RESEARCH

MEMBERSHIP

N2N: New to NZNO Membership Project

Part two

A multi-cultural nursing workforce: views of overseas and New Zealand trained nurses.

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Acknowledgements

The New Zealand Nurses Organisation, and the authors, would like to thank all the members of NZNO who gave up their time to answer this questionnaire, and for the insights that they have provided.

ISBN:

978-1-877461-39-2

Summary

This survey was designed to capture the experiences and views of members who had joined NZNO within the last five years. Subsets of the survey included a repeat of elements from the 2009 NZNO Member Satisfaction Survey (which looked at satisfaction with services provided by NZNO, and participation in NZNO structures, processes and events) the 2010 Employment Survey, (which looked at demographics, qualifications and employment situation), allowing comparison both with previous baselines and between newer and longer standing members of NZNO.

Separate cohort analysis of Members who had joined since 2007 (N2N), members who were initially qualifieded as nurses in New Zealand and had joined since 2007(NZQN), members who initially trained overseas and had joined since 2007 (IQN), and members who had joined pre 2007 (e-N) were performed.

Demographics, member participation and member satisfaction data is presented in part one. Part two focuses specifically on the views and experiences of newer NZNO members who initially trained overseas, as these have made up half of all new registrants with the Nursing Council for the last five years, and now constitute a quarter of the total NZNO membership. Particular exploration of participation in NZNO structures, processes and activities by the cohorts is presented. Views of New Zealand trained newer members about the impacts of the changing dynamics of the NZ nursing workforce are also explored.

An invitation to take part in the survey was sent to the e-mail addresses of all members (nurses, care givers, midwives and assorted allied health professionals and health workers) who were identified from the membership database as having joined since 2007. An administrative glitch meant an invitation was additionally sent to longer standing members, and the 423 members who responded in this category were analysed separately both as comparison between the long standing membership and newer members, and as an internal control for context related change.

Respondent Demographics

Respondent demographics show good concordance with the NZNO membership database in terms of age, ethnicity, gender and qualifications. The survey also captured these demographics by health sector, employer, DHB area, working hours and job titles. Demographics are presented in great detail in Part 1.

Part 2, which is reported here, concentrates on the implications of the changing demographics of the New Zealand nursing workforce, many of which may have profound implications for workforce planning and management, and for the longer term functioning and structures of NZNO.

New Zealand trained nurses

Views of NZ trained nurses about working with overseas trained nurses, and their engagement in NZNO activities, structures and processes, and discrimination in the workplace and society are presented. These views are very mixed, but are indicative of strain, and rapid changes for which the work force does not appear to have been adequately prepared. Some of these may have worrying implications for the cohesion of the workforce, and of some very legitimate concerns, particularly about communication and patient safety that have not been addressed.

Overseas trained nurses
Views of overseas trained nurses about living and working as nurses in New Zealand, their perceptions of differences in nursing practice, scopes and roles, their longer term plans and their engagement in NZNO activities, structures and processes, and the racial/cultural discrimination they experience in the workplace and society are presented. Different sub groups appear to have very different experiences and plans, and to engage differently with NZNO.

While some lack of engagement with NZNO may be related to experiences with the structures, processes or people involved, more appeared to be related to the cultural backgrounds and impacts on individuals of migration and settlement, and adjustment to new working situation, rather than to particular disaffection or exclusion.

Other discrimination

Māori and Pacific Island members, male members and lesbian and gay members also reported antipathy and discrimination. Very little discrimination was reported attributed to NZNO staff.

Recommendations

A number of recommendations are put forward aimed at increasing support and engagement for newer overseas trained members in NZNO processes and structures, and educating the wider public of the essential role these nurses play in our health services.

Limitations

Surveying only those with valid email addresses excludes those who do not use email. Currently 70% of the membership does have an e-mail address, and there are no patterns by age, qualification or membership category for those who do not. The demographics of respondents to this survey are comparable to the total NZNO membership. All surveys are subject to potential respondent bias, with those with strong views being more likely to respond.

Introduction

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation of nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. NZNO has a commitment to the Treaty of Waitangi (te Tiriti o Waitangi) as the founding document of Aotearoa New Zealand and articulates their partnership with te Tiriti through Te Runanga o Aotearoa. NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. This report documents the results of a survey sent to around 10,000 members who had joined NZNO since 2007.

The questionnaire was designed using elements from previously tested NZNO surveys, with additional elements being piloted with NZ trained and overseas trained staff and members. NZNO membership is largely representative of the New Zealand nursing workforce as a whole, and it is hoped that the results provide a useful picture of the views of newer members about their membership of NZNO, and their education, employment, plans and morale in the health workforce. In particular, the views and experiences of our overseas trained newer members were sought and compared with those of New Zealand trained newer members.

Context

The survey was carried out during February and March of 2012, before the settlement of a new 3 year Multi Employer Collective Agreement between NZNO members and District Health Boards. The previous two to three years had also seen a tightening financial climate for New Zealand as a whole, and for the public sector and health care, with accompanying reports of restructuring, re-organisation, less job security and some loss of senior nursing leadership posts. The survey also coincided with a fee increase for NZNO members, and a potentially profound change to the organisation's constitution.

Method

A web-based survey of NZNO members was undertaken in February and March 2012. The project was described in an article in Kai Tiaki Nursing New Zealand, and invitations to participate were sent by e-mail link, along with a covering letter. Participants were offered a reward for their time spent participating with (voluntary) entry into a ballot, with a chance of winning $50. Contact details for the entry into the ballot were separated at source from all answers, and participation was kept anonymous. A reminder e-mail was sent two weeks after the initial invitation to all who had not responded to the first invitation. (Responders were identified by the web-mail software, not from the survey responses)

Questionnaire Design

The survey was extensively and iteratively designed combining elements from pre-tested NZNO surveys in consultation with the NZNO Professional Nursing Advisory team, and Industrial Advisors. The questionnaire covers core employment issues (employment sector and location and hours) along with demographic details. It also replicated a previous survey examining motivation for NZNO membership, satisfaction with NZNO services and membership and participation in NZNO structures and activities. These results are presented in Part one of the report. New elements were added to explore experience or views of discrimination in the workforce and wider society. These elements were added in response to previous findings from surveys, and from anecdotal reports from members, organisers and professional nursing advisors regarding bullying based on place of training, accent or language skills, race, gender, sexual orientation and age.

Results

Sample and Response Rate

10202 invitations were sent out, 165 were returned as invalid address. 2162 responses were returned, giving a response rate of 21.5%. This is considered a good response rate for a detailed web-based questionnaire where one reminder is sent out. 1669 respondents who had joined post 2007 filled in the survey. This group is called the N2N cohort, and is the ***main*** cohort reported.

The **N2N** cohort was further divided into: members who initially trained in New Zealand and had joined since 2007 (**NZQN** n= 1085); and members who initially trained overseas and had joined since 2007 (**IQN** n= 584).

Members who joined pre 2007 (**e-N** n=423) were analysed separately, and results compared.

Respondent Demographics

Age and Sex
The numbers, age and sex of the N2N cohort are shown below.

Sex / Age	21-25	26-30	31-35	36-40	41-50	51-60	60+
Female	275	219	128	153	362	234	42
Male	32	33	14	18	35	37	4
blank	1	5	10	5	16	26	10

By place of initially training to be a nurse, the percentage who answered the question is shown below. The proportion of male nurses who trained overseas is higher than that of NZQN nurses. Two thirds of these IQN male nurses were non-European.

Percentages are also given separately for the Total sample, the N2N cohort, the IQN cohort, the e-N cohort, and for comparison, respondents to the 2010 Employment Survey.

Cohort/Age	21-25	26-30	31-35	36-40	41-50	51-60	60+
% N2N	18.4	15.4	9	10.5	24.7	17.8	3.3
% IQN	7.2	22	9.1	13.8	28.6	17.2	1.8
% e-N	0.7	2.8	5.4	10.6	31	34.75	13.7
% Total	14.9	12.9	8.1	10.7	26	21.2	5.4
% 2010 ES	0.1	2.5	5.2	7.3	30.3	42	12.5

It can be seen that the N2N respondents have a younger profile than the 2010 Employment Survey. This is heavily skewed by the number of student and recent graduate members of NZNO who responded. Though the age brackets are not directly comparable to the data reported by the Nursing Council, N2N data is also showing a much younger profile than Nursing Council data. IQN cohort is also significantly younger than either NC or 2010 ES, though there are different groupings in the IQN cohort which are explored in more detail later.

Ethnicity, N2N

Over 13600 people had joined NZNO since 2007.To explore whether the ethnicity of the sample who responded to the survey was representative of the membership database, initial workings showed that 6029 members joined since Jan 2007 who described themselves as non-Māori or non NZ European. (Some may be NZ born and nursing-trained, but ethnically so described) Multiple admixtures mean totals exceed respondents. 'Other' may also have included people who describe themselves ethnically as New Zealander, Kiwi, or specific admixtures – any of whom may have lived and trained in NZ)

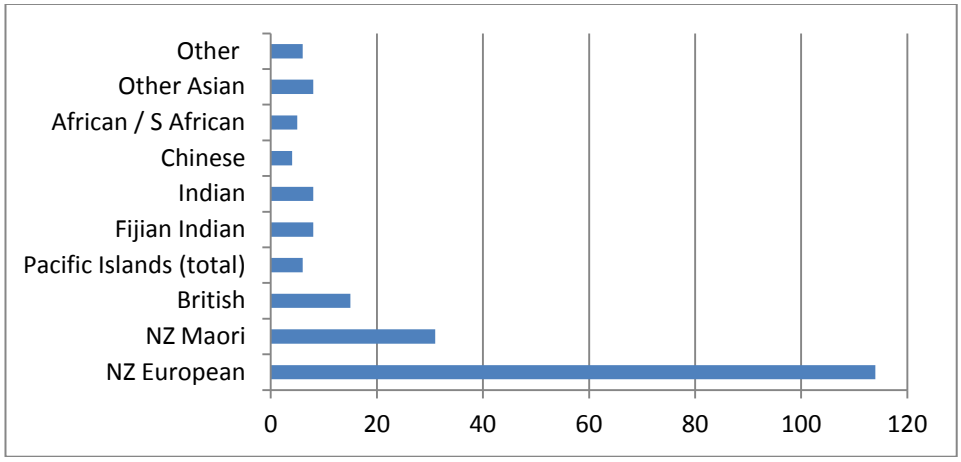
17 respondents identified as NZ Chinese or NZ Indian, all except one of whom initially trained as a nurse in New Zealand. These respondent's experiences of racism is explored specifically in more detail later.

Ethnic origin	Count
NZ Māori	1252
NZ European	6407
CHINESE	448
COOK ISLAND	71
INDIAN	1582
NIUEAN	32
OTHER ASIAN	1975
OTHER EUROPEAN	1268
OTHER PACIFIC	175
SAMOAN	308
TONGAN	170

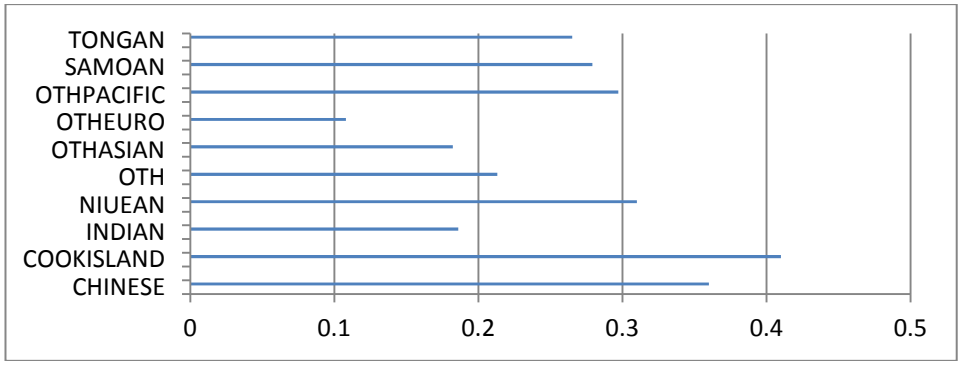
Ethnicity was checked against those for whom we had Email addresses, and found to have good concordance

Seventy seven percent of respondents were registered with the Nursing Council, and a further seven percent were awaiting registration. Nearly 12 percent were not seeking registration. Nearly 200 of the respondents were nursing students.

The numbers and ethnicity of students is shown below:



The *percentage* by ethnicity for non New Zealand Māori or NZ European who are students is shown below.



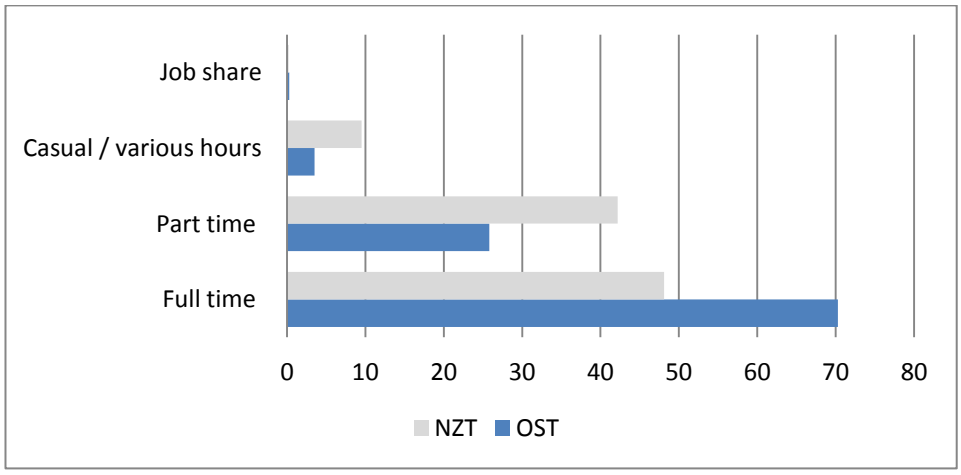
It can be seen that proportionately, Pacific Island respondents are highly represented in the student statistics. This graph also shows that a relatively high proportion of Chinese new members are currently students – many of them in the process of completely retraining as nurses in NZ.

Hours worked, N2N showing percentages, of those employed.

	N2N	Total	ES 2010
Full time	58.26	50.12	48
Part time	31.13	34.1	38
Casual	8.3	7.02	12
Job share	0.01	0.24	0.09

The N2N cohort has a higher proportion who work full time than either the Total sample, or the ES 2010

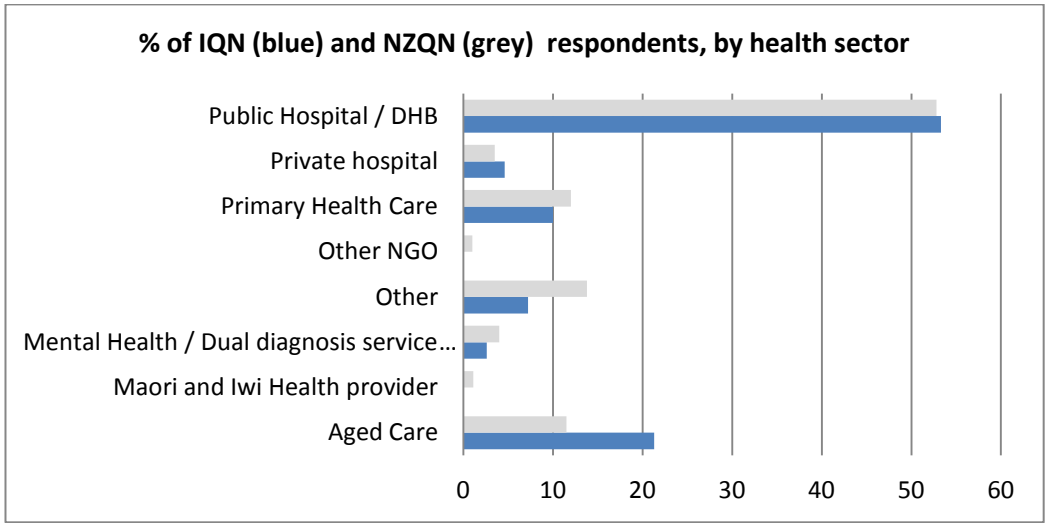
When the N2N cohort is further separated into percentages of IQN or NZQN by hours worked, it can be seen below that IQN nurses are more likely to work full time. This is likely to be confounded by the effects of age, where older nurses are more likely to work part time than younger nurses.



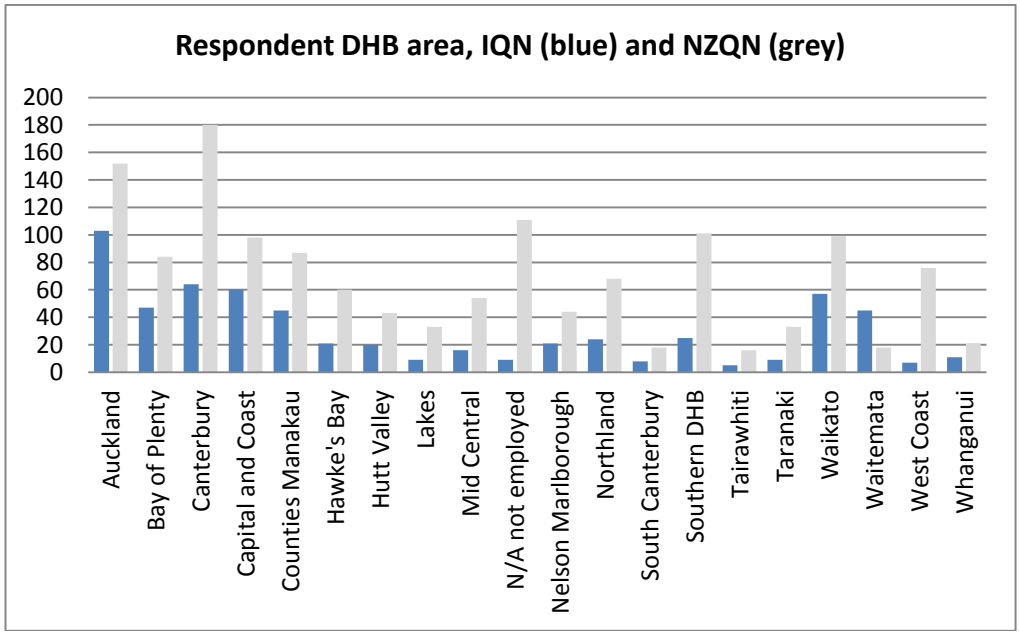
Health Sector Employer, N2N

Employer	%	Employer	%
Public Hospital/ DHB	49.15	Hospice	0.47
Aged Care	14.11	Education	0.42
Primary health Care	10.61	Occupational health	0.24
Private Hospital	3.65	Maternity	0.19
Mental health / dual diagnosis	3.2	NZ Blood service	0.14
Maori and Iwi Health	0.85	Other	8.9
Other NGO	0.76	Not applicable	6.44

When separated into where IQN and NZQN N2N respondents work, this is seen below:



DHB Area, N2N



This shows a good representation from all DHB areas, suggesting newer members are not clustered disproportionately in particular locations, though there is some clustering of IQN nurses compared to NZQN, with proportionately more in Auckland and Waikato.

First nursing training undertaken in New Zealand, compared to years membership of NZNO.

Years NZNO	Percentage who first trained in NZ
Less than 1	**52%**
1-3	**67%**
4-5	**68%**
More than 5	**82%**

It can be seen that the more recently a new member joined NZNO, the lower the likelihood their first training to be a nurse was undertaken in New Zealand. Around half of new registrations with the Nursing Council of New Zealand for 3 out of the last 4 years have trained overseas, so this finding is consistent, and represents a significant change in the membership demographics.

Overseas trained nurse cohort specific data

Forty eight percent of nurses who originally trained as nurses overseas undertook further assessment to gain registration in NZ.

Just over 50 % took an English language test. The rest were mostly British, American or New Zealand born nurses who had originally trained overseas and did not need to undertake an English language test at the time they registered to practice in New Zealand. Current requirements for language testing now apply to all new applicants.

Nearly twenty percent of those who initially trained overseas re-trained as nurses in New Zealand. No information was given as to credits for prior learning, which are likely to be variable.

Those who completely retrained came from the following countries:

Country	number	Country	number
Fijian	1	Nigerian	1
Fijian Indian	1	Filipino	86
Indian	17	South African	1
NZ European	3	Tongan / Niuean	1
NZ Indian	1	Chinese	3

Of those who completely re-trained in New Zealand, forty two percent have so far gained Nursing Council (NCNZ) registration to be nurses in New Zealand.

Twenty seven percent of those who had trained overseas were recruited from overseas to become nurses.

The recruitment experiences were very mixed, and can be themed:

- Those who were recruited directly by District Health Boards (DHBs), or via agents for DHBs generally paid their own immigration and nursing council registration costs, but were paid relocation allowance, 2 week accommodation and flights in return for either one or two year bonding arrangement. Almost all were from the UK, were very satisfied with the process, and many said they got great support through the process.
- Those who paid agents, many thousands of New Zealand dollars for flights, Competency Assessment Programmes (CAP) and job offers with aged care, sometimes also charged by employers for Aged Care Education (ACE) , Dementia 1&2 and bonding for 1-3 years. Most of these came from the Philippines.
- Some found their own agencies, with mixed results, though usually they paid their own expenses, while fees were paid by DHBs. Found the information and support useful, though some were disappointed to subsequently find they could have been employed directly by the DHB and received help with relocation.

- Much disquiet at UK resident/trained nurses having to sit expensive International English Language Testing System (IELTS).
- Mixed experience with NCNZ, from “quick and easy” to ‘rude and frustrating’
- Many wished they had had more information about NZ nursing salaries and jobs before they came, and found their previous nursing experience and seniority was not recognised.
- 2 respondents reported help from NZNO to break restrictive contracts.
- Some reported disappointment that though they had been approached and recruited in their home country, that when they started nursing here, some colleagues appeared to resent overseas trained nurses.
- Full responses are seen in the appendix

Asked about their expectations, the following responses were received:

Question	Yes %	Uncertain %	No %
Does nursing in New Zealand match your expectations?	63.4	17.9	18.6
Does living in New Zealand match your expectations?	79.5	12.3	8.2
Do the wages for working as a nurse match your expectations?	46	16.5	37.5
Do the opportunities for career advancement match your expectations?	50.2	21.2	28.6

Twenty three percent of overseas trained nurses felt they were working in a position with less scope and responsibility than their previous employment in their home country. Of these, the number and percentage by origin answering this question is shown below. 13 out of 14 or 93% of Non-South African, (Other African) nurses felt they were working in a lesser role. In comparison, only 2 out of 62, or 3.2% of Indian nurses who answered this question felt this.

Country	Number	%	Country	Number	%
British	45	35.4	Fijian	3	21.4
Filipino	31	35.6	Indian	2	3.2
Other	17	33.3	USA	2	40
South African	9	34.6	Chinese	1	20
Other African	13	93	Samoan	1	33.3
Other European	4	13.7	Tongan	1	50

Free text comments related to this are themed below;

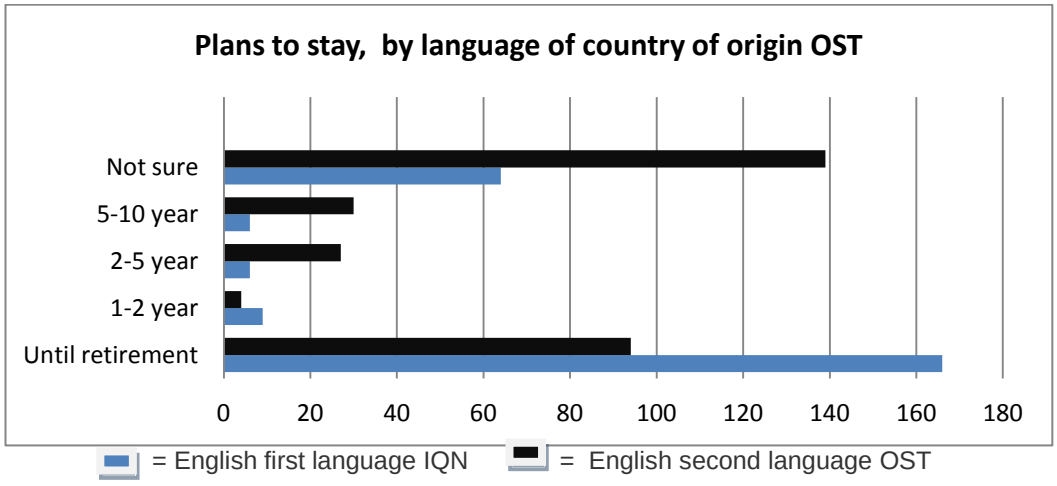
- Due to differences in scopes and training in other countries, especially having trained and practiced skills such as venepuncture, cannulation, epidurals, suturing, treating minor injuries, IV medication, vascular Doppler scans, PEG insertion and anaesthetic technician tasks, many feel de-skilled and underutilised.

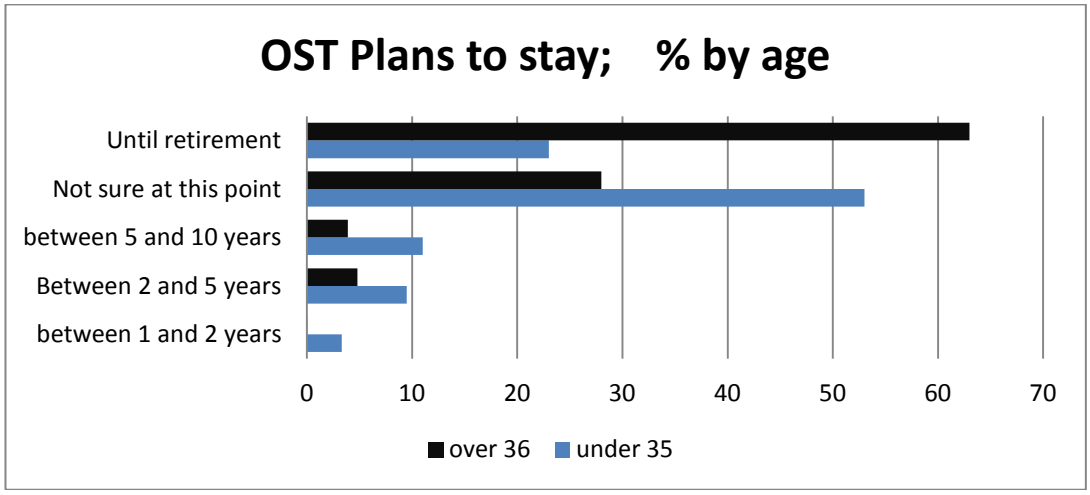
- Due to geographical location, many are unable to get jobs in their previous clinical specialities.
- Practice nurses in particular expressed frustration at not being able to work as previously, for example running chronic disease clinics, titrating and prescribing medication. Several felt that doctors in NZ have not passed over responsibility for many of the tasks that nurses were well trained and capable of doing to the same extent as in other countries.
- The largest group who felt under-utilised however, were those confined to working in Aged Care as care givers, unable to gain NZNC registration, where previously they had been specialised registered hospital nurses.
- Many felt that colleagues distrusted and dismissed their training or experience. This was more from non-UK / USA trained nurses.

One exception was those midwives who felt their skills were more able to be utilised in the NZ midwifery setting.

These responses are available in full in the appendix.

Plans to stay
These differed considerably between countries of origin, and by age



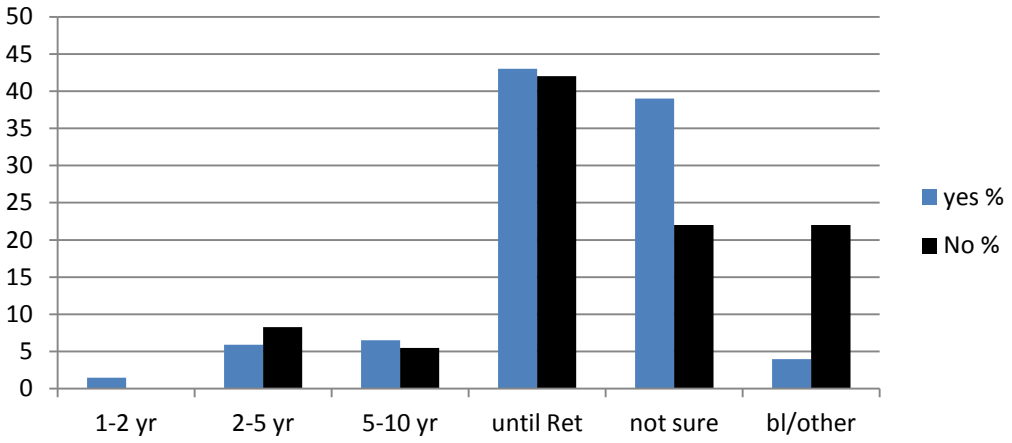


There is evidence of very different cohorts: older, English language country of origin nurses who are more likely to stay till retirement, and younger, mainly SE Asian and Indian nurses who have not yet decided how long to stay.

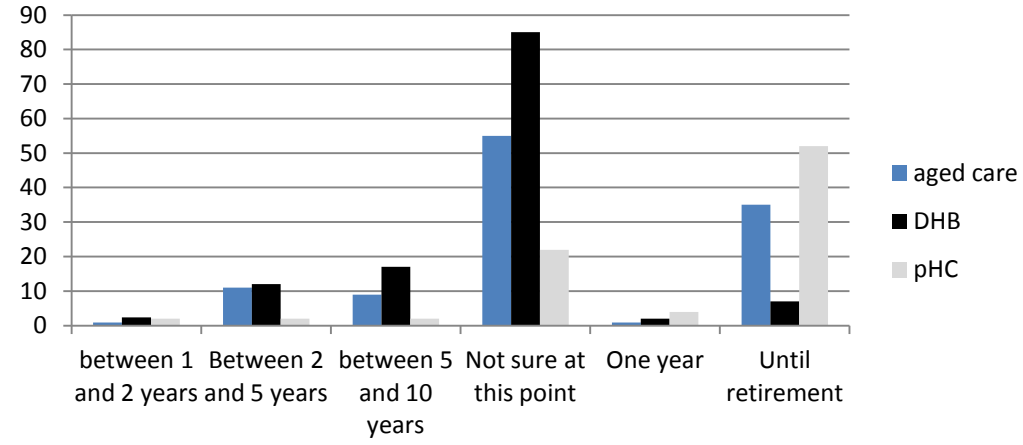
Given previously reported experience of discrimination, a question was specifically asked to ascertain whether this was likely to be a factor in their decision to stay.

The majority (77.85%) responded that experience of discrimination at work or towards migrants in general did not influence their plans to stay in New Zealand. However, recent New Zealand research by Harris et al in 2012 has re-confirmed that experience of racism is unhealthy, and overseas research conclusively shows that racism in healthcare is not only personally damaging, but also reduces productivity and leads to failure to fully utilise the potential of the workforce. (Adams and Kennedy, 2006)

Intention to stay, by NCNZ registration

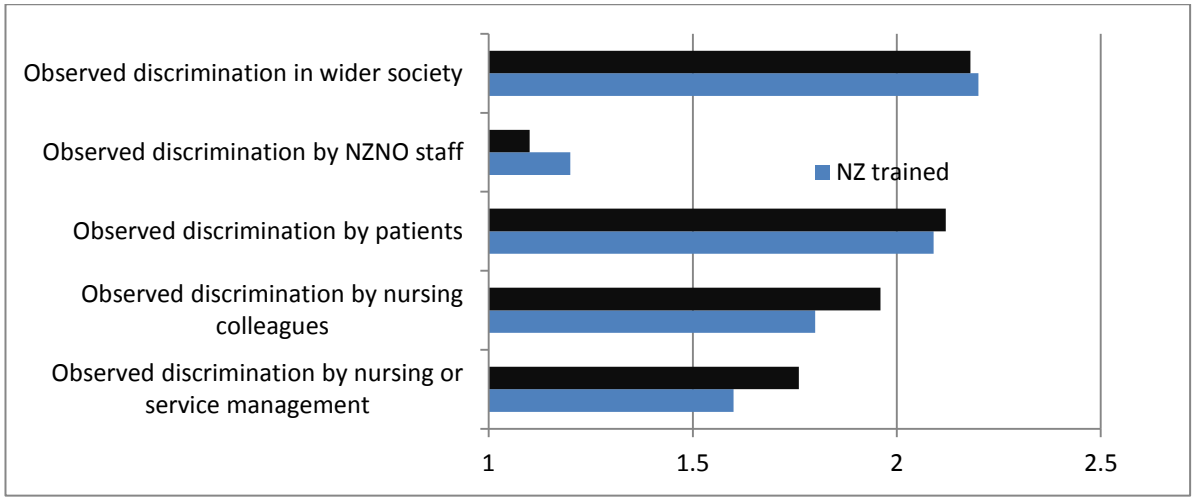


Intention to stay by health sector (%)



Discrimination

When asked about observing or experiencing discrimination, observation of discrimination was reported very similarly by both NZ and OS trained nurses. The numbers represent weighted means (a weighted score was calculated by the percentage answering yes/ uncertain/ no divided by the numbers responding, allowing comparison) Such that the possible scores are between 1 and 3, with the higher the score, the more discrimination has been seen. The same issues were largely identified in free text comments by both NZ and IQN nurses.



Free text comments

Although discrimination was described relating to gender, sexual orientation age and weight, overwhelmingly, descriptions related to country of origin and ethnicity. The main themes from *both* NZ and IQN respondents are summarised below, in order of frequency, along with the description. Representative quotes are shown for each below; each paragraph is from a separate respondent.

Theme	Description
Patients refusing care	***Very high*** numbers reported patients verbalising not wanting to be cared for by a 'foreign' nurse

I sometimes was treated badly from patients and some nurses as well. One patient even said that" why can't the hospital find Europeans to work instead of Asians." and "bloody Asian go back to your country"

An elderly patient once told me, "No offence, but I'd like a NZ nurse!" Another patient, who was talking to the hospital aide referred to me as "the other dark little girl!"

Another patient said, "I want to see someone white and important!"

Asian, Indian & Filipino (AIF)	Where specific ethnicities were reported as being subject to discrimination, the largest by far were Asian, Indian and Filipino. Many British IQN commented that integration was easier than for their AIF colleagues. This mostly referred to patient responses.

Most of the discrimination I have seen has been toward Asian and Filipino nurses by patients because the nurses didn't have good English skills, and because of a pervasive sense that "these foreigners are taking over ". I've had patients say to me: "Where are you from? Well thank God you can speak English."

Asian nurses appear to be less respected and 'spoken down' to by both management and patients.

Other countries	Anti - South African, German and American sentiments were reported, some based on historical or recent war time allegiances. Pacific Island nurses were often mentioned as being institutionally undervalued.

" I can hear where you come from why don't you just go back we don't need your sort here"

I have witnessed managers refusing to interview Pacific applicants because they are perceived to be lazy.

Distrust/ disrespect for training	Very many reported a sense that there was little belief that despite Nursing Council verification of training, non-NZ training was seen as inferior

Found that the culture in NZ Nursing was to be suspicious of overseas nurses. After spending all my career in OR I was asked 6 weeks into my theatre position if I knew how to scrub up! Although I am over it now I was very frustrated for quite a long time, as my 24 years of OR experience was not accepted readily.

Language	While NZQN nurses frequently struggled to understand accents, IQN also reported jargon, accent, idiom and speed of communications

	causing problems

I have witnessed language barriers causing frustration and impatience from colleagues towards migrant staff. Colleagues have spoken to them like they are of less intelligence, speaking very simply and shortly with them. I have seen them roll their eyes during handovers towards migrant staff and later talk about them with other colleagues.

Less favourable rosters/workload	Some felt that favourable rosters, workload, access to interviews or promotions was linked to ethnicity, &/or perceived reticence to complain.

Treatment and workload division is always unfair, Asians get all the rubbish rosters

Not valuing prior experience	Separate from differences in scope were feelings that non-NZ experience / service /management was not reflected in grades or progression through grades.

Despite my qualifications and extensive nursing experience I have been told not to apply for Senior Nursing positions even though I held those in the UK 'as you have not done your time in NZ'.

As I trained in India and haven't had NZ experience many applications from many of us are being rejected from a lot of employers in NZ. Also some employers do not consider the overseas experience we have had when deciding salary and I am being paid as a fresh graduate.

Nurses are started on a very low grade (same as a new grad), and then have to work up the ladder after commencing employment. I know particularly of a nurse who is experienced in ED, her skills are made use of because it suits the department, but is still paid a low scale of wage.

Other frequent observations	Many either made or reported comments related to there being 'too many' OST, 'taking Kiwi jobs/promotions', tensions between IQN from different countries, and many stereotypes about particular cultures. There were clear examples of lack of understanding, respect or tolerance of difference shown by both NZ and IQN respondents.

Previous place of employment, ward manager placed a sticker on me that said "I'm Australian and I'm a moron". Consistently get comments about being inferior being Australian; although these are in jest, it can be incredibly annoying when it is constant.

A colleague said that opportunities for NZ trained nurses are fewer, because of all our immigrants. She can't understand how we get employed and NZ nurses struggle to get a job.

There are too many nurses from overseas coming to NZ to work, no jobs for NZ nurses, too many immigrants coming into NZ, taking jobs and cheap housing

There were a small number (17) of NZ born and trained nurses of Chinese and Indian ethnicity. Of interest, virtually all of them had direct experience of discrimination and racism at work or in wider society. Illustrative examples of the range of responses by this group include:

Some nursing colleagues clearly consider overseas trained nurses (particularly Filipino nurses) as inferior to themselves.

Some older patients have strong prejudices against Asian nurses and express these views without reservation.

Society does tend to favour the dominant culture and discriminate against minority cultures regardless of whether those minority cultures are indigenous or immigrant.

There are often patients who are reluctant to have certain race, gender or sex nurse them but it is understandable and easily managed.

Patients and general public consider nurses for whom English is a second language to be inferior and to not have had as good a training as NZ or Western Countries.

Discrimination almost happens on a daily bases if you really think into it. I have been sworn at for just being an Asian & have been taken lightly by management people or doctors for giving my own opinions as an employee or nurse.

One issue raised by many NZ trained respondents clearly causes friction;

Working in a hospital you see a lot of different ethnic groups, when there is a majority group, ie Indian what often occurs if they help and support their own ethnic group and ignore the minority and will talk among themselves in their native language even in front of patients, who get confused by this

One common complaint is that staff from some countries openly communicate with each other in their own language during work time. In this situation I have just politely asked to be included and have often received a quick apology.

Also, NZ clients do not like them due to their language barriers, the way they 'group together; and speak in their own language, giggling and not wanting or trying to be a part of our society.

Participation in NZNO activities

The graph shows percentages of the various groupings reported participation, comparing NZQN (red bar) and IQN(blue bar)

Following up on perceptions from the free text responses from NZ trained nurses about participation by IQN being different for those for whom English is a second language, separate analysis of the responses of newer members of NZNO by first language country of origin was performed.

The graph shows percentages of the various groupings reported participation, comparing IQN respondents from non European language countries (green bar) or European language countries (purple bar)

Contrary to perceptions voiced in the responses, first language English speaking recent migrants were slightly *less* likely to have contributed to the professional activities than the IQN cohort as a whole. They were slightly *more* likely to have undertaken overt activities such as wearing tee shirts or signing petitions than the IQN as a whole.

When asked why IQN nurses were less likely to be engaged with NZNO structures and processes, very many responses were returned. When these were analysed separately for NZQN and OTS respondents, some differences and similarities emerged. These are shown fully in the appendix. Common themes, along with exemplar quotes, and suggestions for change are shown in the table below.

Quotes from NZQN :

Theme	Exemplars
Alienation	*Do they feel uncomfortable with getting involved because they are not citizens here?* *Maybe they feel somewhat disempowered in our workforce and that it is not their right to get involved.* *perhaps because they do not agree with NZ culture or would rather stick to their own culture* *Transitory employment and disconnection to NZ are problems. I am aware of many foreign-trained nurses using NZ residency as a stepping stone to living and working as a nurse Australia.*
Competing demands	when people migrate, it's tough to make ends meet, and some also have responsibility back home thus there is no time set aside for anything else. Uncertain of their entitlement or settling in can take time especially if from other countries and cultures, so you tend to prioritise the needs of the family first and foremost. Too busy with family and no financial reward for doing so They often have enough going on in their lives, especially if they are women with children, as a lot of nurses are. Shift work and children are hard. A lot of women, especially nurses, give a lot back to their communities in unpaid work. mostly when they first arrive they have so many other things to think about when adjusting to a new work environment a new country that the last thing they think about is being active in committee's or organisations Most International Nurses work full time and are (possibly) the primary income earner. They have to cope with the transition into a foreign country - trying to understand and fit in (at work and in New Zealand in general) - the last thing they need is to offend anyone by speaking up. I personally think the international nurses work so incredibly hard (at everything) that they are too exhausted to have time to take part in anything

	else!
Lack of information	*Also it takes a long time to settle into a foreign environment to learn all the basics let alone to comment on structures and processes in a system you are unfamiliar with* *They may not know what these are, I am a NZ nurse and I don't even know what half the processes are* *They may not be properly informed of the structures/processes, possibly due to language/understanding barriers. A tutorial or something similar could be held, in specific for ethnic cultures, to better aid their understanding* *Tell people what your structures and processes are. I often find it impossible to know how or even why to get involved with NZNO as there is never any contact*
Fear of "rocking the boat"	*Those who I worked with were young and alone in New Zealand. They were vulnerable in that they needed their job to pay the bills, send money home to family - therefore they did not want to cause 'trouble' and would just put up with the treatment from employers, and just try and do their work without getting involved in any work 'politics' - they couldn't afford to lose their jobs! So perhaps it's the same with NZNO - they don't want to do anything that could cause them to lose their job, because too much is at stake.* *Certain cultures are not comfortable to openly discuss problems or issues in the same way as "kiwis" would. This can be due to differences in how they express themselves, language colloquialisms, feeling comfortable and confident to speak up in a group of people or even face to face with colleagues.* *They need to know that it is safe to speak out. They often come from Countries where there is conflict, maybe they just need time to adjust.*
Cultural differences	*They are often too shy, they are not yet as outspoken as we are. To me they are not yet confident to stand and speak out. It's often not in their nature to complain, even at home. They need to live here a while to harden up, so to speak.* *Perhaps cultural and language barriers prevent them from fully participating. Maybe discrimination from those formulating structures and processes exist by them excluding overseas trained and migrant members.* *overseas nurses - mostly typically those from India - do keep to themselves and their own cultural group. They do not participate in ward social events or mix socially. They tend not to complain or question processes, and find it difficult to advocate for patients when it means questioning or challenging the opinions/actions of others. They would deem it disrespectful to do this - I think culturally they would find it*

	difficult to challenge work conditions or other matters through active involvement in NZNO. *Politics! As hard as it is being an Asian nursing in the work place, the last thing they want to be labelled is, oh she is with the 'union' or she is representing the 'union'* *Culturally, it is not a woman's place to be active in a political way. It intrigues me that while they are modern women and men in many ways, the cultural mores of their background still have great sway. Perhaps it will be different with the second generation. In a nutshell, they don't see it as their business, and have no desire to rock the boat. They also have a different expectation from life. They are much more used to things, "not being fair" and have a more passive response to it, for the reasons above*
Language barriers	*Sometimes the language barriers are too much and it takes time to explain certain things.* *It is a language barrier thing so possibly making structures and processes easier to understand* *I think it is due to communication or lack of for migrant members especially those with English as a second language* *migrants to New Zealand and are not aware of the colloquialisms, which are challenging to decipher. Many Maori, Pacific Island etc words have been absorbed into day-to-day use, and are commonly used in conversation can also be a struggle*
Seniority	*Some of our ward reps are elected because no one else will pick up the role and that could be because family commitments, inexperience, fear, lack of confidence, or not wanting to rock the boat. Seniority. Come in and see us- be proactive- come into our workplace regularly*
A need for Support or promotion?	*Put them into roles of leadership where they get a chance to "shine" and prove themselves whilst demonstrating increased responsibility.* *perhaps using examples of good news stories in Kai tiaki that feature nurses from ethnic minorities who are now working in our health system* *Perhaps create an role to speak for and help with the development of NZNO members who have come from overseas* *Perhaps an advertising programme focused on the benefits these people can bring to New Zealand and our communities* *You could encourage active participation when they register with NZNO ? Support groups for each culture. Give everyone the option of wanting to know/meet other nurses from their culture working in either their speciality or location.*

Education	*Education and awareness being raised among nursing groups and associations.* *Providing a safe environment for overseas trained and migrant groups to express their opinions.* *Media role in supporting minority groups.* *Nurse training programs to support and enhance improved intercultural communication.* *Education of how the NZNO can benefit its members is the primary key. Get delegates from these minority groups involved, actively recruit them. One way may be to recruit them associate delegates, in this way they can have a more passive role while observing and learning the role (scaffolding them into the system).* *New Zealand general public and nurses; those of the dominant pakeha culture, are commonly culturally illiterate and often unconsciously/purposefully act in ways that make migrant colleagues/clients feel culturally unsafe. Education in cultural literacy .....and maintaining cultural safety .....competence would help to reduce this issue.*
Suggestions	*Try to get them involved in the leadership and make them realize that their views are valuable and can make a difference.* *Have a cultural representative within the NZNO - for majority ethnicities, keeping in contact with the overseas migrant nurses.* *Try employing a person of their own ethnicity, who can understand their values/cultural upbringing. And is able to speak-up and negotiate on their behalf?* *These staff seem very shy about coming forward with ideas - having meetings with small groups would be helpful* *Ask them what they do not wish to actively take part in our structures and processes. Having those conversations with them first would help and then formulating a plan forward.* *More mentoring. To be a NZNO rep there is I understand some support for this and it would help if migrant or overseas nurses could work in pairs to take on a rep job OR can the "job" be shared by 2 people. i.e. 1 migrant or overseas nurse and 1 "kiwi" trained nurse.* *Start a foreign nurse section. This will probably be very un-politically correct, but somehow they need to get together to discuss these issues and then perhaps present to a wider audience in a workshop format. Foreign nurse are here to stay and we need to support and see them as valued team members. We need to be made aware that some of our attitudes are institutional racism.*

Comments from IQN:

Theme	Exemplar
Alienation	*Knowing and feeling that if we take part in any structure we will always be overlooked because of our ethnicity. Our opinion won't be taken seriously because the NZNO structure and processes are dominated by the Europeans.*
Cultural differences	*Maybe we have a different priority in life and world view? As a Nurse with an Asian background, we have been taught at a young age to not get involved with politics, probably because of the wars that happened 3-4 generations ago.* *Cultural appropriateness would make a significant difference here. For instance the NZNO membership computer membership system does not allow for "foreign" usages when it comes to names. An example would be that my surname begins with a lowercase letter. The NZNO system force changes this to a capital. When I enquired about getting the spelling of my surname corrected I was told, rather rudely, that such a change was impossible because it was a computer default*
Competing demands	*Family commitments (my husband & I care for his dependent parents who cannot be left alone) make all outside commitments challenging.* *As it is mainly for nursing I feel that I'm alone with my problems.*
Feeling unwelcome	*It's just hard when you don't know people, when they stick together and make assumptions - I was asked if I was a cleaner the first MECA meeting I went to!* *Voting for the latest NZNO-MECA negotiation outside my DHB, not welcoming. Unfortunately it is related to the human factor, personal mannerism and attention to other people.* *Sorry, just did not have a good time or good representation I'm afraid.* *I have found that there are cliques of people who often do these things and take part, and they know each other so it is sometimes difficult to break into the group.*
Fear of rocking the boat	*When I was asked to be a delegate I at first refused to agree for the reason that I am new RN and my employer may not like it but now I am starting to realized that it has nothing to do with my employer but more of me and my colleagues. So I am now better prepared to participate in activities in a wider spectrum.*
Disengaged	*Sorry, but I have not felt that NZNO participation essentially relevant to me in some ways. This possibly reflects the stress of moving country and then relocating down to the Main Island then having moved around several jobs to find a role that suited me*

Poor experience of NZNO service	*As a lactation Consultant I feel I have not been well looked after. I have made contact in the past with trying to negotiate my pay and was given little advice.* *I felt a previous NZNO representative was quite defensive and hostile in her manner. I didn't think she was approachable and she didn't listen to what was being voiced by members as though she was irritated by peoples questions; a poor first experience for me.* *I attended a workplace meeting for the last pay ratification to find out i was one of 3 people to turn up and no NZNO person. This resulted in not being able to vote in the last ratification meeting* *I have applied for membership of the gastroenterology section but have never heard back from them or received a copy of their journal - not sure why, a colleague in the same office belongs and gets these.*

Recommendations

- **NZNO continue the project to engage with IQN newer members to explore issues, barriers to involvement and support.**
- **NZNO work with employers to better orientate and support new migrant nurses to New Zealand and to nursing in New Zealand. Some DHBs are currently doing this well, but many employers are not. This might include language support.**
- **NZNO look to designing welcome packs specifically for new migrant members, with input from them about the gaps in knowledge that would have been helpful at the start.**
- **NZNO look into providing pastoral / social support on a regional basis, and use these as hubs where mentoring into NZNO activity and activism could be provided.**
- **NZNO advocate for more awareness of the issues new migrant members face, perhaps running cultural awareness training for NZNO delegates to help them be more welcoming and inclusive.**
- **NZNO use media and publications to educate the wider public of the registration, training, experience and roles undertaken by our minority ethnic members, to help reduce discrimination and reassure patients.**
- **NZNO test the interest, resourcing requirements and value of establishing a web-based discussion page for overseas trained nurses new to New Zealand**

References

Harris R., Cormack, D., Tobias, M., Yeh L-C , Talamaivao, N., Minster J., Timutimu B. (2012) The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains *Social Science & Medicine* **74** p 408-415

Adams E., Kennedy, A. (2006) Positive Practice Environments:
Key Considerations for the Development of a Framework to Support the Integration of International Nurses. *International Centre on Nurse Migration*, accessed at www.intlnursemigration.org