affect the best possible health outcomes (Durie, 2001b). The ‘building of cultural awareness may not be an easy task, but once accomplished, it definitely helps [get] a job done efficiently’ (Hofstede, 1997, p. 7). Cultural barriers are overcome through the sharing of knowledge (McDermott and O’Dell, 2001), hence the participants’ recommendation on accessing available information and support.

**Self-motivation**

While a majority of the participants were extrinsically motivated to re-train or study again so that they can work in their professions, their intrinsic sense of service and satisfaction for working as health workers or professionals appear to be dominant. Some were happy with the process of helping, while some were happy with the end result of their work which reflects their satisfaction of being connected to the New Zealand culture, being part of a team or community and giving something back to the host country.

More than a majority (16) of the participants took pride in their work and desire to continue working in their profession as registered nurses or as a social worker, and for the support workers to work out their registration. They appeared to be self-actualizing, more concerned with fulfilling their potential and were self-aware with their personal growth as health workers.
Workers’ needs and motivations affect their individual performance level and their organizational service performance and productivity. The globalisation of health workers and patients/clients is a continuing phenomenon; hence managers of health service providers are faced with the challenge to understand the motivations of their migrant health workers since they comprise a considerable part of their human resource. Motivated workers can perform their roles well, and thus contribute in the development of the health service and the nation as a whole.

**Positive attitude, perseverance, working hard and holding hope**

The participants present an attitude of ‘keep on keeping on’ despite their difficulties. Aside from the personal and family concerns they have other work-related concerns such as getting trained, learning English, getting a good job, dealing with discrimination, unfair treatment and bullying, and, as well, the challenges of working with difficult clients and unfamiliar systems. They struggled, but they did not give up and return to their own countries. They stayed, worked hard and held onto hope instead. They trained, retrained, qualified, registered, did low paid jobs well below their level of competence, worked in secondary centres, and with the help of networks and agencies created long-term strategies for achieving their employment goals. They persevered. They demonstrated the strength and determination necessary to cope with their given migration and employment challenges.

The participants in this study also demonstrated the importance of embracing a positive attitude towards themselves, towards others and towards their work. They were able to work in the health sector because they believed in themselves, studied and worked hard to achieve their qualifications and necessary experience to do the job. They also reflected positive attitudes towards others by recommending teamwork or working with others, accessing support and information from others, and accepting clients as they are. Their positive attitude towards work was reflected in their suggestions of being willing to work hard, to be strong and determined, as well as being happy to do the job, and having self control. It was essential for them to stay positive as sometimes depressing situations can cause pessimism and burn out if not managed well. It is also essential that health and community workers and
professionals are willing to examine their own attitudes when working with health care since it is one of the most stressful jobs (Kalliath, 2000; De Jong, Le Blanc, Peeters and Noordam, 2008).

**Faith**

The participants value the virtue of hope, which is the potential to change and the consummation of all things. For many participants (56%), hope and Christian faith were closely linked. Some participants felt that the foundation of all the good things that they do was founded on their spiritual faith in God. This is expressed in their recognition of Divine intervention and the underlying belief that God will add his blessings to their efforts (for example, in achieving competency). Faith was also expressed with the actions of praying and hoping, attending church and Bible studies. Faith meant that one was not at the mercy of a culture or a difficult boss and that it was worth doing one’s best because the employers are not the real boss. The real boss is the Lord God and by Him all actions are weighed. This aligns with the Northern Philippine (Cordillera Region) value system of ‘inayan’ or ‘lawa’ (literally translated as ‘fear’ or ‘bad’), which refers to the observance of not doing any unacceptable thing (Fiar-od, 2010) or not causing harm to others that will displease others and God.

Our beliefs influence what we do. How we act and what we think are valuable in life. These are personal ethics that can affect professional ethics. It is not about rites and ceremonies, but that which comes from our inner disposition. Such faith is seen as being in everything, doing to others what you would have them do to you (Matthew 7:12, NIV Bible), and whatever you do, work at it with all your heart, as working for the Lord, not for men (Colossians 3:17, NIV Bible).

Faith was not a demographic question, so it is possible that it plays a larger part in the lives of this group. What is reasonably clear is that this group brings to health and social services in New Zealand strong beliefs in the value of commitment to service, family and community, cultural tolerance, the importance of hard work and education, and the power of faith to both protect and transform. Such health migrants will all have their individual quirks and foibles, small deficits and limits, but they are
becoming increasingly important to the growth and quality of New Zealand’s social services and absolutely necessary to the growth and quality of New Zealand’s health system.

**Limitations of the study**

The data used in this study were collected from a group of eighteen (18) participants who answered only what they felt comfortable answering in the interview and in the focus group discussion. As a group with good English they may have been more confident and capable than many of their peers. There were six from each ethnicity of Chinese, Indian and Filipino who have been working in the New Zealand health and community sector for a year or more but not earlier than 1995 when the migration point system was used to screen immigrants to New Zealand. During the period of the study, the participants were all based in the Auckland region. There were differences of the duration of work and the type of work that participants had been in New Zealand, and an overemphasis on health as opposed to community work. These differences in exposure to New Zealand and different health and community work places will clearly influence individual participant’s experiences and perceptions, but were not explored in depth in this study.

The focus group participants were the same as those interviewed and added little to the material from the interviews, serving mainly as a point of confirmation of some of the themes emerging from the interviews. These themes are not necessarily representative of the population of Chinese, Indian and Filipino migrant health workers in New Zealand or even in the Auckland region, nor can any differences between the three cultural groups be anything more than suggestive. Due to the small sample size (18) in this study, it cannot be generalized; however, the implications that can be inferred from the study may be useful for similar contexts and areas of study. It is hoped that the data presented in this study will raise questions at all levels and sectors affected by the factors of health workers’ migration, and how they can be best mutually used in the health sector of New Zealand and beyond.
Recommendations

In view of the findings of this study, the following are recommended:

For the migrant health workers

1. *Keep work and personal life in balance.* This is particularly important for those with families in New Zealand. Many health migrants come with family members including children. Some come to join family members who are already established, and bring other family members over subsequently. For those without families members here (in New Zealand), long distance calls, emails and ‘sensible internet working’ with family members, as well as trips back home (as budget allows) could be important in maintaining motivation for succeeding in New Zealand. Although balance of family and work is often commented on, there is also an implied need to balance personal qualities and attitudes with professional qualities (competencies), thus it is recommended that one should strive to integrate personal and professional journeys by being committed in taking care of one’s self in all ways, and by finding time to relax regularly or do some other creative activities so one can give his/her best in taking care of others.

2. *Improve cultural competence and strive for professionalism.* Overall the participants appear to be as culturally competent as any New Zealander. Specific areas were identified that could be improved such as more communication skills training including the processes of active listening, and English language coaching (the need to experience Maori and Pacific Island speakers as well as Pakeha ones); and better understanding of the role of Treaty of Waitangi. This could be done through internet research and attending training seminars; asking for information from the Citizens’ Advice Bureau; asking for and reading the operational policy of the Treaty in one’s workplace; having greater awareness of New Zealand’s bicultural and multicultural natures before migrating, and/or having strategies for dealing with discrimination and racism when it occurs. All migrant health workers who desire to be registered in New Zealand and progress into professional work must understand the language and professional requirements for registration.

3. *Get help when needed.* Some participants gave strong advice in this area. Do not isolate yourself as help is available. Access information and support from friends
and acquaintances, your cultural or church group, general support agencies and from colleagues and managers at the workplace.

**For New Zealand employers**

1. *Provide opportunities for migrant health workers to have a New Zealand experience* by employing them even in junior positions, and then supporting them to get registered in New Zealand, thus giving them a chance to work and prove their worth in helping in the New Zealand health system and the New Zealand economy as a whole.

2. *Design work rosters and policies that are flexible enough* to favour their employee’s family responsibilities without sacrificing the service. Migrant health workers have a strong sense of service and satisfaction with their work, but have family responsibilities as well in terms of babysitting or support, which must be considered.

3. *Negotiate the safe and equitable use of skills beyond the given job role* of migrant health workers. Migrants want to use their skills but felt limited by supervisors or protocols or abused in the use of their skills without fair remuneration.

4. *Link migrants within their workplace and to other support agencies.* Set up mentoring schemes particularly using same country and/or same language linkages. Facilitate the access of migrant support systems. Design or further strengthen a regular assessment/support process for their migrant workers, not only assessing performance but becoming aware of their employee’s needs, issues and concerns, and being able to give timely and appropriate support. Ensure that the occasional instances of exploitative practices around the treatment of migrant staff are addressed through effective complaint procedures and audit processes.

**For the learning institutions**

1. *Further develop cultural competence training requirements in all health care professional curricula.* Two gaps were identified. One was the general lack of understanding of the range and depth of multiculturalism in New Zealand and the cultural institutions that support migrant cultures. The second area of deficit was on the role of the Treaty of Waitangi and the special bicultural relationship between Maori and the government in New Zealand. Further enhancing this cultural competency to include not only the Maori point of view but to include all
the cultures that are now forming the culturally pluralistic nature of New Zealand society.

**For New Zealand Immigration Service (NZIS)**

1. *Provide greater flexibility with their policy on having to work in restricted job categories* before being given a work permit. As long as they (migrants) have qualifications and demonstrate that they are working towards earning an appropriate New Zealand qualification or registration, they should be entitled to a permit.

2. *Be more consistent, transparent and prompt in releasing their decisions*, as well as allow opportunities of appeal if warranted. In particular, reduce the time taken to issue work permits when migrants have met all requirements. This issue has arisen particularly around the time taken between passing the nursing bridging course and the issuance of work permits.

**For immigration agents and /consultants**

1. *Provide quality and in depth information on the nature of New Zealand society.* The participants feel that consultants understate the difficulties that will need to be addressed such as the amount of money you need to survive the first few weeks, the challenges of getting the first job, and the track to professional recognition. Better information on the cultural and general support systems available is also needed.

2. *Emphasise more of the features that migrants identify with in New Zealand.* These include cultural tolerance, safe, family oriented, commitment to community and service, capacity for hard work, high emphasis on individual and consumer rights and social justice, low corruption, strong local cultural communities, opportunities for professional and personal growth.

**Suggestions for further research**

In relation to the findings and limitations of this study, the following suggestions for further research are offered:
1. Research on how to facilitate the registration of other health professionals such as doctors, dentists, physiotherapists, occupational therapists, social workers and others before they can practice in New Zealand. This is to avoid further waste of all these skilled human resources who have been attracted to come to New Zealand.

2. A large-scale survey to evaluate the value and cost (personal, economic, social, cultural) of the contribution of health and community work migrants from developing countries to the New Zealand health system. Such a project would involve a large sample (500-1000), and will have to manage the complexities of the culture of health and community workers, the areas of health and community involved, the duration of engagement with health and community services, other demographic variables that are indicators of socio economic status, stress, wellbeing, etc. Such research could also analyse the trends in health migration and future needs.

3. Research regarding multiculturalism in the international workplace, and an exploration of migrants’ attitudes towards the Treaty of Waitangi and the bicultural policies in New Zealand. This may include the experiences and perspectives of diverse groups of migrant health workers covering cross-sectional comparisons and longitudinal analyses of the situational determinants of coping among migrant health workers in New Zealand.

**Conclusion**

New Zealand needs these health and social migrants. They are making a major contribution to the health services and may, in time, make a similar contribution to the social services. They are hard working, have strong commitments to service, family and spiritual values are very important to them. They are inter-culturally sophisticated in a way that many English speaking migrants of European origin may not be. In other words, they are very desirable migrants not only to mainstream New Zealand but also to Maori and Pacific New Zealanders with whom they share many family and spiritual beliefs and practices. There is a need to be more aware of the value that these migrants bring to New Zealand society and the risks that New Zealand takes if the major issues that confront them are not addressed. These risks include fewer potential skilled migrants; more migrants returning home having
wasted their time and ours, embittered migrants forming enclaves in the New Zealand society, fractured and demoralised health and social services, etc. The economic and social benefits of ensuring that health migration is well managed are huge.

Most of the participants have sought permanent residency and become part of the growing multi-cultural population of New Zealand, with the expectation of better professional opportunities to help people – their families here and overseas, and to help meet the swelling healthcare need of the country, as well as contribute to the revenue of the country instead of taking away jobs and competing for government benefits. They are vulnerable to migration challenges and difficulties yet their responses reflect an attitude of resilience. The initial, ongoing and future coping responses or solutions to the challenging issues and concerns, as well as the support of migration and employment services will determine the mutual benefits of their migration to New Zealand now and in the future. The globalization of health workers and health clients is a continuing challenge that health and social work managers have to accommodate for mutual development.

- oooOOo0oo -
References


- oooOOOooo -
Appendix A: Interview Schedule

A Study Investigating Common Experiences Amongst Chinese, Indian and Filipino Migrant Health Workers in Aotearoa/New Zealand

The interview will start with general or entry descriptive questions relevant to the study and followed by simple evaluation questions then moving into more challenging areas of major evaluations, with solutions to complete the interview. Appropriate unfolding questions and prompts will follow depending on the flow of the interview. This is just a guide and not a rigid set of questions to ask in its order.

Follow-up questions shall build reflectively on the responses of the participants to extend narratives and to seek other experiences that had different outcomes or other aspects that might have been left out.

The starting questions are as follows:

1. Please tell me about your migration experiences right from the start when you first thought about coming to New Zealand.
2. Please tell me about your experiences in finding employment as a health worker in New Zealand.
3. Please tell me about your experience as part of the health work force in New Zealand and the roles that you have had.
4. Please tell me your reasons or motivations for wanting to be a health worker in New Zealand.
5. Please describe any needs or challenging issues that you have had or are experiencing, which could be affecting your potential as a health worker in New Zealand.
6. How did /do you try to cope with your specific identified challenges?
7. Looking at and appreciating your experiences, how do you think people in similar situation would be helped in the future?
8. Do you have any message to inspire or challenge other migrant health workers in relation to your experiences?
9. Is there any other information you prefer to add regarding this interview?

Demographic information needed:
- Ethnicity (Filipino, Indian, Chinese)
- Number of years working in the health/social work of New Zealand
- Job category (RN, Social Worker, RA, HCA, RPW, CSW)
- Age (18-25; 26-35; 36-45; 46-55; 56-65)
- Gender (Male/Female)
- Educational attainment
- Occupation in country of origin
- Year of arrival in New Zealand
Appendix B: Focus Group Discussion Process and Questions

FOCUS GROUP DISCUSSION

Title of Study:
A Study Investigating Common Experiences Amongst Chinese, Indian and Filipino Migrant Health Workers in Aotearoa/New Zealand

Overall question to answer in focus group discussions:
The purpose of the study is to explore about the migrant health workers’ experiences of migration and employment; their needs or challenging issues, and how they try to cope or solve them.

General guide for the focus discussion:

Introduction (5-8 minutes)
Welcome greetings
Informal introductions or acquaintance as necessary
Promote relax environment, offer refreshments or some snacks
State purpose of the focus group discussion, and its organization - (to allow validation or confirmation, to prioritize, re-state or add information or delete)
Give ground rules:
- confidentiality of participants’ contribution
- respect and listen to others’ viewpoint
- no right or wrong answers
- discussions will be digital recorded
- Synthesis of interview given to participants to allow validation, confirmation and prioritizing of the themes arising from the interview
- individual comment sheets to be completed after each question for anyone who wished to make comments separate from the group

Exploration Questions (25 minutes)
1. What are your migration experiences?
2. What are your employment experiences and the roles that you have had?
3. What are your motivations for being part of the health workforce in New Zealand?
5. Are there any needs or challenging issues, which could be affecting your potential as a health worker? Give examples.
6. How did you/do you try to cope with your specific identified challenges?

Wind down/wrap up (15 minutes)
7. How do you think people in similar situations would be helped in the future?
   What are your recommendations?
8. Is there anything we have not discussed that seems relevant?

THANK YOU VERY MUCH.
Appendix C

Information for all Potential Participants

Warm greetings. I am Jocelyn Toclo, a post-graduate student of Unitec, conducting a research on the experience of Chinese, Indian and Filipino migrant health workers in New Zealand. This is in line with working towards completing my Masters in Social Practice. I wish to explore and understand more about the migrant health workers’ migration and work experiences, including how they think people could be helped in relation to their experiences, and how their opportunities be increased to achieve productive potential in the New Zealand context.

In this regard, I invite people who have come from China, India and the Philippines, who have worked in the ‘frontline’ of New Zealand health sector for at least one year, either on a permanent, temporary, part-time or on casual basis and work at least 20 hours per week. ‘Frontline’ health workers here include Registered Nurse (RN), Social Worker, Health Care Assistants (HCAs) or Nursing Assistants (NAs), Community Support Workers (CSWs) and Rehabilitation Program Workers (PRWs). You must have applied for NZ immigration on October 1995 onwards. You need to be over eighteen (18) years old, have a reasonable command of English, and be happy to participate in the project.

I would like to do some individual interviews and focus group meetings with the same group of participants who will choose to participate. I hope that you will be willing to participate and help build our future here in New Zealand.

The Interview

The interview will be done at a negotiated time and place, which will be set in consultation with you. Interviews will start with general questions relevant to the study, followed by unfolding questions from simple evaluation questions then moving into more challenging areas. Each interview may last between 35 to 45 minutes, and will be taped recorded as back up of my notes. The recorded interview will be transcribed, and the notes will be presented to the volunteer participant to review and confirm.

The Focus Group

The focus group is a face-to-face meeting with other participants (of the same culture) to discuss and gain more understanding of the different cultures’ experiences, and to allow validation and confirmation of themes arising from the interviews. The focus group will meet once for approximately one hour from January to February 2010. The time and venue for this will be arranged in consultation with the participants. The focus group meeting will start with a small set of predetermined (after the interviews), sequenced, open-ended questions to structure the
discussions. Issues and themes identified from the interview will be explored further. Discussions may also include other matters that are considered relevant by the participants to their experience. The process shall be flexible thus possible adjustment to the situation may occur as it develops. Each participant can have a transcript of the focus group from which they can review and confirm their contribution. Prior to the focus group meeting, each participant will be given the opportunity to discuss matters or concerns about it. Participants will be required to agree to maintain strict confidentiality of individual contributions to the focus group discussion.

**Inconveniences and Benefits**

I acknowledge that your time is very important as you will need to commit time for the interview and for the focus group discussion with an aggregate of approximately an hour and forty five minutes (roughly two hours altogether). However, I strongly hope that the time committed to this endeavour will be compensated for by the following:

1. Increasing the understanding and knowledge for the immigration service and the health sector of New Zealand with the experiences of migrant ‘frontline’ health workforce.
2. Sharing, being listened to and discussing one’s experience and gaining knowledge and support on how participants may increase their opportunities to achieve their productive potential in the New Zealand context.
3. Promoting through giving input on how other migrant health workers be best helped in relation to their experiences.

**Voluntary participation and informed consent:**

Your voluntary participation in this research will be highly appreciated. I strongly believe that it will provide valuable contribution in understanding the experience of migrants who work in the ‘frontline’ of New Zealand health sector. If you are happy to participate in this research, please complete the attached consent form not necessary and return it to me in person or return it through the self-address envelope (with stamp). Alternatively, you may please contact me so I can collect it from you.

Any participant may choose to withdraw from the research within a period of two weeks from the date of the interview and or focus group meeting. Any information disclosed can also be withdrawn within a period of two weeks from the date of the interview and or focus group meeting.

**Confidentiality:**

Please note that possible risks of involvement include concern on confidentiality and anonymity of disclosed information. I assure you that any information disclosed during the research will not be presented in a way that a participant in the research can be directly identified. All information collected from individual interviews and from the focus group discussions (including consent forms) will be treated with strict confidentiality. Once the transcribed interviews and focus groups are reviewed and confirmed by the participants, all tape recordings will be erased. The transcripts will be stored digitally and anonymously for 5 years in a password protected file. There will be no identifying data on the final write up of the report to protect your anonymity. The only people who have access to your information are the researcher and the supervisors.
Research Results:

The final results of this study will be written as a report, and will be submitted for the examination of Masters of Social Practice at Unitec, New Zealand. A copy will be published appropriately, and journal articles related to this study may be submitted to New Zealand or international journals.

For more information

If you have questions or want more information about the research project, I am happy to answer them. You may contact me:

on my mobile phone no. 02102382833 or
email me at joytoclo@windowslive.com.

In case you have concerns regarding the research but not addressed in my level, you may contact my research supervisors:

Geoffrey Bridgman - (09) 815 4321 extension 5071
Kath Seton - (09) 815 4321 extension 5061

Thank you very much.

Statement of Approval

UREC REGISTRATION NUMBER: (2009-1016)
This study has been approved by the Unitec Research Ethics Committee from December 2, 2009 to December 1, 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretariat (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix D:  Request for Permission to Recruit Research Participants from Potential Health Organizations

Date

Dear ___________________,

I am Jocelyn Toclo, a post-graduate student at Unitec. I am working towards completing my Masters in Social Practice. I wish to undertake a research project into the experience of Chinese, Indian and Filipino migrant health workers in New Zealand. I wish to explore migrant health workers’ migration and work experiences and how migrants opportunities can be increased to achieve their productive potential and be of better service in the New Zealand health workforce and society as a whole.

I intend to conduct interviews and focus group meetings with ‘frontline’ health workers, which involve Registered Nurses (RNs), Social Workers, Health Care Assistants (HCAs) or Nursing Assistants (NAs), Community Support Workers (CSWs) and Rehabilitation Program Workers (PRWs).

I would like your consent to put up a poster (see attached) in your organisation to attract participants for my research. My application to the Unitec Research Ethics Committee (UREC) requires me to gain your written consent.

No reference to your organisation will be made in my report other than acknowledging the support that you have given in the recruitment process.

Your valued support to this research project by granting approval of this request is deeply appreciated.

Very truly yours,

JOCELYN PELIGMAN-TOCLO
Researcher

CONSENT GIVEN

Signature : ____________________________
Printed name : ____________________________
Organisation : ____________________________
Position : ____________________________
Date : ____________________________
Attention
Chinese, Indian & Filipino Health workers

Share your experiences and inspire or challenge other migrant health workers (through interview & focus group discussion).

YOU can contribute to a migrant-run research project on how we may meet our challenges, achieve productive potential and be of better service in the NZ health workforce.

All information from you will be treated with confidentiality.

For more details, please get in touch with Jocelyn
Mob. Ph. 02102382833
Email: joytoclo@windowslive.com

Thanks!

This research study (UREC REGISTRATION NUMBER: 2009-1016) has been approved by the UNITEC Research Ethics Committee from 2 December, 2009 to 1 December, 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix F: Thesis Proposal Approval

9 September 2009

Dear Jocelyn

Thank you for submitting your research proposal *The Experience of Chinese, Indian and Filipino Migrant Health Workers in New Zealand.*

The proposals committee of the Department of Social Practice has approved your proposal.

Your principal supervisor is Geoff Bridgman and your associate supervisor is Kath Seton.

Please be aware that ethical approval will be required for your research. We recommend that you read the Guidelines for Ethical Approval in the Research folder on the Blackboard site Postgraduate Students Resources, to identify any ethical issues that may arise. Discussion with your supervisors or the ethics committee (email: ethics@unitec.ac.nz) may also assist in this decision process. This will help determine the need, or otherwise, for a full application for ethical approval. Ethics applications and accompanying documents should be submitted as email attachments to the above address.

We wish you every success in completing your research project.

Yours sincerely,

Dr Helene Connor
Programme Director

cc:

Principal Supervisor:
Associate Supervisor:
Programme Administrator:
Research Office: Lindsay Richdale
Postgraduate Academic Administrator: Cynthia Almeida
Appendix G: Application for ethical approval for a research project  
(Form A)

Please refer to the Guidelines while filling in this form.  
Research cannot proceed until formal approval from UREC has been given in writing.

(For office use only)
Ethics Committee Ref. No: 2009:1016  
Date received: 15 September, 2009  
Date approved: 2 December, 2009  
Period of approval: 2 Dec., 2009-1 Dec., 2010

DECLARATION:

This application is a true and correct outline of the research project. I, the supervisor and/or the applicant, undertake to notify the Unitec Research Ethics Committee whenever there is any ethically relevant variation in the research process.

The information supplied below is to the best of my knowledge and belief accurate. I have read the current guidelines and policy for ethical approval for research projects involving human participants published by the Unitec Research Ethics Committee and clearly understand my obligations and the rights of participants, particularly in so far as obtaining freely-given informed consent is concerned.

<table>
<thead>
<tr>
<th>Applicant name:</th>
<th>Jocelyn P. Toclo</th>
<th>Date: 12 September, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor name</td>
<td>Geoffrey Bridgman</td>
<td>Date: 14 September, 2009</td>
</tr>
<tr>
<td>(if applicable):</td>
<td></td>
<td></td>
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<tr>
<td>Supervisor signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head of School name:</td>
<td>Helen Gremillion</td>
<td>Date: 14 September, 2009</td>
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<td>Head of School signature:</td>
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</table>

PROJECT/THESIS TITLE:

The Experience of Chinese, Indian and Filipino Migrant Health Workers in New Zealand

For student projects:  
Conducted at which Tertiary Institution? Unitec New Zealand  
Degree: Master in Social Practice  
Course number & name: CSTU 9003 Research Thesis

ATTACHMENTS: Checklist

- [ ] Information sheet(s)  
- [ ] Questionnaire(s)  
- [X] Consent form(s)  
- [X] Interview/focus group schedule(s)

Applications should be received by UREC at least 10 working days prior to the next advertised meeting. Every effort will then be made to resolve each application at that meeting.
## GENERAL INFORMATION

### 1. PRINCIPAL RESEARCHER (APPLICANT) - STAFF OR STUDENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Jocelyn Toclo</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
<td>50 Parrs Cross Road, Henderson, Waitakere</td>
</tr>
<tr>
<td>School</td>
<td>Unitec New Zealand</td>
</tr>
<tr>
<td>Phone No</td>
<td>09 838-2372 Mobile phone no. 02102382833</td>
</tr>
<tr>
<td>Unitec Student ID</td>
<td>1298051</td>
</tr>
<tr>
<td>e-Mail</td>
<td><a href="mailto:joytoclo@windowslive.com">joytoclo@windowslive.com</a></td>
</tr>
</tbody>
</table>

Brief statement of relevant qualifications and experience:

In the Philippines: Bachelor of Science in Psychology; Master of Science in Public Management; Certificate in Early Child Education. Worked for 18 years in public office (as Regional Personnel Officer/Human Resource Management Officer; Regional Coordinator for Community Development & Senior Support Service Officer); 3 yrs. Early Child Education Administrator/Proprietor; Board member of Son-shine Learning Centre; Volunteer in several church & community affairs.

In New Zealand: Certificate in New Life New Zealand; Certificate in Support Work and Rehabilitation program; Five years NZ work experience (in Healthcare, Homecare & Rehabilitation Work); Vice President and Co-Founder of the New Morning Foundation, an NZ based charity organisation that aims to support scholarship and other community projects in the northern Philippines.

### 2. PRINCIPAL SUPERVISOR (if applicable)

<table>
<thead>
<tr>
<th>Name</th>
<th>Geoffrey Bridgman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Bldg &amp; room number)</td>
<td>Bldg. 510, 5th floor Faculty of Social and Health Sciences</td>
</tr>
<tr>
<td>School</td>
<td>Unitec New Zealand, Waitakere Campus</td>
</tr>
<tr>
<td>Phone No</td>
<td>09-815 4321 ext 5071</td>
</tr>
</tbody>
</table>

Brief statement of relevant qualifications and experience:

PhD, MA (Honours) & BA, Auckland Hospital Board Advanced Management Program (Auckland University), 4 yrs. Regional Advisor then 1 yr. Consultant/trainer, IHC Service; 3 yrs. Contract Researcher then another 3 yrs. Director of Research, Mental Health Foundation; 7 yrs. Director of Mental Health Foundation; 10 yrs. Sr. Lecturer; President and vice president, Schizophrenia Fellowship; Member, National Mental Health Advisory Committee to the Ministry of Health.

### 3. ASSOCIATE(S)/RESEARCH PARTNER(S)/ CO-SUPERVISOR(S)/ ADVISOR(S):

<table>
<thead>
<tr>
<th>Name</th>
<th>Kath Seton</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>School of Nursing</td>
</tr>
<tr>
<td>Qualifications</td>
<td>NZRN, BA Social Science, PG Dip. Educ. (Guidance), MA Educ. (Hons)</td>
</tr>
<tr>
<td>Role in project</td>
<td>Advisor</td>
</tr>
</tbody>
</table>
4. **PROJECT DURATION:**
Dates during which the research methods requiring this approval will be conducted:

From: 2 December, 2009  
To: 1 December, 2010

5. **AIMS/OBJECTIVES OF THE PROJECT:**
Describe in language that is, as far as possible, free from jargon and comprehensible to lay people.

Health migrants come to New Zealand with rich fund of experiences and qualifications in many areas of health work, which are may be discounted by New Zealand employers and qualifications authorities. This research seeks to explore the outcomes of and solutions for the dichotomy between the competence of migrant workers and the work that they find in New Zealand. The purposes of the project are:

1. To explore and add to existing literature about the migrant health workers’ experiences: their drivers for migration and their perceived roles and motivations at work.

2. To gather relevant information on the needs of and issues affecting Chinese, Indian and Filipino migrant health workers, and their solutions that may increase their opportunities to achieve their productive potential in the New Zealand context.

3. To promote transformative participation through seeking input on how the participants think people might be best helped in relation to their experiences.

6. **VALUES AND BENEFITS OF THE PROJECT:**
This study will imply the following outcomes:

1. The research information will provide important inputs to the review of human resource development programs (or staff development) in health organizations.

2. The research will also have possible inputs to migration and employment policies, guidelines or directives so as to reduce the difficulties experienced by immigrants in the process of settlement and integration to New Zealand.

3. The research will promote transformative participation through seeking input on how the participants solve their needs and issues, and how they think people might be best helped in relation to their experiences. This will lead to the recommendation or reinforcement of relevant actions, services and support systems that can alleviate the impact of needs, and increase the benefits accruing to New Zealand from these migrant health workers.

4. This research may also serve as an inspiration or a challenge to new migrants who are still adapting to their new environment.

5. The result of this study may also be presented as an article in related research journals as well as in related websites of the internet.

6. This study can serve as a springboard of further and or related studies.
METHODOLOGY

7. **TYPE OF PROJECT AND METHODS: (Mark the appropriate boxes)**

- Questionnaire
- Focus Group
- Interview
- Experimental, Observational or Interventional Study
- Other (please specify)

Will electronic media (e.g. e-Mail or the internet) be used for the collection of data from participants?

- Yes
- No

Please attach copies of relevant questionnaires, schedules, protocols and/or procedures.

MEETING ETHICAL PRINCIPLES

In questions 8 through 13 please describe how you will address the following ethical principles in your project (as applicable):

- Informed and voluntary consent
- Respect for rights and confidentiality and preservation of anonymity
- Minimisation of harm
- Cultural and social sensitivity
- Limitation of deception
- Respect for intellectual and cultural property ownership
- Avoidance of conflict of interest
- Research design adequacy

8. **SAMPLE & ANALYSIS DETAILS**

a. How many participants will be involved in the research project?

Eighteen (18)

b. From what groups are the participants to be drawn (e.g. general public, specific cultural groups, special interest groups, students, geographical groups, etc)?

Participants were drawn from specific cultural ethnicity, gender and range of health roles as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
<th>Sub-totals</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Filipino</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
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<td>4</td>
</tr>
<tr>
<td>Totals</td>
<td>6</td>
<td>12</td>
</tr>
</tbody>
</table>
c. What is the relationship between the participants and the researcher (friend, whanau/family, employee-employer, teacher-student, etc)? How will you minimise any conflict of interest?

The researcher is working in the health care service (particularly in a Rehabilitation Centre). No more than two prospective participants will be co-workers, but other participants will come from other places of health work to maintain diversity. Six of the prospective participants will also be of the same ethnicity (Filipino) as the researcher. Most prospective participants will be unknown to me.

Research activities will be done outside work hours and will not interfere with participants’ obligations to their work. My role is unlikely to have potential conflict of interest. Instead, it has mutual benefits about exploring potential opportunities of health work productivity in New Zealand context.

d. What methods will be used to recruit participants? (Include information about koha, expenses, inducements)

The study will recruit participants for the interviews and focus groups through a purposive quota selection process based on the table at 8b. The selection will be done by referrals from the informal reference group, by placing notices and through networks.

Participants for the interview shall be selected based on the criteria in 8e. These participants shall be invited to join the focus group meetings. Snacks will be provided at focus group meetings.

Possible provision of petrol voucher to participants will be considered on a case-to-case basis.

e. How did you determine your sample size?

The sample size for the research was determined through a purposive quota selection process that enabled me to recruit both a diversity of health roles (nurse, social worker, Health Care Assistants, Rehabilitation Program Workers, Community Support Workers), gender and culture. Respondents for the research will be the migrants from the Asian countries but limited to the Philippines, India and China. These are the largest Asian ethnic groups that are working in the health sector as well as the dominant groups in contemporary Asian migration. Participants must have applied for NZ immigration on October 1995 onwards. They must have at least one year of NZ health work experience, and must be working at least 20 hours per week. They will also need to have a reasonable command of English. Sample size in terms of gender reflects that there are substantially more females than males in health services

f. How will you analyse the data generated from the research project?

The data generated from the research project shall be thematically analyzed. The data will be coded, sorted and displayed into matrices according to prevailing themes. The data will be understood through its larger context and meaning, and will ‘reframe’ discourses to make sense of what will be heard on the narratives in relation to the key objectives of the research.

Any verbatim quotation from the respondent shall be re-checked with him/her before it shall be integrated under thematic headings of the final text of the study. A triangulation of relevant patterns or findings in literature, interviews and focus groups shall be employed, and a final reading of the information shall be done to check the coding accuracy of the deduced themes and patterns. A descriptive narrative and analytic method shall be used in the final research write up.

9. MAORI PARTICIPATION:

Could your research involve Maori participation, either by deliberate selection or by random sampling? Could it impact on Maori, or be of particular relevance to Maori?

☐ Yes/perhaps ☒ No

See HRC Guidelines for researchers on health research involving Maori [www.hrc.govt.nz]
If “yes”, please explain how your research process is consistent with the provisions of the Treaty of Waitangi. State what consultations, and with which iwi/group, have or will be undertaken. What involvement does this group have in the project? How will the results be disseminated to the consulted group and participants at the end of the project?

Not applicable

10. CULTURAL ISSUES:
Are members of a particular ethnic, societal or cultural group the principal participants or a sub-group of the research?

☒ Yes ☐ No

If “yes”, what consultations have been undertaken with appropriate parties?

The researcher recognizes that there are complex cultural issues to be managed in this project. Hence, she has sought support from a number of people, including an informal ‘reference group’ whose members are from the three ethnicities or cultural groups of Chinese, Filipino & Indian and represent the trans-disciplines of social work, health and education. This is important in the trans-disciplinary context of this project. This group will help in refining questions, reviewing data and in referring potential participants to this project.

Both thesis Supervisors have experience in cross cultural research. Ms. Seton has a Masters degree in a related topic, and Dr. Bridgman has supervised numerous explorations on cultural identity.

11. DOES THE RESEARCH PROJECT MEET ALL THE CRITERIA FOR HARM MINIMISATION?

☒ Yes ☐ No

If “no” please explain what are the risks to participants and how the research project minimises those risks and keeps them at an acceptable level.

n/a

12. MEDICAL RESEARCH OR RESEARCH INVOLVING HUMAN TISSUES OR BODY FLUIDS
Note that approval from an accredited Health and Disability Ethics Committee may be required, using their (or the national) application form (www.hrc.govt.nz). Please refer to this form and also contact the Research Office Administrator.

a. Does the research involve the collection or use of human tissues or body fluids?

☐ Yes, Go to 12b ☒ No, Go to 12d

b. If yes, what procedures will be used? Where and how will the material be stored?

n/a

c. How will the material be disposed of (if applicable)?

n/a

d. Does this research involve any invasive medical procedures, exposure to infection, the use of drugs, or constitute a clinical trial?

☐ Yes, Go to 12e ☒ No, Go to 13
e. Describe the safeguards that will ensure against infection, damage, or risk to health.

| n/a |

13. **DOES THE RESEARCH PROJECT MEET ALL THE CRITERIA FOR INFORMED CONSENT?**

| Yes |

a. Are the relevant participant information sheets and consent forms attached?

| Yes |

b. If any of the criteria cannot be met, please explain why and what measures, if any, are being taken to ensure harm minimisation.

| All criteria were met |

c. Indicate whether there are any categories of likely participants in the research project whose ability to give informed consent may be compromised or limited in some way or other.

| None so far |

**DATA ACCESS**

14. **PROPOSED STORAGE AND ACCESS TO FILES AND DISPOSAL / STORAGE UPON CONCLUSION**

**Consent Forms**

*Note: Your consent forms must be retained for five (5) years before physical destruction.*

| a. Who will have access to the Consent Forms? |

| The researcher and the supervisors will be the only people who will have access to the consent forms. |

| b. How will you ensure that the Consent Forms are protected from unauthorised access? How and where will the consent forms be stored? |

| The consent forms and all information collected from the participants will be stored in a secured/locked filing cabinet in the office of the principal supervisor for five (5 years) before physical destruction. |

**Data**

*Note: Your data must be retained for five (5) years before physical destruction.*

| c. Who will have access to the data? |

| The researcher and the supervisors will be the only people who will have access to the data. |

| d. Are there plans for future use of the data beyond those already described? (The applicant’s attention is drawn to the requirements of the Privacy Act 1993.) |

| The researcher has no future plans of using the data beyond those already described. |
e. How and where will the data be stored?

| The data from the interviews and the focus groups will be transcribed, checked for accuracy and stored digitally. Once they have been fully checked, the tapes and paper copies will be destroyed. |
| All information collected from the participants will be stored on a password protected computer file at Unitec for a period of five (5) years. |

**EXTERNAL CONNECTIONS**

**15. INVOLVEMENT WITH ANOTHER INSTITUTION/ORGANISATION**

a. List the names of any organisations who are now or who will be involved in this research project, the type of involvement they have or are likely to have (e.g. funding [please state amount sought or received], co-researcher, venue for research, client), and indicate whether letters of support or approval from these organisations are attached.

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>Type of involvement</th>
<th>Letter attached?</th>
</tr>
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<tbody>
<tr>
<td>n/a</td>
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</tbody>
</table>

b. **ARE FUNDS BEING OBTAINED FOR THIS PROJECT?**

☐ Yes  ☒ No

Describe the investigator’s, the host institution’s, or a sponsoring agency’s financial interest, if any, in the outcome of, or involvement in, the project.

**16. RELATED APPLICATIONS**

a. Have you ever made any related applications to other Ethics Committees?

☐ Yes  ☒ No

b. If yes, have you enclosed copies of the applications and responses?

☐ Yes  ☐ No, Please explain

(Note that if you have already been granted Ethics approval by a University, Polytechnic, or Health and Disability Ethics Committee, you do not need further approval, but UREC must be sent a copy of the application and the approval.)

**17. SUBMISSION AND APPROVAL PROCESS**

- A signed, hard copy of the completed application form must be sent to the UREC Secretary.
- An electronic copy of the application must also be sent, as follows:
  - Unitec students: Please EMAIL this form and attachments (e.g. information sheet, consent form, questionnaire, interview schedule, etc.) to your Unitec principal supervisor, who should in turn email this to the UREC secretary. **UREC will not receive applications directly from students.**
  - Unitec staff (as primary researcher or supervisor): Please forward this form, by email, to the UREC Secretary ethics@unitec.ac.nz
- UREC’s decision, and any conditions, will be relayed to you and your supervisor (in the case of student research).
Appendix II: Ethics Approval

Jocelyn Tocio
50 Parrs Cross Road
Henderson
Auckland

25 March 2010

Dear Jocelyn
Your file number for this application: 2009-1016
Title: The Experience of Chinese, Indian and Filipino Migrant Health Workers in New Zealand

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 2 December 2009
Finish date: 1 December 2010

Please note that:
1. the above dates must be referred to on the information AND consent forms given to all participants
2. you must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely

[Signature]

Lyndon Walker
Deputy Chair, UREC

cc: Geoff Bridgman
    Cynthia Almeida
Appendix I

CONSENT FOR PARTICIPATING IN RESEARCH

Title of Project:

A Study Investigating Common Experiences Amongst Chinese, Indian and Filipino Migrant Health Workers in Aotearoa/New Zealand

Researcher: Jocelyn Peligman – Toclo
Principal supervisor: Dr. Geoffrey Bridgman
Associate supervisor: Kath Seton

I have had the research project explained to me and have read and understand the information sheet provided. I understand that my participation is voluntary and I may withdraw, or any of my information that I have provided, within a period of two weeks from the date of the interview and or focus group meeting.

I agree to participate in both the interview and focus group discussion. I understand that:

- The interview session will take about 35-45 minutes, and will be audio taped and transcribed for analysis;
- The focus group discussion will be roughly run in an hour, and will also be audio taped and transcribed for analysis;
- All information will be secured securely on password protected computer file at Unitec for a period of five years.
- My participation will be confidential and no directly identifiable information about me will be accessible to persons other than the focus group members (focus group information only), the researcher and the supervisor.

I have had time to consider my participation and hereby give consent to do so.

Please Sign: _________________________
Please print your name clearly: ________________________________
Date: ____________________
Telephone contact: __________________ Mobile phone: ____________________

Please do not hesitate to contact me at any time to discuss anything related to this research. I can be reached on my mobile phone no. 02102382833 or email: joytoclo@windowslive.com.
Thank you for your help and participation.

UREC REGISTRATION NUMBER: (2009-1016)
This study has been approved by the UNITEC Research Ethics Committee from December 2, 2009 to December 1, 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.