A PRECARIOUS JOURNEY: EXPERIENCES OF NURSES FROM THE PHILIPPINES SEEKING RN LICENSURE AND EMPLOYMENT IN CANADA

by

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Abstract

Increasingly, registered nurses (RNs) from lower income countries are seeking RN licensure and employment in Canada. Despite efforts to support their integration into the workplace, a significant number do not complete the registration process. To explore this phenomenon, using ethnographic methods informed by postcolonial feminism and relational ethical theory, I set out to learn from nurses educated in the Philippines about their experiences seeking RN licensure and employment in Canada. These nurses make up the greatest percentage of internationally educated nurses (IENs) in Canada and have a long history of migration to learn from.

My goal was to understand how the experiences of these nurses shaped and were shaped by social, political, economic, and historical contexts and mediating oppressions at international, national, and local levels. Over the course of a year, I engaged 47 nurses in individual and focus group interviews. They had come to Canada with diverse immigration histories and work experiences. To enhance understanding of their perspectives I also collected data from secondary participants, such as nurse educators and immigration counselors, and reviewed immigration and regulatory documents.

My analysis revealed that decisions at each stage of the nurse migration journey, which began in the Philippines and progressed to Canada, were not made in isolation. Rather, decisions were influenced by structures embedded within prevailing ideologies of neo-liberalism and neocolonialism and intersecting relations of gender, race, and class. Such structures and processes have the capacity to constrain agency and put nurses in jeopardy of marginalization, exploitation, and powerlessness. In this context, issues considered cultural might be better understood as partial and dynamic implications of broader social inequities. Consequently, it is
imperative to extend our gaze beyond everyday practices of individual nurses, programs, and institutions and critically expose root causes of such inequities. Moreover, it is vital that the voices of IENs be included in health care planning and policy making.
Preface

Ethics approval for this study was received from the University of British Columbia, Behavioural Research Ethics Board. This study was originally approved in July 2010; the last annual renewal was received in February 2013 (Approval number H10-00137).

Permission to interview nurses educated in the Philippines was also granted through Vancouver Community College (Approval Number REB 201004-01) and Kwantlen Polytechnic University (Approval Number 2010-018).
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List of Acronyms

ARNBC Association of Registered Nurses of British Columbia
BC British Columbia
BCNU British Columbia Nurses’ Union
BREB Behavioural Research Ethics Board
BSN Bachelor of Science in Nursing
CELBAN Canadian English Language Benchmark Assessment for Nurses
CIC Citizenship and Immigration Canada
CIHI Canadian Institute for Health Information
CIIP Canadian Immigration Integration Program
CNA Canadian Nurses Association
CLPNBC College of Licensed Practical Nurses of British Columbia
CRNBC College of Registered Nurses of British Columbia
CRNE Canadian Registered Nurse Examination
ESN Employed Student Nurse
FNSG Filipino Nurses Support Group
FSWP Federal Skilled Worker Program
FSW Federal Skilled Worker
GNIE Graduate Nurse, Internationally Educated
HPA Health Professions Act
ICN International Council of Nurses
IELTS International English Language Testing System
IEN Internationally Educated Nurse
IEP Internationally Educated Professional
ISO Immigrant Serving Organization
LCP Live-in Caregiver Program
LPN Licensed Practical Nurse
MHH Multicultural Helping House
MOH Ministry of Health
OECD Organization for Economic Co-operation and Development
PNA Philippine Nurses Association
PNAM Philippine Nurses Association of Manitoba
PNP Provincial Nominee Program
RNABC Registered Nurses Association
SEC Substantially Equivalent Competency
TFW Temporary Foreign Worker
TFWP Temporary Foreign Worker Program
UAE United Arab Emirates
UK United Kingdom
UN United Nations
US United States
VCC Vancouver Community College
WHO World Health Organization
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Chapter One: Situating the Study

Nursing is becoming an increasingly mobile profession. Thousands of nurses, the majority of them women, migrate each year in search of better pay and working conditions and an improved quality of life (Kingma, 2006; WHO, 2006). In 2011 internationally educated nurses (IENs) comprised 8.6 percent of the registered nurse (RN) workforce in Canada (CIHI, 2012). Although Canada, like other higher income countries, has always relied on IENs to play a pivotal role in the provision of health care, as nurse shortages intensify, it is increasingly relying on nurses from lower income countries (CNA, 2006; Dumont, Zurn, Church, & Le Thi, 2008; ICN, 2006; International Centre on Nurse Migration, 2007; Kingma, 2007; McIntosh, Torgerson, & Klassen, 2007). Currently, the leading source country of nurses worldwide is the Philippines (Choy, 2010; Kingma, 2007) and accordingly nurses educated in the Philippines make up the greatest proportion (32.7%) of IENs in Canada (CIHI, 2012).

Despite the rise in nurse migration from lower to higher to income countries, the phenomenon remains poorly understood. It is complex and weighted with many ethical concerns (Allan & Larsen, 2003; Bach, 2003; Ball, 2004; ICN, 2007b; Kingma, 2006; Smith, Allan, Henry, Larsen, & Mackintosh, 2007; WHO, 2006). Indeed, as a nurse educator responsible for teaching IENs in Canadian nurse bridging programs\(^1\), I have become increasingly aware of the complexity of nurse migration and concerned about the vulnerable status of my students. For example, I clearly recall the despair expressed by one student as she recounted her story of separation from her four children and husband for ten years while she came to Canada as a domestic worker through the Live-in Caregiver Program (LCP) and then proceeded to seek

\(^1\)Nurse bridging programs refer to nurse re-entry programs or educational programs that are specifically designed to help individuals who have completed basic nursing education in other countries meet Canadian licensing requirements and integrate into the Canadian health care system (Jeans, Hadley, Green, & Da Prat, 2005).
Canadian RN licensure. While studying to meet the requirements for this credential and working to cover expenses associated with its acquisition, she also supported her family in the Philippines. Although recently reunited with her family in Vancouver, she confided she would never have come to Canada if she had foreseen the difficulty of acquiring RN licensure and employment. In the Philippines she had been a nurse educator, but in Canada, years later, she was working as a care aide in a community hospital while attempting to acquire RN registration.

Listening to this story and others, I became curious about broader structures\(^2\) and processes that shape nurse migration experiences from lower income countries, ones not readily visible to the nurses or to me. Moreover, I realized in my role as a nurse educator that in order to effectively facilitate IEN integration into the workplace, I needed to understand the context of these migration experiences. Thus, in this dissertation I set out to explore how social, economic, political, and historical contexts mediated by the intersection of social relations\(^3\), such as gender, race\(^4\), and class\(^5\), come to shape the everyday experiences of IENs seeking RN licensure and employment in Canada. In the remainder of this first chapter I lay out the empirical and theoretical background that enabled me to move forward with this plan and in subsequent chapters will expand on this content.

\(^2\)I use the term ‘structures’ as it is used by Sewell (1992) to depict sets of mutually sustaining schemas (virtual) and resources (actual) that empower and constrain social action and that tend to be reproduced by that action. In this regard structures are both the medium and the outcome of practices which constitute social systems. The process of enacting structures entails reciprocity between structure and agency: structures are enacted by human agents and agents act by putting into practice their necessarily structured knowledge.

\(^3\)Social scientists view peoples’ doings as embedded within social relations or temporal sequences of action in which “the foregoing intends the subsequent and in which the subsequent ‘realizes’ or accomplishes the social character of the preceding” (Smith, 2005, p.228).

\(^4\)I understand race to be a social construct; not a biological essence (Anderson, 1998).

\(^5\)In this thesis I draw on the Marxian premise that class is defined by one’s relationship to the process of production: autonomy over production and control over the labour process (McPherson, 1996).
A Nurse Migration Trajectory

As nurses move along a trajectory towards securing RN licensure and employment in a higher income country, their lives are shaped by a myriad of social, economic, political, and historical contexts. Structures at international, national, and local levels overlap to influence the demand for nursing services in destination countries, the willingness of nurses to migrate, and the capacity of IENs to enter professional nursing practice in foreign workplaces (Buchan, 2006; Kingma, 2006, 2007, 2010; Kline, 2003).

Structures creating a demand for nursing skills.

As the need for health services in higher income countries escalates, the domestic supply of nurses is dwindling and is expected to shrink (WHO, 2006). For instance, it is anticipated that Canada will experience a shortage of 60,000 full-time RN equivalent positions by 2022 if the health needs of its citizens continue to grow according to past trends and if no new remediation policies are implemented (Murphy, Birch, Alder, MacKenzie, Lethbridge, Little, & Cook, 2009).

The term “nurse shortage”, however, is a relative term as it is measured in relation to a country’s own historical staffing levels, economic resources, and estimates of the demand for health services (Buchan, 2003). As such, it is a label that is used differently by different stakeholders. For example, Canada, with one of the healthiest populations and highest densities of nurses in the world at a ratio of approximately 10 nurses per 1000 population, claims to have a nurse shortage (WHO, 2006). On the other hand, lower income countries, such as the Philippines, China, India, Indonesia, and Viet Nam, with greater health needs and nurse to population ratios of approximately only one to 1000, claim to have an oversupply and encourage the outflow of nurses (WHO, 2006).
While it is important to acknowledge the serious global inequities related to the availability of nurse resources and that the amelioration of nurse shortages in Canada may in fact worsen the provision of health care in lower income countries, nurse shortages in higher income countries are not to be ignored. Thus, it is worth noting the structures that appear to be contributing to the undersupply of nurses in higher income countries; structures such as an aging workforce, the increasing incidence of chronic illnesses, increasing population growth rates, and alternative career opportunities for women (Buchan, 2006). However, it is also reported that this undersupply may be symptomatic of larger systemic problems causing nurses to leave their jobs (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Ball, 2004; Buchan, 2006; ICN, 2006, 2007a; Kingma, 2007, 2010; McIntosh et al., 2007; Rodney & Varcoe, 2012). For instance, it is speculated that in many countries (both high income and low) nursing continues to be undervalued as women’s work and consequently inappropriately funded and supported (Buchan, 2002, 2006; ICN, 2004a).

**Structures compelling nurses to migrate.**

Frequently nurse migration is conceptualized in terms of ‘push factors’, or those causing discontent in source countries, and ‘pull factors’, or those making destination countries more attractive (ICN, 2007b; Kingma, 2006; Kline, 2003). For instance, push factors, such as low pay, poor working conditions, unemployment, and political instability, are commonly cited as reasons that nurses decide to emigrate (Jeans et al., 2005). On the other hand, pull factors, such as opportunities for better pay, improved working conditions, and professional advancement, are often described as attracting nurses to higher income countries (Kingma, 2006).

However, on closer examination structures compelling nurses to migrate are not so straightforward. In some lower income countries nurses who migrate are viewed as “heroes of
development” and their governments have labour policies and international agreements in place to support their migration. The Philippines\(^6\) is an example of a country that deliberately encourages nurse emigration for employment abroad and the channelling of remittances, skills, and knowledge back to the home country (Castles & Miller, 2009; Choy, 2006; 2010; Guevarra, 2010; Kingma, 2006, 2007; WHO, 2006). Indeed, the Philippine government has implemented an official overseas labour policy and established the Philippine Overseas Employment Authority (POEA) and the Office of Workers Welfare Administration (OWWA) to facilitate international migration and protect citizens working abroad (Choy, 2006; Guevarra, 2010; ICN, 2005; Kingma, 2006). As well, to meet the increased global demand for nurses the government has supported the growth of a large number of domestic private nursing schools\(^7\) (International Labour Office, 2005; Kingma, 2006; WHO, 2006). While the emergence of these schools has significantly increased opportunities for nursing education, it has also been problematic. As one illustration, in 2006 it was reported that with the increased number of these institutions the national regulatory body of the Philippines had difficulty enforcing and maintaining educational standards, which consequently compromised students’ performances on national licensing exams and ultimately opportunities for international employment (Kingma, 2006).

Although factors such as opportunities for better working conditions in higher income countries are frequently cited as factors that attract nurses from lower income countries, for many, migration offers an opportunity to escape from structures rooted in gender inequality and poverty. For instance, it is suggested that migration can be an empowering experience for women

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\(^6\)Other countries that are either actively involved or considering export strategies include China, India, Indonesia and Viet Nam (WHO, 2006).

\(^7\)Private-sector companies are opening up their own nursing schools. For example, in the Philippines the number of nursing schools has increased dramatically since in the 1970s when there were 63 schools. In 1998 there were 198 schools and in 2004 there were 370 schools and most are private (Kingma, 2006).
as it may provide increased status, a sense of independence and accomplishment, liberalization from traditional duties, and an acceptable way out of unsatisfactory relationships (Kingma, 2006; Parrenas, 2001; Pratt, 2012; Sarvasy & Longo, 2004; UN, 2006).

As well, the exposure to active recruitment strategies may strengthen a nurse’s resolve to migrate (Kingma, 2006). As higher income countries turn to lower income countries to address their nurse shortages, they are increasingly engaging in intensive recruitment campaigns (Buchan, 2006). In 2008 the province of Saskatchewan recruited 108 nurses from the Philippines (Saskatoon Health Region, 2008) and a provincial recruitment team from Manitoba made conditional offers of employment to a group of 131 nurses from the Philippines (Recruitment Canada, 2008).

Many IENs also seek the services of recruitment agencies, that is, for-profit organizations that link employers wishing to hire staff with nurses looking for jobs (ICN, 2004a; Kingma, 2006; Smith et al., 2007). Although these agencies can be useful, there are ethical concerns around risk of exploitation and abuse (Allan & Larsen, 2003; Bach, 2003; Ball, 2004; ICN, 2007b; Kingma, 2006; Smith et al., 2007; WHO, 2006). For instance, reports from the UK suggest that IENs may be misled about the nature of their employment or charged exorbitant placement fees (Allan & Larsen, 2003; Jeans et al., 2005; Kingma, 2006; Smith et al., 2007).

**Structures influencing entry into RN practice in Canada.**

As nurses move along the trajectory towards RN licensure and employment in destination countries, numerous structures at international, national, and local levels have the potential to both facilitate progress and impede advancement. Policies related to labour and immigration, credential assessment and recognition, and educational programs subject IENs to numerous challenges.
For many, the first challenge, after deciding to emigrate, is the task of navigating through foreign immigration policies. For those intending to migrate to Canada there are several immigration pathways and each has implications for RN licensure and employment. For example, if IENs enter Canada as permanent residents under the Federal Skilled Worker Program (FSWP), pre-arranged RN employment is not a pre-requisite nor is permanent resident status a guarantee of RN employment since RN licensure, unlike immigration, is a provincial or territorial responsibility (Dumont et al., 2008). If IENs enter Canada through the LCP as domestic caregivers they must complete their LCP responsibilities before they can become eligible for nurse bridging programs (CIC, 2012b). However, if IENs enter Canada under the Temporary Foreign Worker Program (TFWP) they must have a RN job offer before they arrive in Canada (Dumont et al., 2008).

In addition to navigating their way through complex immigration policies, IENs must also untangle foreign credential assessment and recognition processes. In Canada, all IENs, regardless of their immigration pathway, must have their credentials assessed and recognized by a provincial or territorial body and pass the Canadian Registered Nurses Exam (CRNE) before they can acquire full practice registration status. This can be a lengthy and costly process and a significant number of IENs residing in Canada never become registered (Jeans et al., 2005); as a consequence, many risk remaining marginalized in low-paying jobs (Dumont et al., 2008; McKay, 2002; Pratt, 1999, 2003, 2010, 2012).

8 On April 18, 2013 CIC announced that nurses will only be eligible to apply to enter Canada under the FSWP if they have a qualifying offer of arranged employment or they are in the PhD stream (CIC, 2013d).
Contributing to the challenge of securing RN licensure is the fact that IENs need an adequate number of recent practice hours and specific educational and language qualifications before they can be eligible to write the CRNE and in British Columbia (BC) they must also complete a 250 hour monitored Canadian work experience\(^9\) (CRNBC, 2011). Meeting these requirements may be especially daunting for IENs immigrating to Canada through the LCP, as many lack recent nursing experience (Dumont et al., 2008; Pratt, 1999). For IENs who qualify to write the CRNE, passing it may also prove difficult. In 2011 only approximately 50 percent of internationally educated first time CRNE writers passed the exam, compared to about 87 percent of Canadian educated first time writers (CNA, 2012b).

**Supports to ease integration.**

Acknowledging that migration may have adverse effects on lower income countries and on IENs, the International Council of Nurses (ICN) (2007a, 2007b) and the World Health Organization (WHO) (2006) propose urgent attention to global nurse retention issues and ethical recruitment and integration practices. Although these organizations accept that nurses should have the freedom to pursue work where they choose, they stipulate that higher income countries must ensure fair treatment of IENs. The Canadian Nurses Association (CNA) also encourages governments, employers, recruiters, and other stakeholders to respect ethical recruitment and integration practices (CNA, 2009). Accordingly, the CNA supports a national integrated health human resource strategy that includes the expeditious licensure and integration of IENs wanting to immigrate or already residing in Canada (Jeans et al., 2005). As a consequence of this

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\(^9\) On March 13, 2013 the RN regulatory college of BC announced that it was removing the requirement for a Canadian reference following 250 hours of practice as a professionally registered nurse and that the change will be implemented over time (CRNBC, 2013c).
initiative, nurse refresher courses and bridging programs have been implemented in many Canadian jurisdictions (Dumont et al., 2008).

**The Complexity of Nurse Migration**

As IENs from lower income countries move along a trajectory towards RN licensure and employment in destination countries their experiences are influenced by an array of contexts: structures that create a demand for nurses in higher income countries; those that compel nurses in lower income countries to migrate; and still others that influence entry into foreign professional nurse practice. Further, such structures mediated by intersecting social relations, such as gender, race, and class, overlap at international, national, and local levels to create a multi-dimensional phenomenon fraught with ethical concerns. Accordingly, it is evident that individual migration experiences cannot be examined in isolation; rather, they must be viewed as embedded within complex social and historical contexts. Further, it appears that licensure experiences in foreign countries need to be viewed as part of a trajectory that begins when nurses decide to migrate and that the trajectory does not necessarily conclude with licensure.

It is also important to consider that the demand for nurses in higher income countries may be related to the low status assigned to nurses and to women, thus IENs are at risk of filling positions that have been directly or indirectly rejected by others. Additionally, the fact that a significant number of IENs residing in Canada never acquire Canadian registration requires explanation. Further, it is crucial to recognize that migration may not be a matter of choice for some nurses, but something imposed on them and renders them vulnerable to exploitation and abuse from recruitment agencies, intense recruitment campaigns, or future employers. Indeed, structures creating a demand for nurses in wealthier countries and those compelling nurses to migrate from poorer countries should prompt exploration of how much control IENs have over
their own actions and raise ethical questions such as “whose interests are served and whose are harmed by traditional ways of structuring thought and practice” (Sherwin, 2000 p. 76). In this light, there is need to consider whose interests are being served by the rapid expansion of private schools in some lower income countries or by immigration or professional regulatory procedures that make it more difficult for some ethnic groups to gain licensure or employment.

**Developing a Focus for the Study**

Recognizing that IENs from different source countries may have unique challenges and that to study them as a homogeneous group may render such challenges invisible (Kingma, 2006; Pratt, 2004), I focused on the experiences of nurses educated in the Philippines. These nurses make up the greatest percentage of IENs in Canada and have a long history of migration and thus significant experience to learn from. Moreover, I suggest that knowledge gleaned from the Philippine experience will inform understanding of migration from other lower income countries.

Further, I limited my study of nurses educated in the Philippines to those who reside in the lower mainland of BC. BC has the highest percentage of IENs in its RN workforce (16.4 percent) compared with other provinces in Canada (CIHI, 2010). The greatest percentage of RNs in BC (94.1 percent) work in urban areas (CIHI, 2010). In addition, due to the profound impact that women have on nursing and nurse migration, I focused on female nurses; specifically, my aim was to uncover knowledge that may be relevant for female nurses educated in the Philippines as they strive to integrate into the Canadian health care system. However, to illuminate the experiences of these nurses, I solicited information from male Philippine nurses though they were not the focus of my study.

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10 In 2009 females comprised approximately 93.8 percent of the RN workforce in Canada (CIHI, 2010). Although I am unable to find statistics that indicate the proportion of female IENs in Canada, a study conducted in the UK indicates that females represent 84 per cent of IENs (Buchan, Jobanputra, Gough, & Hutt, 2005).
Reflecting on the literature.

On stepping back to reflect on the literature related to the phenomenon of nurses educated in the Philippines seeking to continue their professional practice in BC, I found several bodies of knowledge particularly helpful. Beginning with Canadian literature, numerous published accounts provide an overview of credential assessment and recognition policies, challenges encountered by IENs seeking licensure, and strategies to recruit and integrate IENs into the workplace (Baumann, Blythe, McIntosh, & Rheaume, 2006; Blythe & Baumann, 2008; Blythe, Baumann, Rheaume A., & McIntosh, 2009; Brush & Sochalski, 2007; Jeans et al., 2005; Little, 2007; McGuire & Murphy, 2005; Sochan & Singh, 2007).

Unfortunately IENs in these studies are grouped together as a common lot, regardless of their origin, whether a higher income country, such as the UK, or a lower, such as the Philippines. This renders their unique experiences less obvious. As well, these accounts fail to provide an in-depth analysis of how experiences are influenced by intersecting oppressions embedded within broader social, economic, political and historical contexts at international as well as national and local levels. However, in her Master’s thesis, Ronquillo (2010) does provide a historical perspective of nurse migration from the Philippines and sheds light on how colonial relations between the Philippines and the US continue to shape experiences of nurses educated in the Philippines as they transition into the Canadian workforce.

Although not focused specifically on nurses, there are several Canadian studies that provide a thoughtful analysis of how social relations, such as gender, race, and class, intersect within broader contexts to shape migration experiences of women from lower income countries. Pratt (1999, 2003, 2012) and McKay (2002) explore the experiences of domestic workers (many of whom are RNs) from the Philippines living in Canada and raise ethical concerns related to the
marginalization and exploitation of these women. Man (2004) also illuminates gendered and racialized processes, such as professional accreditation systems, affecting the experiences of female migrants from Asia seeking employment in Canada. However, her study population is skilled professionals from China, rather than nurses from the Philippines.

Although not examining Canadian conditions or necessarily focused on nurses’ experiences, there are several studies that add clarity to the context of migration from the Philippine in general. For example, Parrenas (2001, 2008) reveals the shifting gender ideologies that affect women’s emigration from the Philippines; Guevarra (2010) identifies how a neo-liberal framework for managing labour migration in the Philippines influences migration experiences; Lan (2003) illustrates how overseas domestic workers from the Philippines remain burdened with gendered responsibilities associated with their families back home; Choy (2006) examines the effect of American colonialism and racialization on nurses from the Philippines residing in the US; and Lorenzo, Galvez-Tan, Icamina, and Javier (2007) present the benefits and costs associated with nurse migration from a perspective of those residing in the Philippines.

Finally, while not specifically addressing the experiences of those from the Philippines, nor those who have migrated to Canada, findings from two exhaustive studies undertaken in the UK shed light on broader processes and ethical concerns related to IEN transition experiences into workplaces in upper income countries. Studies conducted by Allan and Larsen (2003) and Smith et al. (2007) both explore the experiences of IENs working in the UK and reveal IENs may face discrimination in terms of access to employment and treatment by colleagues. In another study that compares the labour and human rights of Philippine nurses working in the UK and those working in Saudi Arabia, the author argues that IENs in both countries often occupy
marginalized and racialized positions since they typically fill positions that, for a variety of reasons, domestically educated nurses are unable or unwilling to fill (Ball, 2004).

**Generating a problem statement and defining a purpose.**

The existing body of research and policy literature informs an understanding of the complexity inherent in the phenomenon of nurses educated in the Philippines seeking RN licensure in Canada. It does not, however, adequately represent the perspectives of nurses from the Philippines or from other lower income countries. Additionally, it does not help us to understand why a significant number of IENs never acquire Canadian licensure and remain underemployed in low-paying jobs. Nor does it sufficiently expose how social relations, such as race, gender, and class, combine to influence experiences and how these nurses may themselves participate in perpetuating such processes. In a similar vein, this research does not satisfactorily address the myriad of ethical concerns related to nurse migration experiences in Canada. Nevertheless, with only a limited understanding of nurse migration experiences, Canadians are increasingly relying on nurses from lower income countries, especially the Philippines, to play an important role in the provision of health care.

I argue that to add clarity to this complex situation and to fulfill responsibilities for fair recruitment and integration practices outlined by the WHO (2006) and ICN (2007a, 2007b), Canadian nurse leaders and policy makers need to have a contextual understanding of this phenomenon. My purpose in pursuing this study, therefore, was to critically examine the processes that shaped the experiences of nurses educated in the Philippines before and after arrival in Canada as they sought or considered seeking Canadian RN licensure; produce knowledge that can be used to inform policy making and ethical decision-making related to IEN recruitment and integration practices; assist nurses educated in the Philippines to participate in
choices that will make for better overall migration experiences; and ultimately enhance health care delivery in Canada and the health and well-being of Canadians themselves.

**Setting Up the Study**

The next step in moving forward with my research plan was to formulate a research question and situate my meta-theoretical commitment.

**Delineating the research question.**

The overarching research question guiding this study was: *How do social, political, economic, and historical contexts mediated by intersecting oppressions come to shape the everyday experiences of nurses educated in the Philippines as they seek RN licensure in BC?*

Specifically, my objective was to learn from these nurses about their subjective experiences seeking Canadian RN licensure and to work with them, in consultation with an Advisory Group, to understand how their experiences both shape and have been shaped by social, political, economic, and historical contexts imbued with structures at international, national, and local levels. The knowledge generated from these experiences inspired analysis of structures at the international level that compelled nurses to leave the Philippines and at national and local levels that influenced the ease with which they acquired Canadian RN licensure. It was also my intent to explore the reciprocity between structure and agency and to note how nurses negotiated these structures at various points of their trajectory.

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11In my research question I used the expression ‘seek RN licensure’ to include ‘have considered to seek RN licensure’ as I was also interested in learning from nurses not necessarily actively seeking licensure at the time of this study (they may have delayed or abandoned the notion).
Locating a meta-theoretical commitment.

In selecting an interpretive lens for this study I considered four issues. First, I acknowledged that structures coordinating the everyday experiences of this cohort of nurses may not necessarily be visible to themselves or to me. Second, I considered that nurse migration is a multi-dimensional phenomenon, embedded in broader social, economic, political, and historical contexts, and mediated by important issues of social relations, such as gender, race, and class. Third, I realized that such complex structures may constrain the ability of IENs to exercise autonomy over their own nurse migration trajectory. Fourth, I view my work as a catalyst for social change. To address these issues, I located the meta-theoretical context for this study within the critical theory paradigm, in particular, within feminist scholarship. Toward this end I drew on traditions of postcolonial feminism, including intersectional and postcolonial theory, and relational ethical theory.

Postcolonial feminism.

Postcolonial feminism provided an analytic lens for a multi-layered examination of intersecting oppressions such as gender, race, and culture located within broader historical and political contexts (Anderson, 2002). It gives voice to racialized women who have been silenced and it provides a means to examine how broader social contexts variously position and shape lives, knowledge, opportunities and choices (Anderson, 2000a). Anderson (2002) proposes a postcolonial feminist scholarship generated through the convergence of black feminist theory, in particular intersectional theory, and postcolonial theory, arguing that these two scholarships are complementary. While black feminist scholars often focus on how social relations combine to create social injustices, postcolonialism focuses on the construction of race and racialization and
cultural identity (Anderson, 2002). Ultimately, the aim of postcolonial feminism is to generate knowledge that will achieve social justice (Anderson, 2000a).

**Relational ethical theory.**

Relational ethical theory views individuals as rooted in an interconnected dynamic web of social relationships and affinities with others; not as isolated, social units fixed in time (Rodney, Burgess, Phillips, McPherson, & Brown, 2013; Rodney, Canning, McPherson, Anderson, McDonald, Pauly, Burgess, & Phillips, 2013; Rodney, Kadyschuk, Liaschenko, Brown, Musto, & Snyder, 2013). Moreover, it recognizes the importance that such relationships have on influencing each person’s identity, development, and aspirations (Sherwin, 2000). The relational ethical theory that I drew from, however, does not refer only to social relationships; rather, it also refers to political relationships of power and powerlessness. In this regard, relational ethical theory accounts for how forces of oppression can interfere with someone’s ability to exercise autonomy (Rodney, Kadyschuk et al., 2013; Sherwin, 2000). Thus, relational ethical theory directed me to look at the context that influences and sometimes constrains decisions made by study participants pursuing RN licensure and/or employment in Canada.

**Sketching the Study Design**

The nature of my research question led me to a qualitative research design inspired by ethnographic traditions and informed by postcolonial feminism and relational ethical theory. An ethnographic approach offered an opportunity to explore data from a variety of sources and to use interviews, observations, field notes, and documentary evidence to enhance understanding of complex concepts and practices (LeCompte & Schensul, 1999; Sherwin, 2000). Moreover, an ethnographic approach informed by postcolonial feminism directed me to begin my inquiry with the experiences of study participants and to reflect upon and examine how intersecting
oppressions and broader social and historical structures shaped and were shaped by their everyday experiences (Anderson, 2002; Reimer Kirkham & Anderson, 2002). To refine my understanding of this complex phenomenon I also explored documents, such as CRNBC regulatory procedures, and I interviewed secondary participants such as an immigration counsellor, nurse educators, and individuals educated in the Philippine but who became RNs after arrival in Canada.

I was aware that as a white, middle-class professional woman, who is not only a nurse but also had recent experience as a nurse educator responsible for assisting IENs with their integration into the Canadian workplace, I needed to be reflexive and to critically evaluate how matters of privilege associated with whiteness and professionalism affected my research (Anderson, 1991a; Harding, 1987b). Therefore, to operationalize my research plan I continually explored and acknowledged my beliefs, assumptions, and preconceptions about nurses educated in the Philippines and assimilated this understanding into my analysis (Burns & Grove, 2009). I also sought guidance from my thesis supervisory committee and from an Advisory Group of nurses educated in the Philippines and/or of Philippine ethnic descent.

Articulating Relevance

Canada is increasingly relying on nurses educated in the Philippines to play an important role in the provision of health care. However, little is known about the experiences of these nurses aspiring to nursing practice in Canada. Existing literature suggests many have challenges in acquiring Canadian RN credentials and are at risk of underemployment. This study illuminates how structures that extend beyond the boundaries of nurse experiences come to affect their everyday lives. As such, these research findings have the potential to deepen understanding of the daily realities of these nurse migrants.
So far, the voices of nurses from the Philippines have been missing from nursing policy and education initiatives. By positioning these nurses at the centre of this project, this study offers new insights to the phenomenon of nurse migration from the Philippines, in particular, and from other countries in general. The knowledge generated here extends understanding beyond the everyday challenges confronting nurses, regulators, educators, and employers to the broader ethical concerns about whose interests are being served and whose may be harmed. Such knowledge can be used to inform policy making and ethical theorizing related to RN credential assessment and recognition, workplace integration practices, and health human resource planning.

Organization of the Thesis

Having described the key components of my research study, I now turn to a review of the literature in Chapter Two. Here I will offer a detailed discussion of structures that influence the trajectory of nurses educated in the Philippines striving to continue their nursing practice in Canada: structures that create a demand for nurses in Canada; those that compel this migration; and those that influence entry into professional nursing practice in Canada. Using examples from the literature I will demonstrate how such structures may both shape and be shaped by nurse migration. In Chapter Three I describe the theoretical perspectives that provided support for the pursuit of my research question and informed my interpretive lens. In Chapter Four I address the strategies I used to answer my research question, ensure scientific quality, and attend to research ethics. In Chapters Five, Six, Seven, and Eight I present the results of the research study. Consistent with an ethnographic approach informed by postcolonial feminism, each of these four results chapters is grounded in the experiences of the study participants. In Chapter Nine, I offer a theoretical synthesis of the key study findings in an effort to extend understanding of the
broader context of nurse migration. Additionally, I seek to clarify how nurses themselves are active agents in shaping their own experiences and to advance understanding of ethical concerns associated with nurse migration and meaningful ways to promote social justice. Chapter Ten concludes the dissertation with an overview of the study and a presentation of the key conclusions and recommendations for moving forward.
Chapter Two: Surveying the Organizational Context of Nurse Migration

In the preceding chapter I presented the context for my study. In this chapter I propose to summarize the state of knowledge regarding experiences of nurses educated in the Philippines as they strive to continue their nursing practice in Canada. I will review literature that sheds light on the demand for IENs in higher income countries such as Canada, that compel many to migrate, and that influence entry into professional nursing in Canada.

Structures Creating a Demand for Nurses

Higher income countries including Canada are becoming more reliant on IENs from lower income countries to deal with domestic nurse shortages. Consequently professionally active nurses have become a prime resource in an increasingly competitive global labour market (Gordon, 2005; Kingma, 2006, 2010; Little, 2007). Thus the complex of social, economic, political, and historical conditions creating shortages of nurses in these countries have implications for nurse migration experiences.

Representation of IENs in the Canadian workplace.

Data from higher income countries indicate that IENs are making significant contributions to their health workforces. At 21 percent of the RN workforce, New Zealand ranks first amongst countries hiring IENs; Ireland, is second with 14 percent; and the UK is third at 10 percent (WHO, 2006). Canada ranks in fourth place, with IENs comprising 8.6 percent of its RN workforce (CNA, 2012a). Canadian statistics further reveal that there has been a steady increase in the proportion of IENs over the past decade. For instance, in 2002 6.9 percent of RNs employed in Canada graduated from a foreign nursing program (CIHI, 2003).

Statistics gathered by Canadian provincial and territorial regulatory bodies indicate that provincially the highest concentration of IENs work in British Columbia (BC) (16.4 percent),
next Ontario (11.6 percent), while the lowest concentration is in New Brunswick (1.5 percent) and Newfoundland (1.6 percent) (CIHI, 2010). Despite these numbers, it is not known exactly how many IENs reside in Canada, licensed as nurses or otherwise, as the data only represent those registered to nurse not the number living in Canada\(^{12}\). However, in a study published by the CNA, *Navigating to become a nurse in Canada: Assessment of international nurse applicants*, it was estimated that approximately two-thirds of IENs coming to Canada never complete the registration process (Jeans et al., 2005). A study of IENs in Ontario in 2006 reports that approximately 40 percent of IENs applying to the College of Nurses of Ontario fail to complete the registration process and do not enter the workforce whereas between 86.7 percent and 94.6 percent of RNs educated in Ontario register within 12 months of application (Baumann et al., 2006). Further, recent statistics indicate that only approximately 50 percent of internationally educated first time CRNE writers passed the exam, compared to about 87 percent of Canadian educated first time writers (CNA, 2012b).

**The nature of the demand for nurses in higher income countries.**

While the increasing number of IENs employed in RN positions in Canada partly reflects the general trend of movement across national boundaries\(^ {13}\), it also reflects a complex of social, economic, political, and historical conditions that creates a shortage of nurses in higher income countries (Ball, 2004; Buchan, 2006; Kingma, 2006). For instance, in Canada while there was a shortage of nurses in the 1980s due to increased acuity of clients and the demand for increased nurse to patient ratios, there was an oversupply of nurses in the 1990s as a result of restructuring, 

\(^{12}\)Citizenship and Immigration Canada (CIC) cannot provide statistics on the number of IENs residing in Canada as they record immigrants by applicant class, not by occupation.

\(^ {13}\)Recent population projections show that immigration is a major contributor to Canada’s economy, representing 67 percent of its demographic growth and this number is expected to reach over 80 percent in 2031 (Statcan, 2012).
downsizing, and fiscal restraints (Barry, 2002). After several years of nursing shortages in the early 2000s, there was again an oversupply due to the economic downturn of 2008 that prompted many jurisdictions to implement cuts to patient and nursing services. It is reported that in the Vancouver Coastal Health Authority only 171 new graduates found work in 2010, down from 225 in 2009 and the Fraser Health Authority in BC hired only 337 new grads in 2010, down from 460 in 2009 (BCNU, 2011).

The shortage of nurses may vary greatly across jurisdictions and at different times but it is generally acknowledged that due to aging populations and a growing incidence of chronic illnesses there is an increasing demand for nurses. At the same time the supply of available nurses in some countries is declining and is expected to worsen (ICN, 2006). In Canada, for example, it is estimated that the shortage of RNs will increase to almost 60,000 positions by 2022 if the health needs of Canadians continue to follow past trends and if no policy interventions are implemented (Murphy et al., 2009).

Much of the cyclical nature of the shortage of nurses in higher income countries appears on the surface to be related to external conditions. There is, however, speculation among some scholars that the shortage may be closely related to poor work environments and low professional satisfaction (Aiken et al., 2004; Buchan, 2006; ICN, 2006; Rodney & Varcoe, 2012). Kingma (2010) draws attention to the high vacancy rates in caring for the elderly that generates aggressive recruitment strategies and Aiken et al (2004) suggest that the inordinate amount of time RNs are required to spend on non-nursing tasks contributes to job dissatisfaction. A Canadian study indicates that the inability of nurses to find full time employment is another factor leading to nurse attrition (Dumont et al., 2008). In BC, 12 percent of RNs aged 25 to 34 years did not renew their license between 2003 and 2004 (Dumont et al., 2008).
Indeed, it is contended that a long-term underinvestment in the nursing profession and its career structure is ultimately affecting the willingness of nurses to stay in their jobs and the desirability of nursing as a career option (Buchan, 2008). Moreover, some hold that nurse shortages are a symptom of a more deep seated problem in which nursing in many countries continues to be undervalued as “women’s work” (Buchan, 2002, 2006; ICN, 2007b).

**Source countries: The Philippines.**

It is not only high income countries that are experiencing critical nurse shortages. With few exceptions, nurse shortages are present in all regions of the world (ICN, 2004b). Although it is suggested that there are approximately 59 million health workers\(^\text{14}\) worldwide, it is also estimated that there is a corresponding shortage in the order of 4.3 million health workers (WHO, 2006). WHO (2006) has identified 57 countries with critical shortages but paradoxically these countries also report large numbers of unemployed health professionals. However, there is no universally accepted definition of what a shortage is; rather it is a relative term and is measured in relation to a country’s own historical staffing levels, economic resources, and estimates of the demand for health services (Buchan, 2003). As such, it is a label that is used differently by different stakeholders. For instance, both Canada and the US, which have an average of nearly 1,000 nurses per 100,000 population\(^\text{15}\), as well as several countries in Africa, with fewer than 10 nurses per 100,000, claim to have nurse shortages (Buchan, 2006).

Despite these disparities, it is the countries with the higher incomes and the most resources that are fuelling the demand for nurses and nurse migration (Buchan, 2006).

\(^{14}\)The term ‘health workers’ refers to all people (including doctors, nurses and others) who are engaged in paid activities in which the primary intent is to enhance health (WHO, 2006).

\(^{15}\)Between 2007 and 2011 the number of RNs per 100,000 population remained largely unchanged (from 783 to 785 per 100,000 (CIHI, 2012)).
Traditionally, international nurse migration tended to be a North-North or South-South phenomenon (e.g., Irish nurses working in the UK and Canadian nurse practicing in the US) (Kingma, 2007). However, the accelerating movement of nurses from lower to higher income countries is intensifying as higher income countries struggle to fill positions created by their own shortages (Buchan, 2002; Kingma, 2007; WHO, 2006). Further, some nurses take an indirect route to their final destination, using stops along the way to develop their skills and credentials (Kingma, 2006, 2007).

The leading source country of IENs worldwide is the Philippines (Choy, 2010; Kingma, 2007). The precise number is difficult to ascertain, however Kingma (2006) estimates that approximately 250,000 Philippine nurses are working abroad. Reports from the US indicate they comprise 50.2 percent of the IEN workforce (Xu, 2007) and recent statistics from the Canadian Institute for Health Information (CIHI) indicate that they constitute 32.7 percent of the IENs in Canada (in contrast to 15.3 percent of IENs in Canada educated in the UK) (CIHI, 2012).

Although nurses from the Philippines have been making a significant contribution to the Canadian RN workforce since the first major wave of migration from that country in the 1960s and 1970s (McKay, 2002; Ronquillo, 2010), it was not until approximately 2003 that their numbers started to surpass those educated in the UK and the US. For instance, while the percentage from the UK and the US combined was 30.2 percent in 2003 compared to 27.9 percent from the Philippines (CIHI, 2004), in 2009 those from the UK and US equalled 25 percent compared to 31.6 percent from the Philippines (CIHI, 2010). While the US remains the

16 Individuals from the Philippines also make a significant contribution to the nurse aides, orderlies, and patient services workforce in Canada, representing 25.8 percent of visible minority workers, second to black workers who comprise 40 percent of visible minority (Statcan, 2012). Those from the Philippines also make up 44 percent of childcare and home support workers in Canada, the largest visible minority group in this category, and 60 percent of babysitters and, nannies in Canada (Statcan, 2012).
destination of choice for most Philippine nurses, Saudi Arabia, the UK, South East Asia and other higher income countries such as Canada have also become popular destinations (Buchan, Kingma, & Lorenzo, 2005; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007).

We do not have specific demographics for Philippine nurses working in Canada, but data collected from 48 focus groups that include Philippine health workers in the UK report that these IENs are predominantly female, young (in their early twenties)\(^{17}\), single, and come from middle income backgrounds\(^{18}\) (Lorenzo et al., 2007). A few of the migrant nurses have acquired a Master’s degree and, the majority hold a Bachelor of Science in Nursing (BSN) degree (Lorenzo et al., 2007). Some have specialization in ICU, ER, and OR and have rendered between one and 10 years of service before migration (Lorenzo et al., 2007). Although some nurses working overseas eventually return to live in the Philippines, it appears that the majority do not, and others may return temporarily while en route to another job abroad (Lorenzo et al., 2007).

It is interesting to note that migration is not an option for everyone in the Philippines. In an ethnographic account of Philippine migrants working as domestics in Taiwan, participants report that not everyone can work abroad; rather, migrants have to be sufficiently educated, have adequate funds to secure employment abroad, and have a serious and determined nature (Lan, 2003). Thus, migratory flows from the Philippines are selective, as the poor or unemployed seldom migrate (Lan, 2003).

\(^{17}\) Although this study reports that Philippine nurses are predominantly in their early twenties, this may not be the case for those working in Canada. It is reported that the average age of IENs writing the CRNE was over 30 years of age (CNA, 2008).

\(^{18}\) In the Philippines the majority of families live in poverty and a middle income status does not constitute a comfortable and secure lifestyle (Parrenas, 2001).
Implications for nurse migration experiences.

Since the demand for nurses in higher income countries is related, at least in part, to an underinvestment in nursing practice environments, IENs may be in jeopardy of filling RN positions deemed less desirable by others (Allan & Larsen, 2003; Bach, 2003; Ball, 2004; Choy, 2006; Kingma, 2006). In a study commissioned by the Royal College of Nurses (RCN) that explores the motivations and experiences of IENs working in the UK, IENs claim they are exploited in a variety of ways, but most commonly by managers who use them to cover undesirable shifts (Allan & Larsen, 2003). Other studies from the UK indicate that IENs may face discrimination in terms of access to employment and be at risk of assignment to the lower echelons of the job market more than would be expected on the basis of their education (Bach, 2003; Smith et al., 2007). Another study compares the labour and human rights of Philippine nurses working in the UK with those working in Saudi Arabia. The author argues that IENs in both countries often occupy marginalized and racialized positions since they typically fill positions that, for a variety of reasons, domestically educated nurses are unable or unwilling to fill (Ball, 2004). Further, data from an Australian study shows a disproportionate concentration of IENs working in the least prestigious nursing homes (Hawthorne, 2001). Unfortunately, we do not have data to inform us about the nature of IEN employment in Canada.

Structures Compelling Nurses to Migrate

The demand for nurses in higher income countries may foster nurse migration, but the literature suggests there are also a variety of social, economic, political, and historical conditions that further compel nurses in lower income countries to seek employment abroad. As mentioned in the introduction of this thesis, nurse migration is frequently conceptualized in terms of ‘push factors’, or, conditions or circumstances causing discontentment in source countries, and ‘pull
factors’, or conditions or circumstances making destination countries more attractive (Kingma, 2006; Kline, 2003). Push factors compelling nurses to migrate often include things such as low pay, poor working conditions, unemployment, and political instability; whereas pull factors enticing nurses to seek relocation may include opportunities for better pay, improved working conditions, and professional advancement (Kingma, 2006). However, it is also argued that most migration does not begin with a rational decision to migrate; rather, it is initiated by enticements made to people who previously had no intention of doing so (Mahler & Pessar, 2001). For nurses from the Philippines, enticements can take the form of government policies; an Americanized model of nursing education; job opportunities promoted by recruitment agencies; financial incentives; and family and social networks. I begin this section with an overview of these various conditions and will conclude with how they may influence nurse migration experiences.

**Pressure from the Philippine government.**

It is widely acknowledged that overseas labour policies initiated by the Philippine government compel many nurses to migrate (Buchan, 2006; Choy, 2006). Although the Philippines has a long history of migration, it is only since the early 1970s that there has been massive and state-encouraged movements of workers and immigrants; movements that have become part of the country’s everyday life (Rafael, 1997). In the early 1970s, as an attempt to alleviate unemployment and revitalize a failing economy, President Ferdinand Marcos initiated a ‘labour export policy’ and started to actively promote the export of nurses and labourers (Choy, 2006; Sarvasy & Longo, 2004). This led to the establishment of the Philippine Overseas Employment Authority (POEA) and the Office of Workers Welfare Administration (OWWA) to encourage international migration and to protect citizens working abroad (Choy, 2006; ICN, 2005; Kingma, 2006; Sarvasy & Longo, 2004). Previously nurse migration initiatives had been
established to promote cultural and technological advancement but this new labour policy transformed nursing into a nation building enterprise (Choy, 2006). Under it, Philippine educated nurses working abroad became national heroes through their remittances of foreign currency back home (Choy, 2006; Guevarra, 2010). According to Choy (2006), Marcos’ address to the Philippine Nurses Association (PNA) at the 1973 convention in Manila revealed this new commitment to exporting nurses when he stated:

> It is our policy to promote the migration of nurses…We intend to take care of [Filipino nurses] but as we encourage this migration, I repeat, we will now encourage the training of all nurses because as I repeat, this is a market that we should take advantage of. Instead of stopping the nurses from going abroad why don’t we produce more nurses? If they want one thousand nurses we produce a thousand more [sic] (Choy, 2006, p. 115-116).

President Marcos encouraged Philippine nurses working abroad to earn for the country as well as for themselves and as such, recommended that they participate in the dollar repatriation plan by depositing their money in a bank that had a correspondent bank in the Philippines (Choy, 2006). To further show its appreciation and support for workers who sought employment abroad, the Philippine government developed economic and legal means to ease their return to the Philippines and allowed them to bring home duty free purchases (Glick Schiller, Basch, & Blanc-Szanton, 1992). While previously Philippine nurses working abroad had been viewed as abandoning the Philippines, they were now perceived as national heroes and an important economic development strategy (Choy, 2006). Indeed, the economy of the Philippines depends heavily on remittances from nurse and other migrant labourers working abroad (Buchan, 2006;  

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19 The purpose of the PNA is to promote professional growth towards the highest standards of nursing. As such, it directs its attention to the provision of programs to enhance the competencies of Filipino nurses to be globally competitive (PNA, 2011). The association is a member organization of the ICN (PNA, 2011) and accordingly has a voice in advancing nurses and nursing worldwide and influencing health policy (ICN, 2013). It has numerous chapters in Europe and the Middle East, as well as in the Philippines.
Guevarra, 2010; Kingma, 2006). It is estimated that the total mass of migrants from the Philippines remit eight billion US dollars annually (Kingma, 2006).

In *Marketing Dreams, Manufacturing Heroes*, Guevarra (2010) also provides insight into how the market economy of the Philippines is sustained by labour migration. She contends that in order to produce responsible economic citizens the government has created a culture of sacrifice whereby workers have become both objects and subjects of the state: as the country’s resources they are commodified as objects of the state and offered globally in exchange for national economic survival; and as national heroes and ambassadors of goodwill they are subjects of the state and conditioned to save not only their families but the nation through their remittances (Guevarra, 2010). Empowering them by culturally inscribing them as heroes and ambassadors, the government is manufacturing a workforce that can effectively compete in the global marketplace (Guevarra, 2010). Guevarra further argues that while the Philippine government institutionally and ideologically conditions its citizens to believe their future resides outside the Philippines, it maintains that overseas migration is a matter of choice. She asserts that this strategy of empowerment, whereby the responsibility for economic livelihood is shifted onto citizens, reflects a combination of neo-liberal market rationality of economic competitiveness and entrepreneurship and Western values of freedom, individualism, rationality and self-accountability. Moreover, she puts forth that it represents a gendered and racialized moral economy; gendered because women migrant workers’ productivity is informed by the state’s perception of women and racialized because it hinges on the construction of a culturally essentialist notion that Philippine citizens are ideal labour objects or commodities.

Shedding further light on the gendered nature of the Philippine economy, sociologist Rhacel Salazar Parranes (2008) describes the Philippine’s contradictory stance towards the work
of women. On the one hand, its society generally considers that women should assume responsibility for care work in families, values reflected in the 1986 Constitution of Philippines and the 1987 Family Code that construct women as wives and mothers. Yet on the other hand the government promotes the deployment of women workers to help it pay the interest it owes on loans from multilateral institutions such as the World Bank. As she points out, the Philippine government encourages women to leave their home at the same time it reaffirms the belief that they belong inside the home and, indeed, the majority of migrant workers are women and many are re-locating with or without men. Moreover, in its reliance on women to travel abroad and fill low wage positions as nurses and domestic workers in higher income countries it ironically retains the notion of women’s domesticity and gender inequality (Parrenas, 2008).

Further, it is argued that this neo-liberal framework for managing labour migration is a product of colonial and neo-colonial relations (Choy, 2006; Guevarra, 2010; Kingma, 2006; Parrenas, 2008; Rafael, 1995,1997). For instance, the nation’s conversion to Christianity during Spanish occupation from 1565 to 1898 is reflected in the narratives of suffering, sacrifice, and martyrdom that underpin the economic framework. As well, colonial relations with the US between 1898 and 1945 that resulted in economic and trade policies detrimental to the country’s long term economic development, contributed to a vulnerable economy that became receptive to an overseas employment strategy. It is also put forth that the reorganization of the country’s political and educational system under the directive of the President McKinley’s 1898 ‘benevolent assimilation proclamation’ strategy was a pre-condition of contemporary migration (Guevarra, 2010; Rafael, 1995). Rafael (1995), a historian often cited for his research on Spanish and American colonial relations with the Philippines, asserts that in an attempt to govern or control the people of the Philippines the US constructed a parent/child relationship with them: it
infantilized them as racial ‘others’ in need of nurture and education. Just as the Spaniards before them had sent missionaries to convert individuals to Catholicism as a means of having them submit to Spain’s colonial authority (Guevarra, 2010), the Americans built public schools and sent teachers to transform the people into a type of American citizen that embraced an American way of life (Guevarra, 2010; Rafael, 1995).

**Familiarity with an Americanized model of nurse education.**

Idealization of an Americanized model of nurse education is another condition compelling nurses to seek overseas employment. Historian Catherine Choy (2006) who has written a detailed analysis of Philippine nurse migration to the US argues that contemporary international migration of Philippine nurses is inextricably linked to early 20th century US colonialism in the Philippines. In her master’s thesis, Ronquillo (2010) also argues that colonial relations between the Philippines and the US continue to shape experiences of nurses educated in the Philippines as they transition into the Canadian workforce.

In addition to the development of an Americanized education system in the Philippines under President McKinley’s ‘benevolent assimilation proclamation’ strategy, the creation of an Americanized training hospital system that included the promotion of English language fluency and the establishment of gendered notions of nursing as women’s work, during the US colonial period helped to lay the foundation for the eventual mass nurse migrations in the second half of the 20th century (Choy, 2006).

It is also proposed that the Philippine government’s support for the establishment of a large number of private nursing schools\(^\text{20}\) to produce nurses qualified to compete for overseas employment.

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\(^{20}\)The number of schools in the Philippines grew from 63 in the 1970s to 370 nursing schools in 2004 and most of these were private institutions (Kingma, 2006).
employment, is a factor contributing to nurse migration (Guevarra, 2010; International Labour Office, 2005; Kingma, 2006; WHO, 2006). As many as 200 applications for new nursing programmes were submitted for the 2004-05 school year alone (International Labour Office, 2005) and there are approximately 460 nursing colleges that offer BSN programs and graduate approximately 20,000 nurses annually (Lorenzo et al., 2007). To put the number of nursing graduates per year in the Philippines into perspective, in 2010 there were roughly 179,000 examinees taking the board exam in the Philippines (ABS-CBN News, 2011) while in Canada with a population roughly one-third of the Philippines, during the same year, there were approximately 10,500 examinees taking the CRNE, or approximately one-seventeenth of the examinees in the Philippines (CNA, 2011a; CNA, 2011b).

**Enticements from recruitment agencies.**

In a competitive labour market, the international migration of nurses offers endless opportunities for related business ventures (Castles & Miller, 2009; Kingma, 2006). For example, nurse recruiters, travel agencies, banks and telephone companies, in addition to nursing schools, have turned nurse migration into profitable businesses (Kingma, 2006). It is reported that nurse recruitment generates approximately three trillion dollars per year in the Organization for Economic Cooperation and Development (OECD) countries (Kingma, 2006).

Statistics from a London based survey indicate that 96 percent of respondents from the Philippines reported that a recruitment agency had been involved in their move and that the agency was based in their home country (Buchan et al., 2005). Although, we do not know the number of Philippine educated nurses residing in Canada who have sought the services of recruitment agencies, it can be anticipated that many have visited the numerous websites that offer online services encouraging IENs to migrate for Canada. Further, it is known that in 2008
the province of Saskatchewan recruited 108 nurses from the Philippines (Saskatoon Health Region, 2008) and the same year a provincial recruitment team from Manitoba made conditional offers of employment to a group of 131 nurses from the Philippines (Recruitment Canada, 2008).

In BC, Health Match BC, a free health care recruitment service funded by the Government of BC, claims to have successfully recruited thousands of Canadian and internationally educated health care professionals (including RNs) on behalf of facilities around the province since its inception in 1999 (Health Match BC, 2012). However, though they send nurse recruiters to attend career fairs or nursing conferences in Canada, the UK, and the US they refrain from actively recruiting health care professionals from developing countries. But they take the position that individuals have the right to migrate globally to advance their careers and lives and consequently do not deny health professionals from a developing country any recruitment information (Health Match BC, 2012).

**Financial incentives.**

Limited opportunities for employment and poor working conditions and salaries at home are commonly cited as factors promoting Philippine nurse migration (Lorenzo et al., 2007). Based on a production and domestic demand model, the Philippines has a net surplus of RNs: of the total number of nurses registered in the Philippines in 2003, only 58 percent were employed as nurses either in the Philippines or internationally and the majority (84.75 percent) were working abroad (Lorenzo et al., 2007). While it appears that the Philippines are overproducing nurses, there are also reports that they are underutilizing them. In 2003, it was estimated that funding shortages contributed to an estimated 30,000 unfilled nursing positions (Bach, 2003). Thus, there are many nurses in the Philippines professionally qualified but without employment (Kingma, 2006). In her comprehensive analysis of nurse migration, *Nurses on the Move*, Kingma
(2006) refers to this as a modern paradox: nurses willing to work but refused positions by national health systems unable to absorb them, not for lack of need but for lack of funds and/or sector reform restrictions.

Additionally, the disparity between salaries in the Philippines and those abroad makes overseas employment an attractive alternative for many. For instance, while the average monthly salary in 2005 for a professional nurse in the Philippines was 144 US dollars (Worldsalaries, 2005) the hourly wage rate for a new RN graduate in BC is approximately 31 US dollars (HEABC, 2012). Thus, working abroad is viewed by many not only as an opportunity for employment, but as an opportunity to vastly improve their standard and their family’s standard of living (Hefti, 2003; Parrenas, 2001).

A desire for a better future for their families.

In her analysis of the difficulties of family separation and re-unification among domestic workers in BC, many of whom are RNs educated in the Philippines, Geraldine Pratt (2012) draws attention to the fact that hopes for brighter futures for their children were central to many women’s narratives. Despite the fact that Philippine society constructs women as wives and mothers, concerns for a better future for their family inspire many to seek employment abroad (Lorenzo et al., 2007; Pratt, 2012). Indeed, migration offers many migrants from the Philippines and their families an opportunity to escape poverty and advance their social status (Parrenas, 2001). It is estimated that nurses from the Philippines working abroad remit more than 800 million dollars annually to their families (Jeans et al., 2005) and statistics from a London based survey indicate that three-quarters of respondents from the Philippines regularly remit money, while respondents from other countries are less inclined to do so (Buchan et al., 2005).
Additionally, migration of one family member may be viewed by some families as a means to facilitate their own migration (McKay, 2002).

**Encouragement from social networks.**

While nurses may be subject to pressures at home to migrate, they also may be encouraged by social networks, in the form of families, friends, and colleagues, living abroad. It is not uncommon for nurses from the Philippines to emigrate in cohorts or to go where relatives or friends live (Choy, 2006). It is suggested that such networks can be important sources of support and identity and can reduce costs and risks associated with migration (Bach, 2003).

Rafael (1997) offers further insight into how those working overseas have become catalysts for migration. He describes how the Marcos regime in 1973, as part of its plan to improve the economy, offered incentives to balikbayans, or those living abroad as permanent residents primarily in the US, to return to the Philippines as tourists. Rafael puts forward that balikbayans were treated with the deference usually accorded foreigners and encouraged to be consumers. As such, balikbayans have come to symbolize to those who remain in the Philippines the fulfillment of desires realizable only outside of the Philippines.

Thus migration is a social issue. It rarely involves isolated social beings making a decision to migrate; rather, it is about individuals within the context of families and other social networks deciding to migrate (Foner, 2003; Glick Schiller, 2003). Moreover, in the case of the Philippines, migration has become a way of life; one that defines aspirations and is seldom absent from the everyday experiences of a large proportion of the population (Choy, 2006; Guevarra, 2010; Kelly, 2000; Pratt, 2010; Rafael, 1997; Ronquillo, Boschma, Wong, & Quiney, 2011). It is this “culture of migration’ that underpins the desire for nurses to seek work abroad (Choy, 2006; Guevarra, 2010).
Implications for nurse migration experiences.

While the literature offers insights into a variety of conditions that compel nurses educated in the Philippines to seek employment abroad, it also reveals that these same conditions influence a nurse’s capacity to gain overseas employment and the nature of employment ultimately attained; shape social and financial status; and may inadvertently alter family relationships.

Job opportunities and reception in destination countries.

Guevarra (2010) suggests that the Philippine neo-liberal framework for managing labour migration that encourages workers to become national economic heroes renders them vulnerable to exploitation both in the Philippines and overseas. For instance, she claims that this strategy instills a determination in workers to succeed at all costs. She also argues that the “added export value” assigned to nurses educated in the Philippines makes them vulnerable as it generates a standard upon which foreign employers determine their expectations and measure nurse performance (p. 127). As well, she contends that nurses educated in the Philippines may be more likely to tolerate unpleasant working conditions because they may believe their overseas employment opportunity is the only means to their survival.

It is also suggested that the commercialization of nursing education poses a threat to the quality and reputation of Philippine nurses (Buchan et al., 2005; Lorenzo et al., 2007; Xu, 2007). Kingma (2006) proposes that as the educational sector in the Philippines forges more businesses, boundaries between scholarship and commerce are at risk of becoming blurred. Brush and Sochalski (2007) report that many of the new nursing schools in the Philippines are administered by portable deans (deans with administration responsibilities across a number of schools); have ghost faculties (faculties who are listed as faculty but are never seen or available to students);
and have inadequate curricula. It is speculated that such conditions caused the government to close 23 nursing in 2004 (Brush & Sochalski, 2007). It is further revealed that an increase in nursing schools has been accompanied by a corresponding decline in the number of nurses who pass the Philippine national nurse licensure examination (Brush & Sochalski, 2007). Between 2001 and 2004 only 45 to 54 percent of the nurse registration applicants passed the exam compared to a national pass rate of 85 percent in the 1970s and 1980s (Brush & Sochalski, 2007). More recent reports indicate that the national nurse licensure examination pass rate continues to be low, with a pass rate of 41.4 percent in July 2010 and 35.25 percent in December 2010 (ABS-CBN News, 2011).

In 2006 it was again reported that the national regulatory body of the Philippines had difficulty enforcing and maintaining educational standards, consequently compromising students’ performances on licensing exams and ultimately their opportunities for international employment (Kingma, 2006). After disclosure in June 2006 that questions for the national examination had been leaked to hundreds of applicants, officials and industry officials warned that the country’s status as a top worldwide source of nurses could be jeopardized (New York Times, 2006).

Recruitment agencies or large scale recruitment campaigns may also influence overseas RN employment experiences and there is increasing concern that these services place IENs at risk of exploitation and abuse (ICN, 2007a). Although I am unable to find literature that addresses the impact that recruitment services may have on nurse migration experiences in Canada, a study conducted in the UK by Smith et al. (2007) is of comparative interest. It reveals that recruitment and employment patterns can shape migration experiences both positively and negatively. For instance, active recruitment of nurses in a group may facilitate the establishment
of strong social networks and ultimately enhance social adjustment but it also may interfere with
career progression (Smith et al., 2007). It is speculated that members of a group tend to avoid
advancement for the sake of group solidarity (Smith et al., 2007). For those who individually
secure the use of a recruitment agency, it is reported that they are at risk of being hired under
false pretences, may be misled about employment conditions, or are charged excessive
recruitment fees (Smith et al., 2007). While exploitation by recruitment agencies was avoided by
those who sought employment directly from overseas employers, these nurses were at risk of
encountering underemployment in care homes (Smith et al., 2007). Such problems were less
likely to occur if employment was sought once the nurses were already located in the UK (Smith
et al., 2007).

**Family relationships.**

It is also reported that nurse migration experiences are both shaped by family
relationships and shape such relationships (Pratt, 2003, 2012). For instance, some migrants feel
that they are under pressure from their families to migrate and, moreover, to keep remitting
Additionally, they may have financial responsibilities associated with paying off debts incurred
in migrating, as well as saving to sponsor family members from abroad (McKay, 2002). It is
reported that single migrant women, due to cultural expectations imposed on single daughters,
feel especially burdened with responsibilities to provide financial assistance, particularly for the
purposes of sponsoring the education of younger siblings (Lan, 2003).

As well, migrant women often remain burdened with gendered responsibilities linked to
having children or husbands in the Philippines (Lan, 2003; Parrenas, 2008; Pratt, 2012). Though
women are socially defined as the primary caregivers, migration forces many female migrant
workers to rely on extended family members, husbands, or hired help to care for their children (Lan, 2003; Parrenas, 2001, 2008). Consequently, migration may place a considerable emotional strain on mothers who leave their children behind, and for many there is a need to distinguish their transnational motherhood from an act of child abandonment (Lan, 2003). Moreover, it is reported that migrant mothers may become "dollar mommies" with little personal closeness to their offspring (Hefti, 2003).

Long term absences or staggered migration processes can also result in changes in family relationships and can contribute to family breakdown (Hefti, 2003; Kingma, 2006; Lan, 2003; Parrenas, 2001; Pratt, 2012). For instance, husbands may feel inferior or ashamed that their wives are working abroad to support the family (Lan, 2003). If the family eventually re-unites overseas, there is a risk that conflict between traditional societal values may evolve (George, 2005; Hefti, 2003; Kingma, 2006; Parrenas, 2001; Pratt, 2003). Further, Rafael (1997) points out that for those who do acquire permanent residence abroad there is a risk that they will come to occupy an ambiguous position when they return to visit the Philippines: “Neither inside nor wholly outside the nation-state, they hover on the edges of its consciousness, rendering its boundaries porous with their dollar driven comings and goings” (p. 269).

On a positive side, it is speculated that migration may be an empowering experience for women who seek overseas employment without their families as it liberates them from traditional duties as daughters, or provides them with an acceptable method of escaping an unsatisfactory relationship or the impoverishment of single motherhood (Parrenas, 2001). Further, it may provide them with an opportunity to participate in the economic development of both their country of destination and their own country. As such, it is argued by some that women from the Philippines are not just passive victims of international commodification, but
are active agents in their decision to migrate (Parrenas, 2001; Sarvasy & Longo, 2004; UN, 2006). It has also been reported that new technology such as text messaging permitting constant contact between family members helps to maintain long-distance emotional connections (Mckay, 2007). In contrast, however, it is argued that transnational communication does not provide full intimacy to the family and ironically has become a means of retaining gender norms or reinforcing the myth of the female homemaker (Parrenas, 2008).

**Structures Influencing Entry into Professional Nursing Practice in Canada**

Once nurses from the Philippines decide to re-locate to Canada conditions embedded within social, economic, political, and historical contexts influence their ability to secure RN licensure and employment. The literature suggests that these conditions may take the form of immigration policies and professional credential assessment and recognition procedures. As well, support offered to ease integration experiences and approaches to health human resource planning may shape experiences and influence ability to secure Canadian RN licensure and employment.

**Immigration processes.**

One of the first challenges confronting IENs seeking RN employment in Canada is the task of navigating through Canadian immigration policies. Although it is frequently assumed in the literature that nurses are actively recruited to work in Canada as temporary foreign workers (TFWs) under the TFWP, most come to Canada as federal skilled workers (FSWs) or permanent residents under the FSWP (Blythe et al., 2009). However, many also enter Canada as live-in caregivers through the LCP (Health Match BC, personal communication, March 31, 2009). Each of these pathways has implications for RN licensure and future employment.
Skilled workers are economic immigrants, a category of permanent residents$^{21}$, selected for their ability to participate in the labour market and to establish themselves economically in Canada (CIC, 2007a). Prior to 1967 it is contended that immigrants to Canada were selected largely on the basis of their race (Gogia & Slade, 2011). For instance, in the early 1900s black farmers were often deemed unsuitable for the Canadian climate by immigration officials and later in the 1920s race-based immigration restrictions were intensified against the Chinese, Japanese, and South Asians (Gogia & Slade, 2011). On the other hand, during the same period the federal government created measures to increase the number of British immigrants by offering transportation assistance and other immigration incentives. Although immigration restrictions were gradually removed following the Second World War, immigration from Britain, the US, and northern European countries continued to be preferred (Gogia & Slade, 2011). With the introduction in 1967 of a point-based system to recruit skilled workers, it is suggested that overt race-based restrictions were finally removed (Gogia & Slade, 2011).

Although there have been numerous amendments to the point system over the years the general objective has remained constant: applicants are assessed for their overall capacity to adapt to Canada’s labour market (CIC, 2012e). Initially points were allocated in nine categories: education; occupation; professional skill; age; arranged employment; personal characteristics;

$^{21}$Skilled workers are selected to come to Canada as permanent residents. Permanent residence status gives a non-Canadian the right to live in Canada. However, permanent residents must comply with certain residency obligations to maintain their status. Aside from a few exceptional situations, they must be physically present in Canada for at least 2 years within a five-year period. It is necessary to have permanent residence status to be eligible for Canadian citizenship (Government of Canada, 2013).
In 2002 the point system was reconfigured and applicants were assessed on the basis of six selection criteria: education; official language ability; work experience; age; arranged employment in Canada; and overall adaptability (e.g. previous work experience in Canada, spouse’s education and relatives in Canada) (CIC, 2011a). These changes meant that points were no longer assigned for intended settlement locations in Canada and currently Canada does not have a policy that dictates skilled workers seek employment opportunities in certain regions within Canada (Success Immigration Services, 2007). Consequently, IENs who enter Canada as skilled workers can settle in any Canadian jurisdiction regardless of the demand for qualified RNs in that jurisdiction.

In 2008 further changes to the FSWP had significant implications for IENs desiring to immigrate to Canada as nursing became one of the 38 occupations that was assigned priority immigration status. Citizenship and Immigration Canada (CIC) announced that in addition to meeting the selection criteria, applicants had to have an arranged employment offer with a Canadian employer; or, evidence of one year continuous full-time (or full-time equivalent) work experience in one of 38 priority occupations; or be legally residing in Canada as a student or temporary foreign worker (CIC, 2012h). As a consequence of these changes nurses destined for Canada under the FSWP could expect to have their application for immigration expedited and processed within six to 12 months of receipt (CIC, 2012e).

Between 2008 and 2010 there was no limit placed on the numbers of IENs who could immigrate to Canada. As long as they met the selection criteria and had either an employment offer or evidence of one year continuous full-time (or full-time equivalent) work experience they
could settle in any Canadian jurisdiction. However, in 2010 CIC capped the number of new FSW applications to be processed at 20,000, not including applications with an arranged employment offer (CIC, 2013c). As well it reduced the eligibility list to 29 priority occupations and each of the occupations was capped at 1000 (CIC, 2013c). Therefore, although nursing was still considered a priority occupation, under the FSWP, the Canadian government restricted the number of nurses who could enter Canada that year.

Then, effective July 2011 another CIC amendment further limited the intake of new FSW applications by lowering the cap to 10,000, with caps for each of the 29 priority occupations set at 500 (CIC, 2013c). Consequently in 2011 there were only 500 nurses entering Canada under the FSWP and again, in accordance with CIC policy, these nurses could seek employment opportunities in any location in Canada. On July 1, 2012 on the grounds that time was needed to manage inventory pressures and to align the application process with the implementation of proposed regulatory changes to the FSW class, CIC temporarily stopped accepting any new FSW applications aside from those with a qualifying offer of arranged employment or those eligible for a PhD program (CIC, 2013c). Most recently in December 2012, CIC announced that the new selection system for the FSWP will take effect on May 4, 2013 at which time the program will re-open for applications (CIC, 2012g).

Gogia and Slade (2011) argue that although the introduction of the point system eliminated race as a criterion for immigration selection, current immigration practices and policies continue to be highly selective. By privileging education and work experience the

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22 As mentioned in Chapter One, on April 18, 2013 CIC announced that the list of 24 occupations eligible under the FSWP when it re-opens on May 4, 2013 will not include nurses. However, nurses will still be eligible to apply to enter Canada under the FSWP if they have a qualifying offer of arranged employment or they are in the PhD stream (CIC, 2013d).
selection system targets those deemed to be the “best and the brightest” (Gogia & Slade, 2011 p.57).

Concerned that many highly competent newcomers to Canada remain underemployed, the Government of Canada funded the Association of Canadian Community Colleges (ACCC) to begin offering orientation services in the Philippines, China and India on a pilot basis in early 2007 (CIIP, 2013). Canadian Immigration Integration Program (CIIP) is now a three-year program (2010-2013) that is funded by CIC to provide free pre-departure orientation to FSWs, Provincial Nominees, their spouses and adult dependents, while they are still overseas during the final stages of the immigration process. CIIP offices are located in China, India, Philippines and the UK.

*Live-in caregivers.*

In the 1960s and 1970s when individuals from the Philippines started immigrating to Canada, the majority were RNs who had been recruited by hospitals and health institutions (McKay, 2002). However, in the 1980s with the initiation of the Canadian Foreign Domestic Movement Program (FDM, many nurses from the Philippines began entering Canada as domestic workers (McKay, 2002). This program, which was re-named the Live-in Caregiver program in 1992 (McKay, 2002), brings temporary foreign workers to Canada as live-in employees to work in private households caring for children, seniors, or people with disabilities (CIC, 2007a). It is estimated that between 3000 and 4000 domestic workers, mostly from the Philippines, enter Canada each year (Pratt, 2010). To be eligible for the LCP applicants need a positive Labour Market Opinion from an employer in Canada (to show that there is a need for the foreign worker to fill the job offer and that there is no Canadian worker available to do the job); a written contract with an employer; successful completion of the equivalent of a Canadian
secondary school education; at least six months’ training or at least one year of full-time paid work experience as a caregiver or in a related field or occupation (including six months with one employer) in the past three years; good knowledge of English or French; and a work permit before entering Canada (CIC, 2012c). Despite these minimal requirements, most registered in the LCP have postsecondary education and many are nurses (Pratt, 1999, 2010).

Live-in caregivers may apply to become permanent residents after they have worked full-time for at least 24 months or a total of 3,900 hours of full-time employment within the four years immediately following their entry into Canada under the LCP (CIC, 2012a). While working under the terms of their contract they can take non-credit special interest courses, but these courses must be less than six months in duration (CIC, 2012b). They are entitled to a salary that meets at least the minimum wage; extra pay for overtime; statutory holidays; and days off each week. Employment Insurance premiums, income taxes, and Canada Pension Plan contributions are deducted from their pay and room charges may also be deducted depending on the conditions of the employment contract (CIC, 2011b).

**Temporary foreign workers (TFWs).**

Those who enter Canada as TFWs must obtain a work permit for work in Canada and a job offer before they emigrate. The permit may include certain conditions, such as the type of work they can do; the employers they can work for; and the length of time they are eligible to work (CIC, 2007b). Before being considered eligible by a provincial or territorial regulatory body to practice nursing, however, they must have their credentials assessed and recognized by a professional regulatory body in Canada (Dumont et al., 2008).

Once in Canada, TFWs can apply for permanent resident status and most provinces, including BC, have a Provincial Nominee Program to expedite this process (Baumann et al.,
The BC PNP is administered on behalf of the Province of BC in collaboration with CIC. It accelerates the Permanent Resident application process for immigrants who want to settle in BC permanently (Government of British Columbia, 2013a). It is an option that is available for business immigrants and individuals who work in one of the Strategic Occupations (e.g., nursing). The Strategic Occupations component of PNP is intended to help BC employers recruit or retain qualified foreign workers to help meet current and future labour needs. Nominee applicants under the Strategic Occupations component must have been recruited by provincial and regional health authorities administered through Health Match BC (Government of British Columbia, 2013b). Under this program employers can nominate immigrants who have the skills, education, and work experience needed to make an immediate economic contribution. It permits nurses to work in Canada for a specific employer for up to three years; it is renewable; and it also allows spouses to apply for work in Canada.

**Professional credential assessment and recognition procedures.**

Although CIC may recognize an IEN’s education and skills, RN employment in Canada is not guaranteed. Unlike immigration, RN credential regulation is a provincial or territorial responsibility, not a federal one (Dumont et al., 2008; Government of British Columbia, 2013a). Currently, regardless of their immigration pathway all IENs seeking RN licensure in Canada must have their RN credentials assessed by a professional regulatory body23 before they are eligible to write the CRNE and in BC acquire full CRNBC practising registration (CRNBC, 2011). Since credential assessment and recognition processes are a provincial and territorial

23The purpose of professional regulation is to serve and protect the public and the mandate of professional regulatory bodies is to ensure that the Canadian public receives safe and ethical nursing care from competent, qualified registered nurses. Although professional regulatory bodies have the authority to self-regulate, legislated acts ensure that they remain accountable to governments and to the public (CNA, 2007a).
responsibility, these procedures are subject to variation. However, most provinces and territories share a number of similarities (Dumont et al., 2008). In BC the regulatory college cautions applicants that the entire registration process could take from three months to three years to complete and cost approximately 1600 dollars, excluding educational fees (see Pathway to RN Licensure in BC for IENs, Appendix A) (CRNBC, 2011). In the 2005 CNA study mentioned earlier in this chapter it is estimated that the overall application process could cost an IEN as much as 20,000 dollars (Jeans et al., 2005). To initiate the process IENs must submit documentation that verifies their English proficiency, basic nursing education, and competency to practice nursing to determine eligibility for registration (CRNBC, 2011).

Eligibility for RN registration in BC is also determined by a credential assessment process, the Substantially Equivalent Competency (SEC) Assessment. This assessment can take up to five days to complete and uses four strategies to evaluate the competencies of IENs: a written diagnostic exam (including both multiple choice and short answer questions) to test the general nursing knowledge required of professional nurses in BC; an assessment interview to test problem solving and critical thinking skills; a clinical judgment assessment; and a clinical evaluation in a lab setting (Kwantlen Polytechnic University, 2013b).

If gaps in knowledge, skills and abilities are identified applicants may be required to take targeted educational upgrading (CRNBC, 2009). This may take the form of a short term RN qualifying course or a one year full-time RN re-entry program. The objectives of this latter program are to prepare IENs to practice within the Canadian health care setting; to renew and

24 Since 2007, as part of a CRNBC initiative to ensure a more efficient registration process, English language fluency has had to be demonstrated at the time of application for RN registration, rather than later in the process (Brunke, 2007).
enhance previously acquired nursing knowledge and skills; to identify and address individual needs; to ensure graduates meet the professional practice requirements; to foster effective communication skills in the workplace; and to prepare graduates to be eligible to write the CRNE (Kwantlen Polytechnic University, 2013a). In addition to theory, students must complete 500 clinical practice hours (GNIE Re-entry Program, Kwantlen Polytechnic University, personal communication, May 2012). Applications to this program are only accepted from Canadian citizens and permanent residents (Kwantlen Polytechnic University, 2013a).

Additionally, applicants must complete a monitored Canadian work experience (CRNBC, 2011)\textsuperscript{25}. Unlike the SEC Assessment, this new addition to the registration process for IENs is relatively unique to BC. It is the only jurisdiction in Canada that requires a monitored Canadian work experience, aside from Newfoundland and Labrador which require a minimum of 400 hours with a Newfoundland and Labrador employer and a satisfactory employer reference before being granted permission to write the CRNE (ARNNL, 2013).

The final step in the registration process in BC is writing the CRNE (CRNBC, 2009). The CRNE consists of 180 – 200 multiple-choice questions and candidates are given four hours to complete the test (CNA, 2007b) and three attempts to pass this examination (CRNBC, 2012a). Upon successful completion of the CRNE and a satisfactory reference from an employer following the 250 hour monitored Canadian work experience, an IEN may be granted full CRNBC practising registration (CRNBC, 2011).

\textsuperscript{25} As mentioned in Chapter One, on March 13, 2013 the RN regulatory college of BC announced that it was removing the requirement for a Canadian reference following 250 hours of practice as a professionally registered nurse and that the change will be implemented over time (CRNBC, 2013c).
Supports to ease integration.

A review of policies and reports from numerous provincial organizations revealed numerous provisions to ease the integration of IENs into the Canadian workplace after arrival in Canada. Although they do not appear coordinated, a range of support services are available to IENs, including those offered by the provincial regulatory college, trade unions, immigrant serving organizations, and professional support groups.

The provincial regulatory college.

An inspection of the BC regulatory college’s website, *Registration for International Nurses* (CRNBC, 2013d) reveals various sources of support for IENs. For instance the website includes a link to an online self-assessment for readiness to apply for registration; an outline of the registration process for foreign applicants (*Occupational Fact Sheet for Internationally-educated Nurses*); fact sheets related to English tests, the SEC Assessment, and the criminal record check; CRNE resources; workplace environments in BC; and provincial resources for new immigrants. Additionally, the website alerts IEN applicants to monthly information sessions held at the college to assist with better understanding the credential assessment and recognition procedures, English requirements, and the CRNE.

Trade unions.

Although traditionally trade unions have had a protectionist and exclusionary stance towards migrant workers with the dominant concern being erosion of wages and working conditions, they now recognize that immigration is an inevitable component of a more globalized economy (Bach, 2003; Gordon, 2005). Consequently, they have shifted their focus towards a more open and inclusionary approach to internationally educated professionals and are beginning to draw migrants into union membership (Bach, 2003). This shift in perspective is reflected in
the information provided for IENs at the British Columbia Nurses’ Union (BCNU) website (BCNU, 2012). BCNU claims that it recognized that establishing a practice in a new health care context can be challenging and that it is committed to working with IENs to help them understand the regulatory steps to getting RN licensure in BC. As well, BCNU funds and delivers a communication course to assist IENs to better succeed in the Canadian practice environment.

Immigrant serving organizations.

As part of its immigration and integration policies Canada offers a variety of provincial and federal programs and initiatives that are designed to facilitate the inclusion of migrants into society (Scmidtke, 2007). Indeed, it is reported that there are over 235 immigrant serving organizations actively involved in facilitating the settlement and labour market integration of immigrants in Canada (The Alliance of Sector Councils: Gateway Potential, 2013).

In BC the Skills Connect for Immigrants Program is a province–wide program designed to help skilled immigrants connect to jobs in BC that build on their pre-arrival skills, training, knowledge, and experience (Work BC Employment Services Centre, 2012). It is intended to assist those with intermediate level of English language proficiency who have become permanent residents of Canada within the last 5 years and who are unemployed or under employed. More specifically, the program provides customized services that include: qualifications assessments; career counselling; job seeking skills and support; training funds for upgrading or job specific skills training; assistance with regulating bodies or certification; and networking opportunities (Work BC Employment Services Centre, 2012).

S.U.C.C.E.S.S. is another immigrant serving organization in BC that receives provincial and federal funding to provide settlement and integration services to immigrants and their
families. It reaches out to permanent residents, live-in caregivers, refugee claimants and others (S.U.C.C.E.S.S., 2013). The Multicultural Helping House Society—Newcomers Resource Center (MHHS–NRC) is another non-profit society and charitable organization in Vancouver dedicated to helping newcomers to Canada (individuals and families) integrate into the community (MHHS, 2012).

**Professional support groups.**

In Canada, the Philippine Nurses Association of Manitoba (PNAM) has been instrumental in assisting foreign trained nurses in obtaining Manitoba Nursing Registration and offering scholarships to Filipino-Canadian nursing students. Each year, PNAM has organized a one-day workshop focusing on various health topics (Philippine Nurses Association of Manitoba, 2010). In BC IENs from the Philippines who enter Canada as domestic workers may receive professional support from the Filipino Nurses Support Group (FNSG). This group assists registered nurses from the Philippines who are doing domestic work in Canada. The group seeks to facilitate its members’ accreditation and support their personal and professional development by advancing their rights, dignity, and welfare in the Canadian workplace (Filipino Nurses Support Group, 2012).

**Health human resource planning.**

While not specific to nurses from the Philippines, the Creating Access to Regulated Employment (CARE) Centre for IENs is a program funded by the Province of Ontario to enable IENs to practice and excel in their profession (CARE, 2013). A visit to the program’s website reveals that it was initiated in the late 1990s by a partnership of health and social service agencies concerned with the high number of IENs immigrating to Ontario who were unable to practice their profession due to significant barriers in meeting regulatory requirements. Funded
by the Province of Ontario, CARE Centre continues to be a multi-partner initiative that invents, coordinates and delivers flexible, client focused education and support services, such as communication courses, networking, observational job shadowing, CRNE preparation, and professional nursing workshops. Since the fall of 2001, it has served over 1,000 IENs representing more than 140 countries. Although the CARE Centre continues to evolve and adapt to the needs of these nurses and is now located in five major cities in Ontario, it is not available in other Canadian provinces or territories.

The increasing global shortage of nurses and the globalization of labour markets have ignited the interest and concern of a large variety of stakeholders at international, national, and local levels (WHO, 2006). At the international level, organizations such as the ICN, the WHO, the International Centre on Nurse Migration (ICNM), the United Nations (UN), and the OECD, have developed numerous policies and initiatives to address these issues.

Recognizing that combined pressures of an increased demand and a decreased supply have led to heightened competition for nurses and that quality health care depends on qualified nursing personnel, the ICN and its member national nurse associations, including the CNA, has been committed to establishing policy and strategies key to ensuring an adequate supply of nurses and to meeting nurses’ individual needs (ICN, 2007b). In its Position Statement, *Nurse Migration and Retention*, ICN (2007b) asserts that the retention of nurses plays a critical role in the migration of nurses and calls on governments, employers and nurses to promote positive practice environments. It also argues that nurses have the right to migrate as a function of choice and acknowledges the potential benefits of migration, including learning opportunities and the rewards of multicultural practice. However, the ICN recognizes that international migration may have an adverse effect on the health care of source countries and that nurses who do migrate may
be particularly vulnerable according to the employment situation in a receiving country. Therefore, to support its position on migration and retention ICN (2007b) makes numerous recommendations including: promoting the important link between positive practice environments and nurse retention; developing appropriate human resources planning and ethical recruitment strategies; providing orientation for migrant nurses on the local cultural, social and political values, and on the health system and national language of the country; ensuring that migrant nurses have conditions of employment as favourable as those holding similar positions; and ensuring that distinctions not be made among migrant nurses from different countries.

Conscious of the global shortage of health personnel and recognizing that an adequate and accessible health workforce is fundamental to an integrated and effective health system, the WHO adopted the WHO *Global Code of Practice on the International Recruitment of Health Personnel* (WHO, 2010). Similar to the ICN, the WHO cautions member states and other stakeholders to take measures that ensure all migrant health personnel are offered appropriate orientation programs enabling them to operate safely and effectively within the health system of the destination country and that they receive treatment equivalent to domestically trained health workers (WHO, 2010).

At the national level the CNA has been active in seeking greater clarity in understanding issues related to nurse shortages and nurse migration and in developing measures to enhance IEN integration (Little, 2007). Although it repeatedly calls for measures to retain nurses in the workplace and to increase the domestic production of nurses, the CNA also recognizes the right of individuals to migrate (Little, 2007). As such, it has developed a line of support products under the title of LeaRN to help nurses make informed decisions before coming to Canada (Little, 2007). The CNA also spearheaded a project to understand issues related to the increasing
number of IEN applicants and their integration into the workplace. The report emanating from this project, *Navigating to become a nurse in Canada: Assessment of international nurse applicants*, reveals a lack of communication or coordination between regulators, employers, unions, educators, government and community agencies. Further, it offers numerous recommendations, including: the establishment of a national IEN assessment service; development of nationally standardized, flexible bridging programs to ensure IENs are competent to meet Canadian nursing standards; and a principled, comprehensive, and collaborative approach to ethical recruitment practices (Jeans et al., 2005). However, the report also acknowledges that recruitment of IENs as a solution to the shortage of nurses in Canada has not been well received by everyone (Jeans et al., 2005). Those opposed to IEN recruitment argue that it is symptomatic of a failure to address underlying domestic recruitment and retention issues and that it is not a cost-effective solution to Canadian nurse shortages (Jeans et al., 2005).

Indeed, it is estimated that the cost of recruiting one IEN could be approximately 20,000 dollars, once costs pertaining to recruiter salaries, credential assessment and recognition procedures, and educational upgrading are taken into consideration (Jeans et al., 2005).

Another noteworthy report, *Building the Future: an integrated strategy for nursing human resources in Canada*, published by the Nursing Sector Study Corporation, examines the nursing workforce and related human resource issues for all three regulated nursing professions in Canada (Licensed Practical Nurses (LPNs); RNs; and Registered Psychiatric Nurses (RPNs) (Baumann, Blythe, Kolotylo, & Underwood, 2004). In addition to strategies to enhance nurse retention, the report lays out recommendations to facilitate the integration of IENs into Canadian society. For example, it suggests that transition planning, licensure, and educational standards be
implemented and that efforts are made to prohibit unethical ‘poaching’ of nurses from developing countries.

More recently, in 2009, the CNA prepared a study that further addresses efforts to promote self-sufficiency and reduce dependence on international recruitment. Although it is predicted there will be a shortage of approximately 60,000 nurses by 2022, it is also argued that this shortage could be eliminated if Canada reduces dependence on IENs by 50 percent and makes an effort to increase RN productivity, reduce RN absenteeism and attrition, and increase enrolment in RN education programs (Murphy et al., 2009). It is recognized, however, that a move toward self-sufficiency may have negative as well as positive implications for IENs. From a negative perspective, self-sufficiency may reduce opportunities for foreign employment and consequently the potential for professional advancement and improved standards of living; from a positive perspective it may result in the creation of better working conditions for those who migrate (Little & Buchan, 2007).

**Implications for nurse migration experiences.**

A review of the literature suggests that the complexity of processes that confront nurses educated in the Philippines when they arrive in Canada may both facilitate and impede their ability to acquire a Canadian RN credential. Indeed, Canadian immigration processes, professional credential assessment and recognition procedures, support services, and health human resource planning strategies appear to intersect at various levels to shape nurse migration experiences.

**Immigration processes.**

Reports from the literature suggest that immigration policies may significantly influence migration experiences in a variety of ways. For instance, Canadian policies dictating that...
skilled workers have a year of continuous full-time paid work experience may place a particular burden on nurses from the Philippines who often are faced with working for little or no money following nursing graduation due to high unemployment rates (Iredale, 2001). Consequently many need to seek work experience in Southeast Asia and the Middle East prior to emigrating to Canada to build their nursing skills and credentials (Kingma, 2007).

It is also argued that Canadian immigration policy that assigns points for education and work experience may create unrealistic expectations for nurses regarding their eligibility to practice their profession on arrival in Canada (Barry, 2002). That is, when nurses come to Canada under the FSWP, they enter on the basis of an immigration assessment not a credential assessment by a Canadian regulatory college. Consequently they face a lengthy regulatory review which may deem their competence to practice is not equivalent to that required of Canadian RNs (Barry, 2002). Indeed, ICN cautions that nurse associations must alert nurses to the fact that diplomas, qualifications or degrees earned in one country may not be recognised in another (ICN, 2007b). However, it is also reported that Canadian initiatives abroad may lack accurate information about nursing in Canada (Jeans et al., 2005).

As well, Canadian immigration policy has implications for those who arrive in Canada under the LCP. Restrictions preventing domestic workers from participating in educational activities or pursuing RN employment during their LCP contract cause many to abandon nursing (Blythe et al., 2009; Jeans et al., 2005; McKay, 2002; Pratt, 1999). Consequently, many are at risk of becoming ghettoized within marginal occupations (McKay, 2002; Pratt, 2003). The frustration associated with this situation is exemplified by a comment from one domestic worker in a Vancouver based research project who remarked that though she was still an RN in Canada, in Philippines she had been a “Registered Nurse” while now she was a “Registered Nanny”
However, it is also suggested that the risk of becoming deskill may be related to a commitment to send remittances to families in the Philippines or to sponsor their immigration (Pratt, 2010). In addition to being at risk of underemployment, it is also argued that LCP regulations stipulating that domestic workers must complete their live-in caregiver responsibilities before obtaining permanent resident status and family reunification put many at risk of exploitation, and family breakdown (Pratt, 1999, 2003, 2012).

**Professional credential assessment and recognition procedures.**

Professional credential assessment and recognition procedures can also profoundly affect nurse migration experiences. In many countries acquiring the necessary credentials for professional nursing practice can be a lengthy and costly process (Bach, 2003). Canada is no exception and as mentioned earlier in this chapter, a significant number of IENs never become registered (Jeans et al., 2005). Challenges interfering with registration include: problems related to locating information from regulatory bodies; lack of standardization of credential assessments between provinces or regulatory bodies; credentialing expenses; navigating bewildering sets of licensure requirements; acquiring necessary documentation from nurse education programs; finding a space in a RN bridging program; and passing language tests and the CRNE (Jeans et al., 2005). Many IENs also report that they find the culturally based nature of the exam and its multiple-choice format particularly challenging (Jeans et al., 2005).

Statistics gathered from the CNA (2008) regarding CRNE pass rates appear to support the findings in nursing studies. In 2007 approximately 71 percent of IENs passed the CRNE on

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26 In Canada there are 25 regulatory bodies and applicants can apply to more than one regulatory body at the same time. That is, they may apply for licensure and registration with regulatory bodies for RNs, LPNs, and registered psychiatric nurses (RPNs) located in different provinces and territories (Jeans et al., 2005). Each has different credentialing requirements that necessitate different assessment procedures (Jeans et al., 2005).
their first attempt, compared with approximately 95 percent of Canadian-educated first-time CRNE writers. The failure rate, however, appears to fluctuate according to country of education. For example, IENs from countries such as the Philippines and India have traditionally higher initial failure rates than IENs from countries like the US and the UK, which have the same language and a similar health care system and nursing role as Canada (Little, 2007). More recent statistics indicate that IENs continue to do poorly on the national exam compared to Canadian educated nurses. In 2011 only approximately 50 percent of internationally educated first time CRNE writers passed the exam, compared to about 87 percent of Canadian educated first time writers (CNA, 2012b).

In the 2006 study of IENs residing in Ontario (Baumann et al., 2006; Baumann, Blythe, & Ross, 2010; Blythe et al., 2009) it is also noted that IENs experience numerous credentialing challenges. For instance, it is reported that IENs lack adequate access to support resources and to information at each stage of the migration process. Many nurses claim they would have been able to prepare documentation prior to emigration if they had understood national licensing processes in advance (Baumann et al., 2006; Blythe et al., 2009). Cost of language tests may be a deterrent for IENs who are unemployed or working in low-paying jobs. Further, the study suggests that the urban location and temporary nature of bridging programs make accessibility problematic (Baumann et al., 2006; Blythe et al., 2009).

Expense associated with credential assessment and recognition requirements was also a constraint noted by Pratt (2003, 2012) among domestic workers seeking Canadian RN licensure. As she noted, following completion of their LCP responsibilities, women have little money and often work multiple, insecure jobs in order to save enough to bring their families to Canada or to meet their financial obligations at home in the Philippines. Another Canadian study that focuses
The latter study also suggests that inadequate daycare services and lack of childcare subsidies make it difficult for women to engage in full-time positions or to enrol in English language or re-certification programs (Man, 2004).

A further study that explores the experiences of IENs in their efforts to gain entry to practice as RNs in Ontario, suggests that IENs progress through a three-phase journey in their quest for registration (Sochan & Singh, 2007). These phases include: (1) hope – wanting the Canadian dream of becoming an RN; (2) disillusionment – discovering that their home-country nursing qualifications do not meet Ontario RN entry to practice; and (3) navigating disillusionment – living the redefined Canadian dream by returning to nursing school to upgrade their nursing qualifications (Sochan & Singh, 2007). One study participant stated that “becoming a nurse in Canada is something like a ‘big mountain is in front of me’. It’s like an obstacle. Always I fear some difficulties” (Sochan & Singh, 2007, p.134).

Acknowledging that there are significant challenges associated with foreign credential assessment, Barry and Ghebrehiwet (2012), ICN consultants, nevertheless recommend numerous strategies to reduce barriers to migrating nurses. For instance, they put forth that regulators need to ensure that information pertaining to regulatory requirements, policies, and processes be clear, accessible, efficient, and transparent. Additionally, they contend that to reduce the likelihood of governments intervening in regulation, regulators must be able to articulate the rationale for regulatory requirements to applicants, employers, governments, and the public. Further, they argue that regulatory colleges provide IENs with sufficient information on the expectations of
practice and that employers and colleagues offer IENs ample support during their integration into the new practice setting.

**Entry into the workplace.**

There is growing recognition that nurse migration is becoming more prevalent as higher income countries, such as Canada, struggle to fill vacancies created by nurse shortages (Buchan, 2002; Kingma, 2007; WHO, 2006). In contrast, there is a dearth of nursing literature addressing the ease with which these nurses find employment in destination countries.

As noted earlier, although the ICN (2007b) supports the right of nurses to pursue professional achievement and attempt to better their living and working circumstances, it also cautions that career moves may negatively affect nurses’ lives. It describes how the absence of international recognition of nursing diplomas, post-basic studies, or degrees can be a source of frustration and that many internationally recruited nurses have reported that they would have preferred to remain at home in their own culture, close to family and friends.

Bauman (2006) suggests that the ease of entry into the Canadian workplace is in part dependent on the state of the job market. However, literature pertaining to skilled immigrants in general reveals that job opportunities may also be shaped by systemic inequities such as employer preference for Canadian education, training and experience. Preferences that some argue are forms of systemic racism that unfairly constructs immigrants as unskilled labour (Creese & Wiebe, 2009). As a consequence, skilled workers are denied access to the occupations they previously held; are forced to switch careers; and experience loss of social status (Bauder, 2003). Further, such preferences create an unjust division between Canadian-born and immigrant labour (Bauder, 2003) and ultimately put new arrivals at detrimental risk of economic, social,
and health consequences (Beiser, 2005; Creese & Wiebe, 2009; Gogia & Slade, 2011; Shields, Kelly, Park, Prier, & Fang, 2011).

Reflections on the Literature

While the Canadian nursing literature illuminates many challenges associated with acquiring Canadian RN credentials and employment, it appears to be deficient in a number of areas. First, analyses typically focus on economic and health policy issues and the voices of nurses themselves are often overlooked. Indeed, the statistical and impersonal nature of many of the reports contributes to the objectification of IENs. As well, the literature mostly groups IENs together, regardless of their source country, and thus renders unique needs and characteristics invisible. Additionally, nursing reports and studies tend to focus on IEN transition and integration issues in Canada and do not address the broader context of nurse migration. Also, the interplay between structure and agency (e.g., how nurses may both resist and be constrained by structures and also contribute to the very oppressions that shape their experiences) is typically disregarded. Finally, studies that explore the power inequities embedded in nurse migration experiences that have been reported in US and UK literature tend to be missing from the Canadian nursing literature.

In contrast, numerous studies in the social sciences are helpful in depicting how social relations, such as gender, race, and class, intersect within broader contexts to shape migration experiences of women domestic workers (many of whom are RNs) from the Philippines residing in Canada and raise ethical concerns related to the marginalization and exploitation of these women (McKay, 2002; Pratt, 1999, 2003, 2010, 2012). However, these studies do not specifically address experiences related to the acquisition of a Canadian RN credential. I will
return to the literature again in Chapter Nine and expand on some key elements outlined in this chapter.

**Chapter Summary**

In this chapter I have drawn on literature from the nursing sciences as well as from the social sciences to enrich my understanding of nurse migration experiences. I have also turned to the nursing literature in other countries, most notably the US and the UK, and have expanded my review to include insights from the experiences of migrants other than nurses. I have learned that nurses’ experiences in Canada may already be shaped by structures in the Philippines or in other countries prior to arrival in Canada; structures such as the prevalence of private nursing programs; Americanized nursing curricula; labour export policies; and acceptance of a neo-liberal market economy. As well, the literature revealed numerous structures at the national level in Canada (e.g., immigration policies and a nursing licensure exam), at the provincial level (e.g., provincial regulatory requirements and immigrant serving organizations), and at the local level, (e.g., education programs and the job market) that can also influence experiences once in Canada. I have also learned that experiences for those seeking RN licensure in Canada can be shaped by social relations such as class, race, and gender both in the Philippines and in Canada. Moreover, the literature suggests that IENs in general are at risk of becoming deskillled and remaining underemployed in Canada.

In the next chapter I present the theoretical framework I used to address my research question. I will argue that the perspectives of postcolonial feminism and relational ethical theory helped me to achieve a deeper understanding of the complexity of nurse migration. While the former provided a theoretical lens to unmask taken-for-granted processes that structured experiences of study participants, the latter prompted me to explore the context of decision-
making related to migration and RN licensure experiences and to raise ethical questions such as whose interests are being served by nurse migration to Canada and whose may be harmed?
Chapter Three: Surveying the Theoretical Terrain

This chapter provides an overview of the theoretical lens I used to pursue my research question as delineated in Chapter One (How do social, political, economic, and historical contexts mediated by the intersection of social relations, such as gender, race, and class, come to shape the everyday experiences of nurses educated in the Philippine as they seek RN licensure and employment in Canada?). In selecting an interpretive lens I reflected on four issues. First, I acknowledged that conditions coordinating everyday experiences of study participants may not necessarily be visible to them or to me. Second, I considered that nurse migration is a multi-dimensional phenomenon, embedded in broader social, economic, political, and historical contexts, and mediated by intersecting social relations, such as gender, race, and class. Third, I speculated that such complex conditions may constrain the ability of IENs to exercise autonomy over their own nurse migration trajectory. Fourth, I viewed my work as a catalyst for social change. To address these issues, I located the meta-theoretical context for this study within the critical theory paradigm, in particular, within postcolonial and feminist scholarship. Toward this end I drew on traditions of postcolonial feminism and relational ethical theory.

To situate my theoretical position I will commence with a brief discussion of critical theory followed by an overview of postcolonial and feminist theory. I will then turn my attention to postcolonial feminism, within the context of post-colonialism and intersectional theory, and consider how it can inform a critical and gendered analysis of Philippine nurses’ experiences in Canada. Finally, I will examine relational ethical theory and deliberate on how it directed me to pay attention to the context that shapes decision-making for nurses from the Philippines as they progress along a trajectory towards RN licensure and employment in Canada.
However, to lend additional support to my argument for selecting this framework, I begin by reflecting further on the complexity of nurse migration.

**The Complexity of Nurse Migration**

I argue that numerous conditions support adopting both a gendered, racialized, and classed perspective on nurse migration and situating it within a relational ethics framework. To begin, nursing in Canada is a female-dominated profession (93.4 percent of the Canadian RN workforce is female (CIHI, 2012) and Canada relies heavily on women from lower income countries, especially the Philippines, to meet the demand created by its nurse shortages. These nurses possess particular class affiliations in the Philippines: they are predominantly from middle-class backgrounds and hold certain privileges that have been granted to migrants in their home country (Glick Schiller et al., 1992). However, if unable to meet Canadian professional credentialing requirements they are at risk of working in marginalized jobs in Canadian society and losing their middle-class status (Pratt, 1999, 2002, 2012). It is also worth considering that these women may be filling positions that Canadian educated nurses are unwilling or unable to fill. That is, positions that may be vacant as a consequence of an underinvestment in Canadian nursing education programs or in workplace environments. It also warrants consideration that such an underinvestment may be related to the low status assigned to nurses, or indeed to women, in many countries (Buchan, 2002, 2006). Thus, as Canada turns towards lower income countries (such as the Philippines) to address the demand created by its nurse shortages, it warrants examining whether gendered oppression is being transferred from one group of women in Canadian society to another, who happen to be from the global South.

Further, it is worth examining the nature of the conditions that compel nurses to leave their country and seek work abroad. As mentioned earlier in this dissertation, contemporary
international migration of Philippine nurses appears to be greatly influenced by American colonialism and American values related to nursing education and overseas employment. However, opportunities to work in the US or in other higher income countries may come at an emotional cost. The literature from the UK suggests that recruitment agencies, intense recruitment campaigns, or future employers may render these women vulnerable to exploitation and discrimination. As well, IENs may be susceptible to policies that discriminate against certain types of immigration visas or make it more difficult for nurses from some countries to gain RN licensure and employment. Further, while working abroad many nurses have to submit to pressures to maintain gendered responsibilities associated with parenting or supporting extended family members left behind.

It is also important to note that migration may not be a matter of choice, but rather something imposed on nurses. Indeed, conditions creating a demand for nurses in higher income countries such as Canada and those compelling nurses from lower income countries to migrate remind us to query how much control IENs have over their own actions and, as I mentioned in Chapter One, to raise ethical questions such as “whose interests are served and whose are harmed by the traditional ways of structuring thought and practice” (Sherwin, 2000, p. 76). Further, challenges encountered along the way with respect to credential assessment and recognition caution us to consider whether IENs are making informed decisions about migration.

Thus, the complex nature of nurse migration appears to necessitate an examination of nurse migration, not as an isolated phenomenon, but rather as one embedded within broader social and historical contexts that overlap at international, national, and local levels. Moreover, it seems apparent that researchers must seek ways to understand how power and oppression shape the everyday lives of nurses who migrate. For these reasons, I turned to the critical paradigm and
more specifically to postcolonial feminism and relational ethical theory. I contend that as the complexity of nurse migration began to unfold these theoretical perspectives gave rise to an in-depth understanding about how or why nurses decided to migrate to Canada, challenges confronting them upon arrival in Canada, and about how they addressed such challenges.

The Critical Theory Paradigm

Certain beliefs shape how the researcher views the world and acts in it. Such belief systems are referred to as paradigms. Paradigms are the starting points of an inquiry, determining what inquiry is and how it is to be practiced (Guba, 1990). However, because paradigms are human constructions and subject to change they are often difficult to describe, with different theorists using different conceptualizations. For the purpose of this study, I have elected to use Guba’s (1990) method of delineating paradigms. He differentiates four paradigms on the basis of how the researcher views the nature of reality (ontology); the relationship between the knower and the known (epistemology); and how knowledge is gained about the world (methodology). He refers to these paradigms as positivism, postpositivism, constructivism, and critical theory. Further, Guba (1990) contends that each paradigm has its own merits and each ultimately produces a different type of knowledge, with one not being superior to the other.

According to Guba (1990) positivism refers to a set of beliefs that is embedded in a realist ontology (reality exists “out there”); a dualist/objectivist epistemology (it is possible and necessary for the researcher to be able to view nature without altering it in any way); and an experimental/manipulative methodology (hypotheses are stated in advance, subjected to empirical testing and controlled conditions). With respect to postpositivism, Guba (1990) suggests that it is a modified version of positivism and, as such, has a critical realist ontology (reality exists but can never be fully apprehended); a modified objectivist epistemology
(objectivity can only be approximated); and a modified experimental/manipulative methodology (findings should be based on as many sources as possible, including qualitative inquiry). In stark contrast to positivism and postpositivism, constructivists believe in a relativist ontology (reality exists in the form of multiple mental constructions); a subjectivist epistemology (findings are the construction of the interaction between the knower (inquirer) and the known (inquired); and a hermeneutic, dialectic methodology (individual constructions of knowledge are elicited and refined, compared and contrasted in order to reconstruct the ‘world’) (Guba, 1990).

Finally, Guba (1990) suggests that the critical theory paradigm, similar to postpositivism, has a critical realist ontology\(^\text{27}\) (a ‘true consciousness’ exists and that values and meanings extending beyond peoples’ consciousness permeate the world, empowering some, while disempowering others); a subjectivist epistemology (values mediate inquiry); and a dialectic, transformative methodology (the task of the critical theorist is to eliminate a “false consciousness” or, to raise people from oppressive situations to a level of “true consciousness”, whereby they can begin to realize the extent of their oppression and can act to ‘transform’ the world) (Guba, 1990). However, Guba (1990) also challenges these stances, suggesting that a disjuncture exists between the realist posture maintained by critical theorists and their subjective approach to uncovering meaning. He contends that a ‘real’ reality demands an objective epistemological approach. This notion is disputed by other theorists. For instance, Schwandt (1990), citing Bernstein (1976) argues that a ‘false consciousness’ does not presuppose a ‘true consciousness’. Further, Schwandt (1990) citing Giroux (1988, pp., 192–93), contends there is a need “to ‘move beyond the language of critique and domination’ to develop a ‘language of

\(^{27}\)In contrast to postpositivists, critical theorists tend to locate reality in specific historical, economic, racial, and social infrastructures of oppression (Guba, 1990).
possibility”’ (p. 274). My own theoretical position coincides with that set forth by Schwandt. Although I attach importance to lifting false consciousness, I do not foresee the attainment of a true consciousness as a possibility.

Although a single critical theory does not exist and the critical condition is always evolving in light of new theoretical insights (Kincheloe & McLaren, 2005), all such theories possess “the power to affect progress in or transform human life” (Schwandt, 1990, p.274) Indeed, Guba (1990) argues that critical inquiry is a political act and reasons that if values enter inquiry then the choice of a particular value system has the potential to empower some while disempowering others. Thus, critical theorists are not only seeking knowledge, but they view their work as a catalyst for social change (Kincheloe & McLaren, 2005).

Beliefs underpinning the critical paradigm influenced all aspects of my study, such as “...the problem selected for study, the paradigm which to study it, the instruments and the analytic modes used, and the interpretations, conclusions, and recommendations made” (Guba, 1990, p.23). As a theoretical perspective concerned with issues of social injustice and oppression, critical theory prompted me to explore oppressions shaping migration experiences for Philippine nurses. Indeed, as a form of praxis28, it extended my gaze beyond the individual to reflect on broader social and political problems of injustice; caused me to query how these situations came to be and how they could be different; and stimulated me to uncover alternate possibilities for change and to attempt to make change happen (Chinn & Kramer, 2011). Therefore, as a critical theorist, I was not only interested in critiquing how unequal power relations based on assumptions about gender, race, and class intersected to shape nurse migration experiences, but I

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28Praxis implies a dialectical relationship between theory and practice, with each informing the other in the direction of emancipatory social change (McCormick & Roussy, 1997).
hoped that as the study unfolded study participants would become more aware of their oppressive situations and inspired to work towards change. As well, it was my intention that the research findings would encourage policy makers, Canadian educated nurses, nurse educators, administrators, IENs in general, and other internationally educated professionals to work towards change for the better.

**Postcolonial theory.**

Like many critical theories, postcolonialism is highly eclectic and difficult to define (Quayson, 2000). However, Quayson (2000) offers a possible working definition, suggesting that postcolonialism “involves a studied engagement with the experience of colonialism and its past and present effects, both at the local level of ex-colonial societies as well as at the level of more general global developments thought to be the after-effects of empire” (p 2). Cashmore (1996) tells us that:

postcolonial discourse concerns itself not only with the former colonies that gained independence during World War II, but with the experiences of people descended from inhabitants of those territories and their experiences in the metropolitan centers of the “first world” colonial powers – the Diaspora (p. 285).

It is Edward Said’s (1994) work, however, that provided me with the greatest insight into the nature of postcolonial theory. Said’s (2003) book *Orientalism* is said to have “paved the way for postcolonial studies by forcing academics in the West to re-think the relationship between the Orient and the Occident” (Ashcroft, Griffiths, & Tiffin, 2006b, p.10). Said’s (2003) main thesis is that the Western academic discipline of Orientalism was a means by which the Orient was produced as a figment of the Western imagination for purposes of consumption in the West and colonial domination (Quayson, 2000). However, not only was the “non-Western Other” constructed through contrasting images to the West and determined to be different from the Occident, the “non-Western Other” was constructed as inferior (Anderson, 2004). Drawing on
the work of Michel Foucault, Said (2003) inserted a poststructuralist problematic into the study of colonialism and used discourse analysis to discern issues of power, domination, and complex hegemony embedded in the Occident/Orient relationship (Said, 2006). Said’s (2003) work helped establish what was later to be known as colonial discourse analysis and the words ‘Orientalism’ and ‘Orientalist’ have come to mean attitudes of knowing the Third World that are meant to serve Western interests (Quayson, 2000). As stated by Joan Anderson (2000b):

“postcolonial scholars keep reminding us of centuries of colonization, diaspora, and exploitation.” (p. 145).

Thus, postcolonial discourse analysis provides a method of interrupting the essentializing discourses that classify people according to racial categories; classifications that are now understood to be socially constructed in order to define and organize relations between dominant and subordinate groups (Anderson, 2002; Reimer Kirkham & Anderson, 2002). It has become a means for uncovering how conceptions of the racialized “Other”, “race”, ethnicity, fluid identities, and hybrid cultures, have been constructed within particular historical and colonial contexts (Anderson, 2002; Anderson, Reimer Kirkham, Browne, & Lynam, 2007; Reimer Kirkham & Anderson, 2002). Accordingly, postcolonial theory cautioned me to be mindful that images and conceptualizations about nurses from the Philippines may have been developed and sustained to serve the interests of higher income countries, such as Canada, and that such conceptualizations may well cast these nurses as inferior.

As an interpretive lens postcolonial theory helped to unpack the complexity embedded in Philippine nurse migration to higher income countries such as Canada. For instance, it extended my gaze beyond local challenges encountered by nurses from the Philippines to explore how dominant ideologies shape everyday experiences of marginalization (Anderson, 2002; Anderson
et al., 2007; Reimer Kirkham & Anderson, 2002). Indeed, Philippine postcolonial theorists contend that the oppression of subaltern nations by the West continues to shape the lives of people in the Philippines (Rafael, 1993; San Juan, 2000). For instance, as noted in Chapter Two, contemporary international migration of nurses from the Philippines is inextricably linked to early 20th century American colonialism in the Philippines (Choy, 2006). In a similar vein, it is suggested that conditions of economic underemployment and national debt (repercussions of American colonization) are major forces driving Philippine domestic workers to migrate to Canada and that a study of migrant workers is a study of the processes that create global inequality (Pratt, 2004). Further, contemporary postcolonial scholars from the Philippines contend that one of their major challenges is to disrupt dominant discourse sustaining the notion that migrants from the Philippines are the natural domestic servants of the world (San Juan, 2000). Not only are such scholars concerned with exposing oppressions that shape the experiences of migrant workers from the Philippines, they also want to raise awareness of how these individuals contribute to the very oppressions that dominate their everyday world (San Juan, 2000). In this regard, postcolonial theory directed me to explore how nurses educated in the Philippines may contribute to the oppressions that hinder RN licensure and employment in Canada.

Without underestimating its significant contributions, it is important to note, however, that postcolonial theory has been criticized on several grounds. For instance, some argue that the discussion of gender is muted in the mainstream postcolonial narrative (Anderson et al., 2007; Gandhi, 1998; Reimer Kirkham & Anderson, 2002). Gandhi (1998) points out that postcolonial theory approaches epistemological questions in a universal manner, using colonialism as a principle organizing category. She contends that the all-inclusive idea of ‘colonialism’ fails to
account for the similarities between cultures, or societies, which do not share the experience of colonialism, and that such a perspective fails to account for differences in forms of colonization and anti-colonial struggles. Spivak (2006) is also critical of what she sees as a persistent essentialism underlying postcolonialism and argues that for “the ‘true’ subaltern group, whose identify is its difference; there is no unrepresentable subaltern subject that can know and speak itself” (p. 32). Further, in response to critiques of essentialism, Homi Bhabha (2006) extends thinking about culture to include the notion that culture is partial and he introduces the conception of cultural hybridity. That is, when cultures come together (as in the colonizer and the colonized), a third, or hybrid, space is created and the ‘colonized’ become active agents in negotiating and constructing new meanings (Anderson et al., 2007; Bhabha, 1994). This perception of culture reminded me that the meanings constructed by study participants about their migration experiences are not static; that their understanding of events may shift and new meanings emerge as they become more entrenched in the processes of acquiring RN licensure or employment in Canada, or indeed, as they actively participated in the research study.

As I progressed with my research, these concerns about postcolonialism reminded me that if I focus on oppressions related to colonization to the exclusion of other oppressions, such as sexism or classism, I could risk oversimplifying migration experiences. As well, they cautioned me about the hazard of essentializing nurse migration experiences and to be mindful of the differences that emerge from different accounts. For instance, I could not assume that all nurses educated the Philippines were subjected to similar colonial injustices or that they had reacted or were reacting to injustices in a similar fashion.

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29I am using the term ‘subaltern’ as adopted by Antonio Gramsci to refer to those groups in society who are subject to the hegemony of the ruling classes (Ashcroft, Griffiths, & Tiffin, 2008).
**Feminist theory.**

To further untangle the complexity of nurse migration experiences and to position nurses from the Philippines at the centre of my study, I turned to feminist theory. Although there are many variations of feminist theory within the critical paradigm, as critical perspectives they are all political insofar as they offer new visions for social change (Anderson, 1991a; Harding, 1987b). For instance, Anderson (1991a), citing McPherson (1983), contends that feminist theories serve two functions: “They offer descriptions of women’s oppression, and prescriptions for eliminating it” (p.1).

In an early attempt to reconcile the social and political nature of feminist research Harding (1987a) outlined three general types of feminist inquiry: feminist empiricism, standpoint theory, and postmodernism. According to Harding (1987a) each offers a more reliable and objective approach to inquiry than that offered by traditional science\(^3\). She argues that feminist empiricism stresses the continuities between traditional justifications of scientific research and feminist ones, but unlike scientists engaged in traditional practices feminist empiricists recognize the influence of social values on science (Harding, 1987a). Feminist standpoint theorists offer another approach to justifying the results of feminist inquiry. They contend that since traditional social scientists only raise questions that appear problematic within experiences characteristic for men (white, middle-class Western men), research findings are distorted and partial (Harding, 1987a). Thus, these theorists maintain that women should have an equal say in defining what is in need of scientific explanation and that problematics should be generated from the perspective of women’s experiences (Harding, 1987a). Therefore, both feminist empiricists and standpoint

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\(^3\)I am using the term ‘traditional science’ in this paper to refer to the traditions of positivism and postpositivism.
theorists are attempting to ground accounts of the social world which are less partial and distorted than traditional ones.

Postmodern feminists, however, negate claims advanced by both feminist empiricists and standpoint theorists that feminist struggles can tell “one true story” about ‘the world’ (Harding, 1987a). Harding (1987a) contends that there are at least two origins of scepticism about the epistemological project within which postmodern feminists are engaged. One source of criticism arises from feminists who are sceptical of any universalizing claims. These feminists argue that women do not have a unified voice; rather, many different “subjugated knowledges” exist and conflict with, and are never reflected in, the dominant stories that depict social life (Harding, 1987a). Another group of critics, according to Harding (1987a), emerges from women of colour. For instance, bell hooks (2003) argues that since there can never be one unified feminist standpoint, the commonality that binds feminists is their struggle to end sexist oppression.

While some postmodernists may be sceptical of a feminist science, others contend that postmodern feminism can advance the cause of feminism. For instance, Flax (1990) contends that postmodernism can facilitate analysis of gender relations, which she argues is the fundamental goal of feminist theory. She reasons that since postmodernism fosters scepticism about beliefs concerning knowledge, power, the self, and language, it has the potential to encourage feminist theorists to tolerate and interpret ambivalence, ambiguity, and multiplicity, as well as to expose roots of oppression.

Fraser and Nicholson (1990) also maintain that a feminist lens, embedded within postmodern scepticism, will yield the sort of theory that would be useful for contemporary feminist political practice. Addressing the tension between postmodernism and feminism, they
argue that both have complementary strengths and weaknesses: while postmodernism offers persuasive criticisms of foundationalism and essentialism, its conceptions of social criticism is weak; and feminism, while contributing to social criticism, tends to lapse into essentialism (Fraser & Nicholson, 1990). Further, these authors contend that the major advantage of a postmodern feminist perspective is that it recognizes that a single theory cannot adequately address the diversity of women’s needs and experiences (Fraser & Nicholson, 1990).

As I proceeded with my own analysis of the experiences of Philippine nurses seeking RN licensure and employment in Canada, postmodern feminism offered a means of gaining a more in-depth understanding of the oppressions shaping these women’s experiences. It directed me to place the nurses at the centre of my study; to explore the roots of their oppression; to deconstruct universals and meta-narratives that are intended to define them (e.g., that IENs from the Philippines are national heroes); and to focus on understanding multiple meanings of nurse migration. As a critical perspective it also directed me to query how situations could be different and to seek to uncover and introduce alternate possibilities for change.

Postcolonial feminist theory.

In an attempt to bring a gendered analysis to postcolonialism and to speak from the perspective of the postcolonial ‘Other’ situated in countries of the North (i.e., rich countries), some feminists have turned to postcolonial feminist scholarship (Anderson, 2002; Browne, Smye, & Varcoe, 2008). Such scholarship arises from the convergence of black feminist standpoint theory and postcolonial theory (Anderson, 2002).

31In accordance with Anderson (2002) in this study I am using the term ‘black’ to refer to “people of different shades of skin colour in a show of solidarity and coalition to resist labels such as ‘visible minority’ which, unwittingly, designate people as marginal with minority status and, therefore, inferior” (Anderson, 2002, p. 15).
To add clarity to postcolonial feminism and to explicate how such a theory advanced understanding of nurse migration experiences, I begin with an overview of black feminist scholarship, in particular intersectional theory.

**Intersectional theory.**

Intersectionality “provides a lens to address how ‘race’, gender and class relations intersect to shape material existence and the social conditions of women’s everyday lives” (Anderson, 2002, p. 11). As a theory, it offers a means of viewing how various socially and culturally constructed categories interact on multiple levels to produce social injustice (Collins, 2000; McCall, 2005; Varcoe, Hankivsky, & Morrow, 2007). Fundamental to the development of intersectionality has been the criticism put forth by black feminists that feminist scholarship has failed to address the lived experiences of black women at points of intersecting oppressions. Similar to a postmodernist criticism that feminist scholarship has a tendency towards modernity and meta-narratives, feminists of colour criticize feminism for its homogeneous categories that strive to uncover a common essence of all women (McCall, 2005; Racine, 2002). The primary philosophical consequence of such critiques has been for many feminists of colour to render the use of categories such as gender, race, and class suspect, arguing that not only do they fail to address the lived experiences of black women at points of intersecting oppressions, but they also have no foundation in reality, as they are categories that have been created by discourse (McCall, 2005).
Like other standpoint feminists, Collins\textsuperscript{32} (2000) adheres to the premise that all knowledge claims are socially situated and that some social locations are better than others as starting points for the development of knowledge. She argues for the necessity to place black women’s experiences at the centre of analysis:

Oppressed groups are frequently placed in the situation of being listened to only if we frame our ideas in the language that is familiar to and comfortable for a dominant group. This requirement often changes the meaning of our ideas and works to elevate the ideas of dominant groups (p. ix).

Moreover, Collins (2000) contends that the standpoint of black women provides a means for the ‘outsider-within’ location to foster new insights into how a variety of oppressions mutually construct one another and create different kinds of lived experiences and social realities. That is, an outsider’s social location may illuminate contradictions that are not readily apparent to white people. However, she acknowledges diversity within black women’s thought and notes that not all black women will respond to encounters in the same manner (Collins, 2000).

Intersectional theory, as set forth by Collins (2000), provided a means of learning new insights into oppressions which might otherwise have been overlooked. Currently the voices of nurses from the Philippines appear to be missing from nursing policy and education initiatives in Canada. By positioning these nurses at the centre of my study and shifting my analysis from a singular form of oppression to intersecting forms of oppression embedded within institutions (such as regulatory procedures or recruitment policies), I was able to offer new insights to the challenges encountered by IENs as they seek RN licensure or employment in Canada.

\textsuperscript{32}While numerous black feminists have offered insights into intersectionality (for example, Bannerji (2000) and Brewer (1993)) at this point in my research I am drawing more heavily on notions put forth by Patricia Hill Collins (2000). However, as I progress with my research I will also want to learn from others.
The convergence of postcolonial and intersectional theory.

While black feminist scholars often focus on how social relations such as gender, class, and race intersect to create social injustices and postcolonial scholars tend to focus on the construction of ‘race’ and racialization33 and cultural identity (Anderson, 2002), a convergence of the two theories offers a perspective that brings a gendered analysis to postcolonial theory (Anderson, 2000a; Anderson, 2002). Postcolonial feminism, or, the convergence of these two theories, contributed in numerous ways to my research. First, as mentioned above, it directed me to begin my inquiry from the perspective of nurses educated in the Philippines. As well, it directed my gaze to multiple forms of oppression such as exploitation and marginalization embedded in a complex of processes at local, national, and international levels, including American colonization of the Philippines, neo-liberal economic trends, immigration policies, and professional credentialing procedures. It presented a way of situating and historicizing difference by studying the way in which exclusions have been legitimized in Western practices. It also offered insight into how issues that are often considered cultural (e.g., the act of making regular remittances) might be better understood as partial and dynamic implications of broader social inequities. Additionally, it prompted me to explore the tensions between agency and structural constraints and, as a critical perspective, it encouraged me to move beyond descriptions of what “is” to what “ought” to be and to work to make change possible (Reimer Kirkham & Anderson, 2002).

33I use the term racialization as it used by Ahmad cited in Anderson (2000a). Racialization assumes that race is the primary, natural, and neutral way of categorizing individuals and groups as distinct and different. Anderson argues that racialization is neither a neutral nor a benign process and that it can result in the silencing of some groups and their exclusion from positions and privilege (p. 223).
Relational ethical theory.

In light of findings in the literature that migration may not be a matter of choice for some nurses, but rather something imposed on them, I also elected to incorporate ethical theory into my theoretical lens. Indeed, to broaden our understanding of the nature of autonomy it is suggested that we turn to the study of ethics, or to moral theory that is concerned with value related questions about human conduct (Sherwin, 1992). While traditional ethical perspectives tend to view agency as enacted by self-determining individuals, a relational approach to ethics regards agency as enacted through relationships in particular contexts (Rodney, Kadyschuk et al., 2013).

One of the principle tasks of ethical theory is to explain the basis for making sound moral claims. However, it is argued that traditional approaches to ethics often reflect moral decisions as logical outcomes of rational negotiation conducted among autonomous, self-interested individuals (Sherwin, 1992). Further, it is held that such perspectives “do not constitute the objective, impartial theories that they are claimed to be; rather, most theories reflect and support explicitly gender-biased and often blatantly misogynist values” (Sherwin, 1992, p. 43). Consequently, some feminists claim that traditional approaches to ethics must be revised if they are to effectively address how issues of dominance and oppression affect women (Sherwin, 1992).

Accordingly, a relational approach to ethics views individuals as rooted in an interconnected dynamic web of social relationships and affinities with others; not as isolated, social units fixed in time (Rodney, Burgess et al., 2013; Sherwin, 2000). Individuals are perceived as relational because their identities are constituted by elements of the social and historical contexts in which they are embedded (Rodney, Burgess et al., 2013). Such an
approach to ethics recognizes the importance that relationships and context have on shaping each person’s identity, development, and aspirations (Sherwin, 2000). The relational ethical theory that I draw from, however, does not refer only to personal relationships; rather, it also refers to political relationships of power and powerlessness. In this regard, relational theory accounts for how forces of oppression can interfere with someone’s ability to exercise autonomy (Rodney, Burgess et al., 2013; Sherwin, 2000).

Sherwin (2000) cautions that we need to distinguish between agency and autonomy. She argues that exercising agency implies exercising reasonable choice, whereas exercising autonomy implies resisting oppression. She contends that the dominant perspective that agency equates with autonomy overlooks the context of prevailing social arrangements that may in fact perpetuate oppression. That is, although individuals may appear capable of making reasonable decisions or appear to be free of direct coercion, they may not be autonomous free agents. For instance, they may be functioning within an oppressive framework, or they may have access to only a few choices. Citing Michel Foucault (1979), Sherwin (2000) explains that in modern societies the illusion of choice can be part of the mechanism for controlling behaviour and if we limit our analysis to the quality of an individual’s choice under existing conditions, we have the potential to overlook the significance of wider oppressive forces. Sherwin (2000) suggests that in order to ensure that we recognize and address the restrictions that oppression places on peoples’ choice, we need to adopt a broader conception of autonomy one, that will allow us to distinguish autonomous behaviour from mere acts of rational agency.

As a feminist perspective, relational ethical theory, like postcolonial feminism, is also concerned with the oppression of women. As well, similar to postcolonial feminism, such a perspective views individuals as socially constructed complex beings with historical roots
However, I envisage postcolonial feminist and relational ethical theories to be complementary. While postcolonial feminism is concerned with the means by which everyday experiences are shaped by multiple forms of intersecting oppressions embedded in a complex of historical, social, and cultural processes, relational ethical theory accounts for how forces of oppression can interfere with the ability to exercise autonomy (Rodney, Burgess et al., 2013; Sherwin, 2000).

As I examined the experiences of nurses educated in the Philippines and the intersecting oppressions that shaped their experiences relational ethical theory directed me to examine how wider oppressions influenced their agency: that is, it inspired me to extend my gaze beyond individual decision-making to social, political, economic, and historical contexts within which decision-making occurred. Consequently, I had an analytical lens to address questions about whose interests are being served when nurses from the Philippines seek work abroad and to query how much control IENs have over their own actions. It prompted me to consider the consequences of such choices and to remember that relationships (personal and political) both influence and are influenced by choices. It helped me to theorize about why participants decided to seek employment in Canada; why they engaged in RN licensure and credentialing procedures despite daunting challenges; and why they stayed in Canada rather than return to the Philippines.

**Chapter Summary**

In this chapter I have described the theoretical lenses I used to pursue my research question. I have argued that a postcolonial feminist perspective offered an opportunity to place the experiences of nurses educated in the Philippines at the centre of my analysis and from there explored how intersecting oppressions of racism, sexism, and classism embedded within social and historical contexts overlapped at international, national, and local levels to shape migration
experiences. I have also contended that as a critical perspective, postcolonial feminism prompted me to query how these migration experiences could be different and to uncover possibilities for change. As well, I have indicated how relational ethical theory further enriched my study as it provided an interpretive lens to explore how power inequities, embedded within a broader complex of social and historical conditions, shaped the ability of IENs to exercise autonomy over their own nurse migration trajectory. In the next chapter I will sketch out how I operationalized these theories towards answering my research question.
Chapter Four: Implementing the Study

Crotty (1998) suggests that as a starting point in the development of a research proposal, researchers need to consider two questions: 1) What strategy of inquiry and methods will we employ in our research project? and 2) How do we justify this choice? However, he contends that the answer to the second question is dependent upon whether the strategy of inquiry and the methods are capable of fulfilling the purpose of the research and answering the research question. Further, he argues that it is the theoretical perspective which provides the context for the research process and grounds its logic and criteria (Crotty, 1998).

In answer to the first question posed by Crotty (1998), I used a qualitative design inspired by ethnographic inquiry as my strategy of inquiry. Ethnography had the potential for capturing, in some depth, the lived experiences of nurses from the Philippines striving to continue their nursing practice in Canada, and for examining the structures that shaped these experiences. The inquiry was grounded in assumptions underlying postcolonial feminist theory, and as such illuminated the tensions between the agency of these nurses and the structural constraints embedded within social and historical contexts. In response to Crotty’s (1998) second question, I used in-depth interviews, observations of people’s behaviour, document analysis, and extensive field notes to gather my data. Such a variety of methods offered an opportunity to generate deeper understanding of factors shaping nurse migration experiences. In this chapter, I

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34 Crotty (1998) defines a methodology “as the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (p.7). So far in this paper I have used the term “methodology” in accordance with Guba’s (1990) definition, to imply a philosophical assumption underlying a paradigm of inquiry about how knowledge is gained about the world. So as to not confuse the two terms, I have decided to refer to the plan of action lying behind the choice and use of particular methods as my “strategy of inquiry”.

35 Crotty (1998) defines methods as the “techniques or procedures used to gather and analyse data related to some research question or hypothesis” (p.6).
will elaborate on these approaches and justify my choices. Toward this end, I begin with an overview of ethnographic traditions of research.

**Understanding Ethnographic Traditions**

Ethnography had its beginning in the discipline of anthropology in the early 20th century and usually involved living with a group of people for extended periods in a society different from one’s own, in an attempt to document and interpret a distinctive way of life (Hammersley & Atkinson, 2007; Vidich & Stanford, 1994). The philosophic perspective underlying this early stance included an emphasis on the positivist approach to science, with its assumptions that there is something “real” out there that can be captured by objective, accurate observations (Hammersley & Atkinson, 2007). Since these early beginnings, however, the philosophic perspective underlying ethnography has shifted to include multiple paradigms including feminism, critical theory and constructivism/interpretivism, and has been adopted by a host of disciplines such as sociology, human geography and nursing (Hammersley & Atkinson, 2007; Muecke, 1994). Indeed, there is no standard way of viewing ethnography and many variations exist. Regardless, a hallmark of ethnographic inquiry is that it immerses researchers in the midst of whatever it is they study, allowing them to examine various phenomena as perceived by the study participants (Berg, 2007).

Hammersley and Atkinson (2007) suggest that the nature of ethnography can perhaps best be portrayed by paying attention to what ethnographers actually do and considering the sorts of data they collect and how they handle the data. As such, they have outlined five features that commonly characterize ethnographic work. First, people’s actions and accounts are studied in everyday contexts (i.e. in the ‘field’) rather than under contrived structures and usually over an extended period of time. Second, data is often collected from a range of sources, including
documentary evidence of various kinds, participant observations, and informal interviews. Third, data collection is usually relatively unstructured in the sense that it does not involve following a fixed design determined at the start of the inquiry; and, further, categories used for interpreting the data are not built into the data collection process but are generated during the analysis of the data. Fourth, the focus of the inquiry is typically centered on a few cases to facilitate in-depth study. Fifth, the analysis of the data involves interpretation of the meanings, functions, and consequences of human behaviour and institutional practices and how these are implicated in broader social contexts. Commonly such an analysis generates verbal descriptions, explanations and theories.

LeCompte and Schensul (1999) also shed light on the nature of ethnographic research. These scholars maintain that an ethnographic approach to research is ideal for addressing problems that are complex and embedded in multiple structures; for revealing multiple perspectives; and for addressing questions that do not have simple solutions. As such, ethnographic researchers often seek extreme, typical, and unique cases to determine patterns of difference between members of a population. Similar to Hammersley and Atkinson (2007), they stipulate that ethnographic research frames all elements under study as existing within a context. Indeed, they argue that from an ethnographic standpoint, the behaviour and beliefs of individuals or organizations “…can never be understood completely without understanding the social, political, cultural, economic kinship and even personal matrices in which they are embedded...” (LeCompte & Schensul, 1999, p. 19). However, these scholars also maintain that though ethnographers generally strive to conduct research in natural settings where people interact with one another (e.g., in homes or schools) they frequently need to manipulate or create settings
within which to elicit data. For instance, researchers may need to bring study participants together in a single location for the purposes of conducting focus group interviews.

Although my intention was never to conduct a full-blown ethnography whereby I immersed myself for extended periods of time in the lives of nurses from the Philippines seeking RN licensure and employment in Canada, I nevertheless drew on ethnographic traditions to examine the social and historical context of nurse migration as perceived by study participants. Over the course of a year that I spent in the field, developing relationships with stakeholders, engaged in individual and focus group interviews, observing nurses describe their experiences in Canada, and examining documents related to nurse regulation, education, and employment and immigration policy, I became increasingly familiar with issues confronting study participants. An opportunity to present my preliminary findings and participate in an international nursing conference in the Philippines also provided rich insights about structures influencing migration experiences. For instance, I learned about the social status assigned to working abroad, an issue I will refer to later in this chapter. Spending a year in the field also permitted time to note the shifting context of nurse migration and integration experiences. For instance, during the course of the year the nursing labour market was in a state of flux; new immigration and regulatory policies were introduced; and private colleges were expanding to include programs targeting the needs of new immigrant nurses.

**Conceptualizing an Ethnographic Approach Informed by Postcolonial Feminism**

Although an ethnographic approach provided the framework for my research study, postcolonial feminism and relational ethical theory determined the context for the research process. While relational ethical theory was a helpful analytical lens, postcolonial feminism guided my overall research design, informing my decisions about data collection and analysis,
methods and research outcomes (Crotty, 1998). In the following sections I will comment on three defining features of a postcolonial feminist perspective that influenced all aspects of my study: starting from the standpoint of those at the margins; engaging in a multi-layered analysis of intersecting relations of power that influence and are influenced by everyday experiences; and extending analysis beyond generating a description of ‘what is’ to providing a prescription for “what ought to be” (Reimer Kirkham & Anderson, 2002).

**Beginning from the standpoint of those at the margins.**

A central tenet of postcolonial feminist methodology is that research begins with the experiences of marginalized women who have been subjected to intersecting forms of oppression embedded within a complex of historical and social processes (Anderson, 2002; Reimer Kirkham & Anderson, 2002). It is put forth that to make knowledge more representative, the perspectives of oppressed groups must be heard as these groups are more likely to perceive certain types of problematic assumptions that support their continuing oppression (Bhabha, 2006; Reimer Kirkham & Anderson, 2002; Sherwin, 2001; Smith, 1999, 2006).

Inspired by feminist standpoint theory as set forth by Dorothy Smith, Anderson (2002) asserts that by beginning with people’s everyday experiences researchers can reflect back and link these experiences with social forces that structure and are structured by them. To make such connections, the researcher “critiques taken-for-granted assumptions, analyzes discourses and structures that support the status quo, and turns a critical eye upon self (self-reflexivity)” (Reimer-Kirkham & Anderson, 2010, p.199). However, postcolonial feminists do not suggest that those at the margins are passive agents. Rather, a postcolonial feminist perspective directs researchers to explore tensions between human agency and structural constraints located in histories of colonization (Reimer Kirkham & Anderson, 2002; Reimer-Kirkham & Anderson,
2010; San Juan, 2000). For instance, researchers need to question how individuals may both resist oppression and be actively engaged in producing the same oppressions that shape their experiences.

My time in the field facilitated an understanding of the participants’ perspectives and inspired me to challenge taken-for-granted assumptions that underpin nurse migration issues locally, nationally and in the Philippines. I became increasingly aware of broader social/historical structures and power relations that shape and are shaped by their experiences. For instance, I became cognizant of structures that put these nurses at risk of exploitation as they prepared to leave the Philippines and as they settled in Canada and I became conscious of their capacity to both resist and contribute to these very structures that aim to exploit them.

While standpoint theory has much to offer postcolonial feminism, it is not without criticism. For instance, some argue that Dorothy Smith’s notion of standpoint is an essentialist view that overlooks questions of difference as it suggests there is only one way of knowing a socially constructed world (Wolfe, 1996). However, as Wolfe (1996) puts it, the discussion has broadened to include “standpoints” as there clearly is no single standpoint for women with diverse class, racial, and ethnic backgrounds. Indeed, as I proceeded with data collection and analysis I became cognizant of the varied experiences of study participants. They represented a wide range of social locations, perspectives, and oppressions and clearly there was no single standpoint. While some complained at how marginalized they felt by the regulatory process, others conceded that they thought it was fair.

In a similar vein, another criticism of standpoint theory is that it implies that one’s positionality as a woman is crucial to gaining knowledge of other women and thus raises concerns about epistemic privilege, or whether one has to have lived an experience to understand
it (Wolfe, 1996). Indeed, a nagging concern that I had as I entered this research study was whether as an ‘outsider’ I would be able to capture the viewpoints put forth by study participants. This concern was highlighted at an Advisory Group meeting toward the end of my data collection when I commented that I had not heard study members refer explicitly to acts of discrimination. In response, a member of the Group cautioned me that as someone who had never experienced discrimination I would not be able to detect it.

Though this comment was well-meaning, it alerted me to my privilege and filled me with self-doubt. However, it was gratifying to see that a member of the Advisory Group was willing to challenge my insights. Later, I was somewhat reassured when I came across the notion set forth by feminist scholar Narayan Uma, cited in Wolfe (1996, p. 14), that although shared positionalities as members of an oppressed group may create a greater probability of sharing and understanding, it is possible for those with a different social location to also gain understanding. As well, Reimer and Anderson (2002) argue that Dorothy Smith’s notion of standpoint does not privilege the knower but instead it is a means of understanding the socially organized nature of knowledge, or how everyday experiences are shaped by social relations.

**Accounting for intersectionality.**

As mentioned in Chapter Three, intersectional theory provides important insights for postcolonial feminism and has become a key component of such scholarship (Reimer Kirkham & Anderson, 2002). Intersectionality brings to the forefront diversity among individuals. It directs the researcher to move beyond recognizing difference to critically examining it as historicized within colonial relations of power and to analyzing how assumptions underlying difference contribute to social inequities (Anderson, 2002; Reimer Kirkham & Anderson, 2002). More specifically, it disrupts the history of categorizing people according to their presumed race and
guards against Othering or essentializing groups of individuals for the purpose of reproducing the status quo inequities (Anderson, 2002; Reimer Kirkham & Anderson, 2002).

Intersectionality prompted me to be cautious about how participants may be “Othered”, or deemed different for purposes of maintaining the current state of affairs in BC. It also caused me to critically reflect on the complex context of nurse migration experiences and refrain from searching for simple explanations. As well, it directed me to account for the fluid nature of power (Reimer Kirkham & Anderson, 2002). That is, it shed light on the fact that a participant could have multiple identities (e.g., I noted that while study participants frequently implied they were proud of their ability to navigate the immigration process in Canada, they also alluded to feeling marginalized by their inability to meet RN regulatory requirements) and could be contemporaneously both oppressor and oppressed (e.g., one participant of a focus group who had come to Canada as a live-in caregiver revealed that she felt marginalized by those who came under the FSWP and yet this latter group of nurses expressed that they in turn felt marginalized by RN regulatory processes in BC).

**Orienting towards praxis.**

As a critical perspective and a form of praxis, an ethnographic approach informed by postcolonial feminism offers an opportunity to raise people from oppressive situations to a level of awareness whereby they can begin to realize the extent of their oppression and make efforts to address it (Chinn & Kramer, 2011; Guba, 1990; Lather, 1991). Indeed MacPherson (1983) argues that feminist theories have a dual function:

…they offer descriptions of women’s oppression and prescriptions for eliminating it. They are empirical insofar as they examine women’s experience in the world, but they are political insofar as they characterize certain features of that experience as oppressive and offer new visions of justice and freedom for women (p. 19).
As well, Lather (1991) contends that the goal of critical or emancipatory research is to encourage praxis, as much as it is to generate empirically grounded theoretical knowledge. Starzomski and Rodney (1997) suggest that to integrate praxis into the process of the project the researcher must consider how to connect research to political activism and social transformation. They suggest that, “critical perspectives are able to take us from the ‘is’ to the ‘ought’ and thereby provide normative direction for change” (Starzomski & Rodney, 1997, p. 225). Thus, critical theorists are not only seeking knowledge, but they view their work as a catalyst for social change (Kincheloe & McLaren, 2005).

Accordingly, I view my work as a form of praxis; inspired by postcolonial feminism I entered the field with the aim of extending my gaze beyond critiquing issues of social injustice to laying out a plan for action. To produce transformative knowledge, or knowledge about what ought to be, Anderson (2002) contends that the researcher must be “mindful of the principles and processes that underpin rigorous critical theory” (p. 20). Drawing on Lather (1991), Anderson states that researchers engaging in postcolonial feminist inquiry need to be cognizant of three interrelated issues: the need for reflexivity; the need for reciprocity; and dialectical theory-building.

**Adopting a reflexive stance.**

Sandelowsk and Barroso (2002) assert that, “Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share (p. 222). Lather (1991) argues that “if illuminating and resonant theory grounded in trustworthy data is desired, we must formulate self-corrective techniques that
check the credibility of data and minimize the distorting effect of personal bias upon the logic of evidence” (p. 66). That is, to produce credible and reliable knowledge, critical ethnographers need to continuously explore their value orientation at every step of the research process (Carspecken, 1996). Shedding further light on the issue of reflexivity and its significance for a praxis-oriented research project, Reimer Kirkham and Anderson (2002) suggest that such a project:

... begins with the researcher as he or she engages in reflexive critique of the research process itself (e.g., the relationships formed with participants, the influence of the researcher’s positionality, and the dynamics of power at work) and the nature of the knowledge being constructed (p. 14).

However, adopting a reflexive stance about the dynamics of power that pervade a research project can be a daunting task. Said (1994) reminds us, “Politics is everywhere; there can be no escape into the realms of pure art and thought…” (p.16). For Wolfe (1996), the most central dilemma for contemporary feminists in fieldwork is power and the unequal hierarchies or levels of control that permeate all aspects of the research process. Noting that knowledge is always situated, or that the production of knowledge is always shaped by the dynamics of where we are located and positioned, she contends that feminist researchers must bring their own location (historical, national, generational) and positionality (race, gender, and class) into the research.

*Bringing my own location and position into the research.*

I can therefore say that I am a second generation Canadian with mixed English and Scottish ethnic origins. Further, I am a middle-class and middle-aged white, heterosexual, married woman with four adult children and two grandchildren. I also am a practicing registrant with the CRNBC and have more than twenty years of experience working with nurses from the Philippines in both clinical and classroom settings. Indeed, as I acknowledged at the outset of
this dissertation, it is the relationships I developed with nurses educated in the Philippines while working as a nurse educator in various IEN transition programs in BC and as a tutor for the CRNE that inspired me to initiate this project. Experience as an administrator for a nurse transition program for practical nurses also heightened my appreciation for the complexity of regulatory procedures and the interconnectedness of regulation, education, and practise. I also have a Teacher of English to Speakers of Other Languages (TESOL) diploma and experience teaching English to internationally educated students in health sciences programs. On two occasions I have visited the Philippines: first in 2006 in the capacity of a nurse educator from a local nursing college in Vancouver and second, in 2011 as a nurse researcher and PhD candidate. On the first occasion my aim was to determine the feasibility of establishing a partnership with a nursing program in the Philippines; in the second, I presented preliminary findings from this research study at an international nursing forum, *1st Cebu International Nursing Conference*. Both experiences provided insights into Philippine culture. For instance, I was struck by the depth of desire to work abroad expressed by nurses I met along the way. Typically, during introductions, nurses would explain to me that they would like to relocate to Canada, or were in the process of completing Canadian immigration procedures, or that a family member was working abroad. I also learned that nursing is highly regarded in the Philippines. During his welcome address at the nursing conference, the Mayor of Cebu City stated, “The best work of life is service to humanity” and then added, “Life will only be meaningful if you can touch the heart of somebody else”.

Throughout the course of this study I tried to remain sensitive to my privilege and aware of the effects it had on each phase of the research, from gaining access to the field, to collecting, interpreting, and disseminating data. Four interrelated concerns haunted me throughout the
process: the research endeavour could perpetuate colonizing relationships; my research findings could further essentialize and marginalize nurses from the Philippines; I could be advancing my own position of power in relation to study participants; and my position of privilege could distance me from the participants, limiting my ability to access their insights.

With respect to the first concern, I feared that as a white researcher in a high income country studying nurses of colour from a developing country I could be reproducing the very power imbalances that define relationships between colonizers and the colonized, specifically, the relationships that a postcolonial feminist inquiry strives to eradicate (Diaz, 2003; Reimer-Kirkham & Anderson, 2010; Wolfe, 1996). For instance, the very notion that an objective of postcolonial feminism theory is an engagement with voices that have not been listened to could be interpreted as the researcher wielding hegemonic power to allow these women to speak and, further, that they are unable to speak for themselves (Spivak, 2006). Both issues were disconcerting and surfaced early in my research endeavor when a fellow researcher, who was from the Philippines, informed me that nurses from the Philippines were quite capable of speaking for themselves (i.e., “They don’t need your help”). His comment underscored my need to be mindful that my purpose was not to speak for, or represent, study participants but to learn from them and make nursing knowledge more representative (Reimer-Kirkham & Anderson, 2010). As Homi Bhabha (2006) suggests, “…it is from those who have suffered the sentence of history – subjugation, domination, diaspora, displacement – that we learn our most endearing lessons for living and thinking” (p. 246). Further, as Reimer-Kirkham and Anderson (2010) remind us, although the goal of postcolonial feminism is to promote social justice, social justice does not inherently mean ‘speaking for’ a particular group. Rather, through the process of
engaging with study participants in reflexive discourse oppressive structures shaping their experiences can be explicated and strategies developed to address them.

In a similar vein, I also worried that the study findings might foster Othering, or a situation in which nurses educated in the Philippines would be viewed as different and inferior to those educated in Canada (Reimer Kirkham & Anderson, 2002). That is, I was fearful that findings might reinforce existing power inequities and contribute to a West versus non-West binary notion of nursing; one that overlooks the possibility of the merging of cultures described by Homi Bhabha and referred to in Chapter Three.

I was also uneasy that the research project could advance my position of privilege in relation to study participants. Although my stated intent in proceeding with my research was to achieve social justice for nurses educated in the Philippines, I realized that I was undoubtedly empowering myself in the pursuit of this goal. Not only did the research process give me access to knowledge that I might otherwise not have been privy to, I could eventually earn a PhD from the endeavor. Clearly this research study constituted unequal power relations; a proposition that made me more sensitive to ways of equalizing the power between myself and participants.

A further concern was that participants may not be willing to share their concerns because I was not a member of their community. As I will explain later in this chapter, I initially had experienced difficulty recruiting participants and even with those who agreed to participate, I often sensed a degree of reluctance or nervousness. For example, sometimes a potential participant would cancel the interview at the last minute or arrive with a friend. In one situation, two participants who had arrived together at the designated meeting place confessed that they were fearful that participation in the study was a violation of their live-in-caregiver contract. Although I assured them otherwise and once again reviewed the terms of the Consent Form with
them, I remained conscious of how vulnerable this study group felt and how much courage it took for some to step forward.

To address these aforementioned concerns and to minimize biases or preconceptions I took a self-reflexive stance. I regularly examined and documented the values and ideas that I brought to the study. For instance, I stayed mindful of how my background experience as nurse educator influenced my perspective about re-entry nursing programs and how my years of working with nurses educated in the Philippines in the clinical setting shaped my expectations.

**Incorporating reciprocity.**

Reciprocity or the dialectical process of negotiating meaning and power is another valuable aspect of fieldwork in a praxis-oriented research project. From a feminist perspective, not only does it empower women but it guards against theoretical imposition (imposing meaning on situations) and reification (treating abstractions as if they are realities) and fosters rich data (Lather, 1991). Accordingly, throughout my time in the field I tried to incorporate numerous acts of reciprocity into the research process.

Reimer-Kirkham and Anderson (2010) argue that “...empowerment comes through the processes of finding one’s voice, articulating one’s perspectives, and engaging as a person of equal worth with those who have been privileged by their social location” (p. 204). Lather (1991) adds that a researcher/participant relationship can be strengthened by conducting interviews in an interactive dialogic manner that includes incorporating self-reflection and elements of self-disclosure into the exchange. Thus, during the course of an interview I often revealed that I had been to the Philippines; or that my daughter had spent time working in the Philippines; or that a preceptor during my own nurse refresher program had been educated in the Philippines. I also was candid about my struggle to understand their motivation in leaving their own country or my
difficulty in comprehending the complexity of immigration or RN regulatory processes. Such disclosures seemed to reduce the distance between myself and participants, break down hierarchies of power, and foster trusting relationships. However, reluctantly in the end I accepted that this could not offset the inequality that remained (Wolfe, 1996).

Anderson (1991b) contends that for a praxis-oriented research project that aims to empower women, the process begins within the actual research encounter. She suggests that sharing information with participants helps them take control over their lives. Although the consent form alerted participants that the purpose of the research project was to provide an opportunity to discuss experiences and locate sites for potential change, I often felt they wanted something more when they committed to the study. For instance, I wondered if they hoped that as a nurse educator familiar with the registration process, I could offer them guidance and support in becoming a RN in Canada, or even advocate on their behalf. Following one focus group interview I received an email from a participant stating:

I’m sorry for venting out some of my frustrations with regards to the Canadian system [during the focus group discussion]. I know you’re only asking for a feedback. I hope this [interview] help[ed]. Thank you very much for your case study. In a way, you are our angel (Focus group 1213).

I was not sure if this participant was expressing gratitude for being listened to or whether she was hopeful that I could help her along with her colleagues to acquire licensure. Indeed, during or following interview sessions participants often approached me with questions or to express concern about their inability to move forward with their registration plans. They clearly appreciated any guidance I could provide (e.g., I told them about monthly information sessions at the CRNBC and about a new program at a local community college in Vancouver that offered free English preparation classes for IENs); a factor that alerted me to how much these nurses craved support.
However, as a novice researcher I sometimes worried that I was crossing the boundary between researcher and advisor or that I was perpetuating the power imbalance that existed in the research process. Although I had difficulty reconciling these concerns, I discussed them with my supervisor and felt that it would be morally unjust to withhold information or support. As well, I reminded myself that I was not the only person to offer information; rather we were all learning from each other. Collectively we were assembling the pieces of what seemed to be a gigantic and, at times, impossible, puzzle. Further, I sometimes questioned whether my motive in helping was to assuage my guilt over my privilege in relation to study participants. However, I think in the end my desire to offer assistance had more to do with a genuine concern for the well-being of the participants and the sense of gratitude for their commitment to the study.

Lather (1991) also suggests that in praxis-oriented research the researcher needs to help participants move beyond ‘articulating what they know’, to ‘theorizing about what they know’. Toward this end she recommends that the researcher encourage participants to critique ideologies, or taken-for-granted beliefs. Accordingly, I frequently used communication strategies, such as summarizing and reflection, to seek clarification and stimulate further discussion. I aimed to challenge their thinking, although at times I worried that I pushed them beyond their comfort zone. For example, on one occasion I stated, “What strikes me is that people come here in order to have a better life… but in reality is that what’s happening?” (Focus group 1213). In response to this question, there was some laughter and while one participant quickly responded, “yes”, others said “that gives us something to think about”. Such strategies raised discussions to a new level as participants tried to make sense of their experiences. Inspired by focus group discussions, one participant created a website to provide a means for participants to exchange information and offer encouragement. As she explained to me in an email,
It is my way of getting in touch with my fellow nurses and [to] give them positive thoughts.... This is the only thing I can share with them with much conviction that our situation right now will eventually turn into our advantage. And if there would be a chance to be a catalyst for a better and more effective means to get back to our profession... well may[be] this little contribution [might] play a significant role for us and the future of the nursing profession in Canada (Email exchange July 13, 2011, Focus group 1213).

I also used my preliminary findings to stimulate conversation in follow-up interviews. Not only did they provide a starting point for further discussion but also a means of verifying that I was on the right track.

*Engaging in dialectical theory-building.*

In addressing the issue of dialectical theory-building, Lather (1991) holds that “data must be allowed to generate propositions in a dialectical manner that permits use of a priori theoretical frameworks, but which keeps a particular framework from becoming the container into which the data must be poured” (Lather, 1991, p. 62). Although I remained cognizant of the assumptions underlying postcolonial feminism and relational ethical theory, I tried to remain receptive to the notion that data might not support these assumptions. For example, I did not want to fall into the trap of thinking that women who left their children at home in the Philippines, often for several years at a time while they worked in Canada, were always oppressed. Thus, I tried to bracket, or set aside my natural assumptions, to remain open to what participants were telling me, and to allow myself to be surprised.

**The Process of Research: Constructing Meaning and Knowledge**

In this section I provide an overview of processes used for constructing and analyzing data and measures taken to foster scientific credibility and maintain ethical standards. Although I discuss data collection and analysis in a linear fashion, as if they were two separate entities, in fact they occurred simultaneously. Indeed, data collection and analysis was an
iterative process, each informing the other (Hammersley & Atkinson, 2007; LeCompte & Schensul, 1999).

**Constructing data.**

During the process of constructing meaning and knowledge it is imperative to ensure methodological integrity; that data collection strategies be congruent with the philosophical assumptions underlying the research design (Crotty, 1998). Accordingly, I will present strategies employed with respect to negotiating access to the field and recruiting participants, creating a sample, and collecting and managing data. I begin, however, with an overview of my rationale for forming an Advisory Group and its ensuing benefits.

**Forming an Advisory Group.**

Recognizing that as a white middle-class professional woman I may experience challenges with all aspects of the study, I established a voluntary Advisory Group of nurses from the local Filipino community. I sought members who would be able to advise me on strategies for fostering interest in the study and recruiting participants, inspiring dialogue during interview sessions, interpreting the data, and disseminating research findings. Since I wanted to learn from study participants with diverse backgrounds, such as different immigration pathways and at various stages of the RN regulatory process, as well those who had elected not to pursue an RN pathway in Canada, I sent invitations to participate in the Advisory Group to nurses who represented different segments of the community. Ultimately, I was able to form a group which consisted of five female Philippine nurses: four who had been educated as nurses in the Philippines and one who had been educated as a nurse in Canada. Of the five, three were currently employed as RNs (one had only just acquired her practising license), one was currently working as a practical nurse, and one was seeking RN registration. Of those who were educated
in the Philippines, one was a Canadian citizen who had returned to the Philippines as an adolescent; another had come to Canada under the LCP, another had immigrated under the FSWP, and one had come with her family under the Family Class category.

Our first Advisory meeting was held shortly after I received ethics approval to proceed with the study. As with subsequent meetings, the date, time and location of the meeting were determined by the members. After signing confidentiality agreements and introducing each other, I presented a detailed overview of the research project and reviewed my expectations regarding group participation (attend a minimum of three group meetings, each lasting approximately one to two hours, over the course of the project). After some useful discussion, the Group felt that we would probably need to meet at least once during each of the different phases of the project: recruitment, data collection, data interpretation, and data dissemination.

Since my first objective in moving forward with the study was recruitment of participants, much of this initial meeting centered on recruitment strategies. I provided members with copies of the recruitment letter and advertisement that had been approved by the Behavioural Research Ethics Board (BREB) and sought advice on how to distribute them. While the Group agreed that it would be helpful if they forwarded the letter to their friends and colleagues, they also suggested posting the advertisement in various community settings frequented by Filipinos (e.g., community centres and restaurants).

During the first meeting I also raised concerns related to data collection. For instance, I wondered about the practicality of assigning participants to specific focus groups according to their position on the RN regulatory/employment trajectory, a strategy that I had contemplated during earlier conceptualizations of the study. Although the Advisory acknowledged that such a tactic might generate useful discussion, they concluded that it would be logistically problematic.
since the composition of focus groups would probably be determined by the availability of participants. On reflection, this was valuable advice. As I would soon find out, it was often challenging to recruit participants and, regardless of the participants position on the RN trajectory, focus group discussions often evolved into problem solving sessions with participants appreciating feedback from those who were at different stages of the regulatory process. Additionally, conversations were not confined to regulation, rather encompassed socio-political and economic concerns experienced by nurses prior to arrival and after arrival in Canada (e.g., immigration challenges, locating ‘survival jobs, and family responsibilities).

Moreover, I sought the Advisory Group’s opinion on the utility of hiring a research assistant, such as a Filipino RN or graduate student, to participate in some capacity during focus group interviews. I suggested that participants might be more forthcoming with information if a Filipino research assistant was present or that observations captured by an assistant would enhance the quality of the data. Interestingly, the Advisory was opposed to this on several counts. First, they argued that I would not have any problems generating discussion since Filipinos tend to be very talkative (they proved to be correct). Second, they seemed confident that they had the capacity to assist me with challenges I might encounter with data interpretation (again, they were correct). Finally, they raised the concern that an assistant might not be able to make objective observations and further, might upset the group dynamics (a factor reminiscent of the influence that a researcher’s location has on the study and also of ethnicity being both a liability and an asset).

As with subsequent Advisory Group meetings, I found this first session extremely helpful. The members’ familiarity with the Filipino community and their diverse perspectives and experiences provided rich insights. Further, their interest in the research study was gratifying.
and inspirational. However, unlike the first meeting which was attended by all, follow-up sessions were often only attended by one or two at a time since I had difficulty coordinating work schedules. Consequently, to keep everybody in the loop, I often resorted to sending email updates and scheduling meetings with members individually.

During our second meeting, several months later, I summarized my recruitment activities to date (I had interviewed seven participants by this time) and described my frustration that on several occasions individuals who had originally expressed an interest in participating, had not followed through. Members suggested that it may have been difficult for some to find time to commit to an interview, since many worked long hours and had numerous other responsibilities. Also, it was suggested that since the community of people I was drawing from was a marginalized group, they perhaps lacked confidence to step forward. As well, they speculated that as new immigrants in Canada, some may have felt they had little to contribute to the study; that they were unfamiliar with Canadian culture or regulatory and employment processes in Canada. Although I think I anticipated these recruitment issues before I ‘entered the field’, these reminders and the Group’s encouragement were appreciated.

The next several meetings with the Advisory Group occurred towards the end of my data collection as I began to formalize some preliminary findings. As always feedback was helpful, offering a range of insights into the nurse migration phenomenon. As an example during one session, a report of the findings inspired a discussion about discriminatory regulatory practices in BC, and the comment that as a white person I would not notice these practices, a point that I alluded to earlier in this chapter. Such comments reminded me of the situated nature of knowledge and that numerous interpretations of data were possible (a factor that speaks to the complexity of the research topic). As well their feedback cautioned me to examine data in more
detail, to listen carefully to what participants were saying, and to cast a more critical eye on structures shaping nurse migration and integration experiences. The Advisory Group also directed me to references in the literature that ultimately helped to advance my appreciation for challenges expressed by study participants.

**Negotiating access to the field and recruiting participants.**

Even prior to seeking ethics approval to proceed with my research, I began meeting with community members (see Field Work Calendar, Appendix B). For example, I had informal discussions with members of a Filipino nurse support group, a nurse recruiter, immigration counselors, English language teachers, nurse educators and administrators for nurse bridging programs, and representatives of the local nurse’s union and nursing regulatory bodies. Not only was my intent to raise awareness about my study but, also, to learn from these individuals, to gain a broader contextual understanding of migration and integration issues; knowledge that would eventually serve me well during data collection and analysis. Additionally, during these encounters I was mindful of prospective Advisory Group members and study participants. I also became a volunteer at two immigrant serving organizations and subsequently a mentor for IENs pursuing RN licensure in BC.

People generally seemed receptive to meet with me and I could not help but think my nursing background was paving the way for my research endeavor. Not only did I already know some of the people but there seemed to be a credibility assigned to my role of nurse educator. When I initially introduced myself to people I always explained that I was PhD nursing student and that I was meeting with them in the capacity of a student. However, during the course of discussions I also revealed my personal interest in the research and my position as a nurse educator.
Once I had gained approval from the BREB and established an Advisory Group I began recruitment in earnest, posting recruitment advertisements and engaging the Advisory Group and professional colleagues to disseminate recruitment letters. Prospective participants were invited to participate in two to three focus group interviews and/or individual interviews, each lasting one to two hours, over a period of six months. They were also informed they would receive a 10 dollar Gift Card for a local grocery store for each interview attended to compensate for transportation expenses.

Although I was told by one member of the Filipino community that as an “outsider” I might have better luck than an “insider” recruiting participants due to the fractious nature of the Filipino community, my initial attempts at recruitment were disappointing. Despite following my Advisory’s advice to post recruitment advertisements at specific locations frequented by Filipino nurses, including Vancouver Community College (VCC) and Kwantlen Polytechnic University\(^{36}\), I never had a response to these efforts. Further, many of the prospective participants identified by the Advisory Group were reluctant to come forward (e.g., half of the participants who contacted me, either never followed up with their initial interest or cancelled interview sessions before we were able to meet).

Though I had been forewarned that prospective participants, as members of a disenfranchised population, might be reluctant to participate, I do not think I fully appreciated reasons for their reluctance until I became more immersed in the field. As mentioned earlier, on one occasion a nurse commented that she worried that participation would put her at risk of

\(^{36}\text{Since both VCC and Kwantlen Polytechnic University offered programs for IENs, I had acquired ethical approval to recruit from their student populations.}\)
violating her contract as a live-in caregiver. Others expressed fear that I may not be able to understand their English. Still others implied they did not have the necessary time to commit to a research study.

Despite initial difficulties, individuals gradually did come forward. Some also encouraged their friends to contact me and consequently after three months of recruitment I had interviewed eight nurses. While engaging in these early interviews and waiting for responses from further recruitment efforts, I continued to establish relationships with stakeholders and to present my research proposal at various local conferences. My most significant breakthrough with respect to recruitment, however, came after I made contact with counselors from three different immigrant serving organizations in the Greater Vancouver Region. These individuals expressed an interest in my study, largely in part, I think, because they hoped that their clients, many of whom were nurses educated in the Philippines, would benefit from the support offered by focus group discussions. While they agreed to disseminate recruitment letters, they speculated that interest in participation would more likely be achieved if their clients had an opportunity to meet with me first. Subsequently I was invited by four different immigrant serving organizations to be a guest speaker and provide an overview of steps required for RN licensure in BC. My experience as a nurse educator in a BSN program and as a tutor for the CRNE prepared me for these presentations. I referred attendees to the CRNBC *Occupational Fact Sheet for Internationally-educated Nurses* (2011) for information and explained I was not an “expert” but was willing to work with them to try to understand the process. Thus, sessions became interactive and attendees were often forthcoming with their own registration experiences, which was appreciated by everyone. The sessions also helped to advance my own understanding of how many perceived the regulatory process in BC and it gave me an opportunity to observe
interactions between nurses, many of whom were educated in the Philippines. Following these presentations I gave a very brief overview of my research study and invited attendees to participate at a later date in either a focus group or individual interview. The result was the formation of three focus groups and three individual interviews; factors that alerted me to both the advantage of face-to-face recruitment over solicitation by advertisement and the benefit of having the study acknowledged in advance by a person or a group that has the confidence of prospective participants (Polit & Beck, 2004).

I always remained cognizant of the need for objectivity in my research intentions when I met with prospective study participants. However, because my reputation as a nurse educator familiar with the RN regulatory process usually preceded me, I worried that I might unwittingly position myself as an “advocate”, or somebody who could speak on their behalf or enable them to meet the criteria for licensure. I also was concerned that I might be generating an expectation that research findings would alleviate their problems (Reimer-Kirkham & Anderson, 2010). Such concerns cautioned me to be vigilant about how I was presenting myself to participants.

My literature review suggested gaining access to the field could be time consuming (Hammersley & Atkinson, 2007; Mulhall, 2002), however, I do not think I anticipated that it would exceed the time spent in the field collecting data. For many months I had a steady engagement with both stakeholders and study participants. Stakeholders sometimes contacted me to inform me about changes to nurse migration or integration processes and participants often emailed me with further questions about issues they were struggling with or to discuss ideas that had come to them after we had met. Despite the extra time involved, relationship building was the part of the research process that I relished the most. It provided an opportunity to become
connected with an array of interesting individuals who generously offered me their time and invaluable insights.

Creating a sample.

Ethnographic researchers usually select study participants because of their ability to inform the researcher about the nature of the experience being explored (LeCompte & Schensul, 1999). Accordingly, they often seek extreme, typical, and unique cases to determine patterns of difference between members of a population (LeCompte & Schensul, 1999). To answer the study’s overarching research question (How do social, political, economic, and historical contexts mediated by intersecting oppressions come to shape the everyday experiences of nurses educated in the Philippines as they seek RN licensure in BC?) I used purposive sampling to identify nurses educated in the Philippines who had sought or had considered seeking Canadian RN licensure and/or employment within the past 10 years, who could converse comfortably in English, and who would be willing to talk about their experiences. Although my focus was on female nurses as they make up the greatest percentage of RNs from the Philippines, to further illuminate their experiences I extended an invitation to male nurses educated in the Philippines. To reflect the complexity of nurse migration, I also deliberately selected those who represented a mix of social identities, such as different ages and different employment and immigration histories.

As patterns and themes emerged from the initial phases of data collection and analysis, I turned to theoretical sampling to refine my understanding of the impact of varying immigration pathways on nursing experiences in Canada. In particular I wanted to learn how experiences of nurses coming to Canada as TFWs varied from those with other immigration pathways. I also solicited insights from an immigration counselor; three nurse educators; two Philippine nurses
who were not nurses on arrival in Canada but who later pursued a Canadian nursing degree; and one nurse educated in the Philippines who immigrated in the 1970s. This latter group of participants advanced my understanding of issues that were raised by primary participants and were considered secondary study participants.

While there does not appear to be any set of hard rules about an adequate sample size in qualitative research, several researchers offer helpful suggestions. Morse (2000) puts forth that important considerations include the scope of the study, the nature of the topic, and the quality of the data obtained. For instance, a larger sample is generally required if studies have a broad scope; address complex issues; or if the participants have difficulty expressing themselves (Morse, 2000). Sandelowski (1995) also maintains that the adequacy of a sample is relative to the intended purpose of the research project and to the research method. She asserts that typically an acceptable sample size in qualitative research is one that is small enough to permit deep analysis, but large enough to allow for a new and richly textured understanding of experience (Sandelowski, 1995). Thorne (2008) concurs, and, further, advises that the best way to justify a sample size is to offer a rationale that demonstrates how the research problem can reasonably be tackled with the anticipated exposure.

Prior to data collection I had anticipated I would require a sample of approximately 30 participants to reflect a mix of social identities, professional backgrounds, and migration challenges and to capture the complexity of nurse migration issues. However, since organizers at immigrant serving organizations extended open-invitations to participate in focus group discussions, numbers swelled beyond my expectations. In total I interviewed 47 primary participants (see Table of Participants, Appendix C). They ranged from 21 to 57 years, with the mean age being 37 years. There was a mix of single and married participants, some had brought
children with them to Canada and others had left children in the Philippines. Thirty-five were female and 12 were male. Twenty-eight had been in Canada for less than one year, 17 less than five years, and two more than 10 years. Thirty-five came to Canada under the FSWP, two under the Family Class provision, eight with the LCP, and two came as TFWs to work as RNs. Two had acquired their RN status in Canada, 18 had not yet started the RN application process, 21 were at various steps along the RN trajectory (e.g., waiting to do the SEC Assessment or the CRNE, enrolled in RN upgrading courses, or seeking the 250 hour supervised work experience), three had pursued the practical nurse pathway in Canada, and another three were unaccounted for. Of those who had begun the RN application process, seven said they had started the process prior to arrival in Canada. As well, the sample represented a range of previous RN work experience: from a minimal amount of volunteer nurse experience in the Philippines to almost 20 years of experience in the Middle East. Some had held nursing positions in critical care (e.g., ICU, ER, OR); others in medical-surgical, obstetrics, or community health nursing; and still others had been teachers and administrators. At least three had been physicians in the Philippines prior to earning their nursing degree.

In retrospect I feel that the sample was large enough to provide rich data and foster understanding of nurse migration issues. Though I would have preferred to have interviewed more nurses who had come to Canada as TFWs, time constraints, the scarcity of these nurses, and the reluctance of some to come forward, made it impossible to do so. However, it is a topic that can be taken up in future research endeavors.

Collecting data.

In keeping with the traditions of an ethnographic approach to qualitative research I collected data from a range of sources. These included individual and focus group interviews,
participant observations, and documentary evidence. As well, I used ongoing journaling to help keep track of my thoughts and sort out my ideas and impressions as I progressed with data analysis.

Conducting interviews.

Constructing meaning and knowledge for an ethnographic study informed by postcolonial feminism, demands “...an engagement with voices that have not been listened to, to bring these voices to the forefront” (Reimer-Kirkham & Anderson, 2010, p. 203). Toward this end I drew upon in-depth individual and focus group audio-taped interviews.

Reflecting on my position of privilege discussed earlier in this chapter, I paid particular attention to how I presented myself to research participants during interview sessions. I aimed to maintain professional boundaries and at the same time demonstrate respect and an eagerness to learn from them. As with nurse/client relationships, the needs of the research participant were foremost in the relationship. I aimed to remain courteous and available; uphold confidentiality; and engage in communicated understanding (e.g., I would give participants my full attention, and use strategies such summarization or reflection to clarify that I understood their message). I also remained cognizant of the fact that English was not their first language and refrained from complex English. Where possible I adopted expressions that were familiar to the participants, such as “show money” and “survival jobs”. As I reflect on these interviews it seems that my nursing background prepared me well for the role of researcher. Not only did it help me to recognize professional boundaries and engage in communicated understanding, my years of teaching nurses from the Philippines and working alongside them in the hospital familiarized me with their communication patterns.
However, though I had been confident about my interviewing skills when I first began interviewing participants, I quickly became aware of my shortcomings. During the process of transcribing audio-tapes I had time to critically examine my style and note my errors. In particular, I noticed that I often left insufficient time for participants to speak; that is, I would move onto another question without fully exploring what they might be meaning. Indeed, it was humbling to listen and analyze these conversations. Nevertheless, since the acts of interviewing and transcribing took place in close succession, I was able to learn from these mistakes and hone my skills for the next interview.

In addition to maintaining professional and respectful relationships with study participants, I was cognizant of my theoretical commitment to postcolonial feminism and engaged in methods that fostered reciprocity described earlier in this chapter. I aimed to conduct interviews in an interactive dialogic manner that included self-reflection and elements of self-disclosure. Additionally, I readily shared information with participants and encouraged them to critique taken-for-granted beliefs (e.g., I commonly prompted participants to reflect on how life was better for them and their families in Canada).

Initial conceptualizations of the study included a plan to begin data collection with a series of focus group interviews and then to extend invitations to participants that had unique experiences. However, accessibility to participants overruled my intentions and data collection began as soon as individuals volunteered to participate. Ultimately, I did recruit several members of focus groups to expand on their insights in individual interviews. For example, I had a revealing interview with one participant who had declared during a focus group that she thought Philippine nurses were ‘willing victims’. I also had a more in-depth interview with a participant
who had worked as a RN in the US before returning to the Philippines and then migrating to Canada.

In total I held 17 audio-taped individual interviews and six audio-taped focus group interviews. Each interview, regardless of whether it was an individual or a focus group, lasted from one to two hours which seemed sufficient for interactive exchanges and self-disclosure. I began each by reviewing the Consent Form (see Appendix D), assigning a participation number, and asking participants to complete the Data Sheet (see Appendix E).

My Interview Guide (see Appendix F) consisted of seven open-ended questions and because I was interested in learning about experiences prior to arrival in Canada, as well as after, and about plans for the future, questions began with “Can you tell me how you came to decide to immigrate to Canada?”, and concluded with, “What are your thoughts about your future?”. Although questions often flowed in this chronological order, I did not necessarily adhere to this sequence of questioning nor confine my inquiry to the questions in the Interview Guide. Rather, after the initial question, I pursued cues elicited by participants and explored the subject matter they perceived most relevant. Also, answers did not necessarily emerge as a direct response to a question. For example, although I asked how life had changed since arriving in Canada, answers might emerge indirectly during an exchange involving plans for the future. However, during the course of the interview I tried to ensure that each participant had an opportunity to reflect on the entire set of interview questions.

While individual interviews offered an opportunity to explore in greater detail various individual attitudes, opinions, and experiences, and revealed insights that may not have been

37Although the term individual interviews suggests a one-to one researcher/study participant interaction, out of 17 individuals interviews, five were attended by participants who brought along a friend or sometimes a prospective participant.
gleaned from a group interview (e.g., despair associated with not being eligible for RN status in Canada), comments exchanged between members of focus groups often generated animated debates and yielded a greater breadth of understanding. As well, focus groups provided a means for participants to draw strength from one another (e.g., participants began to see that many of the challenges they faced seeking RN registration were not the result of individual deficiencies but were related to inherent barriers and inequities of existing structures) and to examine strategies for change.

Even though it may have been beneficial for participants to engage in individual interviews rather than, or, in addition to, focus group interviews (e.g., they provided an opportunity to expand on their situation in relative privacy), they appeared to be anxiety producing encounters for many. As mentioned earlier, participants arriving for these interviews sometimes appeared unexpectedly with a friend or another prospective participant. Though initially I had been unprepared for this eventuality, I quickly realized its benefits and began explicitly offering this option to other participants. Having the support of a friend appeared to mitigate nervousness. Also, the fact that I engaged in acts of self-disclosure and sharing of information seemed to lessen anxiety, as did respecting preferences for interview locations. We often met in social spaces such as public libraries, cafes, college cafeterias, and shopping malls. Additionally, rather than immediately jumping into my prepared set of research questions, I opened by offering refreshments and engaging in what I believed was non-threatening social interaction.

In contrast to those participating in individual interviews, those in focus groups generally seemed relaxed. They often appeared to enjoy socializing with other members and exchanging contact information. Unlike individual interviews, where participants determined the time and
location of the meeting, the organizers at the immigrant serving organizations made the arrangements.

Although I had envisaged that a focus group of four to six members was a manageable size, they ultimately ranged from three to nine participants. Further, since I did not know in advance how many to expect I had to prepare for any number. I remember my surprise when nine showed up at my first focus group interview. I adhered to my initial plan, however, and assigned each with an identity number, had each sign a Confidentiality Agreement (see Appendix G), complete the Data Sheet (see Appendix E), and then, following introductions, extended an invitation to comment on how they had decided to migrate to Canada. Though lively discussion usually ensued during these interviews there was always a tendency for some to dominate and frequently I had to tactfully seek opinions from less assertive members. Another problem I encountered with large focus groups was keeping track of which participant was speaking, as participants frequently interrupted one another and it was not uncommon for more than one to speak at a time. I usually concluded each session by inviting participants to make a closing remark; a strategy that worked well as it provided each participant with a final word and offered insight into issues deemed significant.

I anticipated I would need a sequence of two or three individual interviews to produce sufficient depth and breadth of understanding (Polkinghorne, 2005) but in most situations this was not feasible. The population under study had numerous time constraints, with many needing to balance jobs or the pursuit of employment with family responsibilities and educational upgrading activities. As well, in most cases, a single interview seemed sufficient for learning from the participant and clarifying my perceptions. However, I did schedule follow-up focus
group interviews. Due to the volume of ideas generated from these sessions, I found it helpful to meet a second time to clarify and reflect on my preliminary understandings.

*Utilizing observations.*

My immersion in the field offered many occasions to observe nurses educated in the Philippines in their pursuit of RN licensure and to consequently advance my understanding of structures shaping their experiences. I began entering my observations in an electronic journal on February 13, 2010, following my first meeting with a group of nurses attending a FNSG meeting. At the time I was waiting for my BREB certificate of approval and was establishing relationships with nurses in the community to develop awareness about my study. My first entry began:

There was a group of about 10 nurses. I was so keen to meet these women and excited to finally be in the ‘field’ after having spent so long planning and in the ‘literature’. But I also felt nervous. I felt like an ‘outsider’, or an ‘intruder’ and the power point presentation seemed too formal. I wonder if I’ll ever earn their trust?

I continued to make notes in my journal on a regular basis. I kept track of thoughts and ideas that occurred to me before and after meetings with my Advisory Group, my committee, and community members or when I came across something of interest in the literature. Journaling or maintaining an ongoing reflexive analysis of my work and my thoughts as I progressed with my research helped me to achieve greater understanding of how my values and attitudes were shaping my data collection and analysis.

I also kept notes about my observations during interview sessions. I referred to these notes as my field notes. Immediately following each interview I would audiotape and later transcribe them. These notes provided the context for each interview and I filed them with the transcription in a single folder. I usually began by reflecting on how the interview session went
in general. For example, the following field note dictated after a focus group interview captures my enthusiasm and my respect for the agency exercised by study participants.

This research is helping me uncover the stories beneath the surface…the backgrounds to the students I meet in the classroom. Now I can see that each student is like the tip of an iceberg…there is so much that I hadn’t noticed or paid attention to before…the educational, regulatory, immigration, and work related hoops that they have gone through to get where I see them today… sitting in the classroom, or working in the lab. It is truly amazing.

I also included specific details about what I learned from participants. For example, I paid particular attention to comments or exchanges that surprised or upset me. In one case I noted my surprise on learning that some participants, who had arrived in Canada under the FSWP, were relying on financial assistance from family members back home. I also recorded emotions that I had observed during exchanges, such as grief or despair when talking about an unsuccessful attempt at an English proficiency test or the gratitude expressed when somebody learned something new about navigating the regulatory process. I also recorded observations about the way in which participants responded to each other during group interviews. For instance, I entered a field note that participants frequently shared contact information and on one occasion offered to accompany each other in search of information. I found such insights helpful in understanding the meanings participants attached to their experiences. That is, these notes offered a glimpse into structures that constrained agency and strategies employed to negotiate such constraints.

According to Hammersley and Atkinson (2007) writing field notes enables ethnographers to move beyond mere data collection to developing ideas that will illuminate data. Indeed, this seemed to be the case. Ideas generated from field notes became a foundation for further insights. I would often discuss my notes with my committee supervisor and together we would explore how they were informing my theorizing. Additionally, they became a means for communicating
my interpretations with my Advisory Group. On one occasion when I expressed my dismay to an Advisory Group member that participants seemed to sacrifice so much to come to Canada, she helped me understand that migration was a “way of life”, that the West is perceived as a land of opportunity, that soap operas and movies feature families going abroad, and, further, it is a childhood dream to leave the Philippines. Insights gleaned from these exchanges were then tested with further data. The process of recording and transcribing field notes, and then reading, reflecting, and sharing them with others, informed my ongoing analysis.

*Employing documentary evidence.*

Beginning from the standpoint of participants I also conducted a document review to examine in detail how the domains of RN regulation, employment, education, and immigration intersected to shape experiences. This review led to questioning whether institutional practices at local, national, and international levels may have inadvertently contributed to marginalization and exploitation of this sample of nurses. As well, it directed my attention toward broader structures such as neo-liberalism, neo-colonialism and globalization, and caused me to query how they in turn contribute to oppressive practices and to explore whose interests these practices serve. My analysis, therefore, moved beyond the micropolitics of everyday experiences, to a deeper and more profound exploration of root causes of social and economic inequities.

*Managing data.*

Data management is concerned with protecting, organizing, and tracking the construction of data to ensure that it takes a form that can be readily accessed and used throughout data collection and analysis (Thorne, 2008). To safeguard confidentiality I assigned an identification (ID) number to each participant; attached the ID number to the actual data; and maintained identifying information in a locked file. Further, as I transcribed the tapes I took precautions to
ensure that any identifying information was removed. I used NVivo 8, a data management software program, to organize my data for ease of retrieval.

**Analyzing data.**

Analysis permits ethnographers to make sense of the information they have assembled. It is an iterative process and begins upon entering the field with the first set of field notes and experiences and continues until a fully developed and well-supported interpretation emerges (Hammersley & Atkinson, 2007; LeCompte & Schensul, 1999). Thus, to understand what they are observing, ethnographers must engage in several levels of analysis since the overall picture is not immediately apparent.

From the beginning I had an ongoing engagement with my data, continually comparing and contrasting findings and expanding upon conceptualizations. I found the following set of questions adapted from the writings of Emerson, Fretz and Shaw (1995) helpful: “How do participants talk about, characterize and understand what is going on?”; “What assumptions are they making?”; “What do you see going on?’; and “What did you learn from this?” (p. 146). Such questions helped me to develop interpretations rather than causal explanations of the data; to focus on the ordinary and taken for granted as well as on the unusual events and situations; and to elicit the meanings and points of view of those under study (Emerson, Fretz, & Shaw, 1995). As I read and re-read data and field-notes and considered these questions I produced memos which gave rise to codes and eventually to themes. Thus I moved from the particular to capture a more general theoretical dimension of nurse migration to Canada.

**Organizing data.**

As mentioned earlier, interview data was in the form of transcriptions from audio-tapes and as soon as possible following each interview I transcribed these recordings. Doing my own
transcriptions provided a lengthy engagement with the data and a familiarity that served me well once I began to code it. Listening and transcribing each interview, I was able to explore the data in a reflexive manner; to raise the questions posed by Emerson et al. (1995); to enter memos on the transcripts; and to reflect and re-consider my interpretations. Insights gleaned from this process often directed me to areas for further consideration (e.g., to explore structures that marginalized participants in Canadian society). Another advantage to doing my own transcriptions was that I learned to recognize voices and recall the sequence in which participants spoke. This helped to assign the correct code to the speaker. In some cases, however, due to the large number of participants and the fact they frequently interrupted each other, this was not possible. Here I simply had to assign “other” to the participant descriptor. As mentioned, after completing each transcription I uploaded it to NVivo 8.

To provide a pragmatic means of organizing data and making it readily accessible, I began sorting it according to pre and post-arrival experiences and further, according to the general questions outlined in my Interview Guide (e.g., “How has life changed for you?”). However, I had to resign myself to the fact that not all the data could be organized along pre-configured headings. For example, family reunification issues and efforts to settle did not necessarily fit under “How has life changed for you?”

As I became more familiar with the data, I noted a disjuncture amongst the accounts of participants who came to Canada along different immigration pathways. For instance, those who came under the FSWP often shared stories about difficulties finding employment in Canada, while live-in caregivers were typically pre-occupied with completing their live-in work contract, and TFWs largely focused on licensure experiences and integration into the RN workplace.
Consequently, I further grouped data according to participants’ entry visas. It was now easier to manage my large data set and to make comparisons and contrasts within and across groups.

*Open coding.*

As I read each transcript line by line, I paid attention to what participants were saying and I tried to bracket, or set aside my natural assumptions, and remain open to their narratives. By remaining flexible and permitting the element of surprise, I was able to identify events and situations that were significant to the participants (e.g., passing an English assessment test or failing the CRNE); recognize relationships between structures and experiences (e.g., between the type of immigration visa and the ease with which participants pursued RN licensure); and notice incongruence arising from experiences (e.g., participants becoming deskilled in Canada while waiting to enter a re-entry program). This open approach to coding fostered a wide range of new ideas, linkages, and connections.

*Focused coding.*

Through an iterative process of coding, reflecting, and memoing, and discussing my interpretations with my Advisory Group and my committee supervisor, my initial codes were refined and my approach became more focused. I selected core themes used by study participants to describe their experiences. Themes such as “we created a story”, “they don’t accept us”, and “the countdown” captured participants’ sentiments and were broad and theoretical in nature. They helped me to cluster experiences and conceptualize them as temporal sequences on a journey that began in the Philippines and progressed to Canada.

Clustering data in this manner directed me to the interconnectedness of structures and mediating oppressions at local, national and international levels and to relationships between structure and agency. Additionally, it helped me to understand the nature of decisions that
participants made at various points of their journey, to note narratives constructed to support
decision-making or justify actions, and to reflect on power dynamics at play. As one example, I
started to explore in more depth how particular kinds of stories were used to justify decisions to
migrate to Canada (e.g., for the future of their children) and to consider if these stories served
participants well.

Fostering Scientific Credibility

It is widely acknowledged that the measure of credibility of scientific statements in
qualitative research rests on the degree to which the researcher follows methodologically sound
principles (Crotty, 1998; Schultz & Meleis, 2004; Thorne, 1997). In this section I outline the
measures I took to ensure the scientific rigor of this qualitative research project. However, since
my goal as a critical researcher was to encourage praxis, as much as it was to generate
empirically grounded theoretical knowledge, in the final chapter of this thesis I will also put
forward recommendations for promoting social transformation.

Each qualitative tradition has distinct guidelines by which it may be judged
methodologically sound. Thorne (2008) suggests, however, that the rigor and credibility of any
qualitative project is grounded in a set of general principles: epistemological integrity (the
research question must be consistent with the epistemological standpoint and the methodological
strategies); interpretive authority (researcher interpretations are trustworthy and account for the
reactivity, or bias, that occurs within the research process); representative credibility (theoretical
claims need to be consistent with the manner in which the phenomenon are sampled); and
analytic logic (the logic of the research process must be apparent).
Epistemological integrity.

I contend the study had epistemological integrity. Knowledge claims arising from the data appeared compatible with the underlying assumptions of an ethnographic inquiry informed by postcolonial feminism. As well, the strategy of inquiry was an appropriate fit for the research question. It helped me to produce idiographic knowledge, or knowledge of the particular, about the context of the participants’ experiences. Additionally, data collection methods fit with the purpose of the research project.

Interpretive authority.

Interpretive authority is about assuring the reader that the researcher’s interpretations of the data are trustworthy; that there is some truth to the findings beyond the researcher’s own bias or experience and knowledge gleaned about the particular is credible (Thorne, 2008). To achieve trustworthy data, Patterson (1994) argues that it is necessary to account for the reactivity (the response of the researcher and the research participants to each other) that naturally occurs during the research process. However, she adds that accounting for reactivity is more than simply acknowledging the subjectivity of data collection; rather, it includes identifying how the researcher’s values, behaviours, attitudes and experiences inform the collection and interpretation of research data. As described earlier in this chapter, I consistently tried to incorporate reflexivity into the research project.

Representative credibility.

To achieve representative credibility I took measures to ensure that my theoretical claims were consistent with the manner in which I sampled the phenomenon under study (Thorne, 2008). As one example, I avoided making inferences from my study that apply to all nurses educated in the Philippines or to different ethnic groups of IENs; rather, I acknowledged that my
findings reflected the social processes associated with the specific group of IENs from the Philippines whom I sampled.

**Analytic logic.**

To illustrate my inductive line of reasoning and to clarify the logic behind my interpretations, I used numerous examples of verbatim accounts from the data in support of my claims. As well, I tried to demonstrate why or how I had selected such exchanges to underscore a point. I drew heavily on my journal entries and field notes and findings in the literature to help with these interpretations and tried to communicate to the reader how I arrived at a particular decision.

**Attending to Research Ethics**

To protect participants' rights and eliminate researchers’ biases, proposed research plans normally are subjected to institutional review (Polit & Beck, 2004). Prior to undertaking my research plan this type of ethical review was obtained from UBC, BREB and from sites I used for recruiting participants, the Research Ethics Review Board at VCC and the Research Ethics Board at Kwantlen Polytechnic University.

However, ethical issues in ethnographic research can be complex and solutions not always straightforward (Hammersley & Atkinson, 2007) and attention needs to be paid to ethical considerations throughout each phase of the research process (Goodwin, Pope, Mort, & Smith, 2003). Accordingly, from the outset of the research project I tried to anticipate ethical problems that might arise and in addition to obtaining the aforementioned ethical approvals, I implemented numerous measures to ensure that ethical considerations were properly addressed.

First, in addition to providing participants with information about the study prior to participation (see Appendices H and I) and providing them with time to review the Consent
Form (see Appendix D) in advance of the interview session, I reviewed the Consent Form with them to prevent any misunderstandings. Also, recognizing that qualitative research consent is often viewed as an ongoing, transactional process (Polit & Beck, 2004), I continuously checked participants’ willingness to participate with each new interaction. Additionally, for those participating in interviews with other participants I discussed measures to ensure confidentiality and had each participant sign a Confidentiality Agreement (see Appendix G) prior to participation.

Another important consideration to promote the safety and well-being of participants is to ensure that the research project is free of any sort of coercion, or any explicit or implicit threat of penalty from failing to participate in a study, or excessive rewards from agreeing to participate (Polit & Beck, 2004). It is recognized that the issue of coercion may require special attention when the researcher is in a position of authority, control, or influence over a potential participant (e.g., a teacher/student relationship) (Polit & Beck, 2004). Therefore, I did not engage my students as research participants. However, in consultation with my Advisory Group, on one occasion, invitations to participate in the study were extended to a former cohort of students. I also was mindful that participants might see me as someone who was in a position of authority to advocate to the regulatory body, to an educator, or to an employer on their behalf. Since my research role was to learn from participants not to advocate for them, I needed to be consistently self-reflexive: not only about how my values and experiences shaped my interpretations but also how I was presenting myself and the research to participants.

Aware that discussions related to migration and integration experiences might be upsetting, I took several precautions to minimize harm to participants. For example, I assured participants that, if necessary, I could direct them to counselling services. Further, I reminded
them at the beginning of interview sessions that they could refrain from answering a question, discontinue the interview, and ask to have the audio recorder stopped at any time during the interview. I also was sensitive to their verbal and nonverbal reactions to questions and if they appeared anxious about a matter, I ceased pursuing the subject. Though several participants cried during interviews and I turned off the audio recorder during these times, no one wanted to discontinue an interview or seek counselling. I did follow up with these individuals, however, after the interview session to check on their condition.

Although I understood that my research role was not to advocate on behalf of participants I found myself in the uncomfortable position during the course of data collection in which I felt obliged to notify the regulatory body of ethical concerns arising from the data. In particular, I was concerned about reports from participants about difficulties encountered while trying to meet the requirement for the 250 hour monitored Canadian work experience. Before presenting my findings at an international nursing conference I wanted to alert the regulatory body of these results and clarify my interpretation of the requirement. Therefore in consultation with my committee supervisor, I sent a draft of my preliminary findings to the regulatory body and met to follow up with my concerns. They appeared receptive to my feedback and explained an administrative particular about the requirement.

**Disseminating Data**

In compliance with the social responsibility assigned to critical ethnographers to produce transformative knowledge for action, I engaged in strategies to disseminate my findings in an ongoing process throughout my engagement with the study (see Fieldwork Calendar, Appendix B). I gave numerous formal and informal presentations of my research findings at international, national, and local conferences and symposiums. In addition, I discussed my findings with those
in positions to influence change at the provincial and local level (e.g., I initiated a meeting with educators, employers, and regulators to discuss strategies to support for IENs striving for RN licensure) and I plan to continue these efforts following completion of the study. I will also be sending participants a summary of the results; presenting findings to ISOs, educational programs, the regulatory college, the union, and nursing conferences; and publishing my work.

**Chapter Summary**

In this chapter I have offered a description of an ethnographic informed by postcolonial feminism and relational ethical theory that I used to pursue my research project. Further, I explained how I constructed data and accounted for strategies used to gain access to the field, recruit participants, and address sampling and data collection. I also accounted for how I managed and analyzed data and I outlined efforts for ensuring scientific credibility. Finally, I provided an overview of the ethical issues I encountered as the research project unfolded and illustrated methods taken to disseminate findings.

In the next four chapters I will present the results of the study. Consistent with an ethnographic approach informed by postcolonial feminism, each chapter of results is grounded in the experiences of the study participants. Further, each chapter represents a temporal sequence of a journey that begins in the Philippines and progresses to Canada; each influenced by and influencing the other (see Appendix J: The Journey to RN Licensure in Canada). The first chapter of results, Chapter Five, addresses experiences of nurses before arrival in Canada. Whereas, the focus of Chapter Six and Seven is experiences after arrival in Canada and in Chapter Eight I attend to thoughts about the future.
Chapter Five: Beginning the Journey - Seeking “Greener Pastures”

As Chapter Two depicts, the migration of nurses does not commence with arrival in Canada, rather the phenomenon begins with the decision to migrate. Accordingly, to understand the structures and processes shaping participants’ experiences pursuing RN licensure in Canada, I begin analysis with a detailed exploration of pre-arrival experiences. In particular, I examine findings arising from the two interview questions: “Can you tell me how you came to decide to migrate to Canada?” and “How did you prepare to come to Canada?” The major themes constructed from responses to these questions, “We created a story that Canada is a green pasture” and ‘Using “stepping stones”’, though interrelated, are separated for analytical purposes. Together, they comprise the first segment of a journey that starts in the Philippines and progresses toward RN licensure in Canada.

As I reflected on interview responses and field observations I was frequently impressed by their resemblance to those reported in the literature and presented in Chapter Two. They also often reflected what I had learned from students while teaching in nurse bridging programs. Therefore, as I present what I learned from participants in the next four chapters, I will also compare the findings to the literature and offer comments about similarities and differences.

Deciding to Migrate: “We Created a Story”

Participants expressed numerous reasons for migrating to Canada, but their rationale was typically linked to the notion of *hopefulness*. When asked, “Can you tell me how you came to decide to migrate to Canada?” most responded without hesitation, “for a better future”, and in particular, “for a better future for my children”. For many this was a dream or a magical story they created about re-locating to Canada; one that would have a happy ending for themselves and their families. One telling reflection was, “We created a story that Canada is a green pasture”
(Focus group 1213). I was interested in learning the origin of their “green pasture” characterization of Canada and, further, comprehending their compulsion to seek these “green pastures”. Thus I begin with an analysis of the substance of their dreams.

**Their dreams: “Land of milk and honey”**.

During numerous conversations with participants I learned that a better future for most meant a better economic status. One explained, “...number one priority, the number one reason, it’s economic. That’s why you come here” (Focus group 0126 follow-up). The significance of money was highlighted during one focus group interaction when participants discussed family expectations upon a return visit to the Philippines.

P\(^{38}\): It’s so hard to go back if you don’t have money; attained a certain thing.
P\(_2\): If you go back you’re expected to spend...everybody gets [something]...so when you go home...you’re like *up there* [emphasis added].
R: You have status when you go home?
P\(_1\): They expect something from you.
P\(_2\): Even though you’re like a cleaner here, or just cleaning somebody’s house, it doesn’t matter. As long as you’re abroad, you’re [respected].
P\(_1\): They don’t care about the status [in Canada]; they care about your money (Focus group 0210).

For this group money appeared to trump all; that is, life would be better, regardless of where they re-located, as long as they were able to earn money. I was not surprised to learn this from participants as it was frequently reported in the literature that the economy in the Philippines is dependent on remittances from abroad (Buchan, 2006; Choy, 2006). Moreover, I recall Rafael (1997) discussing that migrants have historically been treated with the deference usually

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\(^{38}\)The designation of P indicates a study participant. The designation of R indicates the researcher. Following each excerpt, the participant code appears in parenthesis. If the exchange occurred during a focus group interview the code number for the focus group appears in parenthesis and the different members of the group are distinguished by the subscript 1, 2, etc. Occasionally ‘individual’ interviews involved a second or third participant and in these situations participants are distinguished by letters A, B, C. The code for the interview also occurs in parenthesis at the end of the exchange. If the exchange occurred during a follow-up interview, the term, “follow-up”, is included in the description.
accorded foreigners when they return home and encouraged to be consumers; a factor he states reflects both the neo-liberal market economy of the Philippines and the legacy of American colonialism.

The destination country may have been irrelevant for some, but for others an opportunity to live in Canada was the realization of a childhood dream. One nurse, who had previously worked as a RN in both the UK and Australia and had come to Canada with a temporary work permit to work in an acute care RN position, expressed how he felt when he stepped off the airplane in Vancouver: “This is my dream; I’ve fulfilled my childhood dream”.

To further illuminate the substance of participants’ dreams, I turn to an exchange amongst FSWs:

P_1: It’s a status symbol being successful in a certain land.
P_2: Yes.
R: What’s a status symbol?
P_1: It’s a status, like a certain land like here in Canada. Successful nurse, successful doctor successful here.
P_3: Going abroad is the greatest achievement.
R: Oh, going abroad is the status?
P_2: Yeah.
P_1: It’s like a status symbol. Only the richest and the most famous people can go to a certain country.
R: Would Canada be considered one of those countries?
P_2: Yeah… it’s part of North America; it’s America (Focus group 0210).

The foregoing revealed the social status attached to going abroad particularly to a North American destination, such as Canada. As well, it drew attention to the fact that one’s economic position (“only the richest can go”) in the Philippines shapes ability to migrate, a factor that I will expand on later in this chapter. However, it also introduced the notion that the highest social status is derived from practicing as a nurse or a physician in Canada, or living the dream.

Another nurse, who had recently arrived in Canada under the FSWP, echoed a similar sentiment:
P: The goal is still there…the star is still there.
R: Which is the star?
P: To become a RN in Canada. Because when we finished college after a few months we started working already ...and so being a RN was our life. That’s all we know…caring for people (P1012 B).

For this nurse, her dream meant employment not merely residence in Canada.

Themes such as money and status commonly surfaced during interview sessions, but this next example shows not everyone shared the same motivation. This federal skilled worker stated, “Like money, it’s not a big deal ‘‘ we were making…I mean we were doing okay back home”.

Later, offering further insight into his economic situation he added:

’Cause we had a good practice back home…we’re both actually general physicians back home as well as nurses. I was going on duty as a nurse and I had my own clinic, so we’re debating to go or not. But then we decided okay let’s do it for the kids, ‘cause we wanted to have a better future, you know, a better education, stuff like that….so we decided to come (P0203).

For this participant, in contrast to most, money was not a major element of his dream; he and his wife, both physicians and nurses, appeared more concerned that their children have a better future.

Indeed, for those with children the notion of striving for a better future in Canada seemed to include a better future for their children. One mother who had migrated to Canada as a live-in caregiver three years previously, left behind her one year old son: “I want to give… my son a better future” (P0213A). However, I had difficulty ascertaining just what a better future might involve for this mother and because she looked sad and lowered her tone at the mention of her son, I shied away from the topic. During another interview, I tried once more to gain a better appreciation for what a better future for children might mean:

R: I hear that a lot of people say “for the future of my children”, but can you tell me more about that? As far as education?
P1: Education and opportunities.
Indeed, a desire for a better future for their children in Canada often included the hope employment opportunities.

Frequently discussions did not progress beyond this point and I was left wondering whether participants were deliberately withholding information or felt that the answer was so obvious that explanation was superfluous. At other times, however, participants were more forthcoming. For example, one nurse who had left her children behind to come to Canada as a live-in caregiver informed me that she had migrated chiefly for her children’s, “future immigration purposes” (P1028B). In contrast, another who had re-located with her children to Canada as a skilled worker mentioned that she had hoped Canada could offer an opportunity to spend more time with her children; in the Philippines she had to work long hours to support them. Another who had also immigrated as a skilled worker with his family offered that Canada granted his children an opportunity to get what they deserved in life; a prospect that was not possible in the Philippines.

Actually for me it’s not that we have a lower education back in the Philippines because modesty aside I could send my children to good schools ..., it is the political economic situation like even if they graduate from a good school they cannot earn the amount that is, you know, that they deserve (Focus group 1213).

His comment reflected hopelessness about life in the Philippines, another factor that is well recognized in the literature (Choy, 2006; Guevarra, 2010; Parrenas, 2008; Rafael, 1995,1997).

In addition to immigrating for economic reasons, social status, or their children’s future, I discovered a wide range of other motivations to migrate, specifically to a higher income country such as Canada. Freedom from political oppression was one example. This notion surfaced when
one participant attempted to clarify why he and his wife selected Canada rather than the Middle East as their destination of choice. He declared:

P: We’d heard bad stories about the Middle East so that’s why we didn’t want to go there.
R: What sort of bad stories?
P: Like, you know, all the women that are being oppressed and the culture is quite different than what we we’re used to. My wife believes in women freedoms; and the rights are so oppressed over there so she didn’t want to go there (P0203).

For this couple life in Canada promised greater liberty and a tolerant society.

This next example also linked the notion of freedom with migration to Canada, but freedom of a different sort. During one focus group interview several younger participants who had immigrated under the FSWP reflected that a key component of their dream involved freedom from family constraints:

Like we actually were talking about it. We were going out the other day and we were just talking about …why we decided to come here. Then suddenly it just came to us, “‘cause we’re both the youngest in the family and we just found out that it’s one of the best reasons for us…to be away from our families” (Focus group 0210).

This recent self-discovery of motive reminded me once again of references in the literature to migration becoming a way of life in the Philippines (Choy, 2006; Guevarra, 2010; Pratt, 2010; Rafael, 1997; Ronquillo et al., 2011); that drivers of migration may be taken for granted or relatively invisible to individuals.

Yet another motivation was revealed by a participant who had worked in the Middle East for approximately ten years prior to immigrating to Canada as a skilled worker. She raised the point that she had come to Canada for health reasons:

For my asthma I had a lot of medications for this thing. I took Ventolin, I took Symbicort puffer. The environment is not good [in the Philippines]. When I tried to see a specialist then he advised me if you have the chance to go to Canada then, “this the right place for you, for your health” (P101).
This participant also shared at various points in the interview that she hoped Canada could offer a better education for her daughter, improve her economic status, and provide her with an opportunity for a professional RN career. The diversity of motives alerted me to the fact that there was no single driving force compelling these nurses to seek greener pastures in Canada.

Analyzing the commonalities across the data thus far, it appeared that the dream of migration to Canada provided hope: about their future and that of their children. The specific elements of the dreams, though different, usually included the ideas of improved economics and better educational prospects for their children. Additional elements were living in a fair country, RN employment, and increased social status in the Philippines. I now turn my attention in search of some possible origins of these dreams.

**Structures shaping their dreams: “So I’ll go there”**.

As I proceed with analysis I attempt to expose underlying structures compelling participants to search for “greener pastures”. Further, I aim to examine how such structures limited or empowered participants’ decision-making or their agency to move forward with migration, and to speculate on who may benefit by these dreams.

**“The salary is just too small for a family”**.

Participants commonly cited limited opportunities for employment in the Philippines and low incomes as incentives for migration. One stated, “Because there is a lot of unemployment now there. Those who are unemployed are already university graduates there” (P1028). In other interviews the suggestion arose that the economic situation in the Philippines was dismal even for those with jobs. One nurse explained, “Like salary wise. A month’s salary in the Philippines is just one day salary here” (Focus group 0210). Further, one nurse said there was no will on the
part of the government to rectify the situation: “...the Philippines they are not doing anything about the wages of nurses so it’s kinda like they can’t really complain why people leave” (P1012). Listening to these exchanges reminded me of the notion of “forced migration” that Pratt (2012, p. 144) alludes to in her description of the migration experiences of domestic workers. Similar to findings by Pratt, these participants recognized that the economic situation in the Philippines left them with no choice but to seek overseas employment.

Another nurse put the economic situation into perspective when she offered, “Well first of all I worked in the community in the Philippines and um you know in the Philippines you know the salary is just too small for a family” (P0213A). Shedding further light on why prospects were bleak, another pointed to the Philippines’ private education and health care systems as contributing factors and explained, “Expenses are majority from out of pocket in health and education where the private sector always offer better and quality services because of the meagre government investment in health and education” (P0705). In another discussion two live-in caregivers, were quick to draw attention to the government’s lack of investment in education as a factor compelling them to migrate:

PC: You tend to give your children to private schools because if they go to public schools they will not learn anything because of the number of [students].
PB: Too much over-populated.
R: And so to get a better education in the high school years you need to pay to go to a private school?
PC: Yes.
PB: And also university.
PC: And usually for us to have a job there, you have to be a university graduate…and you have to go to …
PB: It’s politics.
PC: Go to well-known, I mean very good schools, and that costs a lot and of course because of the unemployment parents tend to send their children to the good schools so that they will have employment after college (P1028).
Citing the government’s limited investment in health as the main factor that compelled her to migrate as a temporary foreign worker and leave her family in the Philippines, one stated:

I will tell you the reason why I came abroad…..so my daughter got really sick. We have to stay in the ICU for 2 months. We have to spend everything that we earned…sell properties just to come up with the millions of pesos she needs for the hospital. So we are bankrupt, we are totally bankrupt. That’s the reason I came abroad. If I am not bankrupt because of my daughter’s condition I would prefer to stay in my country (P0801).

For this participant, although she had nursing employment in the Philippines, remaining there was not an option. An underinvestment in a public health care system had driven her to look for greener pastures abroad.

Another informed me that though it was her family’s tradition to help each other, it was also a necessity, as the government could not be relied on for financial assistance:

That’s the way it is. So, I’m the first and so I decided in order for me to help my parents for my two sisters, they’re still in university at that time, so I decided to go here in Canada,…it’s our tradition in our family that we have to help each other. …we don’t have loans there, for student loans; we don’t have funds from the government. If you’re gonna send your children to university it’s from your own pocket (P1116).

In this foregoing example the need to migrate seemed to be fostered by a tradition of interdependency among family members, in addition to limited financial support from the Philippine government. Again, remaining in the Philippines was not an option for this participant.

One participant who had been both a doctor and a nurse shed further light on the economic climate in the Philippines when she explained why she and her husband had at one time contemplated re-locating to Bangladesh to work as domestic helpers:

You can see the mindset of Filipinos going out to sustain their families in the Philippines. So it’s anywhere. Because really the economy cannot support and the government already embraced the fact that to sustain this economy it just has to continue exporting its people to the labor market (P0705).
Similar to findings put forth by Guevarra (2010), this nurse’s comment indicated that nurses educated in the Philippines have limited autonomy with respect to decisions to work overseas; that they have become a commodity\textsuperscript{39} for export and are being exploited\textsuperscript{40} by the Philippine government.

During another discussion when a participant who had come to Canada as a live-in caregiver was lamenting the difficulty of acquiring RN licensure in Canada, I asked if she thought rigorous Canadian regulatory requirements would deter future nurses from re-locating to Canada. She replied that nurses would migrate regardless and provided the following rationale:

P: ’cause back home we’re really overpopulated, it’s more than 90 million, and then a lot of nursing graduates are unemployed. And so they still want to come.

R: Because?

P: It’s a passport.

R: It’s still a better option?

P: Yeah, rather than staying back home unemployed (P0120).

From the perspective of this participant, underemployment in Canada was more appealing than unemployment in the Philippines.

“Everybody was going away”.

While political and economic situations in the Philippines may have been key factors compelling study participants to seek RN employment abroad, encouragement from family and friends was another. One RN who had come to Canada under the LCP stated:

I decided to come to Canada, through the regular encouragement of my siblings, who entered here as immigrants. …they used to tell me “you are staying long in Saudi Arabia, what about your immigration status? Just think of the future of your children” (P1028B).

\textsuperscript{39}I use the term commodity to refer to a service for sale in the market place (Coburn, 2010).

\textsuperscript{40}I am drawing on Iris Marion Young (2011) to use the concept of exploitation to describe oppression that occurs through the process of transferring the results of the labour of one social group to benefit another.
Whether encouragement came from family members living abroad or at home, it seemed to be a significant factor shaping migration decisions and in some cases, it constrained agency. For example, in this next excerpt, parents in the Philippines along with a family member in Canada were driving forces behind this nurse’s migration plans:

I came here because I have a sister here who’s living already two years…so my parents really wanted me to come here, for me to have a better future…. Yeah, I’m enjoying life here. I chose Vancouver because my sister is here, and I have no choice. And that’s it. I just need to accept the fact that I need to be with my sister (Focus group 0210).

Although it is impossible to discern her parents’ underlying motives, it is clear that migration for some may be considered an honorable endeavor. This point was illustrated by another participant: “But really it’s [going abroad to work] Filipino, I mean our families, they look up to us if we get out of the Philippines” (P0705).

The next example further illuminated the extent to which family pressure may have constrained decision-making. In this circumstance a nurse described how she had let her mother down when she failed to meet immigration requirements to work in the Middle East:

That’s why my mum is so mad with me. I had just graduated and got my license and she was counting on me to …be of help with them in their schooling knowing that I already have my RN license. And then for sure I can go overseas to work and then earn big money (P0120).

Additionally, this foregoing scenario underscored the interconnectedness between gendered responsibility associated with caregiving in the Philippines and decisions to migrate, a relationship that is well described in the literature (Parrenas, 2008).

In addition to encouragement from family members to migrate, peers may have an influential role. One study participant illustrated this point stating: “… everybody was going away to different countries and we were like, ‘Oh my gosh, I’ve got to get out of here’ ‘cause
everybody was going away. So that’s what drove me to apply to Canada” (P1012). For this nurse the notion of migration seemed entrenched in her everyday life. It was a societal expectation that required little reflection.

“So you’ve got to make a sacrifice”.

Discussions related to how decisions about going abroad were also frequently couched in terms of self-sacrifice and moral responsibility. Even those who had claimed that the decision to migrate was their own would often add that it was intended to serve the interest of others (i.e. family member(s). One nurse who had come to Canada with his wife and young family under the FSWP explained:

R: Was there pressure perhaps from family to migrate?
P: Not at all. It was totally our decision. They were holding us back. They wanted us to stay back home…because we had patients, we had stuff going on and so they just wanted us to stay. But we decided to go because of, we were thinking of the children (P0203).

From this participant’s perspective, although he and his wife felt the decision to migrate was made independently, the sake of their children was a factor. He seemed proud of his sacrifice.

The same sentiment arose during other interview sessions. One male nurse who had migrated with his family under the FSWP confided that he had sacrificed his medical practice and a good income in the Philippines for the future of his children, “I would like to explain to them that I migrated here with my children because I wanted to give them a better future. Actually it’s a big sacrifice for me. I left my profession, fairly lucrative practice” (Focus group 1213 follow-up). In another instance a nurse coming to Canada as a live-in caregiver described enduring a lengthy separation from her family for the sake of her children’s future:

R: How long have you been apart from your family?
P: Here in Canada, 4 years. Plus 9 years in Saudi Arabia.
R: Wow, it’s a long time
P: It’s a challenge (I think she is smiling). I need to be away from my kids
because of their education…that’s my main reason I had to leave the Philippines…They have to continue with their college…and education in the Philippines is so expensive and so you’ve got to make a sacrifice (P1028B).

Again, staying in the Philippines had not been an option for this nurse; rather, she seemed to accept that making sacrifices for family, such as enduring lengthy separations, was a necessary even noble sacrifice. Another commented that people from the Philippines are “willing victims”.

When I asked her if she could expand on this idea she replied, “You know what the consequences are, you know it is unknown out there but any place other than the Philippines is a better choice. ‘So I’ll go there. I go there’” (P0705). So, from her perspective, despite the prospect of further unknown challenges, she was willing to take the chance.

Shedding further light on their inspiration to make sacrifices for their family, one participant explained:

Because we…Asians, not just Filipinos, feel that we have a moral responsibility to care for our parents when they grow old…like they took care of us when we were a child. I don’t know what you Europeans or Americans feel about it? (Focus group 0210).

While some felt empowered by such self-sacrifice, it is also possible that the moral responsibility associated with going abroad may have constrained decision-making. In the next scenario a nurse recalled how she had been coerced to serve the needs of her family members living in Canada:

It wasn’t actually my plan to come here. I was trying to process my papers to go to, like any other nurse, they would prefer to go to the US…but then my relatives who, ‘cause I do have relatives here, and they would want me to come here and live with them for like to stay with them like a caregiver….And so I have to come here as a live in caregiver. And so I have no choice but to come here (P1219).
In this case, familial responsibility intersecting with moral and perhaps gendered responsibility contributed to her sense of powerlessness\textsuperscript{41}.

\textit{“I’m sorta westernized in the American system”}.

A familiarity with the West may also have inspired dreams of greener pastures that many alluded to at various points throughout the interviews; a familiarity that Choy (2006) argues is a legacy or a consequence of American/Philippine colonial relations during the first half of the 20\textsuperscript{th} century. For instance, one nurse provided the following rationale to explain her interest in immigrating to the US:

’cause Philippines has [American base], at that time we were under Americans, for how many years? And so I’m sorta westernized in the American system…we’re used to the American system…because…the US base was there…a long time (P1116).

For this nurse the presence of American military in the Philippines fostered a sense of American identity.

As well, participants often made reference to the fact that they felt comfortable conversing in English; another example that Choy (2006) contends is a remnant of their colonial past:

You know, I have been taught English since I was in grade one and I have been using English until I become a doctor. In every conferences we use English, the newspapers we read are in English, the books are in English. The movies that we watch, the news television that we watch, CNN, BBC, are in English (Focus group 1213).

Others told me that Philippine movies often featured families going abroad to the US. Another participant said that it is common for people in the Philippines to hold childhood dreams of

\textsuperscript{41}Drawing from Iris Marion Young (2011) once again, I am using the term powerlessness to depict a form of oppression in which individuals are denied the capacity to make decisions or to develop to their own capacity in their working lives.
migrating to “America” because “you have seen a lot of pictures from ads, from your relatives, from your neighbours... and you also want to go there” (Focus group 0210 follow-up).

In addition to a lengthy exposure to American culture while living in the Philippines, some nurses suggested that their familiarity with it arose from experiences working with Canadian nurses in the Middle East. One stated: “My co-workers before are all Canadians in Dubai. …and that’s one of the reasons people come to Canada…they meet Canadians in Dubai.” This nurse had worked for 15 years as a nurse in Saudi Arabia and Dubai before coming to Canada as a live-in caregiver.

“This is a chance for us”.

Canadian immigration policies also shaped migration decisions and provided a sense of hopefulness for study participants. All three groups of participants, those who arrived in Canada under the LCP or as FSWs or TFWs, disclosed that the ease of acquiring Canadian immigration approval was a key factor determining their selection of Canada as a destination. Live-in caregivers frequently expressed surprise over the short wait period for their immigration papers, especially if they were emigrating from the Middle East:

So the agency offered us to come here as a live-in caregiver. So I quickly decided to get the offer. So right away I got the agency 2008, July, and then I paid the fee, August. And then from then we started the processing and I arrived here in Canada. I got my visa November and I come directly from Saudi. So, it only took me four months. So it’s really fast (PO213B).

Also, the fact that Canada offered an opportunity for eventual permanent resident status for live-in caregivers and their families may have prompted the aforementioned nurse, a mother with three children in the Philippines, to comment, “For me even whatever reason or way that I could come here I would grab it. Because opportunity-wise I know I can have a better future here in Canada than in Saudi” (PO213B).
However, I also learned from participants that the ease of Canadian access could suddenly shift, or that opportunities to work abroad were fleeting in nature, and accordingly decisions to migrate had to be made hastily. For instance when I further asked the above-mentioned nurse if she had considered going to the US, she replied, “Canada was the fastest and so I grabbed the opportunity” (PO213B).

Similarly, skilled workers implied that decisions to migrate to Canada were often made quickly while the opportunity lasted. For instance, one stated, “It’s because Canada at that time was accepting immigrant families, independent immigrants. This is a chance for us [emphasis added]” (P0705). FSWs were also impressed by the short amount of time it took to complete the Canadian immigration process. One commented, “…it took us about just eight months to process everything. Which is pretty quick because some of my relatives here when they came it took them five years of waiting time before they could process their papers” (P0203). However, the ease of entry into Canada may have prompted another to act pre-maturely:

Well I started in UAE. I applied in an agency. I came with a friend. I actually, me and my wife, just um help her to apply but in the process of assessing we were also assessed, we also applied then. So it’s not really our option to go to (Canada)...we don’t have any plan to go here (Focus group 0126).

At the time of this interview the participant was upset about his decision to come to Canada as he only learned after arrival that it would not be easy to secure his Canadian RN license.

This next exchange illustrated another important factor that shaped the desire for many participants to come to Canada: the difficulty of acquiring an immigrant visa to the US in a timely manner\textsuperscript{42}. While Canada was granting priority immigration status to nurses at the time of

\textsuperscript{42}The US Department of State (DOS) has quotas on the number of immigrant visas (green cards) available each year for immigrant visa categories and countries. In 2005, due to the high rate of demand for immigrant visas from nurses from the Philippines, the DOS began to impose limits on the number of immigrant visas issued to these applicants.
this study, the US was imposing restrictions on them. Consequently, most expressed appreciation for being able to enter Canada, but some were disappointed at being denied re-location to the US. Their disappointment may have been worsened by the fact that those who were on a waiting list to go the US (held visa certificates to work in the US) had already met American requirements for RN licensure and, as such, would have been eligible for RN employment upon arrival:

I have a license in the United States. Since 2005 I have a visa certificate. …I’m not serious actually coming here in Canada. I’m serious in going to the US. So my agency told me in Dubai that it will took for more than two years to come here to Canada, since I started with my application. But eventually the visa was given. I just only [waited] for about 6 months so I’m not really prepared to come here. Just only anxiety (Focus group 0126).

This participant was currently underemployed as a support worker in Canada and fearful that she may never achieve Canadian RN licensure. She expected she would have had RN employment in the US if she had been able to secure an entry visa.

In keeping with findings reported in the literature, (Buchan, 2002; Kingma, 2007; WHO, 2006), participants, in particular those who came to Canada as FSWs and TFWs, mentioned that job opportunities or the demand for nurses in Canada inspired them to re-locate; a sentiment expressed by this next participant:

One of the important reasons why I chose Canada, the agent that we applied for umm told us that they we’re needing nurses. There was a list of federal skilled workers that Canada needs and the process would only take a year. So we took the opportunity and we got oriented about it. So, Okay, why not? Canada is a great country. It is a stable economy and they are needing nurses and so that means they need [emphasis added] us” (P1012B).

However, at the time of this interview the participant was struggling to find an employer to fulfill the regulatory requirement for a Canadian work experience and I noted his frustration as he

This has caused a temporary backlog or "retrogression" of visa numbers and consequently nurses from the Philippines have to wait until their priority date becomes current before they can receive an immigrant visa (Jackson & Hertogs LLP, 2013).
explained his situation. Having come to Canada with the impression that his skills were needed, he now faced uncertainty about his future.

Thus, the ease of acquiring Canadian immigration approval and the demand for nurses inspired many to seek Canada as their destination of choice. However, my findings also indicated that this ease of access caused some to act impulsively and be less than adequately prepared for life in Canada. Additionally, I learned that for some, Canada was a second choice; those with American RN licensure would have preferred re-locating to the US if they had been able to obtain immigration visas.

“It was God’s plan us coming here to Canada.”

Yet another factor that shaped decisions to migrate was a religious belief that their lives and/or daily decisions were part of a larger pre-determined plan. During one focus group discussion participants tried to help me understand ‘God’s’ role in their decision to migrate to Canada:

P1: It’s a purpose why we’re in Canada not in other countries.
R: Oh, so it wasn’t necessarily your plan?
P1: It was God’s plan us coming here to Canada not to another country
Others: [nodding and expressing agreement]
P2: ... it’s like when we applied for the visa, it’s like we wanted to come here but we’re not sure if we’ll be granted for it and so we offered everything, like say, “If it’s Your will, then I’ll be there”, something like that (Focus group 0210).

When I asked the group if they could expand on their perspective, they added:

P1: It’s like a big hope in your head…basically.
P2: Something better is coming up for you.
P3: So if this door was closed, then a window will open for me [laughter].
P1: Like the US was closed, Canada was open [laughter] (Focus group 0210).

Thus, religious beliefs, in addition to relieving them of the full responsibility for their decision to migrate, also provided a sense of hopefulness or optimism for a brighter future. In another
Interview a nurse put it this way, “I keep on praying. ‘Lord, I know You are not gonna leave us. You made us come over here. You have a purpose. I know that I trust in You one hundred ten percent’” (P0413). In addition to offering hope for a better future, this woman’s Christian faith seemed to make her feel less vulnerable.

**Summary.**

In summary, participants revealed green pastures, or structures inspiring migration, included opportunities for improved economic situations, increased social status, RN employment, and better prospects for their families. The findings I synthesized from the participants’ accounts also revealed, however, that structures fueling migration were mediated by social and economic inequities in the Philippines; encouragement from the Philippine government to migrate; traditions of moral, familial and gendered responsibilities; an American presence in the Philippines and an ongoing exposure to Western media; religious beliefs of a greater purpose in their lives; market forces that led some to believe they were needed overseas; and Canadian immigration policies that prioritized nurses and offered Canadian citizenship. Such structures had the potential to empower some and constrain others. They also revealed the inevitability of nurses’ migration. I learned that migration is a social issue; that decisions to migrate were seldom made in isolation and further, it may not have been a matter of choice for some. I now turn my attention to an analysis of structures that shaped participants’ preparation for migration.

**Preparing to Migrate: Using “Stepping Stones”**

The focus of the second part of this chapter is the participants’ responses to the interview question, “How did you prepare yourself to come to Canada?” Many alluded to the fact that preparation for going abroad required taking a series of “stepping stones”. For instance, one live-
in caregiver said, “I know that [being a live-in caregiver] is temporary, a stepping stone for myself”. Indeed, analysis exposed four stepping stones that participants typically took in preparing to re-locate to Canada: pursuing nursing education in the Philippines; gaining RN work experience; seeking Canadian immigration status; and for some, initiating the application process for RN licensure in Canada. Although the analogy of “stepping stones” suggests that migration pathways are linear, beginning with becoming a nurse in the Philippines and proceeding chronologically towards migration, in reality participants revealed that migration pathways were often more convoluted, with some, for example, only deciding to migrate after graduating as a nurse or after having gained RN work experience. However, this conceptualization is helpful in that it illustrates that there are a series of steps necessary to acquire RN employment in Canada. In this section I aim to understand participants’ experiences as they made their way along these various steps.

**Stepping stone #1: “Taking up nursing”**.

Some stated emphatically that they had entered nursing school for the purpose of going abroad:

P₁: Most of the young people are taking up nursing so they can [work overseas].
P₂: All of them.
P₁: …because they know that it’s their ticket [emphasis added] out of the Philippines (Focus group 1213).

While I had learned earlier in my analysis that nurses educated in the Philippines were considered by to be commodities for export, in this foregoing exchange participants implied that the nursing profession itself had been a commodity; that it offered a ticket for migration. This perspective was not uncommon among participants and supported findings by Kingma (2006)
and Choy (2006). Further, similar to findings in this body of literature, many revealed that they had pursued nursing as a second career as a means to emigrate:

Well you see the trend back home is everybody is taking up nursing as a second job…I guess a lot of people are trying to get out of the country and that is one of the options that they took…but for us…a fallback or something…just in case (P0203).

For this participant, who was also educated as a physician, the profession of nursing had been an insurance policy; a career to be used if needed. He also referred to nursing as an “investment” for future purposes and said, “You know the reason that a lot of families send their children to nursing schools, right? And the thinking I guess is to get them out of the country and send remittances back home…probably an investment [emphasis added] or something”(P 0203).

While several had been physicians prior to pursuing RN licensure, many had held other prior occupations and this next participant, like numerous others, held a previous degree:

P: …before I graduated from BSN I graduated in BA majored in political science.
R: So when you decided to go into nursing in the Philippines to get your BSN were you thinking that if you went into nursing that this would provide you with opportunities to work abroad?
P: Yeah, that’s right. But most of the Filipino nurses they are not working in the Philippines. They are working abroad (P101).

From the perspective of these nurses the profession of nursing was linked to emigration.

However, not everybody had pursued nursing with the intention of working abroad; for some the nursing profession was more than “a ticket”, it was a calling. For example, the next participant while acknowledging that nursing was a “passport,” also explained that an interest to serve others had been a major incentive for embarking on a nursing career:

R: What prompted you to go into nursing in the first place? Was it to go abroad?
P: Yeah, one thing…since I was in high school that’s my career choice. That’s the course that I wanted to go into because my father had an accident when he was working abroad and then he was bedridden for a year. That’s why it interests me to go into that program. Because nursing career is a rewarding career. You have to be hands on, looking after someone who is ill, you have to be caring. So that’s the
number one decision that I made.
R: But also, to travel?
P: Also a passport [emphasis added] to go abroad (P0120).

The notion that nursing was highly regarded in the Philippines was not a new concept to me as I had learned while attending an international nursing conference in the Philippines in 2011 that it was considered a noble profession. As I explained in Chapter Four of this thesis, the mayor of Cebu in his welcome address at the conference had stated, “The best work of life is service to humanity”.

Though it was commonly acknowledged that being a RN in the Philippines offered an opportunity for migration, some disclosed it was not their decision to study nursing; rather, it was imposed on them by family members. One nurse stated, “… it’s the choice of my sister…who sent me to college” (P0801). Unable to afford university she had become dependent on a family member for financial assistance and as a consequence needed to forfeit her own aspirations.

To help me understand how commonplace it is in the Philippines to become a nurse, this next group of participants described the recent development of a vast number of private nursing schools, a phenomenon that also matches findings discussed in Chapter Two and that illustrates the extent to which the profession has become commodified in the Philippines (Kingma, 2006):

P₁: They [private schools] sprouted like mushrooms.
P₂: They produce some [nurses] that are not so qualified.
P₃: Yes. The chances to pass the licensure [exam] are very low. That is why the government is now regulating them.
P₄: ‘cause [private] schools are expensive and they just accept students…..I met some people who just graduated even if they barely know half of the lessons which is bad. I mean, [private] schools just taking out money from people (Focus group 1213).
This foregoing example also raised concern that those attending private schools may have been at risk of exploitation and receiving an inferior education; consequences also reported in the literature (Kingma, 2006).

As Guevarra (2010) reported, participants also revealed that pursuing a career in nursing was not for everyone. This next example illustrated the expense associated with becoming a RN in the Philippines and the measures some took to fund themselves.

R: You got your BSN also in the Philippines?
PC: Yes, it was my second course. When I was younger I went to the university. And I was out of the country because of unemployment and then go back because when you go to nursing at the first, when you are younger, it is very expensive and we cannot afford it because we are poor.
R: So you went out of the country to earn money to go into nursing?
PC: Yes, to go back to school (P1028).

Not only does this exchange support findings cited in the literature that nurses are predominantly from middle-class backgrounds, it underscored Kingma’s (2006; 2007) observation that some nurses take indirect routes to their final destination, using stops along the way in countries in the Middle East, for example, to develop skills and credentials and earn money.

**Stepping stone #2: Finding “a training ground”**.

Following graduation from nursing school, the next step in the immigration pathway was to acquire RN work experience. Although such experience did not appear to be a requirement for RN positions in the Middle East, it was a requirement for those interested in immigrating to Canada as FSWs\(^\text{43}\) or TFWs. Unable to find paid work experience, however, some participants took volunteer positions in hospitals in the Philippines and as this next nurse explained, sometimes even had to pay for this experience: “Many nurses now are doing voluntary work just

\(^\text{43}\) Potential applicants for the FSWP require at least one year, continuous, and paid RN work experience (CIC, 2012d).
to get experience. They do volunteer work in the hospitals and pay [emphasis added] the hospitals to get their voluntary employment… before going out to other countries” (P1028B).

While the hospitals were clearly exploiting these nurses, the nurses were also benefitting from having the work experience:

PC: Yeah, well I think people like us, before applying to the States, we just think of our hospital as solely as getting experience, that’s basically [it].
PB: Like a training ground.
PC: Yeah, like a training ground…or, something that we can learn by or can get experience but not really something that we love doing. We are just there mainly for the experience and not really there because we love doing the job.
P: Yeah.
PC: Like I say that loving the job in, for example in totality…but we only love the experience of that job, that’s it.
R: Because…?
P: It’s overworked and underpaid.
PC: That’s it, that’s it (P1012).

As these participants explained, they perceived their places of employment as “training grounds” for future immigration purposes.

Again, as shown by Kingma (2006, 2007), going to the Middle East was also a means of acquiring RN work experience. For instance, the participant mentioned earlier who had first worked in the Middle East to acquire necessary funds for a nursing education, reported that the Middle East also provided work experience unavailable at home after graduation:

PC: ..and then when I graduated I was able to pass the licensure exam there in the Philippines and then do some voluntary work there in the hospitals and there was a friend who said ‘You want to go there? And, it’s better to go there [Middle East] and have experience while being paid’. While you are here in the Philippines you do voluntary work without pay and you even pay the hospitals and after the university you are drained because it is very expensive. You don’t have any money. Transportation, food, and (sounded very emotional)
P: Books.
PC: And so I say ‘I will try’ and I go out of the country.
R: Where did you go?
PC: I went to [the Middle East] (P1028).
This nurse worked for almost two years as a RN in the Middle East before ultimately finding her way to Canada as a live-in caregiver. At the time of our interview she had completed her live-in caregiver contract but was struggling to meet Canadian RN licensure requirements. Worried that she might remain “stuck” and underemployed in Canada, she was researching the option of becoming a LPN.

Those who sought RN work contracts in the Middle East for future immigration purposes told me that while such contracts provided them with valuable experience, there were drawbacks. One nurse who had re-located to Canada as a live-in caregiver described being concerned that her employer in the Middle East would not “allow” her to break her work contract before finally “releasing” her:

And I did not even finish my contract there and I thought I will not be able to come here in Canada because they will not allow me, “You did not finish your contract”. “But my visa has already arrived, I have to go”. And I have to talk to the director of the hospital. “I have to go, this is my only chance to go over there and if I will not go…please”. So, he was able to release me earlier (P 1028).

While she had been allowed to exit her employment, she disclosed she worried that her employer would not submit the necessary employment records to the BC RN regulatory college. For this nurse, the urgency to immigrate may have jeopardized her ability to pursue her nursing career.

Stepping stone #3: Immigration, “a lot of fees.”

In addition to needing funds to support an RN education and then RN employment to fulfill the work experience requirement for immigration purposes, participants also disclosed challenges associated with meeting financial requirements for immigration. This was a particularly daunting task for those who had applied to Canada as FSWs. Participants in one focus group were particularly forthcoming about such challenges. One put forth, “Yeah, a lot of fees, a lot of fees” and another commented, “We have to go through the eye of the needle before
we can come”⁴⁴ (Focus group 1213). As they explained, “There are two fees … to pay when you come to Canada, one is the processing fee for the applications [immigration] and then the landing fee which gives you the right to land in Canada⁴⁵”(Focus group 1213). In addition to these fees which amounted to approximately 3,300 Canadian dollars for a family of four, participants recounted needing to have “show” money⁴⁶:

   P1: Plus our show money which is…20,000 dollars  
   R: Your what money?  
   P1: Show money.  
   P2: Settlement money.  
   P3: Proof of funds (Focus group 1213).

They also talked about needing to pay fees to complete medical examinations and to cover travel and re-location expenses. One nurse added, “In addition to that proof of funds you also have to have the 8,000 - 10,000 dollars for the consultancy fee”. Another explained, “A lot of Filipinos choose to go through an agency because they thought the processing, the facilitation of papers, will be easier”. When I asked these same participants how they had managed to meet these expenses, they replied: “That’s why we owe a lot” and “We applied for loans”. During interviews with other participants I also learned that some had sold businesses or properties or used their savings from the Middle East to meet expenses. One nurse put it this way:

   It is not easy for an ordinary Filipino to meet all the [FSWP immigration] requirements especially the financial aspect. I heard of several stories about

⁴⁴ Acknowledging the difficulty of preparing for their journey to Canada several referred to a phrase from the Bible in which Jesus said: “It is easier for a camel to go through the eye of a needle, than for a rich man to enter into the kingdom of God” (Matthew 19:24). From the perspective of these participants it appeared that the challenges encountered in preparing to enter Canada were as rigorous as those confronting individuals trying to enter heaven, or the kingdom of God.

⁴⁵ The processing fee ($550 per adult and $150 per dependent) is payable to the Government of Canada and has to be fully paid when an application is submitted. The Right of Landing Fee ($975 for applicants and accompanying members 22 years and over) is due when the application has been approved by the Government of Canada and the visa is ready to be issued (CIC, 2013b).

⁴⁶ Applicants under the FSWP also must show that they have enough money, or proof of funds, to support themselves and their dependants after arrival in Canada. This amounts to $20, $654 for a family of four (CIC, 2010).
accumulating the needed money for the immigration. One has to sell properties like their family house, farmland, farm animals and implements or borrow money from banks and lenders with interest rates between 12 to 20 percent per annum. Some would borrow money from parents and other relatives. One would be lucky if she has a relative abroad. A nurse who comes from a lower middle income family could hardly come (Focus group 1213D, email October 27, 2011).

Another participant, who had come to Canada under the LCP and was now a Canadian citizen, confirmed the notion that those from the lower middle-class in the Philippines could ill-afford the move. She explained her rational for coming to Canada as a live-in caregiver:

As an independent immigrant you have to show some money, some …what else? Like money, properties. But at that time I don’t have ‘cause I’m just a year graduate…we have property but that’s not mine. That’s from my parents and so I decided to go for a live-in caregiver and I know that that is temporary, a stepping stone [emphasis added] for myself. And I read it in the pamphlets from the embassy that after the live-in caregiver two years you could apply for immigrant status without any show money and so I decided to go there and from there I went here [care aide] (chuckle) (P1116).

Though this woman had the same skill set as those who came to Canada as FSWs, she could not meet the FSWP financial commitment. As noted in Chapter Two, Canadian immigration practices and policies continue to be discriminatory, privileging a class of society who are educated and skilled and have the financial means to pay expensive immigration fees (Gogia & Slade, 2011).

Another live-in caregiver also referred to the LCP as a “stepping stone” and added that though the LCP was easier from a financial perspective, she still needed to pay a recruitment fee47. Further comparing the two immigration pathways, she stated, “The advantage for them [FSWs] is that they can come here with their family. As for us, we need to wait for two to three years until we get our permanent residency …then we can get them” (P2013B). For this woman

47While several participants reported that they had paid recruiters or agencies a recruitment or placement fee for helping them locate a live-in caregiver job in Canada, such fees became illegal in 2010; rather, it has become the responsibility of the employer to pay third-party representative fees (CIC, 2011d).
and others who had come to Canada as live-in caregivers, insufficient funds to enter Canada as skilled workers meant having to endure extended absences from family members.

In contrast to those who had entered Canada under either the LCP or FSWP, one study participant who had been educated in the Philippines and then recruited as a TFW from Australia to work as a RN in Canada, reported that his employer had paid his re-location fees (up to 5000 Canadian dollars) (P0623). Further, he had been able to bring his family with him. He declared, “Wherever I go I bring my family. I make sure that the job offer is suitable for [all of us].” This participant’s experiences helped me to further understand the differences between immigration pathways and the differing impacts on new arrivals in Canada.

**Stepping stone #4: “Parallel processing”.

In the US IENs are required to complete a visa screening program to ensure compliance with American RN licensure requirements before becoming eligible for either a permanent or occupational visa (CGFNS, 2013). In contrast, IENs immigrating to Canada as skilled workers do not need to be screened by a RN regulatory body before being issued a permanent resident visa. As mentioned in the literature review in Chapter Two, CIC screens visa applications whereas RN regulatory bodies screen applications for RN licensure; one is not dependent on the other. However, similar to CIC requirements, the provincial regulatory body in BC requires demonstration of English fluency (if English is not their first language) and documentation verifying RN registration, nursing education, and work experience (CRNBC, 2011). Participants referred to the two sets of assessments (immigration and regulation) as “parallel processing”. In

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48 This visa screening includes: an assessment of an applicant’s education to ensure that it is comparable to that of a U.S. graduate in the same profession; a verification that all professional health care licenses that an applicant ever held are valid and without restrictions; an English language proficiency examination; for RNs, a verification that the nurse has passed either the CGFNS Qualifying Exam or the NCLEX-RN (CGFNS, 2013).
this section I examine structures shaping participants’ experiences related to initiating the RN application process prior to arrival in Canada.

Though it is not mandatory that IENs immigrating to Canada have a license to practice nursing prior to arrival, the provincial regulatory college of BC cautions IENs, “You are strongly encouraged not to move to British Columbia or commit to an employment start date until your application has been assessed and you are aware of the requirements you need to meet to become registered” (CRNBC, 2011, p.2). As explained in Chapter Two, an assessment of an IEN’s application typically consists of a document review and a face to face assessment (SEC Assessment), which can take from one to five days to complete. Therefore, to complete the assessment in advance of immigration requires obtaining a visitor’s visa and making an extra trip. Participants explained the difficulty associated with obtaining a visitor’s visa: “Oh yes, a lot of ‘denied’, ‘denied’, denied’ [chuckle] (Focus group 0126). Another said, “But most people get denied if they come here with visitor’s visa…even when they have the letter from CRNBC” (Focus group 0210 follow-up). As well, they implied one would need to be “rich” to travel to Canada twice: “They [nurses educated in the Philippines] will think twice. It’s going to be costly” (P0413). One participant pointed out, however, that travelling to Canada as a visitor might be an option for nurses from the UK: “The British nurses who took the SEC [Assessment] with me, they just came here to do the SEC and so they stayed in a hotel for four days and go

49 Although live-in caregivers could also begin the RN application process prior to arrival in Canada, it is unlikely any would consider this option as they first must complete a 24 month live-in contract prior to becoming eligible for assuming a RN position in Canada.
50 Applicants for RN licensure are advised that if they require a travel permission visa to come to Canada to attend a SEC Assessment they will need to contact the Canadian Embassy, High Commission, or Consulate in their country of residence for application procedures. Although the IEN Assessment Service is not involved directly in visa applications they will provide the Canadian Embassy with a “letter of invitation” confirming that they have been referred by CRNBC to do a SEC Assessment (Kwantlen Polytechnic University, 2013b).
back to UK, wait for the results” (Focus group 0126 follow-up). However, nurses in this study had not considered travelling to Canada for the sole purpose of completing the SEC Assessment.

While none had completed the assessment for RN licensure prior to arrival in Canada, several had initiated the application process (submitted documents and the 500 dollar assessment fee) prior to departure and were grateful they had done so. They explained it eliminated the need to rely on relatives in the Philippines for the retrieval of documents after departure and it shortened their wait time for licensure once in Canada. However, most had not initiated the application process and numerous reasons were put forth to explain their reluctance. First, some complained about the redundancy of having to undergo two sets of assessments:

You know when I applied to become an immigrant here I submitted all the original requirements, documents as a nurse, as a doctor, as a med tech, all those were assessed and now here I am to be assessed again by [the regulatory college]…so there is redundancy (Focus group 1213).

In addition to the inconvenience of needing to acquire a duplicate set of records, there was the extra cost involved.

Another challenge associated with initiating the RN application was the need to make sense of the process. While many had turned to immigration agents to assist them with processing their application, they complained they did not have anyone to assist them with their RN application: “But then we had to do all the CRNBC stuff ourselves. They [immigration agency] are not involved with any of that. We have to assert on that ourselves, to have it processed” (P1012B). Though many had attended CIIP (the free pre-departure orientation program referred to in Chapter Two), similar to findings reported by Jeans et al. (2005), most found Canadian missions abroad lacked accurate information about nursing in Canada. One stated, “It [CIIP] was just merely an information session about Canada and policies but…they didn’t include that getting there as a nurse was really that hard” (P1012C). Another who attended
an orientation session shed light on the power relations that shaped her encounter with CIIP advisors.

I took part in that but its, how many days? … just a two day thing, yeah CIIP Canada. But you know when I went there … I just wasn’t assertive enough to tell them that I’m trying to go there [Canada] as a nurse. So, uh, like um what forces now came into play? Is it lack of assertiveness on my part? Lack of information on my part? And then you have these people coming from Canada and we see them as experts [emphasis added] and so, so like, did I allow myself to be led into that (P0705)?

Because she considered these councilors to be “experts” she had relinquished her plan of immigrating to Canada as a professional nurse.

Others revealed they had been uncertain about whether their application for immigration would be approved and resigned themselves to the notion that preparing to migrate involved taking one step at a time. Once their Canadian immigration visa had been approved, however, they found they had insufficient time to prepare for re-location and initiate an application for licensure\(^{51}\). Another participant said that he had not initiated his application prior to departure because he did not necessarily want to pursue a nursing career after arrival; that nursing had just been his “ticket” to come to Canada (Focus group 0210). This nurse also put forth, “Maybe because we’re overwhelmed that we’re flying to Canada now” (Focus group 0210). Thus there emerged a myriad of reasons for not initiating their RN application prior to departure.

**Summary.**

Reviewing the experiences related to me thus far, my analysis revealed four stepping stones that participants typically took in preparing to re-locate to Canada. These included

\(^{51}\)Skilled workers immigrating to Canada are warned, “You must arrive in Canada before the expiry date, which appears on your Canada Immigration Visa. Usually, the expiry date is one year from the time medical examinations were completed”. As a general rule, the expiry date will not be extended and failure to land in Canada before the expiry date may result in the necessity of re-application (Campbell Cohen - Canada Immigration Lawyers, 2013).
becoming a nurse, gaining RN work experience and Canadian immigration status (or, in the case of live-in caregivers, a Canadian work contract), and for some, initiating the application process for RN licensure in Canada. Participants taught me that private nursing schools in the Philippines and hospitals both in the Philippines and the Middle East were prospering from this desire to migrate and that participants in some capacity also benefitted from having access to these experiences. I learned that immigration to Canada under the FSWP was an expensive endeavor and not an option for lower middle-class individuals. Additionally, there was a disconnect between immigration (federal level) and RN regulation (provincial level) that created a redundancy in application processes and made it unlikely that any could complete the foreign credential assessment prior to re-locating to Canada.

**Chapter Summary**

While most participants declared that they had re-located to Canada because they were seeking a better future for themselves or their families, structures fueling decisions and preparations were complex and had the potential to empower some and constrain others. Moreover, participants revealed the inevitable nature of migration. Commonly cited reasons for migration included issues related to social and economic inequities in the Philippines; exposure to Western media and Americanized nursing education programs and hospital systems; traditions of moral, familial and gendered responsibilities; religious beliefs that there was a greater purpose to their lives; and Canadian immigration policies that prioritized nurses and offered the prospect of citizenship to domestic workers. Preparations to migrate included acquiring a nurse education and work experience, meeting requirements for Canadian immigration, and, for some, initiating the RN application for registration in Canada. Meeting these latter two requirements, however, meant duplicate processing. Further, a disconnect between CIC and provincial regulation made it
unlikely that applicants could complete their application for registration prior to arrival in Canada. Findings also indicated that migration is a social issue and that decisions and preparations are made within the context of families and social networks and further, migration may not have been a matter of choice for some. The focus of next two chapters of results is the nurses’ experiences as they transition to their new life in Canada.
Chapter Six: Being a New Immigrant in Canada - “It’s Not for the Faint of Heart”

The focus of this chapter and the next are the nurses’ experiences as they transition to their new life in Canada. These two chapters primarily address the interview questions: “How has life changed for you since you came to Canada?”; “Can you tell me about challenges you have encountered in Canada?”; and “Where have you found support along the way?”. While analysis revealed that those who arrived with temporary work permits\(^2\) to assume RN positions tended to focus on the challenges encountered meeting regulatory requirements, those who arrived as skilled workers and live-in caregivers faced two distinct hurdles: the day to day challenges associated with being a new arrival and those related to acquiring a Canadian RN credential.

One live-in caregiver characterized her new life in Canada as, “The great struggles of being a nurse and immigrant”\(^2\). Although each set of struggles played a role in shaping the other and frequently occurred simultaneously, for purposes of analysis I describe them separately. Struggles associated with being a new arrival are examined in this chapter, while those associated with pursuing RN licensure, in Chapter Seven. In this chapter, I have also centered my analysis on those who came to Canada under the FSWP and LCP but will draw on the experiences of the two TFWs in the study to illuminate structures shaping experiences for those who arrived without RN employment.

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\(^2\) The two participants in this study who arrived in Canada with temporary work permits to work as RNs arrived in Canada prior to the introduction of the SEC Assessment and therefore were not required to meet this particular regulatory requirement.

\(^2\) Strictly speaking live-in caregivers are not considered immigrants until they acquire immigration status after completing their live-in caregiver contract. Although they often refer to themselves as ‘workers’ in contrast to ‘immigrants’ who arrived in Canada under the FSWP, in the context of this conversation the caregiver was referring to herself as an immigrant, or a new arrival in Canada.
Despite a resolve to pursue their dreams there was a dissonance between what they had hoped for and the reality that awaited them in Canada. As one nurse who came as a skilled worker put forth, “I thought I was prepared but it’s not really that easy. It’s not. No amount of preparation can deal with reality” (Focus group 0210). As I became more familiar with their stories it became increasingly apparent, however, that structures defining experiences for those who came as skilled workers differed from those who entered Canada as live-in caregivers. While the former often couched their stories in terms of betrayal and despair over not having their RN credentials readily recognized, live-in caregivers commonly framed their experiences in terms of endurance as they counted off the months remaining in their contract. I begin by examining the experiences of federal skilled workers and then turn my attention to live-in caregivers. For both groups I aim to identify factors that stirred participants to comment that their new life in Canada was unequivocally challenging and “not for the faint of heart”.

The Federal Skilled Worker Story: “They Don’t Accept Us”

The overarching structures that influenced daily experiences of newly arrived skilled workers were the rejection of their foreign RN credential and the limited support they received upon arrival in Canada. There was an irony in that they were given preference at the federal level as “skilled workers” because of their education and work experience but denied licensure at the provincial level because these qualifications are foreign. Unable to work as RNs, they felt marginalized and unappreciated – sentiments captured in the following comment: “They don’t accept us, they don’t give us jobs” (Focus group 1213). Another offered, “‘Cause, you know,
your points are being assessed. It’s a point system. But when you come here you’re back to zero [emphasis added]” (P0205).

From another nurse I learned that the dismissal of her RN credential represented a rejection of her integrity: “I believe that a nurse’s integrity cannot be taught, it stems from within. Therefore no training or re-entry [program] could change that” (Focus group1213 follow-up). For this participant the standard of excellence with which she measured her performance differed from the standard expected of Canadian educated nurses; a factor that seemed to set her up for disappointment in Canada.

The limited support they received after arrival further marginalized these participants and caused one to offer:

The Canadian government issued to different countries that, “Okay we need these kinds of workers” and so they put a priority on this. As long as you pass the points, “Okay you can apply”. But the backdrop of it was they didn’t tell us that once you land, it’s going to be hard, “You’re on your own. We’re not going to help you” (P1012B).

To further capture the degree to which she felt rebuffed she added, “It’s like you’re being dropped off in a field where you are by yourself, there’s the enemy zone [emphasis added], and you’re like ‘what am I supposed to do to survive?’”. The label “enemy zone” seemed a far cry from the belief that Canada is a fair country that had inspired many to immigrate.

As they described their new life in Canada many struggled to understand why events were unfolding in a way contrary to their expectations and to make sense of why they were ill-prepared for their reception in Canada. Accordingly, some turned their gaze toward CIC and argued that the pre-departure orientation provided by CIIP conveyed “a very false hope” (Focus group1213). For example, when asked specifically if any had anticipated the challenges that awaited them, members of one focus group offered:
P1: Nobody knows [laughter].
P2: There was a workshop when we left but all they told us was, “Very easy”.
P3: Like Canada is like a Promised Land for us [laughter] (Focus group1213).

It was interesting to note that, despite the challenges confronting participants, many were able to joke about the irony of the situation engulfing them in Canada. As in the above excerpt, they frequently resorted to humour to ‘lighten’ the atmosphere during focus group discussions.

Yet another suggested that private immigration agencies in the country of origin (e.g., the Philippine or countries in the Middle East) may have deliberately deceived prospective immigrants:

And may I just tell you…when I talk to people who come here from the Middle East who come here and have their papers processed by the [private agencies] they are painted a picture that they can easily go into [nursing]. So I can sense a little deception (P0705).

This foregoing nurse, however, also argued that nurses should bear more responsibility for their predicament and questioned whether a lack of preparation or unrealistic expectations may have contributed to the sense of despair noted among many. She suggested that some nurses may have misinterpreted the intent of the FSWP:

P: Okay, looking back at the process, when we apply for application um actually points are given , the point system, so points are given if you have a degree in nursing... but I don’t think they, unless you were recruited by a hospital, that they really told you that you will be here as a nurse. I don’t think Immigration Canada ever promised that you would become a nurse here. I don’t remember that and so I think it’s …you know what I’m saying?
R: Yes.
P: I think we have too much of … an expectation that once we land here we will become nurses when in fact when we applied we didn’t apply here as a nurse, we applied here generically (P0705).

Although this nurse admitted that pre-arrival information may be misleading she added, “Shouldn’t we have, like you know, as adults, shouldn’t we have researched that these are the
hurdles” (P0705)? Listening to her comments reminded me of earlier study results in which eagerness to migrate seemed to override the need to exercise due caution.

Another offered that the capacity to work as a RN in the Middle East may have fostered unrealistic expectations and set nurses up for disillusionment.

The negativity of the challenge of becoming a nurse via the permanent resident route falls heavily on those who had more to give up [nursing careers in the Middle East] as compared to those who came from the Philippines where anywhere is a greener pasture except back home (Email correspondence February 2, 2011, P0705).

Indeed, one participant who had worked for over ten years in the Middle East described her difficulty adjusting to the change in her professional status in Canada:

P: Like when I arrived in that country [Middle East] I worked right away as a RN in the hospital. But when I arrive here...[crying]...I work like cleaning house, ... I mean, professionally it’s not the one I expected.
R Because you expected to work here [Canada] as a RN
P: Yeah [crying] (P101).

However, one nurse who had recently vacated a nursing position in the Middle East seemed to blame his predicament (i.e., not having his credentials readily recognized in Canada) on miscommunication between CIC and the regulatory college:

Why Immigration Canada [CIC] is inviting nurses to come here when they don’t even know the status of [the regulatory college]. So how about Immigration Canada contacting [the regulatory college] first before nurses come here. When you come here you have nothing [emphasis added].You are nothing [emphasis added] (Focus group 0126).

The emphasis he placed on having “nothing” and being “nothing” and the expression of disappointment on his face clearly communicated the degree to which he felt rejected by Canadians.
Another new arrival described the extent to which a pre-occupation with dreams of “greener pastures” that inspired migration may interfere with the ability to adjust to a new life in Canada:

We made a story out of nothing. We made a fairytale story from the beginning…which is not reality-based. And once we get here it shatters …we can see the reality applied. And so the more you, since we deny on things, because of the story we’ve made at the back of our minds and then the more we tend not to accept things. Which makes it a little bit worse, or more difficult to adjust especially during this transition phase (Focus group 1213 follow-up).

That is, from her perspective reluctance to abandon unrealistic dreams ultimately impedes adjustment to the reality of a new existence.

Despite feeling marginalized and betrayed at not being able to immediately resume their professional career, participants described numerous ways in which they dealt with their new reality. I now turn my attention to efforts made to “survive” in Canada during this period of transition and challenges encountered along the way.

“What am I supposed to do to survive?”

The need to quickly find alternate employment weighed heavily on the minds of study participants newly arrived in Canada, both females and males alike. As one male participant noted, “I don’t have a job. It’s very frustrating. And my family is spending every day” (Focus group 1213). Though “show money” had been a requirement for the FSWP, most admitted this money did not last long. Compounding their difficulties, many reported being burdened with debt acquired to finance their immigration and re-location expenses:

R: But I thought that people often sent money back to the Philippines to support their families?
P1: No, majority to pay the banks.
P2: They give it to the family, so that the family can pay where the loan is.
P1: Yes, I send it to my aunt and then my aunt pays the bank (Focus group 1213).
Although the literature typically focuses on the need for Philippine nurses in Canada to remit family support money (Choy, 2006; Guevarra, 2010; Kingma, 2006; Pratt, 2010), this foregoing exchange was a reminder that many are also saddled with loan payments. In this section I examine numerous strategies participants undertook to meet their financial obligations.

Some willingly took any ‘survival job’\(^{55}\), but acknowledged finding a job was not easy: “… I applied any job from McDonalds to Old Navy to everything from cashier…but they didn’t call. I wasn’t even called for an interview” (Focus group1213). Although this nurse did not offer any rationale for being overlooked, others suggested several barriers to employment. For instance, the need for Canadian experience was an obstacle for many:

\[\text{P}_1: \text{The funny thing is they ask for Canadian experience but then how would they get the Canadian experience if they’re not going to hire anybody?}\]
\[\text{P}_2: \text{Yeah, exactly. So who’s going to hire us?}\]
\[\text{P}_3: \text{So, it has to come from somebody else, the Canadian experience. That’s basically what they’re saying, “Not from us”. That’s one of the challenges I faced, too (Focus group 1213).}\]

That is, although Canadian experience appeared to be a pre-requisite to employment, employers were often unwilling to provide the experience. The irony and the discriminatory nature of this situation did not escape their attention.

\[\text{Participants also explained that a requirement for Canadian certificates restricted employment opportunities:}\]

\[\text{P}_1: \text{But when we applied for immigration as an immigrant in Canada we are assessed for our skills and of course we have to pass by a screening, we have to submit all the documents needed to approve that the person is competent and yet when we arrive in Canada there is no use at all because she cannot even apply as a [care aide]}\]
\[\text{P}_2: \text{Caregiver.}\]
\[\text{P}_1: \text{Without a certificate (Focus group 1213 follow-up).}\]

\(^{55}\text{Participants frequently referred to transitional jobs as ‘survival jobs’.}\)
Despite coming to Canada on the basis of their skills, without any kind of Canadian certificate, participants often felt helpless.

Further, some female participants revealed that family responsibilities constrained employability:

…but I have no relatives here at all. I have to be with my daughter. She’s only eight that time. I have to bring her to school and fetch her… my priority is my family and so I’m not paying somebody else to take care of my kid. I’m doing that (Focus group 0126).

Another, however, lacked the option to remain at home with her daughter and described her anxiety over not having access to child care:

P: Yeah, [crying] Then I have a child with me. And then I don’t have any money to live for my daughter. Then I need to work and I don’t know where. And then when you apply you get asked like, “certificate or license?” I don’t have anything. Then I first work like cleaning…[crying].
R: Yeah.
P: It’s just so hard [crying]…and I don’t have anybody to leave my daughter…my husband is working (P101).

Indeed, gendered responsibilities related to child care intersecting with the need for Canadian experience and certificates left many feeling powerless and concerned about meeting daily expenses. One nurse described that she relied on her parents in the Philippines for financial support:

R: When you talk about coming here then, how has life changed for you? I mean in the Philippines were you working?
P: Yeah, I was working as a technician and I was also working as a nurse. It’s a big difference because sometimes now I have to ask money from my parents [laughter].
R: In the Philippines?
P: Yeah, they have to send it here because I have to pay for the rent and for my kids also. Although I have an allowance, so that’s enough for the food, but for the rent it’s [not] (Focus group 1213).

Recalling dreams for greener pastures that had prompted migration, I wondered whether
this nurse was surprised and disappointed at becoming dependent on her parents in the Philippines.

Another nurse supported her family in Canada by commuting to the Middle East to resume a RN contract. She explained:

It [commuting to the Middle East] was an advantage in a way so it has given my husband a chance to find work and at the same time I got work in [Middle East]...so our funds will not be depleted because it is so difficult to find work here, the minute you arrive here (Focus group 0126).

Despite having been prioritized to immigrate to Canada on the basis of her nursing skills she now felt compelled to seek RN employment elsewhere. Similarly in the next exchange a participant, experiencing difficulty finding Canadian employment, described his plans to return temporarily to the Philippines:

P1: So what I’m thinking...when worse comes to worse, I’ll go back to the Philippines and work there as a doctor and send money here.
P2: For your kids?
P1: For my children, to study.
P2: ‘Cause you have good income in the Philippines. You’re a doctor.
P1: Yes, fortunately I am a doctor. I have good income in the Philippines. If I don’t find a job [in Canada] then I go back there and send the money here. It’s just the reverse (Focus group 1213).

Although this individual had both the financial means to return to the Philippines and the fall back to work as a physician, others were less fortunate. One nurse summarized the challenge encountered by most: “What if we forgo with our resources there, we sold everything and coming here not landing with a single job because they need certificates, they need [Canadian experience]?” In other words, returning to the Philippines was not a viable option for most, at least not during this transition period.

Some sought assistance from ISOs and expressed gratitude for their resume writing workshops and employment counseling. Others assumed volunteer positions in health care
facilities in the hope that this might eventually lead to a job. One nurse suggested that a member of the Filipino community had been instrumental in her search for employment:

P1: …your volunteer experience…really opened doors for you…where did you volunteer?
P2: At the same [facility I got the job]…it’s a friend of a Filipino.
P3: Which facility56? It’s like networking.
R: So that seemed to be the key, knowing somebody and starting off with a volunteer job, which led you to a paid job and which helped you to get registered at BC Care Aide57
P2: Yeah (Focus Group 1026).

Many also sought support from other members of the focus group, often exchanging email addresses and sharing employment information. In one instance, a nurse volunteered to accompany another to the BC Care Aide & Community Health Worker Registry, stating, “We will go together” (Focus group 0126).

Numerous participants disclosed they had found work with private home support agencies58. One nurse described his rationale for selecting this latter pathway:

I was considering that…for the first week…any job will do, right? …but then I was thinking, “Okay, let’s make it more tailored to my experiences. I want to be smart about getting a job and I want to write down in my resume later on, right? And make it look good on my resume”. So I thought, “Okay, I have to get a job…in anything in the health care related, I have to get a job”. So that’s why I decided on applying for care aide positions. “‘cause that’s the only position for us that doesn’t require anything [certificate]…right now [emphasis added] (P0203).

As he explained, working for a private agency currently negated the need for a Canadian care aide certificate and also provided valuable work experience. However, his comment also alerted me to the transitory nature of health care policies and the difficulty of keeping abreast of changes

56 Participants typically referred to long term care residences for the elderly as a ‘facility’.
57 The BC Care Aide & Community Health Worker Registry is a database of credentialed, or “registered”, care aides and community health workers (BC Care Aide & Community Health Worker Registry, 2013).
58 Although it is necessary for care aides or community health workers seeking work in a publically-funded health care facility to be credentialed and registered with the BC Care Aide Registry, currently the same is not true of private organizations (BC Care Aide & Community Health Worker Registry, 2013).
(perhaps inspiring some to attend these study focus groups). From the perspective of this participant, it might be only a matter of time before care aides in private health care facilities in BC will be required to have a Canadian credential.

While most were reluctant to pursue a health care certificate of some kind, asserting that “it’s very expensive to take these certificates” (P1012), one nurse disclosed that she had entered a certificate granting program at a private college. She soon realized that she had been deceived by the institution and exclaimed:

> We thought that any training will do to improve ourselves and lack of research on our part made us fall prey to promises of access to employment opportunities from private learning institutions which lowered their entry qualifications to accommodate our training aspirations (Email correspondence July 21, 2011, P0705).

Unable to find employment upon graduation she concluded “…of course we are so vulnerable…there’s this vulnerability among us immigrants. So, if there’s a faster and easier way and with all our misconceptions about the system [we’ll take it]” (Email correspondence August 2, 2011, P0705). She also thought that her faith in Canada’s reputation as a “fair” country had skewed her judgment and contributed to her vulnerability:

> I thought all institutions here in Canada are credible and so I went to a private training institution… I should have been [more] discerning. But then I had so much faith in the Canadian way that I thought nothing would go wrong” (Email correspondence August 2, 2011, P0705).

Although she accepted responsibility for her situation, she felt letdown by the Canadian government and lamented that the experience had put her into debt:

> But I just treat it as a learning experience. …but it could have been avoided. …and I’m thinking now, “Where is regulation”? Because in a way it’s false advertising and you see, it also preys on the government because most of us use government loans and so this money is supposed to help us and not put us into debt.
Her comments reminded me of what I had learned from participants about private nursing schools in the Philippines. In both countries private colleges readily accepted students regardless of their qualifications, provided what appeared to be an inferior education, and charged high tuition rates.

In contrast, another participant who had received a certificate from a private college in BC felt his education had paid off. He contended that public programs often had long waiting lists, while the private college he attended had none. Despite having paid approximately 15,000 dollars more for tuition at a private college, he had been able to recoup his money from his new job in the time it would have taken to acquire a seat in the public program. He also added that he understood why new arrivals from the Philippines could be misled about the quality of some private colleges in Canada as they were accustomed to paying high tuition rates for private high school or university education in the Philippines (P0811).

In summary, study participants showed remarkable agency in their search for a means to support themselves and their families. While some resorted to survival jobs, others sought employment with private agencies as home support workers or care aides, some returned to employment abroad, and some returned to school. However, their stories also alerted me to gendered responsibilities regarding childcare and to vulnerabilities facing both female and male participants regarding unemployment or underemployment, poverty, and exploitation. Next I will explore implications of their new lifestyle.

“But in reality, it’s really very hard”.

Although most participants ultimately managed to secure alternate employment (i.e., not as an RN), they confessed that their new life in Canada was “very hard” (P101). Explained one
nurse, “When you’re still in the Philippines ‘Oh, wow, you are already in the place where…paradise…lots of money dollars, like that. But in reality, it’s really very hard” (P101).

To help me understand how different her life in Canada was, one young participant during a focus group exchange provided a glimpse of her previous life; a description that seemed to entertain the others. Once again, I reflected on participants’ use of humour when recounting difficulties and noticed how it elevated the mood of the group:

R: What is it that you miss?
P1: Like when I wake up the food is ready [laughter]
P2: “Senorita”. [laughter]
P1: Yeah, the food is ready and the clothes are, you just grab them and use them. You don’t need to think, “I need to wash them so I can use them in the next week or something”.
P3: To avail to have a maid in the Philippines.
P1: Yeah.
R: Would that be your mother doing that for you?
P1: Mother and a helper. Like you don’t need to think about that food you will prepare for that day. You just need to sit and eat it [laughter]. Watch TV and then [no responsibilities][laughter].
R: Wow. That’s really different from here.
P1: Yeah, you need to prepare for your food, wash your own plate, wash your own clothes [laughter] (Focus group 0210).

Despite these differences, this nurse acknowledged that she found her new life in Canada liberating and explained, “… my father used to drop me in school, fetch me in school. And now I have the freedom to ride on the bus on my own, to do stuff”. The fact that migration was an empowering experience for this young woman, one that freed her from parental scrutiny, was similar to findings by Parrenas (2001) and noted in the literature review.

For many, however, the decline in social status was disheartening. For instance, during another group discussion one participant, who had been both a physician and a nurse in the Philippines and now was unemployed, surprised the group when he stated: “I’m not ashamed to tell you…I queued at the food bank because you know I don’t want my children to be hungry.
It’s very degrading for me, you know” (Focus group 1213). The next comment, made during yet another focus group encounter, further illustrated how marginalized some felt by their inability to contribute in a meaningful capacity to Canadian society:

Actually it’s a good thing they’re [immigrant serving organizations] giving us support but then actually it’s also *doling out* [emphasis added]... instead of giving us opportunities to fish in the ocean, they are just giving us a few money just for you to sustain [yourself and your family] (Focus group 1213 follow-up).

The irony did not escape this participant in that money and programs intended to facilitate integration were unintentionally perpetuating injustices.

While a decline in social status had implications for the entire family, this next participant who held two jobs outside the home, revealed that as a mother and wife, without access to domestic help, she now assumed most of her family’s domestic responsibilities:

R: How has life changed for you since you’ve come here? You were sorta implying that it may be easier for your children here?

P1: Yes, for my children. But actually for my husband and myself it’s difficult. Because my husband even if he studied in a prestigious university in the Philippines he is not used to working. He used to have three maids at home.
P2: It’s really true.
P1: He used to have a driver. Here we don’t have car, we don’t have helpers. I do the housekeeping, cleaning, washing, everything. Groceries, cooking. Oh my God, I really sacrifice a lot. And I’m still working, I’m reviewing [for my RN license].
P3: Superwoman [laughter] (Focus group 0210).

This participant’s story reflected reports in the literature suggesting Philippine society typically assigns women the responsibility for family care work (Parrenas, 2008). It also shed light on the numerous intersecting challenges confronting nurses educated in the Philippines as they strive for Canadian RN licensure. In addition to domestic responsibilities, she needed to review for her Canadian RN credential.
Others confided that changes in lifestyle put a strain on family relationships, a finding resembling those described in the literature review that suggest underemployment among highly skilled immigrants contributes to stress, poverty, and social isolation (Gogia & Slade, 2011; Shields et al., 2011). For instance, in this next passage a participant who had recently immigrated to Canada from the Middle East with her husband and young child exposed that a decrease in her husband’s professional status coupled with a meager Canadian income had ultimately led to marital breakdown:

…the frustrating part is that we keep on fighting with my husband and later we got separated. Yeah, and that’s the frustrating one. We just came here and then we got separated. Because my husband is a site supervisor in [the Middle East] and then he accepted the job as a packager in a bread company [in Canada] and then I think he cannot compensate that he’s working a very hard job and receiving a very small salary (Focus group 0126).

At the time of the interview this participant, faced with responsibilities of being a single parent, contemplated her future. She stated, “It’s frustrating here in Canada because in the Middle East it’s very easy really to have the money” and considered returning to Middle East once she had acquired Canadian citizenship. She reasoned: “I’ve spent a lot of money already here so, why not [stay]”. Her comments were a reminder that new immigrants, in addition to providing Canada with skills, had put a great deal of money into the Canadian immigration process. As well, her resolve to remain in Canada until she at least received Canadian citizenship reflected the sentiment noted among many participants. Indeed, Canadian citizenship was a hope that sustained many.

As I listened to their stories I searched for clues to determine how their new life might affect their capacity to acquire a Canadian RN credential. I learned that a drop in social status could contribute to feelings of social exclusion, increased gendered domestic responsibilities and
family breakdown. I also paid attention to how participants endured these obstacles. Some focused on their desire to provide a better future for their children and used humour to lighten their load. Others turned to their religious faith for support. For example, summing up the sentiments expressed during a focus group session one participant stated: “We will achieve our goal in His time”. Many seemed to draw support from each other, offering encouragement and words of advice. One stated, “Yes, we can make it, we are very good nurses, we know. Filipinos can adjust anywhere in the world and so we will make it” (Focus group 0126). As well, the notion that their situation was temporary and would improve over time and ultimately lead to Canadian citizenship seemed to help many endure their difficulties. One participant shared the words of encouragement she had offered her husband: “I keep telling him, ‘Just hold on, give me two years, we will be there’” (P0413). Next I will focus on the nature of the live-in caregiver struggle.

The Live-In Caregiver Story: The “Countdown”

The overarching obstacle defining daily experiences for newly arrived skilled workers was their inability to work immediately as RNs; conversely, for live-in caregivers, it was the nature of the live-in caregiver contract. During interview sessions these participants frequently referred to the time spent completing their contract as the “countdown”. For instance, one nurse stated, “The 24 months [of our contract] is just the countdown for us to apply for the open permit and permanent residence”. Moreover, they seemed to keep close track of the time remaining in the contract, as if it was a test of endurance, or something to be completed as soon as possible. For example, another declared, “Yeah, [I just have] four months to complete my 24 [months]. I just can’t wait to finish” (P1219).
However, as participants revealed, the process could take longer than 24 months:\footnote{Live-in caregivers may apply to become permanent residents after they have worked full-time for at least 24 months or a total of 3,900 hours within the four years immediately following their entry into Canada under the LCP (CIC, 2012a).}

Like I just work for them for one year then they told me that they don’t need me. So I need to find another employer, then my work visa stopped for two months and that’s, you know, \textit{wasteful} [emphasis added] for the countdown (P0213B).

Desperate to avoid “wasting” time, participants seemed willing to forego their own aspirations. Explained one nurse:

I tried to apply for elder care but … I wasn’t able to find one. And I’m just so in a hurry to get a working permit, so that I could count the months so I just went into a child care (P1219).

As Pratt (2012) found, I also learned that, despite having legal rights to fair working conditions under provincial labour laws (CIC, 2012f), urgency to fulfill the terms of their contract made participants vulnerable to exploitation. One caregiver stated:

P: The worker will just follow whatever the employer, you know. We have the choice but, you know, but if it we choose one from the other still we are the loser [chuckle].
R: Because you might lose your job?
P: … if you quit then you have to wait for another one, look for another one, and you have to stay longer in the program (P0210).

The foregoing excerpt also exemplified the caregiver’s powerlessness, an issue which frequently surfaced during discussions related to challenges associated with meeting RN regulatory requirements that will be addressed in Chapter Seven.

While 24 months was the countdown to complete the live-in caregiver contract, participants alerted me to a second ticking clock: the time remaining until they could have an open work permit\footnote{At the time of this interview participants could not receive an open work permit until their application for permanent residence had been reviewed. However, in December 2011 Citizenship, Immigration and} and leave the home of their employer to pursue employment in another field.

\footnote{Live-in caregivers may apply to become permanent residents after they have worked full-time for at least 24 months or a total of 3,900 hours within the four years immediately following their entry into Canada under the LCP (CIC, 2012a).}
Participants revealed that this wait period was approximately a year, or as one stated, “11 months and one week of duty to be exact” (P 0213B). Capturing the sense of powerlessness participants continued to feel during this second waiting period, she exclaimed, “In reality it is three years that you’re tied up [emphasis added] with one employer… we still need to work for one employer until the open work permit comes” (Focus group 0210).

However, once “open”, participants continued to count the months until they could become permanent residents and family reunification: “So we still have to wait for our permanent residence like another 15 months” (P0213). Further, in another interview a participant revealed that her ultimate goal was Canadian citizenship:

P: Then after the permanent residency that is really gearing towards citizenship and on the fifth year of staying here in Canada and if you are qualified [for citizenship]
R: You have to be here five years before you get citizenship61?
P: After your PR [permanent resident status].
P: So, I’m at the stage of my open work permit (P1028C).

Indeed, it appeared that participants were on a trajectory with several significant hurdles until the ultimate goal of citizenship was achieved. In this next section I focus on structures and processes that contributed to their sense of urgency to complete their Canadian immigration requirements for permanent resident status; structures and processes that ultimately shaped their opportunities for Canadian RN licensure. These included: lengthy separations from their family; limited resources; and a drop in social and professional status.

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Multiculturalism Minister Jason Kenney announced that rather than waiting for their application for permanent residence to be reviewed, live-in caregivers who had completed their live-in caregiver contract, would now be able to get their open work permit as soon as they had submitted an application for permanent residence (CIC, 2011d).

61Permanent residents must have lived in Canada for at least three years (1,095 days) out of the four years immediately preceding their application for citizenship (CIC, 2013a).
“The homesickness and loneliness, you name it”.

Lengthy separations from their families appeared to be particularly challenging, especially for those with children remaining in the Philippines. Underscoring the difficulty, one nurse who had left behind her infant son and husband, explained how she had been rejected by her son when she returned home for a month’s visit after completing her 24 month contract:

When I came back home and see my son, he doesn’t even know me at all. That’s the sad part. I wanted to hug him and kiss him. “Stay away from me”. Even at night time I want to be with him, he will go to his Dad. Like the emotions are totally different. I’m like a stranger to him [sad tone and facial expression] (P0120).

She also described her feelings when she returned to Canada and exclaimed, “The homesickness and loneliness, you name it”. Moreover, she still had “another two years to wait” before acquiring permanent residence and eligibility to bring her family to Canada. She recounted her son’s aloofness when she finally greeted him in Vancouver and implied she felt responsible for his reaction:

R: So now your son was five years old. What was that [reunification] like?
P: Stranger, my son. I’m a stranger to him. It’s really hard to win his emotions back. I said, “You came from me”. I said “I carry you for the whole months of pregnancy and then look at you, why are you so distant to me?” It’s like that, all those questions. ‘Cause the bonding between him and his Dad and they’re so close. I think that’s what I get from being away from them [sad tone and facial expression] (P0120).

Although more than five years had elapsed since she had been reunited with her family, she had not forgotten the grief she experienced during their lengthy separation, nor her son’s rejection when he finally joined her in Canada. She also revealed that her relationship with her son has continued to be strained, a factor that alerted me to potential longstanding implications of family separations and again to findings reported in Pratt’s (2012) extensive review of family separation issues for domestic workers living in Vancouver, BC.
Another nurse also explained difficulties associated with leaving her young son but added: “because of technology right now, like the internet, so it’s not very difficult because we can see them and we can talk to them” (P0213A). However, detecting sadness in her voice and facial expression I wondered how much the internet eased the separation and queried if she was trying to console herself with this notion. Indeed, the sorrow expressed by both participants cited above helped me to understand the urgency associated with becoming permanent residents.

Participants also disclosed that extensive separations put them at risk of family breakdown; a factor that could jeopardize their chance to bring their children to Canada. One participant explained:

P: ... for us, long distance relationship is very difficult especially I don’t get support from my husband right now because he doesn’t want to come here.
R: Oh?
P: He wants to just stay in the Philippines and so right now I’m doing some legal actions to just get my children ‘cause my goal here is not for myself. I still have to continue what I started for them to have a better future. So it’s kinda a really difficult and hard time for me right now.
R: Yeah.
P: Since I’m having marital problems but I need to just look on a brighter future for my children (P0213B).

The hope for a better future for her children seemed to sustain this nurse. Another caregiver, stated, “He’s [God] the giver of our strength”. Thus, participants turned to a variety of strategies to help them endure their lengthy family separations.

“You have to budget”.

Another challenge for participants was managing their limited income. One nurse explained: “I [am] receiving 900 dollars a month for working as a live-in caregiver which is really all the money I need to send to the Philippines” (0213B). Her story caused me to reflect on

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62 Divorce is not legal in the Philippines. However, the country is currently engaged in a legislative debate regarding legalization (Morley, 2011).
the one relayed earlier by the skilled worker who had returned to his profession as a physician in
the Philippines in order to support his children in Canada and to note how privilege and social
positions shape daily lives. In contrast to the skilled worker, this nurse had to remain in Canada
in order to provide for her children left behind in the Philippines. She also explained that she
needed to save money to cover living expenses in the event her contract terminated and she
became unemployed. She explained, “…it’s very stressful… the money that you get from your
previous salary, you have to budget that” (0213B). As well, participants shared that they had to
save for immigration and family reunification expenses 63. Another informed me that those with
open work permits continue to face financial challenges. She explained:

…being a live-in caregiver my salary is only minimum per hour 64 and because
I’m open now [emphasis added] I am buying my food, I am paying my rent…so
where the money goes? It is not enough even though I budget it very tightly, you
know (P0210I).

That is, despite having an open work permit, this nurse continued to work as a caregiver, earning
a caregiver’s salary.

“In the Philippines we have someone doing that for us”.

Adjusting to a decrease in social status along with shifting class relations was another
challenge noted by participants. One live-in caregiver offered these insights: “It’s really
challenging because in the Philippines…we hire people to clean the house and then do the
cooking, laundry” (P0213). She added: “Before I came in Canada, my friends who are nurses
there in Saudi, they discouraged me to come here as a live-in caregiver because it’s kinda

63Principal applicants in Canada must pay a right of permanent residence fee (RPRF) of 490 dollars for all family
members (aside from the applicant’s dependent children) included in the application for concurrent processing for
permanent residence (CIC, 2011c).
64In BC the prevailing wage is $10.25 per hour and the maximum hours per week is 40 hours (HRSDC, 2013).
degrading for us… I will put myself in a low position”. Another, who had been in Canada for over ten years, recalled the “shock” she received when she began her first job as a domestic worker:

R: And when you said it was “shocking”. Was it the people? Their attitudes?
P: The way they treat people, like that. …it’s like they’re distant. It’s like there is a difference between the employer and the servant. But then, when after six months, like they’re also getting to know you, right? But first few months they were just like rough but then after six months they’re getting friendly (P0120).

Accustomed to hiring others to do domestic work, this participant found herself in the position of needing to answer to the demands of her employer.

Participants also alerted me to class differences between themselves and skilled workers, with caregivers relegated to an inferior position. Following one focus group encounter a caregiver revealed her surprise that she was the only one without permanent resident status: “I was the only worker [emphasis added], they were all immigrants”(P0210I). Although she had employment while some in the group were unemployed, she seemed to feel marginalized on the basis of her immigration status.

Seeking clarification about class differences between caregivers and skilled workers, I raised the subject with another caregiver:

R: I talked to a nurse lately who came through the LCP and she referred to other people who came through the Federal Skilled Workers program as … “immigrants”…and herself as a “worker”. And I thought, “What does she mean by that?”
P: That’s also my feeling. All the immigrants, “You came here as immigrant”. Kinda I feel like I don’t have anything to show. I still, what’s this? [searching for word]. There’s a feeling.
R: That you don’t [fit in]?
P: Me. I’m still working. It’s kinda like on probation. But they already have the security of [permanent resident status]. For us we need to go through application, wait for another year. That’s our feeling (P0213A).
Similar to the previous participant, from this nurse’s perspective, live-in caregivers are marginalized on the basis of their immigration status.

As with skilled workers, I searched for clues to determine how their new life in Canada might affect caregivers’ capacity to acquire a Canadian RN credential. I learned that their primary focus was completing their contract and gaining permanent resident status. Similar to skilled workers, they were faced with living in poverty and social exclusion. Moreover, their immigration status had the potential to alienate them from their skilled worker colleagues. As well, I paid attention to how live-in caregivers endured their new life in Canada. I learned that similar to the skilled workers, caregivers situated their reality as temporary and were hopeful for a brighter future. One nurse asserted that she could endure being a live-in caregiver, “since it’s only a stepping stone [emphasis added] for me” (P0213B).

Chapter Summary

In summary, both groups of participants indicated that they were ill-prepared for their new life in Canada. Rather than finding greener pastures, skilled workers unable to resume their RN profession in a timely manner faced a daunting task of finding alternate employment. Caregivers, on the other hand, had to endure a 24 month live-in contract that constrained their agency and separated them from their families. Structures at international levels (e.g., a Philippine economy that necessitates working abroad in order to sustain families at home), at the national level (e.g., immigration policies that restrict domestic workers from bringing their children with them to Canada and privilege those with the financial means to pay expensive immigration fees), at the provincial level (e.g., regulatory policies that reject foreign credentials), and at the local level (e.g., employer preference for Canadian education and work experience) put both skilled workers and live-in caregivers at risk of exploitation, marginalization,
powerlessness, family breakdown, poverty, and loss of self-esteem. Participants also disclosed that the dream of Canadian citizenship and a brighter future for themselves and their children, along with their religious faith, helped them endure these difficult times. I now turn my attention to struggles associated with pursuing RN licensure; struggles that both shaped and were shaped by experiences of being new arrivals in Canada.
Chapter Seven: Being an IEN in Canada - “And One Block After the Other”

In addition to struggling to survive or endure their transition to life in Canada, participants revealed numerous challenges they encountered trying to meet regulatory requirements. One nurse in the midst of the application process exclaimed: “It’s like you’re so near, yet you’re so far away from the reality of being an RN” (Focus group 0126); a sentiment that reflected how many seemed to feel about the elusive nature of the Canadian RN credential.

In this chapter, starting from perspectives of participants positioned at various stages along the RN trajectory (ranging from not having initiated an application for registration, to having completed it and acquired practicing registration, or to having abandoned the notion all together), I analyze how their experiences both shaped and were shaped by structures at each phase of the registration process (see Appendix A: Pathway to RN Licensure in BC for IENs).

I begin by examining the experiences of those working on English language proficiency and proceed to uncover structures shaping experiences for participants submitting an application for registration, completing the SEC Assessment, taking educational upgrading, meeting the Canadian employment requirement, and writing the CRNE. Following ethnographic traditions, I also turn to a variety of resources including secondary participants and numerous documents to shed further light on these structures.

“It’s So Hard to Pass the English Test”

As noted in Chapter Two, for IENs whose first language is not English the first step in applying for RN registration in BC is demonstrating English language fluency (CRNBC, 2013f). As English was not the first language for study participants, this was their first hurdle and participants told me about numerous intersecting structures that shaped their experiences as they worked toward meeting this requirement. In the next section I will first describe their
experiences and impressions regarding preparing for the test and then shift my focus to their encounters with taking the test.

Preparing for an English language proficiency test.

Although test preparation is not mandatory, CRNBC strongly recommends it since failure necessitates a test re-take entailing expense and delaying eligibility to apply for registration (CRNBC, 2011). While some participants reported attending publically funded test preparation courses at local societies or colleges, none had enrolled in a privately funded program, allegedly due to the expense of the program. One live-in caregiver, however, unable to attend regular English classes at a public college due to time constraints imposed by her caregiver contract sought individual tutoring at a private review centre and described her horror when she discovered the cost: “...he’s telling me fifty dollars an hour and I can’t afford that. That’s one day salary for me already and so I cannot afford that” (P0213A). Typically, however, there was no single factor that constrained agency or desire to take review classes. In the next excerpt a live-in caregiver described her situation:

P: If they (employer) don’t permit then I can’t go. Which is why when I am working with my relative I can’t do that because money, financial problems, too. Even if I wanted to, I can’t and I didn’t have the time to go and inquire about anything else because I was so stuck with taking care of kids, my relative’s kids. 
R: So you have to make some sacrifices for family? 
P: Yeah. Yeah. I mean even if I ... don’t want to, I need to ‘cause um ‘cause (laughter) maybe it’s hard for me to say “no” to them ‘cause I owe something to

65 The cost of test preparation courses varies depending on the length of the course and whether it is publically or privately funded. For example, the Immigrant Services Society (ISS) of BC offers International English Language Testing System (IELTS) test preparation courses ranging from approximately 180 dollars (for a 6 week evening course) to 450 dollars (for a 6 week day course) (ISSBC, 2013) and a local publically funded college recently launched a tuition-free 40 hour Canadian English Language Benchmark Assessment for Nurses (CELBAN™) preparation course for IENs (personal correspondence Professional and Career English Department, VCC, April 23, 2012). In contrast, a private school for nursing in BC offers a 4 week full-time CELBAN™ test preparation course for approximately 1200 dollars (OMNI College, 2013).
them…like my coming here is a great help to me. So, yeah, I, there is nothing much I can do with regards to my career (P1219).

In this case, restricted autonomy and time constraints related to her live-in caregiver contract intersecting with limited financial resources\(^{66}\) and moral and family responsibilities constrained her from pursuing English preparation and consequently RN registration. Another participant who had also come to Canada as a live-in caregiver, but was currently working with an open work permit, explained that even without the constraints of a contract she could not afford the time or the expense of attending classes\(^ {67}\). She stated, “I’m working seven days a week” (FG0210I). Thus, there appeared to be numerous reasons for participants not to pursue English preparation.

**Taking an English language proficiency test.**

Numerous factors also discouraged participants from taking an English proficiency test. Cost\(^ {68}\) associated with test taking was one commonly cited deterrent. Further, the cost of a test appeared to add stress to test taking:

PA: Like right now I am just talking to you, like there’s no grade. It’s different. But there, I know that I paid 200 dollars.
PB: It gives you lots of pressure.
PC: That’s right, there’s pressure. Like right now, I’m calm. I can think. It’s different (P0213).

\(^{66}\) While skilled workers may be eligible for funding from ISOs to pay for expenses related to English preparation, those working under live-in caregiver contracts were not eligible for such funding. Skilled workers in the study, though grateful for this funding opportunity, reminded me that the funding (approximately 2000 dollars) would only cover a small portion of their RN upgrading expenses and needed to be used judiciously.

\(^{67}\) Live-in caregivers working with open work permits were not eligible for free tuition for the English preparation course offered at the local publically funded college and needed to pay an international student rate of approximately 600 dollars (personal correspondence Professional and Career English Department, VCC, May 24 2012).

\(^{68}\) It costs 295 dollars to take the IELTS academic test (SFU Test Centre, 2013) and 320 dollars for the CELBAN™ test (CELBAN™, 2013).
Both participants in the foregoing exchange were live-in caregivers and both needed to remit the bulk of their monthly income to families. From their perspective they could ill-afford to fail the exam and pay to re-take it.

Indeed, it was not uncommon to have to re-take an English fluency test and participants provided several reasons for this. One was failure to achieve a sufficient test score and the participant who had more than 10 years of experience in the Middle East as a medical surgical nurse described her devastation when she failed the exam:

For me I like the place, only my profession...I was so angry with myself, “Why I cannot [crying] pass the English?” [crying]…because I really miss my work. But when I tried again, the score I mean the score was deteriorating because I didn’t have any confidence for myself. I don’t know. I give up [crying] (P101).

Another reason for needing to re-take a test was the limited validity of exam results. In the following exchange a participant expressed his frustration that the regulatory college does not accept test scores more than two years old:

It was hard for me because when I came here, I don’t have a job and when I went to [the regulatory college] I was told again to re-write the exam in IELTS even though I have already passed and have an average band score of seven. Yeah, in 2004, in 2008. Now I have to re-take it (Focus group 0213).

The fact that English fluency test scores are only valid for two years is not unique, however, to the regulatory college. CIC also requires that test results must not be more than two years old at the time immigration applications are submitted (CIC, 2012h).

Another commonly cited reason for repeated test-taking was incongruence between CIC and provincial regulatory language requirements. Benchmarks required for immigration purposes
are lower than those required by regulatory college\textsuperscript{69}. One nurse stated, “I had my IELTS before but that was for the Federal Skilled Worker Program” (P1029).

Some participants also challenged the need to re-take tests on the grounds that they are unreliable indicators of work performance. For instance, one stated, “...because when you interact it’s not how good English you have but it’s the quality of interaction. How you communicate empathy, does that depend on the [grammar]?” (P0705). Others were frustrated at needing to re-take a test because they felt they deserved some recognition for being socialized to English since childhood.

You know, I have been taught English since I was in grade one and I have been using English until I become a doctor. In every conferences we use English, the newspapers we read are in English, the books are in English. The movies that we watch, the news television that we watch, CNN, BBC, are in English (Focus group 1213).

Similarly, another who had been unsuccessful with previous tests queried why the regulatory college was not more tolerant of English as second language speakers from the Philippines: “For Filipino nurses, our medium of learning in school is English, however, we are not as perfect [emphasis added] as the one whose native language is English” (P101). She also described her encounter with the regulatory college when she presented them with an English language waiver that had been signed by her English review teacher:

And then I tried my best to go to [regulatory college] to get some kind of waiver and so...“Oh, I’m sorry we cannot waive your English, just take another exam” ...and so I was so depressed when I left [regulatory college]...and I was crying. Oh my goodness [crying]. They are very firm with their decisions [crying].

\textsuperscript{69}At the time of data collection immigration points for FSWs were granted according to English proficiency, with highest proficiency scores receiving the most points. To obtain points for the highest level of proficiency the following IELTS scores were required: Speaking (6.5); Listening (7.5); Reading (6.5) and Writing (6.5). For the moderate level of proficiency: Speaking (5.5); Listening (5.5); Reading (5.0) and Writing (5.5) (CIC, OP6 Federal Skilled Workers, 11-06-17). In contrast, proficiency requirements for CRNBC were IELTS Speaking (7.0) and a minimum overall test score of 6.5 (CRNBC, 2010a).
While the college’s seemingly dismissive approach reflects a 2005 policy change regarding waivers, for this individual it also appeared to represent a lack of appreciation of the hardship imposed by re-takes and the dire consequences of failure. As a new arrival in Canada, with limited resources and a child to support, taking another exam was an expense she felt she could not afford. Yet to decline it meant abandoning her professional aspirations.

Some participants also expressed fear of impending changes to the regulatory body’s English language requirements. One nurse stated, “The problem now in the Philippines is they say it’s so hard to pass the English test. It’s not the nursing exam [CRNE] anymore, it’s the English test” (P0801). Although she had met her English language requirement she seemed to be aware of how other nurses who had not yet arrived in Canada felt toward this requirement.

In summary, participants revealed that cost of test preparation, intersecting with work, contract constraints, and family responsibilities deterred many from partaking in English language preparation classes. Similarly, the cost of taking a test prevented some from moving forward and, in some cases, became a threat to exam performance. Participants also disclosed that in addition to needing to retake an exam due to failure, some needed to retake a test due to

Prior to 2005 applicants for registration had been able to apply for a waiver if they could demonstrate fluency by an alternative approach (RNABC, 2002). For example, they may be eligible for a waiver if they could provide two references attesting to fluency from credible persons whose first language is English; or if they had completed a minimum of 4 years of secondary and/or post-secondary education in English in a country or province where English is recognized as the primary language; or if they had been employed as a registered nurse or graduate nurse in an English-speaking setting for a minimum of 1,125 hours in the past 5 years. Since September 2005, however, IENs have not been offered an option for a waiver (CRNBC, 2005).

Planned changes to regulatory policy governing English language fluency for IENs whose first language is not English included: the reduction in the number of English fluency tests accepted as indicators of proficiency to two tests, the IELTS and the CELBAN™; an increase in benchmarks for both tests; and removal of the option to mix and match test scores (CRNBC, 2011). Such changes to English fluency requirements are not unique to BC; rather, a visit to the websites of RN regulatory bodies across Canada reveals that they are consistent with changes made in most jurisdictions.
incongruence between required thresholds for immigration and regulation. As well, some had not been able to submit their scores to the regulatory college within the two year time period. Some also queried why they should need to take the test since they were well accustomed to speaking English, and, further, why the regulatory body was making it increasingly challenging to meet the English language requirement.

“I Haven’t Applied Yet”

The next step in the process towards RN licensure is submitting an Application to be Assessed for Nurse Registration in BC (the components of which have been described in the literature review and referred to in Chapter 5, the first chapter of results). As previously mentioned some participants had submitted an application prior to arrival in Canada but most had not. While the primary deterrent after arrival in Canada for not initiating a licensure application was inability to meet the English language proficiency requirement, those who did qualify faced further barriers to advancement.

Untangling the complexity of the registration process.

As seen in the literature, many study participants seemed overwhelmed by the complexity of the Canadian registration process (Jeans et al., 2005; McGuire & Murphy, 2005; Sochan & Singh, 2007). This next participant also expressed surprise at having to assume so much of the responsibility for the process:

Before landing here I researched about the nursing system here and the market that they are actually in need of nurses. But then when I researched on how you can become a nurse here…the processes just amazed me that it’s quite complicated on my part. And I have to do all this stuff. But then again I try to comply with it (P1012).

Despite the daunting nature of the process, the foregoing participant recognized he had no choice but to ‘comply’. Keeping abreast of changes to the process was also challenging and as
mentioned in Chapter Four, participants frequently used focus group sessions to share information about new developments as they occurred.

The registration process appeared especially onerous for those familiar with the US process or who had worked in the Middle East, where “things” are “laid out to you” (Focus group 0126). Noting the differences between the American and Canadian nurse registration processes, one nurse commented, “[unlike Canada] the US really recognizes education from the Philippines” (Focus group 1213). This latter comment seemed to exemplify the degree to which many felt rejected and marginalized by Canadian nurse regulation policy. Unlike the US, which only requires a successful score on the national licensing exam (NCLEX-RN® Examination), as noted in Chapter Two, BC requires IENs to complete three assessments (the SEC Assessment, the Canadian work requirement, and the CRNE) and possibly educational upgrading (CRNBC, 2011).

**Fearing rejection.**

Another factor discouraging some from initiating the application process was fear that their application would be rejected. This fear appeared grounded in several sources. One was that they may have insufficient practice hours. Maintaining competence was of particular concern for live-in caregivers whose contract hindered pursuit of educational programs and RN employment. One stated: “By July I’ll be four years and so I’m in a hurry. I don’t know if I can make it” (P0210I). This nurse’s comment alerted me to another countdown caregivers endured:

72 In preparation for the application process IENs are notified that they must have a minimum of 1,125 hours of practice hours within the past five years, for the college states: “Nursing is a skilled profession that people must practice—that is work as a nurse—to maintain their skills (competence)” (CRNBC, 2013b).
the need to be mindful of the time remaining before they were considered ineligible for
application for nurse registration.\footnote{Although they can begin the registration process while working under their live-in caregiver contract, in the event that they require educational upgrading, immigration and education policies constrain them from moving forward. For instance, as mentioned in Chapter Two, immigration policy prevents live-in caregivers from undertaking a study program or course that lasts more than six months (CIC, 2012b). Additionally, education policy restricts access to the nurse re-entry program to Canadian citizens and permanent residents of Canada (Kwantlen Polytechnic University, 2013a). This latter policy also affects nurses who have completed their live-in caregiver contract and are working with open permits as they await permanent resident status. Considering the nature of these policies, live-in caregivers would have to wait approximately three years before they would be eligible for enrolling in the nurse re-entry program.}

Participants also expressed concern that their application would be rejected due to inability to obtain necessary documents from previous employers. The next exchange illustrated the potential vulnerability of a nurse to the whim of her employer in the Middle East:

R: When did you submit your application to [the college]?
P: That’s the problem with me. …the difficulties of getting the papers.
R: From the Philippines?
P: And from the Middle East….it took a long time because the company will never bother to send any information about you. “Who are you?” they say, “You only work here for …”. And so … some of my co-workers here, that is the problem. It is difficult to get [documents] ‘cause they will not bother to send that information, that number of hours (P1028C).

Thus, while this nurse may have gained valuable work experience in the Middle East, inability to verify this experience may impede opportunities for RN licensure in Canada.

Concern was also expressed by two participants that the regulatory college might not recognize their RN credential from the Philippines since they wrote the Philippines’ nursing board examination for June 2006. As mentioned in Chapter Two it is widely known that questions for this examination had been leaked to applicants and that as a consequence certain countries, including the US, refrain from considering graduates from this cohort, although only a fraction of the examinees had been implicated. Anticipating rejection in BC, these participants

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claimed they were faced with either returning to the Philippines to redo the board exam; starting from the beginning and enrolling in a Canadian nursing degree program; or relinquishing their RN aspirations.

**Considering family and financial responsibilities.**

As with career aspirations for Canadian migration, decisions related to commencing the RN licensure process were shaped by numerous intersecting structures and seldom made in isolation. For instance, family responsibilities delayed some from applying, especially if supplemental education courses might be needed. As one mother explained, “Sometimes it’s [family] a factor that dampens your hunger to apply right away. Family matters, especially if you have minors because of course minors have to be looked after” (Focus group 0126).

Another deterrent was the expense associated with the endeavor. In the next example, a nurse once again draws attention to the parallel struggles confronting many study participants: that of being a new arrival in Canada and a foreign educated nurse. She stated, “I needed to work two jobs to compensate loss of my wife’s income”. For this individual, it was necessary to work and support his family while his wife completed a nursing program (Focus group 0126). Further capturing the relational nature of decision-making, another nurse who began on arrival as a live-in caregiver and then worked as a care aide after family reunification, described her decision-making process:

…because my feelings [about pursuing RN licensure] are really mixed…Having a family and working at the same time full-time, I couldn’t decide for myself alone. If I’m living alone then I can focus with my nursing career right away. But then I have a family of my own now. There’s a lot of hindrances and I don’t have enough, like the means, for sure financially, to support myself, my family, and if I will go to school full-time?…that’s also my thinking. If I will go to school full-time and then I have to leave my work, take a leave of absence (P0129).
Ultimately this nurse abandoned her plans to be a RN in Canada and turned her attention to securing a practical nurse license.

**Considering future aspirations.**

Another factor that delayed some participants from moving forward with the application process was uncertainty about working as an RN. For instance, one participant shared:

I haven’t applied yet [chuckle]. Actually …when I came in here I didn’t really want to [be a nurse]. Nursing was my *ticket* [emphasis added] to come here…to put on the application. …I already had in mind that to be a nurse here I had to study again and again (Focus group 0210).

Having used the nursing profession as a “ticket” to facilitate immigration, he now hesitated to take the step towards RN licensure.

Skilled workers who were already licensed to practice nursing in the US and awaiting American immigration visas were also less inclined to begin an application for registration in Canada. Indeed, for some, Canada appeared to be merely a “stepping stone” towards the realization of their American dream.

For those who did initiate the application process, concerns were also raised about the length of time it took the regulatory college to receive and assess their documents:

But then it took a while before they [the regulatory college] said that “We’ve got everything in hand”. It took me six months in waiting of that process. …I’m out of practice…all the theories that I knew before and all the clinical knowledge that I knew before it sounds like it’s obsolete already. You get deskilled already (Focus group 0126).

Though waiting for application assessment had been only one of several delays that confronted this applicant, his comment revealed a common concern about loss of confidence and becoming deskilled while waiting to complete registration requirements.
To sum up, participants disclosed numerous factors that shaped their decisions and capacity to initiate an application for RN licensure. Although some had been prevented by low English proficiency scores, others found the complexity and lack of commensurate support daunting. Some feared rejection on the grounds of insufficient practice hours or incomplete documentation. Beyond the particulars of the registration process, participants revealed that financial, time, and family commitments intersected to prevent them from fulfilling their dream. Finally, several participants shared that nursing was not their career choice and that they were considering other options.

“I Tried All the Techniques That I Know in Preparing for the SEC”

Once an applicant’s documents have been reviewed, the college sends notification of the next steps in the registration process, which may include the SEC Assessment. This assessment is not used for every IEN coming to BC; rather, it is used if the regulatory body is unable to determine an IEN’s competence based on paper documentation alone (CRNBC, 2009). All the participants engaged in this study, other than those who had initiated their application prior to 2008, were required to do the SEC Assessment and participants typically expressed frustration at having this additional step thrust on them. First, they queried why it had been implemented. During one focus group discussion, one nurse stated, “’Cause the SEC just took affect 2 years ago…so something happened along the way for them to create that thing”. Another wondered if increased scrutiny was intended to protect the public or to regulate the supply of nurses in BC (and, in particular the supply of IENs): “I just don’t know whether they’re [regulatory body] more strict because they wanted to preserve the integrity of the profession or if they have more registered nurses in BC and that is why they become…they tend to regulate the profession” (Focus group 1213 follow-up).
When I presented these observations to another participant during an individual interview, I learned a different perspective:

Yes, in a way they’re [regulatory body] putting barriers, in a way discriminatory. But if you look at what’s really the goal which is to provide safe practice …because it’s always safety… and acknowledging that there really is a difference [between nursing practice in different countries], like theoretically it’s the same, but the practice itself is different (P 0705).

In contrast to the previous study participants this nurse was enrolled in the nurse re-entry program and I wondered the extent to which this experience had shaped her opinion and heightened her awareness about differences in nursing education between Canada and the Philippines.

I learned yet a different perspective from a member of another focus group:

“Cause I met this American guy, he’s also a nurse, he just came here to work of course as a nurse. And fortunately Canada is so fair, or Vancouver is so fair [chuckle] that he needs to undergo the same process that we, Filipino nurses or nurses from other countries also need to undergo. The same process. And I’m so happy that they’re so fair [emphasis added]. They don’t consider like. “Okay, you can speak English, you can communicate clearly, now you can work as a nurse here”. No, “You need to undergo and pass [the regulatory requirements], and everything, the same thing as others” (Focus group 0210).

While these latter comments clearly demonstrate an appreciation for being treated the same as IENs from other countries, in particular the US, the participant appeared to equate the notion of ‘fairness’ with ‘sameness’. That is, for this participant it seemed more important that nurses educated in other countries have to undergo the same registration process as those educated in the Philippines, as opposed to whether the requirements themselves are just.

In addition to feeling frustrated that the regulatory process in BC now included a SEC Assessment, participants presented several other concerns about the assessment. They were upset about its limited transparency, uncertain about how to prepare for it, and troubled by the length of time it took both for an assessment appointment and for results.
Limited transparency.

Limited transparency surrounding the decision process and the need to undergo the assessment was a concern expressed by many. Though they were forewarned that “Each person is assessed individually” and “Your education and work experience are taken into account” (CRNBC, 2011, p.9) participants argued that they were not provided with a specific rationale regarding document review that caused the regulatory body concern. Nor were they provided with information about how assessor(s) reached conclusions regarding supplementary education. That is, they were curious to know why some applicants merely needed a single qualifying course yet others, a one year re-entry program. The frustration of one nurse, who had recently received her SEC Assessment results, was clear: “You see...this is what I’m telling [you] we don’t know exactly what is the basis for their assessment” (Focus group 0126 follow-up).

In addition to limited transparency surrounding the need for a SEC Assessment and/or educational upgrading, it was also argued that there was lack of clarity as to the option of bypassing the assessment and directly enrolling in a nurse re-entry program. For instance, one participant stated, “You have no choice. If you don’t do it [SEC Assessment] we won’t get to our goal” (Focus group 0126 follow-up). However, another explained that she had received a waiver for the SEC Assessment. She described her conversation with the regulatory body:

“Okay, you’re asking to undergo SEC but my case is that I know that I need this one year refresher course and that would really make me, you know, fit into the Canadian health system”. Then they allowed me that waiver (Focus group 0126).

This nurse was the only one in the study who had received such a waiver but she may have been the only one had who had approached the regulatory college. Most thought they had no choice but to take the assessment.
Preparing for the assessment.

There was also uncertainty about how to prepare for the assessment. Although it is clearly stated on the IEN Assessment Service of BC website: “The SEC is not a test or examination. You cannot fail your SEC Assessment” (Kwantlen Polytechnic University, 2013b), participants saw the SEC Assessment as an ‘exam ‘of sorts: one that could be passed or failed, with a pass meaning no need for educational upgrading and a failure implying such a need. As one participant stated, “I failed my SEC and I have to go to re-entry program” (Focus group 0210 follow-up). Others feared that failure might mean starting their nursing education from the beginning. Indeed, it states in the Occupational Fact Sheet for Internationally-educated Nurses (2011), “In certain circumstances, CRNBC may determine that applicants are not eligible for registration until they have completed a new post-secondary nursing program acceptable to CRNBC” (p. 12).

For some the task of preparation appeared overwhelming. One nurse explained, “In my country we don’t do physical assessment. It’s done by doctors and so how would I [know how to do one]. And it’s a Canadian way [emphasis added] here” (P0116). Her comments reflected a significant difference between nursing practices in the Philippines and Canada.

Clearly participants saw the SEC Assessment as a daunting experience: one that required preparation and could ‘make or break’ their dream of becoming a nurse in Canada:

I tried all the techniques that I know in preparing for the SEC for it could make or break me in pursuing the board exam. … I really focus on it so much that sometimes fear is eating me up. I was a little nervous but since I miss my nursing profession, I felt so happy that even for just two days I was somehow a nurse here in Canada.

Not only does the above excerpt illustrate how unsupported this nurse felt in her endeavor to prepare for the assessment, but the fact that a two day nursing assessment helped her feel part of
the nursing community in Canada, also illustrated the extent to which she otherwise felt excluded.

**Waiting for the assessment.**

Others expressed frustration at having to wait for both an appointment for the SEC Assessment and for the results. As an illustration, one skilled worker with five years of experience in the Philippines, explained that despite careful planning prior to departure, he still needed to wait two months for a SEC Assessment when he arrived in Vancouver and possibly two months for the results; factors that necessitated finding a ‘survival job’ and that put him at risk of becoming deskillled:

PB: Because really I think it’s a waste of time for nurses like us to take an exam [SEC Assessment] and then wait.
PA: And then the waiting period and the experience and every day that they wait.
PC: Then we find out, okay, period [didn’t ‘pass’]….may as well stick with, change our career. When in fact I am entering here as a nurse but then because of the lengthy process I could change my mind and change to another career in which I am having fun. Like for example, I’ll become a manager of a donut place [laughter] or like, “I don’t like being a nurse anymore”.
PA: We came as Federal Skilled Workers but it defeats the purpose of why we came here. Canada is not really receiving what they want from their immigrants (P1012).

From this participant’s perspective it appeared that hurdles imposed by BC regulators obstruct CIC efforts to attract the most skilled individuals to Canada. Not only did this individual need to get a ‘survival job’ while awaiting the SEC Assessment, he feared losing his nursing career.

In brief, the SEC Assessment created a variety of concerns for participants. They questioned why they had to undergo additional scrutiny. Further, they were upset by the apparent arbitrary nature of its application and the subsequent need for educational upgrading. There was also uncertainty regarding proper preparation for the assessment and distress at the long delays both in actual assessment and its results.
“I Will Not Be Taking Anymore Because You Know We Will Go Hungry”

For those requiring supplementary education, it could be a short term RN qualifying course or a one year full-time RN re-entry program (depicted in Chapter Two). Participants offered their insight into numerous and often intersecting impediments influencing their capacity to pursue upgrading, and in particular the one year full-time re-entry program.

**Waiting to enroll in supplemental education classes.**

A frequently mentioned constraint to moving forward with upgrading was the inordinate amount of waiting time for an available opening. It was not uncommon to wait over a year before being admitted into the re-entry program:

P₁: They [re-entry program] told me that waiting is at least September 2011 and probably it’ll be in 2012.
P₂: Wow, two years.
P₃: Waiting two [emphasis added] years to study (Focus group 1213).

Even those requiring a one month practicum complained of lengthy wait times: “In my case in practicum I had to wait almost a year to have a schedule for the…hospital” (Focus group 0210 follow-up). Consequent frustration provoked one participant to question, “Why only one [re-entry program]? When there’s a backlog, a long waiting list … can’t they not get another university?” (Focus group 1213 follow-up) and another to proclaim, “Why are they doing that [making us wait] to us?” (Focus group 0126 follow-up). Deliberate exclusion of IENs from upgrading opportunities seemed their natural conclusion. Limited enrollment for students in the re-entry program (approximately 70 students per year) caused another to question, “So what will happen to those people [who are unable to get a seat in the re-entry program]”? (Focus group 1213). The look of concern on this participant’s face and her anxious tone underscored the urgency of the situation.
Meeting educational expenses.

In addition to extensive wait times for upgrading, there was also concern about cost. Tuition for the one year re-entry program and books totaled approximately 8000 dollars (Personal correspondence with admission’s assistant Kwantlen Polytechnic University January 18, 2011). This next exchange depicted once again how financial pressures intersecting with family responsibilities limited participants from moving forward with their aspirations:

P₁: Oh, the re-entry! Oh, I think I would not be able to take that because you know it’s very hard for me to be feeding four mouths and then I’ll be studying.
P₂: And so you’ll be giving up your plans for nursing?
P₁: If they require me that, I will not be taking anymore because you know we will go hungry, we will starve here (Focus group 1213).

Although this participant recognized that as a skilled worker he could qualify for financial assistance from immigrant serving organizations, he added, “You know I did not come here to beg. I came here to work, to be able to be productive and to be part of the Canadian workforce”.

From his perspective resettlement funding did not preclude marginalization.

Another provided further insight into the burden of educational upgrading in Canada:

Yeah, economics will play a big role on that [attending the re-entry program]. We can compare the Canadian dollar with the Philippine Peso…. if we will get our resources or funding from the Philippines it is really really a big problem, unlike if we’re going to send money from Canada going to our country (Focus group 1213).

As she explained, newcomers to Canada were often dependent on money from the Philippines to pay for educational programs.

Participants also reported that despite the full-time nature of the re-entry program they would have to work while attending school. One commented, “It’s very exhausting for me to be working at the same time [as] schooling”. Although students in nurse re-entry programs are typically discouraged from working, as a nurse educator I have noticed that students frequently
maintained part-time or casual work positions and sometimes arrived in class after having worked a night shift in a “survival job”. These factors once again drew attention to the parallel struggles that confronted participants.

**Accessing educational facilities.**

Participants also revealed that the location of educational facilities was a barrier to moving forward with upgrading. One nurse said, “It’s too far. It’s really impossible for me” (Focus group 0210) and another stated:

…I’ll tell you…I had to travel…we are living here in downtown and I had to travel all the way to [campus] for that. An hour and a half of travel by bus so…it’s a little difficult. And I even called up [the regulatory college], “Is there any school nearby that can cater to this?” and they said it’s only [one] that they recognize for now (P0203).

Evidently, participants felt their needs were unheeded. In addition to attending classes on campus participants reported that they were responsible for their own transportation to clinical facilities located anywhere in the lower mainland of BC. In the next exchange a participant explained her difficulty getting to her clinical placement: “And I’m not driving. If I’m driving it only takes about 40 minutes but I don’t have a license here yet for driving” (Focus group 0126). Another responded, “Even a [driver’s] license takes time and it’s expensive” (Focus group 0126). For these nurses, scarce resources intersecting with limited time interfered with getting a driver’s license, which in turn dampened enthusiasm or ability to partake in upgrading experiences.

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74 Since the time of data collection the one re-entry program in BC has been re-located to a campus that is further from the downtown core of Vancouver.
Contemplating usefulness of the re-entry program.

Despite these aforementioned constraints, several participants had managed to enroll in supplementary educational courses and/ or the re-entry program. One, who had been both a physician and a nurse in the Philippines, was currently a student in the one year re-entry program and expressed her gratitude for the experience:

R: I’m really glad you’re finding the [re-entry] program helpful.
P: Yes, I don’t know if it’s because I don’t have a hospital experience or even a um solid nursing job experience before but I love it. But even those who had jobs before, they do not regret going (P0705).

Another participant, a former ICU nurse in the Philippines who had entered Canada as a live-in caregiver, had graduated from the re-entry program several years prior to commencement of the research study. In contrast to the aforementioned participant, she expressed disappointment with the program. From her perspective it limited the type of employment one could expect following graduation. She argued that employers in acute care settings overlooked international graduates, despite Canadian upgrading, preferring to hire graduates from Canadian nursing degree programs. She said, “They shouldn’t have that one [one year re-entry program] because it’s a waste of time for one year and then all of a sudden they won’t hire you for that…they would hire more of the BSN [Canadian educated nurses]”(P0116). She continued:

P: I talked to some of my classmates and they have the same problems.
R: They can’t get employment?
P: Yes…[but]they [employers]would recommend for facility (P1116).

She further pointed out that because she had accepted an RN position in a long term care facility she had reduced the likelihood of ever acquiring an acute care position. She stated. “They [employers] won’t hire me because my base is in facility already” (P1116). Feeling defeated by this catch-22 situation and unable to fulfill her ambition to be an acute care nurse in Canada, she contemplated restarting her career and enrolling in a Canadian nursing degree program.
Curious about these observations, I sought two secondary participants who had immigrated to Canada under the FSWP with non-nursing degrees from the Philippines and who had recently graduated from a Canadian BSN program. In contrast to the foregoing participant, both had immediately secured RN employment on acute care units, one a regular full-time position and the other a casual position.

As an overview, those who had enrolled in supplementary education typically were grateful for the experience. However, several intersecting barriers interfered with admission. Some described extensive wait periods before entry. For others the expense and time required to participate in upgrading were unaffordable and accessibility was a deterrent. Further, one participant regretted the uncertainty of acute care employment despite graduation from the one year re-entry program.

“If Only They Will Give Me a Chance”

Not every IEN seeking RN licensure in BC is required to do supplementary education. But all must apply for provisional registration and meet the 250 hour Canadian employment requirement introduced in 2009 before being eligible for full registration (CRNBC, 2011). Moreover, these nurses are responsible for locating an employer to provide this experience (CRNBC, 2011).

Participants had several reactions to this new requirement. Like the sentiments voiced earlier in this chapter regarding the SEC Assessment, frustration was expressed about the seemingly endless number of hurdles IENs need to jump: “And one block after the other, there

75 As noted in previous chapters, on March 13, 2013 the RN regulatory college of BC announced that it was removing the requirement for a Canadian reference following 250 hours of practice as a professionally registered nurse and that the change will be implemented over time (CRNBC, 2013c).
will be another wall to go through” (Focus group 1213 follow-up). Another stated, “They [the regulatory college] keep changing their requirements. Like four years ago I was sent a package of the requirements and then if you compare that to today, there are a lot of differences” (P0126). Numerous participants questioned the need for the requirement and one put forth: “I was just wondering about that. It’s three assessment tools already. I mean can’t they decide that you’re fit to work or not” (P0203). Many appeared to feel marginalized by the need for increased scrutiny.

Additionally, participants expressed confusion about fulfilling the requirement and fear of inability to do so. In particular, they were upset that employers would not hire them with a provisional license and that the regulatory college refused to assist them in locating an employer to complete the requirement. One nurse observed, “They’re [regulatory college] passing over the burden to the nurses” (P0413). Equally as disturbing for participants was the apparent lack of concern on the part of regulators about their predicament:

So that’s why in the information session [at the regulatory college]…, we ask all these things about the 250 hours. So, it’s not only Filipino nurses who are asking for this one, “Where we can find this 250 hours, where can we have this 250 hours in the hospital?”, because most of the hospitals are not accepting us. All of us are asking for this. “It’s very hard to apply for this [250 hour monitored work experience]…to become licensed here”…and then they [the regulatory college] responded, “It’s up to you” [emphasis added] (Focus group 0126).

Another participant, unable to locate an employer to monitor the requirement and faced with diminishing time before his application for registration expired, described his futile attempt to raise the regulatory body’s awareness about his dilemma. “These are all the emails. They [employers] don’t accept me. What do I do? My application will expire in August” (Focus group 0126 follow-up). Rather than assisting him, he reported the regulatory body advised him to pay the 500 dollar re-application fee and it extended his application for another two years. Though pleased to receive an extension, he claimed he would have appreciated help in locating an
employer and expressed concern that he was becoming further deskillled in the process of searching for one.

Regarding this lack of assistance one nurse put forth this recommendation: “[The regulatory body] should give a list of facilities where RNs can get the 250 hours” (Focus group 0126 follow-up). However, the next exchange illustrated that participants yearned for more than information. Comparing the support they themselves received from regulators to that offered primary grade students in BC, one nurse reasoned:

P: Here [Canada] the teachers will see to it that the child will be able to make it to the next level. And here we are, we are all professional, I guess, and how come we are treated lesser than the primary students?
R: You mean you’re not getting the support?
P: Yeah, because we’re left nowhere to go (Focus group 1213 follow-up).

From this nurse’s perspective, professional nurses, unlike primary school students who are nurtured along their educational pathway, are abandoned and not heard by those in positions of authority to assist them. Expressing a sense of powerlessness about her predicament, another commented “it’s like you’re so near, yet you’re so far away from the reality of being a RN” (Focus group 0126). That is, despite careful planning and having complied with all of the previous requirements she felt incapable of meeting her goal for Canadian licensure. In the remainder of this section I will describe obstacles that participants perceived were preventing them from acquiring a Canadian work experience and strategies used or contemplated with respect to finding employment.

**Obstacles encountered finding an employer.**

Participants offered several reasons why employers may be hesitant to hire them. One thought was that the requirement meant an excessive commitment from the employer. This nurse stated, “...nobody wants to hire [IENs with] provisional licenses. Then the employers will have
to have the responsibility of looking after you” (P0203)\textsuperscript{76}. Another reason offered for employer 
hesitance was the reduced demand for RNs in BC\textsuperscript{77}:

P\textsubscript{1}: They’re [employers] saying that there are too many nurses available. Because 
I’ve learned that there are [were] many Filipinos working as RNs and they’ve 
been laid off. 
P\textsubscript{2}: [In] nursing homes? 
P\textsubscript{1}: Yeah. … And most RNs are doing part-time jobs. The LPNs are doing the 
full-time jobs (Focus group 0126).

However, the foremost reason for not being hired from the participants’ perspective was 
employer preference for Canadian nursing education and RN work experience:

P\textsubscript{1}: That’s like the major [obstacle]. I do have several interviews with that one and 
so I usually get caught with that question, “Do you have any formal education 
here in Canada?” Then, that’s it. 
R: Really? So you’re finding they do want Canadian education? 
P\textsubscript{1}: Yes… like they are asking like “Your experiences?” and then after there is one 
point when they usually ask, like “Do you have any formal education here in 
Canada?” and you say “No” then like, the doors will close. [laughter]. Like 
there’s no other follow-up questions, like they just end the interview, so, like “Oh, 
no” (Focus group 0210 follow-up).

Similar to the reluctance encountered as they searched for ‘survival jobs’, they faced a similar 
attitude when seeking RN employment. Such resistance prompted one to lament: “I have the 
skills and experience. If only they will give me a chance to work under supervision” (Focus 
group 1213). From his perspective the Canadian work requirement was simply a means of 
exclusion.

Participants also questioned the usefulness of the SEC Assessment since employers 
demanded Canadian education and experience regardless of the SEC outcome:

\textsuperscript{76} There may be some merit to this observation since the regulatory college demands that employers be held 
accountable for ensuring applicants are monitored and evaluated by a RN or nurse practitioner who will be readily 
available for consultation and collaboration throughout the experience (CRNBC, 2013a). 
\textsuperscript{77} According to a BCNU News Release: “… work opportunities for experienced RNs coming to BC from other 
provinces or from overseas are extremely limited. Rather than expanding nursing services to keep up with increased 
demand in this province, health authorities have been cutting them back. Since mid-2009 health authorities have 
eliminatied more than 600 positions for Registered Nurses in BC” (Fayerman, 2010).
…they (IEN Assessment Service of BC) had already assessed you and you got your [SEC] result but yet once you apply for a job, they say “You don’t have Canadian experience” or “You didn’t upgrade” and so “Why should I hire you?” (Focus group 1026 follow-up).

That is, while regulatory policy currently excuses international applicants from taking educational upgrading if they can demonstrate their competence to practice is equivalent to competencies required of BC RNs, BC employers prefer that IENs complete supplementary education. Indeed, it seemed that efforts expended to perform well on the SEC Assessment (in order to reduce the likelihood of needing supplementary education) were in vain as employers were the ultimate gatekeepers.

To illustrate this point further, another nurse expressed frustration that an employer had demanded a letter from a nurse re-entry program verifying he had taken supplemental education, a requirement that he had been exempted from on the basis of his performance on the SEC Assessment. He described his phone interview with the health authority:

I got stopped because they were looking for clinical experience here, as a nurse in Canada and they were looking for a clinical reference and um they were asking for a letter from [the re-entry program] that I did the clinical experience which I didn’t do…so the thing is …that’s where I’m stuck right now…[laugh] a big problem, right? (P0203).

One nurse, who had encountered a similar reaction, shared a letter he had received from the recruitment office of one health authority. It stated:

All applications are reviewed individually, however, in order to be successful in your employment, we recommend that international nurses complete a Canadian Nursing Re-entry program…. These programs provide internationally-educated nurses the opportunity to learn and practice within Canadian Nursing culture and to confidently integrate into working with individuals, families, groups and communities in a variety of Canadian health care settings. (Correspondence, December 7, 2010, Focus group 0126).
Participants were clearly disturbed by this catch-22 situation and one exclaimed, “What I am saying is since they [the regulatory body] decided for you not go through the SEC or the re-entry program, the employer should respect that” (Focus group 0126). Conversely, it also caused another to offer this suggestion, “So, I’m just wondering why not just let everybody take the clinical course [supplementary education], get the exams and then give them full registration?” (P0203). That is, from his perspective, instead of implementing a SEC Assessment, the regulatory college should require IENs to take supplementary education.

Participants also speculated that Employed Student Nurse (ESN) and New Graduate nurse Transition programs reduced their opportunities for employment. They recounted numerous job postings for new Canadian graduates but upon inquiry were told, “Those nurses who have graduated here in Canada... those nurses will be the ones to be prioritized first” (Focus group 0126). The fact that these programs exclude IENs prompted one nurse to add:

> I know student nurses have their own like their own, what is it? Employed Student Nurse Program? So I’m thinking, well, “I see the point that employers want Canadian experience”, right? But then they’re willing to train student nurses and here’s some nurses coming in with lots and lots of experience [and they don’t hire us] (P0203).

For this participant, who had vast experience both as a physician and a nurse in the Philippines and whose competence to practice were determined equivalent to the competencies required of BC RNs, exclusion from these programs contributed to feelings of marginalization.

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78 Funded by the MOH, each health authority in BC has an ESN and a New Graduate Transition program to ease the transition of new Canadian nurse graduates into the workplace. The ESN program allows RN students to continue their professional development and become part of an interdisciplinary team. This paid employment experience provides an opportunity for students to consolidate the knowledge and skills while gaining increased exposure to the clinical setting (Providence Health Care, 2013). Similarly, the New Graduate Nurse Transition Program is designed to support the transition of a new graduate registered nurse throughout his/her first year of practice (Interior Health, 2013).
Strategies used to find an employer.

Despite such resistance from employers many participants remained resolved to meet the Canadian work experience requirement. One stated, “I will find a way. I have to finish … the RN requirement” (P1028B). Accordingly, participants revealed several strategies they had used, or were contemplating to use, in meeting the requirement. Overlooked by public acute and long term care institutions in the lower mainland of BC, some sought RN work experiences in the interior of the province; others tried to access clinical nursing courses; some tried to expand their professional network by volunteering their time in hospitals; and some sought RN employment in private long term care facilities. Many seemed reluctant, however, to accept this latter option on the grounds that it would limit future options for acute care employment. In the next exchange, participants in a focus group discussion shared the excitement expressed by one nurse about being able to finally secure employment:

P1: Oh [excitement] congratulations! Where did you do the 250? Yukon? [laugh]
P2: Luckily Vancouver, just 17 minutes away from my home.
P1: [acute care hospital]?
P2: No, no, no. I tried all the facilities under the health authorities…they don’t give 250 hours…I phoned a facility (owned) by a Filipina…she owns a facility [in the lower mainland of BC] (Focus group 0126 follow-up).

Although he was relieved at finding employment I also noticed he sounded slightly discouraged by the fact that it was in a facility. As the next participant pointed out, working in a facility could ultimately restrict future employment opportunities; a factor that was raised earlier in this chapter:

I think it [finding an employer in a long term facility to monitor the work requirement] would limit you to long term facilities ‘‘cause I know some of the nurses that I’ve connected with and they had their 250 hours in a facility. They now have difficulty getting into a hospital, acute care setting. Which is quite difficult…’’cause I’d love to go to acute care setting with my experience and all (P0203).
Therefore, while employment in a facility may helped to secure licensure, it did not guarantee RN employment or the ability to fulfill aspirations for acute care nursing work.

Several participants reported seeking unpaid work experiences from private care facilities to fulfill their regulatory requirement. For example, one reported, “I’m willing to volunteer my time just to get the 250 hours” (Focus group 0126). Rumors also circulated among participants that some IENs had paid private employers for a workplace experience. Both these unfortunate scenarios exposed the vulnerability of these nurses. It also drew attention to the fact that study participants, previously at risk of exploitation by their Philippine employers because of aspirations for migration, were again at risk of exploitation in Canada because of the nursing registration requirement.

Reflecting on participants’ comments, I learned that locating an employer to monitor the 250 hour Canadian work experience requirement was a major obstacle interfering with prospects for RN licensure in BC. Not only were employers reluctant to hire them on the grounds that they lacked Canadian education and work experience, but the regulatory body would not help them locate employment. Moreover, many felt marginalized by ESN and New Graduate Nurse Transition programs that accept only Canadian educated nurses. Left to their own devices, some tried to expand their professional networks and others sought RN positions outside of the lower mainland of BC. Still others accepted unpaid work positions.

“When the Time Comes That We Pass the Exam They’ll Say That We’re Not in Practice”

The CRNE is often the last step in the registration process though applicants may be deemed eligible to take the examination prior to completing the Canadian work experience (CRNBC, 2011). Considering the complex registration process, one participant articulated a sentiment commonly expressed by others: “When the time comes that we pass the exam they’ll
say that we’re not in practice” (Focus group 1213). From the perspective of many, the registration process was too lengthy – a factor that put them at risk of becoming deskillled and unemployable.

Participants also had numerous concerns about the CRNE itself. Much of what I learned about the nature of these concerns arose from listening to them compare the exam to the NCLEX-RN® exam since many had written or reviewed for NCLEX-RN® in preparation for possible US immigration. Most notably, participants expressed concern that they were unable to take review classes or write the CRNE prior to arrival in Canada. In this next excerpt a participant explained why she preferred the NCLEX-RN® exam:

…we can take preparation [for the NCLEX-RN®] in the Philippines, or in our country of origin. That would be easier for us because even if we are there [in the Philippines] we can prepare for the exam, we can write the exam there [in the Philippines] and…it’s cheaper (Focus group 1213).

As she pointed out, the NCLEX-RN® fee 79 is less than the CRNE fee, and considering the expenses incurred with travel to Canada to take the CRNE, less expensive in total.

Another major concern expressed by participants was the difficulty of the CRNE. Most had not taken it at the time of data collection, but the majority of those who had, failed it at least once. These findings reflect those reported in Chapter Two indicating approximately half of internationally educated first time CRNE writers failed the exam in 2011 (CNA, 2012b). One nurse, who had previously passed the NCLEX-RN, struggled to come to terms with her failure on the CRNE and stated: “But in Canada, ‘Why is it that I did not pass the CRNE? What’s wrong with me?’” (P0801). From her perspective, the CRNE was more difficult than the NCLEX-RN®.

79The NCLEX-RN® Examination costs 200 dollars (NCSBN, 2013), whereas the CRNE costs 615 dollars (CRNBC, 2011).
Others who had also failed the CRNE but passed the NCLEX-RN® shared this sentiment and queried whether success on the NCLEX-RN® had given them a false sense of confidence.

Those who had failed the exam disclosed their grief and also fear of future failures:
“…it’s like if I fail for the second time and you’re working in one hospital there is some kind of depression or you… your confidence is shut down…. it’s a shame [to fail]” (P0623). As well, since applicants only have three attempts to pass the CRNE, there was fear that a third failure would destroy their dream of Canadian RN employment. Rather than risking a third failure, one participant (P0116) contemplated starting her nursing career from the beginning and enrolling in a Canadian BSN program.

In conclusion, numerous concerns were raised about the CRNE. In addition to expressing fear that they may be deskillied and unemployable by the time they write the exam, participants reported that it would be easier and less expensive to have access to exam preparation and test taking prior to arrival in Canada. They also revealed that they experienced less difficulty passing the NCLEX-RN® and that success on the NCLEX-RN® had generated a false sense of confidence and interfered with CRNE preparation. Finally, they taught me that failing the CRNE could be a humiliating experience and one with career-changing consequences.

**Chapter Summary**

Findings revealed that experiences seeking RN licensure in Canada were shaped by structures at the international level (e.g., differences between a Philippine nursing education and a Canadian education), at the national level (e.g., immigration policies that restrict live-in caregivers from engaging in educational programs), at the provincial level (e.g., regulatory policies that are becoming increasingly rigorous and educational policies that generate lengthy wait lists), and at the local level (e.g., employer preference for Canadian education and work
experience). Participants also felt their voices were not heard by regulators, educators, or employers. These structures, intersecting with financial and gendered responsibilities, made participants vulnerable to exploitation and becoming deskilled and remaining underemployed in Canada. However, findings also indicated they were not passive observers. Confronted by these disempowering structures, participants turned to each other for support, sought professional networks and demonstrated a resolve to persevere.
Chapter Eight: Reconciling the Journey - “I Have to Move On”

In the previous three chapters I presented challenges encountered by study participants before and after arrival in Canada. In the first chapter of results, Chapter Five, I examined structures that shaped decisions and preparations to migrate to Canada and explicated ways in which participants drew on personal and structural resources to pursue greener pastures. In Chapters Six and Seven, I focused on structures shaping experiences as they transitioned to a new life in Canada and sought or contemplated RN licensure. As well, I drew attention to the means by which participants coped with these two parallel struggles. In this final chapter of results I want to build on foregoing interpretations and use examples of data to identify structures that shaped experiences as nurses reconciled or attempted to reconcile their journey and “move on” with their lives. In particular, I examine findings arising from the interview question: “What are your thoughts about your future?”

Discussions about the future, however, took different directions depending on where participants were located on the RN trajectory. While many at the time of data collection were still hopeful about acquiring a RN credential, some who had started the application process had abandoned their goal, and others were hesitant to begin the application process. In contrast several had achieved licensure and were working in RN positions. I begin with thoughts expressed by participants still hopeful for a Canadian RN credential and then will focus on how others tried to come to terms with relinquishing their goal and options they considered.

“My Main Goal Is at Least to Go Back to My Profession”

Those who still clung to their desire to nurse in Canada revealed several strategies for fulfilling their goal. The first was to persevere with the regulatory pathway laid out for IENs in
BC. For instance, one nurse with 15 years of medical/surgical and emergency room experience in the Philippines and Middle East who had come to Canada as a live-in caregiver stated:

Well, for me, I’m thinking it’s a challenge, you know this part of life. It will add to your knowledge and experience. But the only thing is, my main goal is at least to go back to my profession. To health care. Like community worker, then slowly, slowly…I have to support myself in going back to nursing. Because it’s not easy, it’s not easy. More time and more money… yeah, but I have to go on [chuckle]. I have to move on [chuckle] (P0210).

This excerpt revealed that the realization of RN licensure in BC required significant determination.

Others struggling to meet regulatory requirements looked at other Canadian provinces. One skilled worker, unable to find an employer to monitor her 250 hour Canadian work experience requirement, explained why she would leave BC: “[Registration in BC is difficult] compared to other provinces. That’s why I am thinking, ‘Should I go to Manitoba?’ ‘Should I go to Halifax?’ to move [laugh]?” (Focus group 1213). Another, having heard that the regulatory process was less challenging in Alberta, had already re-located there by the time I tried to reach him for a follow-up interview.

Participants also mentioned pursuing further education as a means of advancing their professional career. For instance, several desiring employment in an acute care setting contemplated starting their RN education from the beginning at a Canadian college or university. Another who had already acquired practising registration and RN employment in a facility for the elderly revealed her future plans might include a specialty course in geriatrics. However, she expressed concern about cost and explained she was also saving for her children’s education in the Philippines. Once again it appeared that family and financial responsibilities intersected to shape professional aspirations.
For those committed to a RN career in Canada, preparations for the future were shaped by personal resources such as a determination to succeed and a desire for professional advancement. They were also mediated by the complex interplay of family and class relations. As well, for some, the future would involve re-location.

“But if It’s Not for Me, It’s Not for Me”

While some remained determined to acquire a Canadian RN credential, others disclosed their struggle coming to terms with lost aspirations. Although one nurse simply said, “I still want to [become a nurse here] … but if it’s not for me, it’s not for me” (P0213B), others expressed more personal remorse:

Honestly speaking, if I had known that I would suffer this kind of fate, I would have not chosen Canada. … before applying for the skilled immigrant worker, I applied first to [regulatory college]. Unlike most nurses who came here who have not yet applied for licensure. I thought that I planned everything well because I can start [working] as an RN [when I arrive]. I just never thought that I would be deskilled in pursuit of my nursing career. (Email correspondence April 12, 2011, Focus group 0126)

For this nurse and others, ‘moving on’, was not easy and conversations about the future often focused on the challenge of reconciling to a new reality.

During these discussions participants turned to a variety of narratives to support their shift in focus. Such accounts often resembled those expressed in support of migration to Canada. To illustrate, a desire for the betterment of their children’s future helped some to reconcile difficulties in Canada:

P1: The majority of us would say that the reason why we are here is for our kids, mainly.
P2: Yeah.
P1: And if in case, for example, I also have some friends who have not been able to pursue their RN, that’s fine as long as their kids will have a good education and get established (Focus group 0126 follow-up).
Another nurse who had come to Canada 15 years earlier as a live-in caregiver took pleasure and solace in the realization that her life was better than if she had remained in the Philippines:

But still I’m a little bit luckier than them in the Philippines [laugh]. ’Cause in the Philippines although you finish a four year course mostly there is politics. A lot of nurses have been graduated, they’re not employed. ’Cause it’s mostly not ‘what you know’ but ‘whom you know’. And then after you graduate you have to go to the hospital, you have to pay for all your own training. Like volunteer job you have to pay the hospital just to get in (P0120).

Despite the disappointment of “hindrances” in her life that pre-empted plans for a RN career, she was now working as a practical nurse, and felt a “little bit luckier” than those back in the Philippines.

Others rationalized their situation by reflecting on their goal for permanent resident status and Canadian citizenship. For one skilled worker achieving permanent resident status was in itself an accomplishment. He stated: “Because we come in as immigrants even if we’re not [nurses] at least we are grocery clerks” (P0210). Similarly, the dream of family reunification coupled with Canadian citizenship sustained many live-in caregivers. One nurse struggling to complete her caregiver contract and anxious about meeting the English language benchmark shared these thoughts:

P₁: I think my goal right now is to just get my PR [permanent resident status] and then to see where to go from there. Like maybe nursing, or to other jobs.
R: Well, as you said, it’s one step at a time.
P₁: … I’m going to get open visa, then PR, and the Canadian citizenship (P0210).

For this nurse and others, planning or preparing for the future involved a relentless and never ending series of steps.

With remarkable resilience another participant accepted her failure with the CRNE by focusing on the opportunity it provided for personal and spiritual growth: “I think what life taught me is that in the areas where you are frustrated, God will allow you
to be in that area so that you will grow” (P0801). Another nurse also illuminated the role of religious faith in shaping perceptions of their future. She explained, “As the saying goes ‘If God closes a door He opens a window’ and sometimes the difficulty we face in life in the end, it will be to our benefit” (Email correspondence July 13, 2011 Focus 1213). From their perspective, the Christian faith that had born optimism prior to arrival also provided hope for a brighter future in the face of adversity in Canada.

The next exchange demonstrated the extent to which personal resources such as resilience and optimism also informed plans for moving forward:

P1: And there’s no stopping us from being happy and contented with our lives. If we don’t get it [RN licensure], there are other things to do.

P2: It’s not the end of the world for us really ’cause…there are options…like in my case, while I’m getting frustrated with this RN business and so I’ve decided to apply for the LPN exam (Focus group 0126 follow-up).

Indeed, these skilled workers appeared committed to making the most of the situation that confronted them.

The foregoing perspectives thus demonstrated the wide range of responses to aspirations beyond reach. For some it was profound disappointment, yet for others it was refocus and re-adaption. Some looked to their accomplishments, whereas others situated their experiences within a grander framework and a sense of optimism emerged. In the next section I will describe alternate pathways pursued or contemplated by some.

“You Should Always Have an Option”

Those who had abandoned the hope of a Canadian RN credential were often quite forthcoming about potential alternate careers. Even those still hopeful of licensure often speculated about options in the event of failure. Alternate plans often included a different health-related career. One nurse who had recently applied to the College of Licensed Practical Nurses of
British Columbia (CLPNBC) said: “Why not join the CLPNBC? After some months you can have your license [and] work” (P1028). Another indicated, “If in case I will not be able to do [a] nursing career maybe I will just [enter another] medical field. You should always have an option” (P0213). One nurse stated:

Being a nurse from other country would never hinder me to render service in the event that I won't make it. ... I'll indulge to other things that I can be productive and may just do my nursing side on a voluntary basis with some institutions or something (Email correspondence July 13, 2011 Focus group 0126).

This narrative highlighted a relationship between self-sacrifice and nursing, an interconnectedness that surfaced in numerous discussions related to a nursing career.

Some participants revealed that they had set their “horizons” beyond nursing. For instance, a single nurse who had arrived in Canada under the LCP expressed an interest in becoming a writer, a career she had not had an opportunity to pursue in the Philippines. She stated:

…I don’t regret coming here because I’ve learned a lot. Like seeing the realities of life, my horizons [have] expanded. Like when I was in the Philippines I was just focused on getting settled in my career...being a nurse. But when I come here, I can’t practice my nursing. The way I see things is different. I see how [others] live and it’s just interesting. Opening myself to other opportunities (P1219).

Despite having earlier voiced complaints about being exploited by her family and the live-in caregiver contract, this nurse was also grateful that she had been able to come to Canada and enthusiastic about her future. Though her nursing education in the Philippines had not prepared her well for RN employment in Canada, it seemed to have paved the way to her liberation.

Another nurse revealed that future plans did not always include employment:

P₁: For me, if in case [I can’t get through it] I said, ‘I’m happy because I’m with my family because in Dubai I cannot bring them, it’s so expensive, its more expensive living in Dubai than in here. That’s fine with me’.
R: Oh, I see.
P₁: And as long as my husband can find his work … and I can stay home and
enjoy Canada [laugh] (Focus group 0126 follow-up).

This nurse, having worked previously in the Middle East, expressed gratitude that despite forfeiture of RN employment, life in Canada allowed her to spend time with her family.

While options for some included re-locating to the US or perhaps temporarily resuming a RN career in the Middle East, return to the Philippines (on a permanent basis) was not one of them. The following conversation with a group of skilled workers helped to illustrate this point:

R: Would you consider going back to the Philippines?
P1: Not Philippines, definitely not [agreement from all; much chatter and laughter].
R: Definitely not?
P1: It’s no life for nurses there.
P2: The nurses in the Philippines are paid by the minimum wage.
P3: Underpaid.
R: So when people say they are considering “going back”, do they mean going back to other countries [emphasis added]?
P1: Other countries [agreement from all]
R: Okay.
P2: Not the Philippines (Focus group 0126).

From the foregoing exchange it emerged that despite marginalization in Canada, these participants foresaw a bleaker future if they returned to their homeland.

To clarify my interpretations about returning to the Philippines I raised the question with a different group of skilled workers who had been forthcoming about their disillusionment with the nurse regulatory process in BC:

R: So do any of you consider going back… to the Philippines?
P1: Yeah, if worse comes to worse.
P2: In our case we gave up everything.
P3: Yeah, like a job.
P4: No turning back; no turning back.
P3: No turning back (Focus Group 1213).

From this group I learned that many, forfeiting so much to come to Canada, felt they had no choice but to remain. I was curious about their comments because I had learned from previous
students and from attendees at a nursing conference in the Philippines that occasionally nurses do return home.

When I introduced this notion to another group of skilled workers, I was met with initial silence followed by the comment, “That’s the unfortunate thing” and then a word of advice from another, “We should be positive” (Focus group 0210). However, when I pushed the question further and asked, “What happens if you don’t like it here?” I received this outpouring of revealing comments:

P1: Just make sure you paid everything you owed there [laughter].
P2: Make sure you pay it [loan].
P1: Well, “At least I made it there”.
P2: Embarrassment.
P3: It’s a failure.
P3: When you go back to your country of origin that means that you failed in a way.
P4: That’s their impression.
P3: It’s a failure.
P4: I think that’s the statement you will face if you will go back with [nothing].
P3: Nothing. It’s okay if you will go back if you are [rich].
P3: Rich.
P3: Already successful here. Then there’s no problem. But if you go back and you weren’t able to prove anything, that you were able to establish yourself here in Canada, so that is a sign of failure, I guess.
P1: But there are some other people who come here just for the citizenship and after getting the citizenship they went back to the Philippines (Focus group 0210).

These remarks exposed that fear of losing social status was a factor constraining some from returning to the Philippines.

When I asked another participant who had come to Canada 15 years earlier as a live-in caregiver if she felt that Canada was now her home, she replied:

Yeah, I think so. ’Cause way back in 2005 when I went home again in the Philippines it’s like I feel like I’m a stranger there already because of the water, the environment like that. It’s so hot and then I get allergic already to the air, or, I don’t know (P0120).
Although this nurse did consider Canada to be her home, her comments uncovered the notion that nurses educated in the Philippines, in addition to feeling marginalized in Canada, could feel alienated from the culture they left behind.

In review, conversations about alternate plans were often framed in terms of career changes that typically maintained a health related focus. However, for some, aspirations extended beyond the realm of health care and one participant revealed that staying at home with her family would be a worthy option. While some spoke of re-locating to the US or returning to the Middle East, permanent return to the Philippines was not an option that emerged.

**Chapter Summary**

Reflecting on participants’ thoughts about the future, challenges with acquiring a Canadian RN credential and employment were ongoing. The fulfillment of BC regulatory requirements remained realistic for some, but those less optimistic considered an RN credential in another province or even starting their RN education from the beginning at a Canadian institution. However, intersecting financial and family constraints continued to inform aspirations for advancing professional careers. For those who had relinquished the dream of RN employment, the task of reconciling their journey could be challenging and it took a variety of forms. Structures that had compelled many to seek greener pastures, such as a desire for a better future for their children, similarly helped some adapt to their current situation. Although participants typically turned to other health related careers if unable to meet Canadian RN regulatory requirements, some sought careers beyond the boundaries of health care. Finally, participants disclosed that despite their vulnerability to marginalization and exploitation in Canada, returning to the Philippines was not an agreeable option. In the next chapter I will attend to the broader context of nurse migration.
Chapter Nine: Discussing the Complexity of the Nurse Migration Journey

In the previous four results chapters I examined a web of structures such as nursing schools in the Philippines, Canadian immigration policies, and provincial regulatory requirements that shaped Philippine nurse participants’ experiences as they made their journey toward Canadian RN licensure. Further, I analyzed how such structures and mediating oppressions put participants at risk of marginalization, exploitation, and powerlessness. I also identified ways in which participants both resisted and contributed to these inequities. In this chapter I will further expose the complexity of nurse migration by turning my attention to its broader global context and root causes of inequities.

Contemporary nurse migration is a consequence of globalization (Kingma, 2006). Globalization refers to the diffusion of commodities and ideas on a world basis rather than on strictly national or domestic bases (Bertram, 2008; Hirschfeld, 2008). Drawing on Rhys Jenkins, Hirschfeld (2008) defines globalization as “a process of greater integration within the world economy through movements of goods and services, capital, technology, and to a lesser extent labour which lead increasingly to economic decisions being influenced by global decisions” (p. 12). These economic decisions involve both provider nations (e.g., the Philippines) as well as consumer nations (e.g., Canada). While nurse migration from one country to another is a longstanding practice (Bertram, 2008; Kingma, 2006, 2010), for years the trend was from developed to developing countries (Bertram, 2008), or between countries of the North (e.g., between Canada and the US or the UK) and countries of the South (e.g., between Cuba and Nicaragua) (Kingma, 2006). Now the direction of flow is changing and there is a wider range of supplier countries in developing countries striving to satisfy the growing labour needs of developed countries (Kingma, 2006, 2010). In this context, educated nurse professionals have
become global commodities subject to market forces – forces which are insensitive to human and social cost (Guevarra 2010; Kingma, 2006).

Drawing on postcolonial feminism I aim to link inequities to global forces of neo-colonialism and neo-liberalism and unmask colonising hegemonic practices that shape the construction of racialized identities as inferior. As well, I will ask how such practices reproduce histories of subordination and domination. Further, drawing on relational ethics theory I will analyze how relationships (both personal and political) interfere with the ability of participants to exercise autonomy and consider whose interests are being served when nurses educated in the Philippines seek RN employment in Canada. I will also explore tensions between structures and agency (and underscore ways that participants resisted and reclaimed their agency). Finally I will offer insights for promoting social justice – locally through to internationally – in nursing and beyond.

From the outset of this study I have argued that participants’ experiences were shaped by the interplay of structures and processes that occurred well before arrival in Canada. Therefore, I begin my discussion with an examination of broader structures and root causes of injustices that influenced participants’ decisions and opportunities prior to migration. I will note how these initiated a cascade of events that influenced experiences after arrival in Canada. I will then proceed to expose prime sources of inequities in Canada that further contributed to the complexity of nurse migration for those seeking a Canadian RN credential.

80 Drawing from the work of Jaggar (2002) I use “neo-liberalism” as a concept which marks a retreat from the liberal social democracy of the years following World War II. That is, rather than representing something novel as its name suggests, it reflects the non-redistributive laissez-faire liberalism of the seventeenth and eighteenth centuries, which held that the main function of government was to make the world safe and predictable for the participants in a market economy. Some main tenets of contemporary neo-liberalism include free trade, opposition to government regulation, refusal of responsibility for social welfare, and resource privatization (Jaggar, 2002).
A Culture of Migration

In the Philippines nurse migration has become a taken-for-granted phenomenon; one that is entrenched in everyday life and one that leaves many feeling they have little choice but to seek employment abroad (Choy, 2006; Guevarra, 2010; Pratt, 2010; Rafael, 1997; Ronquillo et al., 2011). In this section I shed light on structures underpinning this culture and discuss how such structures in turn informed decisions and preparations for migration and ultimately accessibility to RN licensure in Canada.

Deciding to migrate.

Many scholars contend that decisions to seek work outside the Philippines are informed by a neo-liberal market economy in the Philippines (Choy, 2006; Guevarra, 2010; Kingma, 2006; Pratt, 2012). Although the Philippines has a long history of migration, it is only since the early 1970s that there has been massive and state-encouraged movements of workers and immigrants (Rafael, 1997). In an attempt to alleviate unemployment and revitalize a failing economy, President Marcos initiated a ‘labour export policy’ and started to actively promote the export of nurses and labourers (Choy, 2006; Sarvasy & Longo, 2004). Nurses were encouraged to work abroad to earn for the country as well as for their families (Choy, 2006; Sarvasy & Longo, 2004). Findings synthesized from participants’ accounts in my study reflected these sentiments. Nurses revealed that structures fueling their decision to migrate were mediated by social and economic inequities in the Philippines. They described being forced to fend for themselves in the Philippines and encouraged to migrate and remit money to families at home. Consequently many participants, especially those who came to Canada under the LCP, recounted being burdened with financial responsibilities after arrival in Canada.
It is also widely acknowledged in the literature that decisions to migrate are informed by legacies of a colonial past that created and sustained an American dream of greener pastures, gendered notions of caring as women’s work, and the idealization of self-sacrifice (Choy, 2006). Similarly, participants in my study confided that their decisions were shaped by traditions of moral, familial and gendered responsibilities; an American presence in the Philippines; and an ongoing exposure to Western media. As well, many offered that their religious beliefs regarding a greater purpose in their lives inspired them to seek work abroad. Such structures in turn shaped expectations of life in Canada.

Kingma (2006) also draws attention to the important role that professional networks play in decisions to migrate and again alerts us to the fact that nurse migration is a global phenomenon and one that is inevitable. Accordingly, participants in my study revealed that they were encouraged to migrate by family and friends living abroad as well as Canadian colleagues working in hospitals in the Middle East.

It is also well supported in the literature that the demand for nurses in higher income countries, such as Canada, is a major factor encouraging nurse migration; that nurses have become a prime resource in an increasingly competitive global labour market (Gordon, 2005; Kingma, 2006, 2010; Little, 2007). Indeed, many participants shared that they relocated to Canada because they believed their nursing education and skills were needed by Canadians. The fact that Canadian immigration policies had prioritized their immigration status on the basis of these attributes reinforced the notion that they would be well received in Canada.

However, numerous scholars also argue that the demand for nurses in higher income countries is symptomatic of larger systemic problems that discourage many nurses from remaining in the profession (Aiken et al., 2004; Ball, 2004; Buchan, 2006; ICN, 2006, 2007a;
Rodney and Varcoe (2012) suggest that several decades of reform driven by neo-liberalism and corporatization have worsened the conditions of nurses’ work in Canada. Others speculate that nursing in many countries continues to be undervalued as women’s work and consequently insufficiently funded (Buchan, 2002, 2006; ICN, 2004a). Such conditions put IENs in jeopardy of filling gendered and racialized positions that are deemed less desirable by others (Allan & Larsen, 2003; Bach, 2003; Ball, 2004; Choy, 2006; ICN, 2007b; Kingma, 2006). Indeed, in the next section of this chapter I will address the fact that nurses from the Philippines are increasingly filling positions in the care-giving industry in Canada.

In summary, decisions to migrate were not made by fully autonomous agents. Rather, decisions were embedded within broader contexts that may not have been readily visible to participants themselves or others. Though not passive agents, such intersecting structures and processes put them at risk of marginalization, exploitation and powerlessness both in the Philippines and Canada. I now turn my attention to an analysis of structures that subsequently shaped preparations for migration.

**Preparing to migrate.**

As mentioned in Chapter Two, nurse migration from the Philippines has been facilitated by the development of an Americanized education system in the Philippines and the creation of an Americanized training hospital system that included the promotion of English language fluency and the establishment of gendered notions of nursing as women’s work. Such measures originated during the US colonial period in the second half of the 20th century (Choy, 2006). As well, the Philippine government’s support for the establishment of a large number of private nursing schools to produce nurses qualified to compete for overseas employment has further

In accordance with the insights furnished in the literature nurses in my study indicated that preparations to migrate typically began with studying to become a nurse in the Philippines. Some shared, however, that nursing had not been their career choice but one imposed on them by their family members and perhaps their society. They shed light on the fact that the rapid proliferation of nursing schools in the Philippines put them in jeopardy of receiving an inferior education, exploitation and financial debt. Further, their Americanized nursing education led some to incorrectly assume that their license would be readily recognized in Canada.

Participants also revealed that they needed to acquire RN work experience in addition to a basic nursing education in order to migrate to Canada. Such work experience typically entailed working in unpaid positions in the Philippines (in some cases even the requirement to pay for this experience), or taking paid positions in the Middle East. While the former exposed them to financial debt, the latter meant family separations. Both raised the specter of exploitation.

Not only have private entrepreneurs turned nursing schools into opportunities for profit, but the international migration of nurses offers endless opportunities for business ventures (Castles & Miller, 2009; Kingma, 2006). Nurse recruiters, travel agencies, banks and telephone companies have turned nurse migration into profitable businesses (Kingma, 2006). Though not specific to nurses, Guevarra (2010) reports that in 2006 there were approximately 1442 private employment agencies in the Philippines facilitating overseas labour recruitment and that these businesses are responsible for 95 percent of the country’s workforce deployment. She further contends that these employment agencies are social institutions that promote and sustain the culture of migration. For instance, recognizing that nurses currently have to wait extensive
periods for US immigrant visa approval, recruiters devise schemes to transform certain countries, such as those in the Middle East, into stepping stones to the US. In this regard entrepreneurs meet the demand for nurses in such countries while simultaneously providing nurses educated in the Philippines with an opportunity to realize their “American dream”. Additionally, following principles of neo-liberal economic competitiveness employment agents construct overseas employment as an obligation to families, the country, and to international relations and they aggressively instil the notion that a good life exists overseas while downplaying social costs associated with its pursuit (Guevarra, 2010).

Guervarra (2010) further argues that agents behave as patriarchal social institutions that (re)produce gendered ideologies and act as a form of labour control. She states:

…in the case of nursing and domestic work–care work that is constructed as in the realm of “women’s work”–marketing Filipinos as upgraded commodities takes the form of selling a type of racialized productive femininity that is supposed to constitute the women’s added export value (p. 126).

Guevarra (2010) reasons that this discourse of productive femininity is grounded in a culturally essentialist logic which sees the Philippines configured as a unique and natural source of skilled, educated, docile, and affordable labour and a labour force with innate care giving abilities. It is argued that such racialized discourse is a legacy of US colonization depicting Filipinas as subservient and compliant service providers (Guevarra, 2010; Parrenas, 2008). Guevarra (2010) adds that in an attempt to further increase marketability, recruiters create a notion that Philippine nurses possess a natural sense of adventure and a readiness to pursue overseas employment; images that are responsible for an emerging general public critique that holds that individuals are pursuing a nursing career as a ticket to leave the Philippines. Indeed, numerous study participants in my study referred to nursing as their “ticket” or “passport” to overseas employment.
While nursing education in the Philippines and the need for work experience had far-reaching implications for study participants, so did the shifting nature of immigration policies and expenses associated with coming to Canada under the FSWP. For example, the former led many to act hastily and ultimately arrive in Canada ill-prepared. The latter caused some to arrive in Canada with financial debt and prohibited others with equal education, and often more work experience (e.g., live-in caregivers), from entering Canada as skilled workers. Thus, Canadian immigration policies based on ability to pay put those already marginalized in the Philippines at risk of being denied access to Canada or in need of finding an alternate immigration pathway (Gogia & Slade, 2011).

Those who came to Canada under the LCP revealed that while it was a less expensive route it meant leaving their families behind. Moreover, there was something contradictory about the need to endure lengthy separations from children for the sake of their future; a situation that Rafael (1995) refers to as a tragedy of contemporary Philippine society.

My findings also demonstrated the exclusionary nature of provincial RN regulatory policy that encourages IENs to delay relocation to BC until their application has been assessed and they are aware of registration requirements. Participants in my study explained that they could not follow through with this recommendation due to their difficulty obtaining a visitor’s visa and the expense associated with travelling to Canada in advance of immigration.

Summary.

A postcolonial analysis sheds light on the notion that issues formerly considered cultural, such as the desire to pursue nursing or seek employment abroad, might be better understood as partial and dynamic implications of broader social inequities. My findings revealed a culture of migration in the Philippines that was deeply embedded within a colonial context and fueled by
contemporary neo-liberal and neo-colonial ideologies and mediating oppressions of class, gender, and race. I learned from participants about the inexorable trend of nurse migration. However, decisions were not made by nurses as purely autonomous agents but, rather, were shaped by a complex web of relationships and preparations that had the potential to affect participants’ experiences in adverse ways. Moreover, the culture of migration initiated a ripple effect that would shape experiences after arrival in Canada. My findings also raised concern that by engaging in migration, or not questioning it, participants were inadvertently perpetuating their own oppression. There were broader structures that shaped the experiences for participants as they tried to settle into their new life in Canada.

**The Precarious Status of Being a New Arrival in Canada**

For those who immigrated to Canada as skilled workers as well as those who arrived as live-in caregivers, the period following arrival was characterized by uncertainty. I begin with an examination of the precarious nature of the post-arrival period for skilled workers and then will turn my attention to those who came to Canada as live-in caregivers.

**Seeking a means of survival.**

Much has been written about the precarious status of new immigrants in Canada (Bauder, 2003; Beiser, 2005; Creese & Weibe, 2009; Gogia & Slade, 2011; Goldring, Berinstein, & Bernhard, 2007; Pratt, 2012; Teelucksingh & Glabuzi, 2007). Contributing to their uncertain position, the Canadian government, while having embarked on the selection of highly skilled individuals as immigrants, has not taken steps to ensure their integration into the workplace; a situation that underscores a neo-liberal ideology whereby citizens are increasingly required to become individually responsible for their own survival (Teelucksingh & Galabuzi, 2007). Although participants appreciated support they received from ISOs (e.g., workshops, resume
writing, language training, and educational funding), their dreams for “greener pastures” understandably included practicing their professional skills in Canada. As one participant explained, instead of providing opportunities to “fish in the ocean” for themselves, these organizations merely gave them money to temporarily sustain themselves and their families (Focus group 1213 follow-up). This notion causes concerns that such financial assistance simply patches over broader inequities and that public funds are not being used to their best advantage. The rapidly changing nature of immigration policy also makes it difficult for new immigrants to plan ahead (Gogia & Slade, 2011; Goldring et al., 2007). For instance, government funding for the aforementioned initiatives are vulnerable to particular political inclinations of various governments (Gogia & Slade, 2011). Consequently, support and funding are not constant and can vary from one year to the next; factors that contribute to uncertainty about the future (Gogia & Slade, 2011).

Gendered responsibilities related to child care were other barriers to employment that generated insecurity for most female participants. In keeping with findings described by Man (2004), whereby inadequate daycare services prevented skilled professional women from China from engaging in employment and re-certification programs in Canada, findings from this study also demonstrated that limited access to affordable daycare interfered with employment prospects and nursing upgrading. Such restrictions reflect both a deeply-rooted problem in which childcare continues to be undervalued as women’s work and a neo-liberal ethos that promotes privatization and deregulation (Man, 2004).

The literature also exposes a trend that has developed over the past 30 years whereby economic outcomes for new immigrants to Canada have deteriorated substantially relative to those native to Canada (RBC Economics | Research, 2011). Further, numerous scholars
demonstrate that the low socio-economic status found among new immigrants to Canada reduces their self-esteem and puts them at risk of poor health and family breakdown (Beiser, 2005; Gogia & Slade, 2011; Lasserter & Callister, 2009). Being part of the growing underclass of immigrants to Canada contributes even further to their instability. In my study, many participants revealed issues related to low self-esteem and family discord. Similar to findings by Gogia and Slade (2011), one participant reported relying on a food bank. Others revealed they received financial assistance from their families in the Philippines and one told how he had returned to the Philippines to earn money as a physician to support his family who remained in Canada. As well, financial difficulties dampened enthusiasm to initiate application for RN licensure.

Further contributing to the precariousness of new arrival experiences is the growing presence of private colleges in BC that charge high tuition but cannot guarantee health care employment. Coburn (2010) draws attention to the potential hazards of a corporate ideology that supports unregulated private education; hazards that raise serious ethical concerns about whether a lack of regulation is harming new immigrants to Canada. Further, it is put forth that neo-liberal doctrines that esteem the free market system for its efficiency and just allocation of rewards, are not held unaccountable for economic and social problems which are instead attributed to individual failings (Coburn & Coburn, 2007). Confronted with the need for Canadian certificates to enhance employability, one participant recalled enrolling in a certificate granting health related program at a Canadian private college; a situation that put her further into debt yet failed to generate employment. Her story reminded me of those I had heard from participants about their experiences with private nursing schools in the Philippines.

Employer reluctance to hire immigrants on the grounds they lack Canadian experience and/or Canadian certificates also contributes to the instability of being a new arrival in Canada.
Some argue that reluctance to hire new arrivals reflects a neo-liberal ideology that focuses on deregulating the labour market (Teelucksingh & Galabuzi, 2007). Rather than governmental regulatory intervention to ensure optimal allocation of human resources, decision-making regarding the utilization of immigrants is left to the discretion of employers in fulfillment of a neo-liberal imperative (Teelucksingh & Galabuzi, 2007). Others assert that these selective preferences are forms of systemic racism that construct immigrants as unskilled labour (Creese & Wiebe, 2009). Indeed, reports in the literature indicate that one in four racialized immigrants experience some form of discrimination during the early years of resettlement and it is speculated that such discrimination is partly responsible for their unemployment (Beiser, 2005).

Although discrimination in employment in Canada has been documented for over a century, the study of racial discrimination in this context among nurses is a more recent phenomenon (Teelucksingh & Galabuzi, 2007). In the Report of the Equality in Employment Commission (1984), racial discrimination in employment was identified as “practices or attitudes that have, whether by design or impact, the effect of limiting an individual or group’s right to opportunities generally available because of attributed rather than actual characteristics” (Teelucksingh & Galabuzi, 2007, p. 203). While discrimination occurs in different ways at different times and in different places, the one constant is the persistence of barriers that disproportionately affect certain groups (Teelucksingh & Galabuzi, 2007). Expanding on the notion of racial discrimination, Teelucksingh & Galabuzi (2007) suggest that it begins when race acquires a social significance attached to certain biological features which become the basis for categorizing distinct groups of people. The social process of racialization imbues these categories with value, leading to socio-economic practises that reflect and reinforce these values.
and contribute to differential treatment; treatment that privileges some members of society and disenfranchises others.

Postcolonial theorists Edward Said and Stuart Hall shed light on how the construction of race has historically been used by Western nation states to manage and control non-Western societies. As mentioned in Chapter Two, Edward Said (2007) argues that the depiction of a particular region, the Orient, did not reflect any reality but instead represented the prejudices and stereotypes that Westerners held about the ‘Orientals’. These stereotypes in turn solidified into taken-for-granted truths that typically depicted the Orient as deficient and inferior and Western society as dominant and superior (Said, 2007).

Building on Said’s notion of Orientalism, Hall (2007) highlights the role of discourse in differentiating the “West” from the “Rest”. He contends that the very act of talking about and creating knowledge about something shapes the ways it comes to be represented or understood and acted upon. Further, he argues that “Orientalism” or the discourse of the “West” and the “Rest” still flourishes in contemporary society; that languages of racial inferiority and ethnic superiority still operate. He reasons that such discourse has consequences for both those who implement it and those who are subjected to it. It situates those in the West in positions of dominance and racialized immigrants in positions of subordination. With respect to discourse about nurses educated in the Philippines, certain perceptions (e.g., that they are natural care providers) may be seen as true and alternate ways of understanding their situation overlooked.

Shedding further light on the nature of racial discrimination, Larsen (2007) depicts how discriminatory attitudes and practices towards overseas nurses in the UK affect their well-being and career progression. Drawing on Bourdieu (1977), he argues that racial discrimination is a form of ‘symbolic violence’ that may be internalized to affect the person’s ‘habitus’ (or, socially
and culturally learned structures that exist in people’s actions, bodies and minds). This conceptualization clarifies understanding of how human beings have a tendency to unwittingly submit to social and institutionalized disadvantage and adjust their behaviour and expectations to it. That is, according to Bourdieu, the disadvantage becomes part of their ‘habitus’ and as such, the habitus is active in reproducing the underlying social and cultural structures that fuel the disadvantage. This notion of embodiment captures the ways in which human perception and experience are inseparable from their physical and social existence in the world. Larsen (2007) suggests that by acting in a way that takes for granted discriminatory practices or not challenging these practices, the nurses in his study inadvertently confirmed them and took an active role in reproducing them.

Similarly in findings generated by my study, nurses appeared to be unwittingly contributing to the increasingly racialized and gendered care-giving labour market in Canada. Constructed as subservient and compliant service providers or natural care providers for the purposes of export (Guevarra, 2010; Parrenas, 2008), they were now at risk of a self-fulfilling prophecy in Canada. Unable to utilize their skill set and marginalized by employer preferences for Canadian work experience and certificates, all participants (aside from those who entered as TFWs with pre-arranged RN work positions) were forced to rely on low paying survival jobs in the service industry or care aide/home support positions in the private health care industry, well beneath their professional status as skilled workers. From a postcolonial perspective (Hall, 81)

81 Though members of the visible minority, non-white in colour and not Aboriginal, represent approximately 16 percent of the total Canadian population, they comprise a significantly higher proportion of the caregiver workforce. Data from the 2006 Census indicate that 21.5 percent of the nurse aides, orderlies, and patient services workforce represent visible minority workers (StatCan, 2008, 2010) and those from the Philippines represent 26 percent of this labour force (86 percent of whom are women). As well, members of the visible minority comprise 19.5 percent of childcare and home support workers in Canada, with those from the Philippines representing 44 percent of these care providers, 94 percent of whom are women (StatCan, 2010, 2012).
2007), this raises serious concern that categorizing nurses from the Philippines as natural care providers reproduces histories of subordination and domination. From a relational ethical theory standpoint these findings also raise concern that such socially constructed stereotypes constrain agency or ability to act autonomously because of oppressive social structures (Sherwin, 2000).

However, Larsen (2007) suggests that nurses in his study had a means of resisting discriminatory practices. He turned to the philosopher Merleau-Ponty to enhance understanding of how individuals can resist discriminatory social and cultural structures. From this, Larsen (2007) suggests that individuals play an active role in their life circumstances; that meaning-making is a dynamic process. Thus, while it may be true that that an individual’s capacity is constrained by external conditions and engrained habits, it is equally true that these limiting conditions are shaped by the ways in which the individual respond to them. This theoretical perspective introduces the possibility that individuals may find ways to resist or change the social conditions or cultural structures that surround them (Larsen, 2007).

Accordingly, Larsen argues that although it is important to seek understanding of the embodied experience of discrimination, it is of equal importance to expose the means by which individuals resist these practices. Sewell (1992) also proposes a theory of structure that expands on Bourdieu’s notion of ‘habitus’. His theory too restores human agency to social actors. That is, Sewell argues that agents have the means of exerting control over the social relations in which they are enmeshed; that they can transform social relations. He explains that agency is inherent in all humans. Although the specific form that it takes will vary and may be culturally and historically determined, all members of society exercise some measure of agency in the conduct of their daily lives. Together, these theories shed light on the possibility that though nurses educated in the Philippines may be constrained by labels such as ‘natural care providers’ they
also have the capacity to resist this categorization. Indeed, numerous participants demonstrated that in spite of multiple challenges they exerted some degree of control over the social imperatives enmeshing them.

Reflecting on the discussion of my study results thus far, although I am not arguing against nursing standards and regulation, it appears that the lack of recognition given to foreign credentials in Canada had a ripple effect that ultimately put participants arriving in Canada under the FSWP in jeopardy of uncertainty and social exclusion.

**Enduring the live-in caregiver contract.**

Life seemed equally or perhaps more precarious for those who entered Canada under the LCP. As reported by other scholars it was not unusual to learn from participants that they felt compelled to comply with employer requests to work overtime or extra shifts (Mckay, 2002; Pratt 1999, 2012) and powerless to attend nursing information sessions or to schedule English language or nursing review classes. Adding to their frustration and sense of exclusion, they were also constrained by education policy that limits access to the nurse re-entry program to Canadian citizens and permanent residents of Canada. Also, unlike skilled workers, they were ineligible for financial assistance provided by ISOs.

Similar to findings reported by Pratt (2010), participants in this study revealed that responsibilities associated with making regular remittances to families in the Philippines and to save money to support family reunification also interfered with aspirations to pursue a nursing career in Canada. Further, like findings in the literature, those generated from this study indicated that these nurses were at risk of family breakdown (Pratt, 1999, 2003, 2012).

Even after completion of their 24 month contract participants remained in limbo – often for several years – while they waited for open permits and permanent resident status. Without
permanent resident status, they reminded me that they did not have the security of their “immigrant” colleagues. Comparing herself to skilled workers, one said, “… I feel like I don’t have anything to show” (P0213A). Further contributing to the precariousness of their situation, participants disclosed that they may be denied permanent resident status on the grounds that a family member in the Philippines did not pass the medical screening test, or they may be denied the right to bring their children to Canada in the event of marital breakdown.

**Summary.**

I learned from my research participants that regardless of their immigration pathways, they were confronted with numerous challenges that reinforced their precarious status as new arrivals in Canada and left them at risk of poverty, low self-esteem, racial discrimination, and family breakdown. Though on the surface such challenges may have appeared merely related to a lack of recognition of foreign credentials and/or the nature of the live-in caregiver agreement, further analysis revealed that they were embedded in more complex structures. Indeed, participants’ aspirations were shattered by a disconnect between immigration at the federal level that gives preference to skilled workers on the basis of their education, skills, work experience, and affluence; by reluctance of Canadian employers to hire new arrivals on the grounds that they lack Canadian experience and/or Canadian certificates; by gendered responsibilities related to childcare and the need to support families remaining in the Philippines; and by neo-liberal practices that endorse privatization and self-reliance. My analysis further raises concern that nurses educated in the Philippines have become commodities for consumer consumption in Canada as well as the Philippines and that Canadian society profits from the readiness of foreign educated nurses to meet the ever-increasing demand for care providers. This latter scenario raises further concern that, constructed as natural providers for the purposes of export, participants
were subsequently at risk of a situation in Canada that reproduces histories of subordination and domination, and potentially constrains their agency or ability to act autonomously.

**The Elusive Canadian RN Credential**

For those who had initiated the application process for registration in BC and those still contemplating it, the RN credential proved elusive. As shown in the literature, participants confronted numerous obstacles in the way of registration (Baumann et al., 2006; Baumann et al., 2010; Blythe et al., 2009). In particular, they raised concerns about increased regulatory scrutiny, limited access to educational upgrading, employer reluctance to hire IENs, and insufficient support in general. In this section, starting with the perspectives of participants and turning to regulatory documents and the literature, I aim to shed light on broader structures and processes that contributed to these impediments.

**An increase in regulatory scrutiny.**

Although participants typically pointed to the specifics of regulatory requirements to explain their difficulties, at times they stepped back and questioned what might have happened along the way to make it increasingly challenging for IENs to acquire RN licensure and employment in BC. To respond to this, I draw attention to international trends shaping RN regulation in general and then focus on recent changes to regulation in BC.

Numerous scholars argue that nursing’s stance as a regulated profession is constantly assailed (Barry & Ghebrehiwet, 2012; Benton, 2011; Nelson & Gordon, 2006). For instance, in the practice setting, the manner in which nurses deliver care is frequently under attack, administrators are being challenged on their ability to address nursing shortages, and the regulated autonomy of registered nurses is jeopardized by the proliferation of cheaper and/or unregulated workers (Nelson & Gordon, 2006). Moreover, global trends such as high rates of
migration by health workers from poorer to richer countries, prevailing market forces, international trade agreements, technology, and lack of international standards for nursing education and practice intersect to create challenges for regulators (Barry & Ghebrehiwet, 2012; Benton, 2011). Compounding such difficulties, there is increased government oversight and involvement in regulation (Barry & Ghebrehiwet, 2012; Benton, 2011). Some regional trade agreements, such as the European Union (EU), require mutual recognition of workers among countries and include explicit directives that guide education and regulation82 (Barry & Ghebrehiwet, 2012). It is argued that in the face of this constant change nurses must continually re-evaluate the intricacies of regulation and ensure its processes have global as well as local relevance (Barry & Ghebrehiwet, 2012).

Regulators in Canadian jurisdictions have had to respond to these global trends (Blythe et al., 2009). For instance, as the racial composition of immigrants to Canada has shifted83, similar to self-regulating professional and occupational bodies in general (Teelucksingh & Galabuzi, 2007), regulators in BC began to impose stricter credentialing requirements for IENs. Since 2007 there have been changes to English fluency requirements and two new methods for assessing competency to practice as a registered nurse have been introduced.

With respect to English proficiency, as discussed in Chapter Seven, there have been numerous changes to English fluency requirements in the past five years, including the need for higher test scores. Participants disclosed several concerns about these requirements; concerns

82 Although the North American Free Trade Agreement (NAFTA) among the US, Canada, and Mexico, is less directive it does encourage the development of mutual recognition agreements by the professions themselves (Barry & Ghebrehiwet, 2012).

83 As mentioned in Chapters Two, statistics from CIHI indicate that in 2003 the number of IENs educated in the Philippines started to surpass those educated in the UK and the US. While the percentage from the UK and the US combined was 30.2 percent in 2003 compared to 27.9 percent from the Philippines (CIHI, 2004), in 2009 those from the UK and US equalled 25 percent compared to 31.6 percent from the Philippines (CIHI, 2010).
that contributed to the elusiveness of the RN credential. For instance, many feared they would not be able to meet these requirements and questioned their necessity. They argued that they had been educated in English and were accustomed to speaking English in the Philippines. They contended that though their English was perhaps not as “perfect” as native speakers, it was nevertheless adequate. Their sentiments reflect those expressed by scholars who argue that intolerance of imperfect English is a vestige of Western colonialism, as colonizers typically used English proficiency as a discriminator for scrutinizing and civilizing colonial subjects (Breckenridge & van der Veer, 1993). Participants in this study also challenged whether English language scores are in fact reliable indicators of the capacity to communicate appropriately in the workplace, another sentiment reflected in the literature (Jeans et al., 2005). Furthermore, participants reported they could ill-afford English preparation classes or examination re-takes in the event of failure. These latter challenges suggest that English capacity is, at least to some extent, dependent on economic status in BC.

The other significant change to regulation occurred in 2008 when the SEC Assessment was introduced (CRNBC, 2009). The regulatory body in BC argued that this innovation was introduced because the higher volume of international applicants with diverse educational backgrounds and work experiences had made it increasingly challenging to rely on a review of credentials and transcripts to assess whether competency to practice met the same requirements expected of BC RNs (CRNBC, 2009). Participants in this study voiced their concerns with the SEC Assessment. Most notably, they complained that, aside from library and internet resources,

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84 Although the CELBAN™ test is designed specifically for IENs and is a test that is recognized by the BC regulatory college, it is only available in Canada and consequently many were unfamiliar with it.

85 A visit to the websites of regulatory bodies across Canada reveals that most jurisdictions have also recently adopted this comprehensive means of assessing IENs.
they did not have an opportunity to practice their skills or to receive guidance or support prior to the assessment. That is, it was assumed that international applicants were familiar with the Canadian way of practice. Limited access to support and guidance also appears grounded in the narrow ideology of liberal individualism that assumes IENs have the social capacity to prepare independently for the SEC Assessment.

The third change to regulation that participants found troublesome also took effect in 2009 when the regulatory college reported that, “Policies have been revised to clarify that internationally educated nurses applying for registration with CRNBC must demonstrate competence to practise as an RN registrant in addition to other requirements for registration” (CRNBC, 2009, p. 4). Subsequently, a monitored Canadian work experience also became a requirement for RN registration in BC86. Participants shared that the greatest challenge associated with this new policy was that they were left on their own to find an employer to monitor the experience – a factor that again reflects the prevailing neo-liberal ideology in Canadian society whereby people tend to be viewed as autonomous, rational individuals endowed with the capacity to advocate on their own behalf87. This policy assumes that international applicants are familiar with the Canadian RN labour market and can locate Canadian employment. As well, it indicates that BC RN registration is inextricably linked to the RN labour market and that employers have become de facto gatekeepers to regulation.

86 Unlike the SEC Assessment, this addition to the registration process for IENs was relatively unique to BC. However, in 2010, noting a significant increase in IENs, Newfoundland and Labrador also introduced a requirement for a satisfactory reference from an employer (ARNNL, 2013). On March 13, 2013 the RN regulatory college of BC announced that it was removing the requirement for a Canadian reference following 250 hours of practice as a professionally registered nurse.
87 See also Rodney, Harrigan, Jiwani, Burgess & Phillips (2013) for an analysis of neo-liberal ideologies in health care policies.
In summary, regulators in BC, like their counterparts worldwide, have had to respond to intersecting and constantly shifting global trends, including the increasing mobility of nurses from lower to higher income countries. The magnitude of their task cannot be overstated. However, in their effort to maintain the integrity of the profession the regulatory college must exercise great care to avoid creating inadvertent inequities. Accordingly, it is important to question whether the recent increased rigor in English language proficiency reflects colonial practices that perpetuate histories of subordination and domination. And it is essential to query if it is reasonable to assume that new arrivals in Canada have adequate resources to complete the SEC Assessment or secure an employer for the Canadian work experience requirement without assistance.

**Inaccessibility of educational upgrading.**

My findings revealed that educational upgrading is a significant related structure that contributed to the elusiveness of the RN credential for study participants. Although the nurse re-entry program was helpful, numerous constraints limited access and further reinforced the elusiveness of the seemingly unattainable Canadian RN credential. For instance, as seen in other studies, long wait lists, expensive tuition fees, and physical locale limited accessibility to re-entry programs (Baumann et al., 2006; Blythe et al., 2009; Jeans et al., 2005). Such constraints, intersecting with gendered and economic responsibilities I have articulated above, interfered with participants’ agency to pursue required educational upgrading. In turn, these constraints increased participants’ risk for becoming deskill ed and remaining underemployed. Additionally, participants’ observations that the re-entry program did not offer opportunity to study with Canadian educated nurses raises concern that the program may perpetuate social isolation and interfere with the development of Canadian professional networks. Although we know from
other contexts that social networks are critical for professional advancement (Combs, 2003; Pratt, 1999), how social isolation plays out on the part of IENs seeking RN licensure in Canada warrants further investigation. As well, the issue put forth by study participants that graduation from the re-entry programs did not guarantee RN employment in acute care setting, or, indeed, in other areas, raises concern that there are other broader issues interfering with the integration of international graduates into the labour market. In the next section I will discuss one such issue – employer preference for Canadian education and work experience.

Seeking RN employment.

Resistance on the part of employers to hire IENs educated in the Philippines to complete a work experience necessary for BC registration was another factor contributing to the elusiveness of the RN credential. Participants found themselves confronting the same barriers as they did on arrival in Canada: the need for Canadian education and/or work experience. It is interesting to note, however, that while Canadian employers refused to hire IENs residing in Canada, they actively recruit IENs from countries such as the UK to work with temporary work permits to fill specific labour needs (Health Match BC, 2012). Such practices suggest that Philippine-educated nurses coming to Canada without pre-arranged employment – even some with extensive work experience from other countries – were considered cultural entities unworthy of RN employment. This assessment stands in stark contrast to reports in the literature suggesting that the state of the labour market itself determines the ease with which IENs find employment in Canada (Baumann et al., 2006). That is, findings from this study suggest that unemployment of IENs is underpinned by colonizing and racializing ideologies that are embedded in historical notions of the essentialized “Other” (Anderson, Rodney, Reimer-Kirkham, Browne, Khan, & Lynam, 2009). Further, my findings support the recent call for
action put forth by the CNA (2012), which encourages nurses and other health professionals to advocate for and actively support the recruitment, education, employment and retention of visible minority Canadians into the health professions.

**Insufficient support.**

The ICN (2007b) and the WHO (2010) have both issued recommendations that receiving countries take measures to ensure all migrant nurses are offered appropriate support that would enable them to operate safely and effectively within health systems. They also urge receiving countries to treat migrant nurses in the same manner as domestically trained health care providers. Despite these international initiatives, participants disclosed they felt unsupported in their endeavours to acquire Canadian RN licensure, a sentiment echoed by participants in other Canadian studies (Baumann et al., 2006; Baumann et al., 2010; Blythe et al., 2009).

One factor that may have contributed to this alienation was the BC regulatory college’s recent shift in focus. As mentioned earlier, the regulatory college’s mandate is to protect the public. However, until 2005 when the Registered Nurses Association of BC (RNABC) transitioned to the CRNBC under the Health Professions Act (HPA), its mandate had included advocating for the health and well-being of the people of BC in addition to upholding the integrity of the profession. Since this 2005 transition numerous association advocacy functions have disappeared (Duncan et al., 2012). For example, at one time the regulatory body had a

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88 The Health Professions Act provides a common regulatory structure for the governance of health professions in British Columbia (CRNBC, 2010b).

89 Recognizing that the profession no longer had a mechanism through which to engage with government on issues of concern to nurses or advocate for health and public policy matters affecting British Columbians, in 2010 the formation of the new Association of Registered Nurses of British Columbia (ARNBC) was announced (Duncan, Thorne, & Rodney, 2012). Currently, it is the shared goal of the ARNBC and the CNA to work productively with nursing partners in BC (BCNU and CRNBC) toward ensuring that BC nurses regain a strong policy voice for nursing as well as health and health care (CNA & ARNBC, 2011).
support group for IENs (Griffiths, 2001). Under the HPA, the college’s focus is maintaining the integrity of the profession and therefore precludes advocacy work such as support groups.

It is important to note, however, that not all the structural changes have been negative. Despite its 2005 shift in focus, the college did reach out to IENs and in 2007 initiated a business strategy to streamline registration processes for foreign applicants (CRNBC, 2007). As such, it became “committed to ensuring that registration processes are effective, efficient and support the College’s mandate to protect the public” (Brunke, 2007, p. 38). Accordingly, numerous changes were implemented, such as an enhancement of its website to permit submission of electronic applications and strategies to reduce wait periods for assessment of applications. Applicants were reminded, however, that time required for registration can vary significantly among applicants, since, “to be fair and equitable to all applicants, each application is assessed individually” (CRNBC, 2013d).

Despite the CRNBC’s new business strategy and efforts to increase the presence of IENs in BC, participants in my study typically felt overwhelmed with the registration process and unsure about how to proceed. Such findings raise concern that the type of support needed by applicants is misdirected. Indeed, it warrants consideration that rhetoric of “efficiency” and “fairness” and processes directed at attending to assumptions about individual needs are obscuring broader inequities (e.g., structures that limit nurses from lower income countries from being able to complete the registration assessment prior to arrival in Canada) interfering with the capacity to obtain RN licensure. Iris Marion Young (2011) argues that the achievement of social justice is dependent upon attending to the unique needs of groups not just individuals.

As well, my study findings cause one to query if policies considered fair by those in authority may not be different by those in the margins (Anderson et al., 2009; Fraser, 2001;
Reimer Kirkham & Browne, 2006; Young, 2011). Since the introduction of the business strategy in 2008 the number of IEN applicants processed by the regulatory college has steadily decreased. CRNBC statistics reveal that the number of applicants who had met all requirements for registration and had been granted status with CRNBC dropped from 557 in 2008 to 185 in 2012 (CRNBC, 2012b; CRNBC, 2013e). This raises concern that in the college’s efforts to ensure that those not meeting BC professional standards are denied licensure, barriers still exist for some competent IENs who might otherwise qualify. This is not to deny the importance of effective regulation of registered nurses for public safety, but to reveal there are unintended consequences that can be unjust.

Participants in my study also did not feel supported by employers in BC. In addition to refusing to hire them, they felt employers were excluding them from ESN and New Graduate Transition programs. As mentioned in Chapter Seven, these support and mentoring programs are only available to graduates of Canadian nursing education programs (Providence Health Care, 2013). Although it is well recognized that new international graduates have similar learning needs to other transition groups, such as new graduate nurses, re-entry nurses, and new employees in general (Dumpel & Joint Nursing Practice Commission, 2005), and that the latter groups benefit from ongoing support to ease their transition into the workplace (Boychuk Duchscher, 2009; Gamroth, Budgen, & Lougheed, 2006), IENs in BC are being excluded from these support programs. Moreover, study participants were refused employment on the grounds that they were not registered in the programs. Such exclusion is symptomatic of broader forces whereby racialized nurses have historically been excluded from the Canadian workforce (Das Gupta, 2009; Ronquillo, 2010).
Faced with these numerous challenges, participants, when asked about their thoughts for their future, disclosed that struggles associated with acquiring a Canadian RN credential and/or RN employment had an indefinite nature to them. Acquiring the credential in some cases meant re-location to another province or beginning RN education from the start. Moreover, it did not guarantee RN employment. For those who had abandoned their quest, it often meant remaining underemployed in Canada’s racialized and gendered care giving industry. Returning to the Philippines did not appear to be an option worth consideration.

**Summary.**

Despite recommendations from the ICN (2007b) and WHO (2010), participants felt unsupported by their professional colleagues in Canada. Increased regulatory rigour and neo-liberal practices that value individualism and efficiency, along with exclusion from orientation and support programs offered to Canadian educated nurses, contributed to the elusiveness of the RN credential. While some contemplated re-location, re-starting RN education from the beginning, or abandoning their aspirations, returning to the Philippines did not appear to be an option.

**Agency and Capacity to Act**

As I listened to participants recount their experiences of leaving the Philippines, resettling in Canada, and grappling with regulatory processes, I learned they were not fully autonomous agents. Decisions made at each stage of their journey were not in isolation; rather, they were embedded within broader structures and processes. Dominant political, ideological and social values operating at international, national, and local levels intersected to limit resources and opportunities for professional advancement.
Similar to the findings of Larsen (2007), research participants demonstrated that they were not simply passive agents and they had some capacity to resist oppression. Indeed, in spite of multiple challenges they exerted a degree of control over the social imperatives enmeshing them. The interview sessions revealed significant measures of resilience and resourcefulness. Participants raised concerns with each other and exchanged information and support. Faced with unemployment they sought education and social networks. One participant established a website to enable IENs to express their opinions and ideas and others organized follow-up group support sessions.

Despite such evidence of nurses’ active agency, my findings nonetheless indicate that much effort is needed to identify and remove sources of IEN’s oppression. For instance, participants lacked formal channels for making their voices heard among regulators, educators, and employers. They frequently reported that they could not afford the time or expense to attend educational classes and they felt unsupported in their efforts to move forward. It is argued that to achieve social justice effort must be spent attending to the redistribution of resources (money, time, expertise) and recognition of “the Other” as a person of equal worth (Anderson et al., 2009; Fraser, 2001; Reimer Kirkham & Browne, 2006; Rodney, Harrigan et al., 2013). As well, social justice means providing a means for parity of participation (Rodney, Harrigan et al., 2013). Involving individuals with direct experience in decision-making processes helps to remove stigmas and contribute to well-being and positive self-esteem (Pauly, 2013). As Spivak (2000) explains, there is a need to demand and build infrastructure so that when subalterns speak they can be heard. Rodney, Harrigan et al., (2013) further argue that achieving social justice necessitates extending recognition beyond the individual (micro level) and attending to power
dynamics and practices within institutions or communities (meso level) and within provincial, national and global contexts (macro level).

Other scholars contend that as the local increasingly becomes shaped by the global, so too can the local play a role in transforming the global (Ashcroft, Griffiths, & Tiffin, 2006a). They hold that, “By appropriating strategies of representation, organization and social change through access to global systems, local communities and marginal interest groups can both empower themselves and influence those global systems” (Ashcroft et al., 2006a). Findings from this study, in fact, demonstrate that participants were already mobilizing their concerns. As mentioned earlier, one participant was inspired to create a website enabling others to share information and exchange support. Several domestic workers were active in the FNSG, an association described in Chapter Two that seeks to facilitate its members’ accreditation and support their personal and professional development. At the international level, both the ICN and the WHO have taken measures to facilitate a more standard global approach to nursing education (Barry & Ghebrehiwet, 2012). The ICN has developed lists of international competencies to inform curriculum development and in 2009 the WHO released *Global Standards for the Initial Education of Professional Nurses and Midwives* (Barry & Ghebrehiwet, 2012). It is hoped that such efforts will promote a more uniform development of the profession and an international identification for nurses (Barry & Ghebrehiwet, 2012). Thus, significant infrastructure is developing to address inequities locally, nationally, and internationally for IENs.

**Chapter Summary**

In this chapter I have further exposed the complexity of nurse migration by examining broader structures, including neo-liberal and neo-colonial ideologies and intersecting oppressions operating at local, national, and international levels, within which participants’ experiences were
embedded. Drawing on postcolonial feminism I identified how such structures and processes put participants at risk of exploitation, marginalization, and powerlessness not only in the Philippines but in Canada as well. I learned that issues often considered cultural (e.g., the act of taking up nursing in the Philippines or seeking work abroad) might be better understood as partial and dynamic implications of broader social inequities. Further, I explored ways in which exclusion of nurses educated in the Philippines from professional nursing practice in Canada may have been legitimized in local health care practices and policies. Moreover, I questioned whose interests might be served by the desire for migration and acquisition of a RN credential in Canada. I also examined tensions between agency and structure and noted how nurses both resisted and inadvertently contributed to intersecting oppressions that shaped their everyday experiences. I observed that until recently IENs from the Philippines lacked a formal means for making their voices heard among regulation, education, and employment stakeholders, and I noted that much work remains to be done to address the conditions of their oppression. In the final chapter of this thesis I will pull together my conclusions, identify the limitations of the study, and make my final recommendations for moving forward.
Chapter Ten: Conclusions and Recommendations for Moving Forward

In this dissertation I have explored the social, political, economic, and historical contexts and mediating oppressions that shaped and were shaped by the everyday experiences of nurses educated in the Philippines as they sought or considered seeking RN licensure in BC. In this chapter I provide an overview of the study and offer methodological and substantive reflections. In closing, I present my recommendations for moving forward.

Overview of the study

Canada is increasingly relying on nurses from lower income countries to play an important role in the provision of health care. To the world of nursing this phenomenon has become a complex web of issues causing regulators, educators, and employers to focus on how to most efficiently and effectively assess and recognize foreign credentials and facilitate workplace integration of IENs. However little has been said about the experiences of these nurses in pursuit of the RN credential in Canada.

Although the existing body of research and policy literature sheds light on the complexity inherent in the phenomenon of nurse migration, it does not adequately represent the perspectives of these nurses as they seek licensure in Canada. As well, most literature groups IENs together, regardless of their source country and thus renders unique needs and characteristics invisible. Additionally, the literature does not sufficiently help us understand root causes of why a significant number of IENs never acquire Canadian licensure and remain underemployed in low-paying jobs. Nor does it sufficiently expose how social relations such as race, gender, and class, intersect within broader contexts to shape experiences and how these nurses’ agency is implicated and affected. In a similar vein, the existing literature does not sufficiently address the myriad of ethical concerns related to nurse migration experiences in Canada.
To add clarity to this complex situation and to fulfill responsibilities for fair recruitment and integration practices outlined by the WHO (2006) and ICN (2007a, 2007b), Canadian nurse leaders and policy makers need a richer contextual understanding of the challenges facing IENs. Recognizing that IENs from different source countries have unique challenges and that to study them as a homogeneous group may render such challenges invisible (Kingma, 2006; Pratt, 2004), I focused on the experiences of nurses educated in the Philippines. These nurses make up the greatest percentage of IENs in Canada and have a long history of migration, and thus significant experience, to draw from. It has been my contention that knowledge gleaned from nurses educated in the Philippine will also inform our understanding of the experiences of nurses from other lower income countries.

The overarching research question guiding this study was: *How do social, political, economic, and historical contexts mediated by intersecting oppressions come to shape the everyday experiences of nurses educated in the Philippines as they seek RN licensure in BC?* Specifically, my objective was to learn from these nurses about their subjective experiences and to work with them to understand how their experiences both shape and have been shaped by structures and processes at international, national, and local levels. Additionally, my aim was to produce knowledge that can be used to inform policy making and ethical decision-making related to IEN recruitment and integration practices; assist nurses educated in the Philippines to participate in choices that will make for better overall migration experiences; and ultimately enhance health care delivery in Canada.

**Methodological reflections**

My research question led me to a qualitative research design inspired by ethnographic traditions. An ethnographic approach offered an opportunity to explore data from a variety of
sources including interviews with primary and secondary participants, observations, field notes, and regulatory documents (Hammersley & Atkinson, 2007). While ethnographic traditions provided the framework for my research study, relational ethical theory and postcolonial feminism determined the context for the research process. Relational ethical theory helped me identify how participants were caught in an interconnected dynamic web of social relationships and account for how forces of oppression can interfere with someone’s ability to exercise autonomy (Rodney, Kadyschuk et al., 2013; Sherwin, 2000). Postcolonial feminism directed me to begin my inquiry with the experiences of study participants and to reflect back on and examine how intersecting oppressions and broader social and historical structures shaped and were shaped by their everyday experiences (Anderson, 2002; Reimer Kirkham & Anderson, 2002). Postcolonial feminism also inspired me to extend analysis beyond generating a description of “what is” to providing a prescription for “what ought to be” (Reimer Kirkham & Anderson, 2002). Therefore, I view my work as a form of praxis. I entered the field with the aim of extending my gaze to include both critiquing issues of social injustice and laying out a path for action.

To produce knowledge about what ought to be, or transformative knowledge, I was mindful of the need for a reflexive stance. Accordingly, I tried to remain sensitive to my privilege (e.g., as a white middle-class Canadian educated nurse, nurse educator and PhD student) and the effects my privilege had on each phase of the research – from gaining access to the field, to collecting, interpreting, and disseminating data. As I indicated in Chapter Four, four interrelated concerns haunted me throughout the process: the research endeavour could be

90 As mentioned in Chapter Three, praxis implies a dialectical relationship between theory and practice, with each informing the other in the direction of emancipatory social change (McCormick & Roussy, 1997).
perpetuating colonizing relationships; my research findings could further essentialize and marginalize nurses from the Philippines; my own position of power in relation to study participants could be advanced by the research; and my position of privilege could distance me from the participants, limiting my ability to access their insights. To address these concerns and minimize biases or preconceptions, I regularly examined and documented the values and ideas that I brought to the study. I maintained an electronic journal and kept track of thoughts and ideas that occurred to me as I reviewed the literature or met with community and committee members. I also maintained field notes about my interactions with participants during interview sessions and reflected on how my presence as a researcher shaped the course of the interview and the nature of the knowledge being constructed. Furthermore, I established a voluntary Advisory Group of nurses from the local Filipino community. These expert nurses were able to advise me on strategies for fostering interest in the study, recruiting participants, inspiring dialogue during interview sessions, interpreting the data, and disseminating research findings.

To answer the study’s overarching research question I used purposive sampling to seek out nurses educated in the Philippines who had sought or had considered seeking Canadian RN licensure and or employment within the past 10 years, who could converse comfortably in English, and who would be willing to talk about their experiences. Although my focus was on female nurses as these make up the greatest percentage of RNs from the Philippines, to illuminate the experiences of these nurses I also extended an invitation to male nurses educated in the Philippines. As well, in order to reflect the complexity of nurse migration, I deliberately selected those who represented a mix of social identities and employment and immigration histories. Using audio-taped individual and focus group interviews, I explored the perspectives of 47 predominantly female participants. To refine my understanding I also explored documents.
such as CRNBC regulatory procedures, and I interviewed secondary participants such as an immigration counsellor and nurse educators.

This study is, of course, only a beginning. It is limited by the fact that I was learning as I proceeded. For instance, although I used a data collection sheet (see Appendix E) to collect demographic data from participants, I did not consider information such as years and type of work experience prior to arrival in Canada; factors which could have enhanced the context of my findings. While I was often able to collect this data during individual interviews, it was typically impossible to do so during focus group interviews. Another limitation of the study was that I did not have access to a research assistant to record field notes during the course of an interview. Consequently, insightful observations may have been missed. Another shortcoming is that the findings do not adequately represent those nurses who come to Canada with temporary work permits to fill RN positions. Although I was not able to acquire statistics on the number of nurses educated in the Philippines who enter Canada as TFWs, I had anticipated that numerous IENs residing in the Lower Mainland had come to Canada in this manner. For instance, I had the experience of encountering several in my capacity as a tutor for the CRNE prior to the commencement of this study. Though several nurses who had come to Canada under the TFWP did contact me expressing an interest in participating, in the end only two followed up with interview appointments. Nonetheless, I was able to provide a glimpse into the structures and processes that shape everyday experiences of nurses who do enter Canada with pre-arranged RN employment.

Each of the four chapters of results represented a temporal sequence of a journey that began in the Philippines and progressed to Canada, and each was influenced by and influenced the other (see also Appendix J: The Journey to RN Licensure in Canada). In the first of these,
Chapter Five, beginning with the experiences of the participants, I articulated what I learned about structures and mediating oppressions that shaped decision making and preparations to migrate prior to departure from the Philippines. In Chapter Six I focused on those experiences that affected nurses as new arrivals in Canada and in Chapter Seven, on those experiences that influenced nurses’ capacity to navigate BC RN regulatory requirements. In the final chapter of results, Chapter Eight, I attended to participants’ thoughts about the future. In each of the four chapters I analyzed how structures and mediating oppressions put participants at risk of marginalization, exploitation, and powerlessness. I also identified ways in which participants both resisted and contributed to these inequities. In Chapter Nine, I further exposed the complexity of nurse migration by turning my attention to its broader context and root causes of inequities for IENs from the Philippines.

**Substantive Reflections**

To point the way forward I am revisiting conclusions I have drawn in earlier chapters of this dissertation. Progressing from the general to more specific, I offer the following reflections.

Nurse migration is a multifaceted phenomenon and the personal voices of IENs add depth and understanding to its complexity. It consists of the interplay of economic, social, historical, and political structures at international, national, provincial and local levels and incorporates experiences prior to and after arrival in Canada. Consequently, experiences in destination counties such as Canada cannot be viewed in isolation. The international movement of nurses is also inextricably linked to intersecting oppressions of gender, race, and class relations. These are gendered relations because the vast majority of nurses worldwide are women; raced because increasingly nurses seeking licensure in Canada are from the global South; and classed because effective nursing education, immigration, and registration are dependent on a certain level of
affluence. The phenomenon involves individual and groups of nurses and their families, regulators, immigration professionals, educators, and employers. As Kingma (2006) contends, nurse migration is an inevitable consequence of globalization and, further, as I have argued throughout this dissertation, nurses educated in the Philippines have become commodities for export. Moreover, the nursing profession has become a means of sustaining migration, or as participants explained, a “passport” or “ticket” for migration.

Decisions made at each stage of the nurse migration journey are not made in isolation. Rather, they are informed by personal values and beliefs and by structures embedded within prevailing ideologies. For example, decisions are influenced by neocolonial ideologies that fuel the desire to seek “greener pastures” and by neo-liberal forces that favour market economies, privatization, and individualism and underpin assumptions that nurses are making unconstrained choices. Therefore, while migration may be seen as a solution to oppression for some, it also exposes nurses to marginalization, exploitation, and powerlessness in Canada. Nevertheless, nurses from the Philippines and IENs in general, do not appear to be simply passive observers of these structures and processes. Though resisting oppressions, these nurses may inadvertently be perpetuating them by participating in migration.

**Prior to arrival in Canada.**

As I have suggested throughout this dissertation, the capacity to acquire Canadian RN licensure is shaped by structures that are present in the source country, (i.e., the Philippines) and countries along the way (e.g., those in the Middle East), in addition to those that exist in Canada. Accordingly, drawing on my discussion and the literature highlighted in Chapter Nine I put forward the following set of succinct conclusions. I begin by focusing on my reflections about structures and processes influencing nurses’ experiences prior to arrival in Canada.
• The quality of nursing education and work experiences in the Philippines, or elsewhere, has significant implications for the degree of preparedness nurses feel when confronted with RN regulatory requirements in Canada.

• CIC orientation programs and/or regulatory and employer websites that do not clearly inform prospective immigrants about up-to-date regulatory and employment requirements may skew expectations and prevent some from moving forward in a timely manner with licensure plans.

• The ever-changing nature of Canadian immigration policies has serious repercussions for nurses wanting to migrate as well as for numerous stakeholders in Canada. It can cause nurses to make hasty decisions to avoid missing random immigration opportunities and it makes it difficult for immigration counselors, regulators, educators, and employers to predict the number of nurses who may be in need of their services and to plan accordingly.

• The shifting nature of regulatory policies also constrains ability to arrive in Canada ready for registration. Further, regulatory requirements that demand IENs be in Canada to complete applications for registration disenfranchise those who are unable to obtain a visitor’s visa or afford the cost of travelling to Canada in advance of re-location.

**After arrival in Canada.**

Once again drawing on earlier discussions and the literature, I offer the following key conclusions about structures and processes that affect nurses’ capacity to acquire Canadian RN licensure.

• IENs face two overlapping sets of personal struggles: that of being a new arrival in Canada and that of being a nurse seeking RN licensure. Each has its own set of hazards.
As new arrivals in Canada, nurses are subject to the same set of social and economic risks facing all new arrivals: poverty, low self-esteem, racial discrimination, and family breakdown. Specifically, as foreign educated nurses, they are confronted with a complex set of regulatory, educational, and employment challenges. Each set of struggles intersects with the other.

- Acquiring RN licensure in BC is dependent on the intersecting domains of immigration and RN regulation, employment, and education. These departments are inextricably connected; changes to one may have significant implications for the other and, moreover, for nurses themselves. For instance, the disconnect between CIC at the national level and provincial nurse regulatory bodies or provincial educational institutions initiates a cascade of events that place those who immigrate as skilled workers or those who enter as live-in caregivers at risk of remaining underemployed in low paying jobs often deemed less desirable by Canadian workers.

- Increased regulatory rigour that has not been met with commensurate support (e.g., expectations for new arrivals to complete the SEC Assessment with limited preparation or to have the agency to secure an employer to monitor their work experience requirement) increases the risk that competent IENs will be unable to acquire a Canadian RN license. Moreover, regulatory policy that focuses on how to most efficiently assess RN credentials overlooks the unique challenges that some may have in navigating a convoluted set of foreign regulatory requirements.

- Limited access to educational upgrading, manifested by long wait lists, expensive tuition fees, and geographical location, intersecting with gendered and economic responsibilities, prevent some nurses from partaking in these pursuits.
Resistance on the part of employers to hire IENs educated in the Philippines who lack Canadian education or work experience and their exclusion from hospital-based support and mentoring programs offered to their Canadian counterparts make these nurses vulnerable to marginalization and remaining underemployed.

Private colleges that offer spurious Canadian certificates at inflated costs put IENs at risk of exploitation.

The absence of an infrastructure in BC to offer foreign graduates a measure of professional support and guidance when they arrive in Canada and an opportunity to establish professional networks impedes their prospects for Canadian RN licensure and employment. Further, it diminishes the likelihood of IENs of having a voice in matters affecting their professional lives.

In summary, nurse migration to Canada is fraught with ethical, legal, and philosophical implications. It warrants consideration that migration is not a matter of fully autonomous choice for many nurses educated in the Philippines, but something imposed on them. As well, it raises alarm that socially constructed stereotypes of nurses from the Philippines as natural care providers constrain agency or ability to act autonomously and reproduce histories of subordination and domination. There is also cause for concern that many of these nurses are not able to utilize their skills or work to their full capacity in Canada. Although it is not my intention to undermine the importance of regulatory scrutiny in its protection of the public, it is concerning that requirements for high levels of English proficiency without adequate educational resources are sustaining colonial hegemonic relationships. Further, it demands attention that IENs are being excluded from support programs offered to Canadian educated nurses and that they are being exploited by private colleges in Canada. Consequently, it prompts me to query whether the
Canadian nursing profession is fulfilling its responsibility to the WHO (2010) and the ICN (2007a, 2007b) for fair integration practices. As well, it is crucial to recognize that Canadian society is profiting from the readiness of these nurses to meet the ever-increasing demand for care providers.

**Recommendations for Moving Forward**

Based on the outcomes of this study, I propose the following recommendations to provide direction in the areas of political action, policy, regulation, health human resource planning, education, and research.

**Political action.**

To fulfill responsibilities for fair recruitment and integration practices outlined by the ICN (2007a, 2007b) and WHO (2010), effort must be directed at ensuring that policies governing regulation, education, and employment are not marginalizing or discriminating against IENs. Accordingly, as nurses we ought to extend our gaze beyond everyday practices of regulation, education, and employment and expose dominant political, ideological and social values embedded in our organizational and societal institutions. Moreover, we should critically examine how these play out in the lives of IENs. It is also only proper to self-reflect on what we do in our own social roles as nurses or citizens that might unintentionally disenfranchise particular groups of nurses, and consider whether such practices serve our profession or society well.

As nurses it behooves us to refrain from thinking of IENs as a homogenous group. Doing so may potentially obscure group-based oppressions and unique challenges encountered by specific groups of IENs (Young, 2011). Further, we need to welcome the input of IENs at each point of their trajectory so that they have meaningful participation in decisions that influence their preparation to come to Canada and in what happens to them after they arrive (see also
Pauly, 2013; Rodney, Harrigan et al., 2013; Spivak, 2000). Moreover, we need to support IENs in their endeavors to form and participate in local, provincial, national, and international organizations to promote social change.

Policy.

Immigration policy for live-in caregivers should be modified to give nurses the opportunity to prepare for registration, participate in nurse upgrading courses, and apply for permanent resident status before, rather than after, the completion of their live-in caregiver contract. There also needs to be much greater collaboration between CIC and nurse regulators, educators, and employers. For instance, CIC and Canadian RN regulators should work together to obviate the need for duplicate assessment of educational and work credentials so that IENs are aware before they re-locate to Canada of whether their education and skills are equivalent to completed credentials in Canada. These bodies should also ensure that English language proficiency requirements for skilled workers who enter Canada under the FSWP are equivalent to the requirements for RN licensure to avoid duplication of English language tests. Additionally, CIC and Canadian regulators and employers must ensure that pre- and post-arrival orientation programs for new immigrants include current information regarding RN licensure requirements and employment opportunities. Regulators also need to confirm that employers understand regulatory requirements. Further, educators and employers need to combine their efforts to make sure that content embedded in nurse re-entry programs will prepare IENs to enter the workplace at the same level as Canadian educated graduates. Above all, to foster equitable and democratic processes (Pauly, 2013; Rodney, Harrigan et al., 2013), input from IENs must be encouraged in the planning and implementation of these programs.
Regulation.

In the face of constant change, Canadian regulators must work with national and international associations to make certain that Canadian regulatory requirements are fair and serve the profession well (Barry & Ghebrehiwet, 2012). Accordingly, the particulars of regulation need to be continually re-evaluated. In BC attention should be given to the English proficiency, the SEC Assessment, and the (now former) 250 hour Canadian work experience requirements. For instance, effort is needed to ensure that the requirement of higher scores in English proficiency tests addresses the need for appropriate communication skills in the workplace. Further, affordable and accessible resources ought to be in place to help applicants meet such standards. Otherwise, in some cases the special skills they bring may never be put to use.

With respect to the SEC Assessment, there needs to be greater transparency surrounding interpretation of the indications for the assessment and its outcomes and it is imperative that applicants receive an adequate orientation to the process. As well, consideration should be given to implementing a means to assess international applicants for registration prior to arrival in Canada. This would eliminate the need for nurses to come to Canada in advance of re-location to complete the assessment process. It would also mean that nurses would arrive in Canada ready to work. Additionally, as mentioned in the preceding section of this chapter, to avoid duplication of assessment procedures, CIC and Canadian regulators ought to collaborate to develop and implement one comprehensive pre-arrival skills assessment.
The Canadian 250 hour work experience requirement for registration should also be re-evaluated\(^9^1\). Consideration needs to be given to the fact that as new arrivals in Canada, IENs are not familiar with the RN labour market nor do they have professional networks that could assist them in locating a job. Moreover, the requirement for a Canadian work experience makes nurse registration dependent on the labour market and the willingness of employers to hire foreign graduates.

IENs also must have an opportunity to participate in the planning of registration information sessions offered by the regulatory college. Inclusion in the planning of these events would increase the likelihood that delivery options and content would be conducive to their needs.

**Health human resource planning.**

I also recommend that a comprehensive orientation and support program for IENs in BC be established, similar to the CARE Centre for IENs funded by the Province of Ontario (CARE, 2013) that was discussed in Chapter Two. As with the CARE program, the BC program needs to be client focused and flexible. Support services should include professional communication courses, networking, observational job shadowing, CRNE preparation, and professional nursing workshops. Clients should also be assigned a nurse mentor and a case manager to assist them with navigating regulatory requirements. As well, IENs should be part of an advisory committee to oversee the development and implementation of this program.

IENs in BC should be given the opportunity to participate in new graduate transition programs offered graduates of Canadian education programs. It is well recognized that

\(^9^1\) As noted in Chapters One, Two, and Seven, the regulatory body announced in March 2013 that this requirement would be removed and that the change will be implemented over time and all applicants informed by June 1, 2013 (CRNBC, 2013c).
international graduates, not just new graduates, benefit from mentorship and support programs to ease their transition into the workplace (Dumpel & Joint Nursing Practice Commission, 2005).

**Education.**

At the international level, global educational inequities need to be addressed. For instance, infrastructure needs to continue to grow to allow the nursing profession to define more consistently and clearly its role and promote a more uniform development of the profession globally. Provincial organizations such as the ARNBC, with its mandate to advance the nursing profession and influence health and social policy, ought to collaborate with the CNA and ICN and work toward a more standard global approach to nursing education.

At national, provincial, and local levels, re-entry programs for IENs should have flexible delivery options, including distance education. Special consideration needs to be given to IENs with limited resources. To promote professional networking and integration, these programs ought to be combined with re-entry programs for Canadian educated nurses returning to the profession. Further, to ensure fitness to practice in a variety of work settings, in addition to long term care, students must have an opportunity to hone their acute care skills, knowledge, and clinical judgment. Again, to promote parity of participation IENs need to be included on the advisory committees of re-entry programs. I also strongly recommend that private colleges be held accountable for their business and educational practices, as well as their educational integrity.

**Research.**

Since knowledge is always situated, or its production always shaped by the dynamics of where we are located and positioned (Wolfe, 1996), it is paramount that IENs themselves take an
active role in exploring the complex phenomenon of nurse migration. As mentioned earlier in this chapter, as an “outsider” I always had a nagging concern that I could not capture the viewpoints put forth by study participants. Accordingly, the importance of an Advisory Group of IENs to inform a research project cannot be overestimated. Such groups can provide immeasurable assistance with fostering interest in the study, recruiting participants, providing strategies for inspiring dialogue during interview sessions, interpreting data, and disseminating research findings. However, in addition to working in research partnerships with Canadian educated nurses, it is vital that IENs assume leadership positions in such projects.

With respect to recommendations for further empirical research and related forms of inquiry, I suggest that at a macro or global level of responsibility there is need for greater understanding about the ethical implications of nurse migration highlighted earlier in this chapter. There also must to be greater attention given to the effects of dominant political, ideological and social values embedded in organizational and societal institutions on the mobility and integration of nurses in foreign workplaces. Additionally, consideration ought to be given to how nurse migration plays out in the lives of nurses, in health care systems, and in communities left behind. Greater appreciation for the quality of nurse education and re-entry programs worldwide, including differences and similarities, is also warranted.

At individual (micro) and institutional (meso) levels of responsibility implications of Canadian immigration pathways on nurse licensure experiences for both women and men need to be examined in more detail. Little is known about the relationships between resettlement issues and acquisition of RN licensure in Canada. Nor do we understand the personal resources that

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92 For instance, my work was informed by Philippine scholars such as Choy (2006, 2010), Guevarra (2010), Parrenas (2001, 2008), Rafael (1993, 1995, 1997), and Ronquillo (2010, 2011).
nurses bring to resettlement and/or regulation requirements. Similarities and differences between migration experiences of nurses educated in other countries and between nurses and other IEPs have also been overlooked in research endeavors. Additionally, it would be helpful to know the number of nurses who come to Canada as live-in caregivers, skilled workers, or temporary foreign workers and to learn about what happens to these nurses after arrival in Canada. Statistics about these nurses have been collected by regulatory bodies and represent only those who are registered to nurse in Canada, but the number who live in Canada and remain unemployed or underemployed remains unknown. As well, a race based gendered analysis of nurse migration experiences is merited. For instance, as Canada turns towards lower income countries (such as the Philippines) to address the demand created by its nurse shortages, it is essential to examine whether gendered oppression is being transferred from one group of women in Canadian society to another. A race based gendered analysis could also shed light on the extent to which racial discrimination interferes with Canadian RN licensure, workplace integration, and professional advancement.

As mentioned earlier in this chapter, it is desirable that regulatory requirements be continuously re-evaluated for their utility, relevance, and fairness (Barry & Ghebrehiwet, 2012). It would also be interesting to understand the relationship between English language proficiency scores and ability to communicate effectively in the workplace. The role of private nursing colleges in Canada in the preparation of IENs for Canadian licensure also needs to be critically explored. As one example, the possibility that private entrepreneurs are preying on the vulnerability of IENs, warrants examination. Additionally, greater clarity is needed with respect to employers’ perspectives about IENs and their utilization at national, provincial, and local
levels. There is also a dearth of knowledge about the relationships between professional support (e.g., professional networks and mentorship programs) and IEN integration into the workplace.

**Chapter Summary**

When I first conceived of this study I had been curious about broader structures and processes that shape nurse migration experiences from lower income countries; processes that were not readily visible to these nurses nor to me. Moreover, I realized that in order to effectively facilitate IEN integration into the workplace in my own educator role, I needed to understand the context of their migration experiences. Thus, in this dissertation I set out to explore how social, economic, political, and historical contexts mediated by intersecting social relations came to shape the everyday experiences of nurses educated in the Philippines seeking RN licensure in Canada. My findings revealed that migration for these nurses is a complex event rooted in neo-colonial and neo-liberal ideologies and gendered, classed, and racial notions of women’s roles both in the Philippines and Canada. Further, it is a phenomenon fraught with ethical concerns that put nurses in jeopardy of marginalization, exploitation, and powerlessness. Consequently, it is imperative to engage the voices of IENs in integration initiatives. Further, we ought to extend our gaze beyond everyday practices of individual nurses, programs, and institutions and critically examine how dominant political, ideological and social values play out in the lives of these nurses. Above all, it is our moral responsibility as nurses and as Canadians to ensure that IENs from the Philippines and all other countries are treated justly.
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https://www.crnbc.ca/Registration/RNApplication/InternationalEN/Pages/Default.aspx


https://www.crnbc.ca/Registration/RNApplication/InternationalEN/Pages/Step1.aspx


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http://www.careercentre.org/blog/?cat=21


Appendices

Appendix A: Pathway to RN Licensure in BC for IENs

Pathway to RN Licensure in British Columbia, Canada for INTERNATIONALLY EDUCATED NURSES

- Test of English Fluency
- Submission of Application/Documents to CRNBC (regulatory body)

PRELIMINARY ASSESSMENT

- Substantially Equivalent Competency (SEC) Assessment
  - RN Re-entry Program
  - RN Qualifying Courses/Workshops

ELIGIBLE to:
  - write CRNE and work as RN with provisional registration

Canadian RN Examination (CRNE)

250 hrs. Canadian Employment Requirement

PRACTISING RN REGISTRATION
### Appendix B: Field Work Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Preparatory Activities</th>
<th>Participant/ Interview Sessions</th>
<th>Dissemination of Findings</th>
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<tbody>
<tr>
<td>January, 18 2010</td>
<td>Presentation to BCNU</td>
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<td>February 4, 2010</td>
<td>Presentation to Program Manager, S.U.C.C.E.S.S. Employment Services</td>
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<td>February 13, 2010</td>
<td>Presentation to FNSG</td>
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<tr>
<td>March 09, 2010</td>
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<td></td>
<td>Symposium Presentation: Nursing Graduate Student Research, UBC, Vancouver, BC</td>
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<tr>
<td>March 27, 2010</td>
<td>Attended Philippine Women Centre of BC: Filipino Nurses Celebrate their Legacy in Canada</td>
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<tr>
<td>March 30, 2010</td>
<td>Meeting with Health Match BC</td>
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<tr>
<td>April 16, 2010</td>
<td>Presentation to Communication course for Internationally Educated Health Professionals, Vancouver Coastal Health</td>
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<tr>
<td>May 6, 2010</td>
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<td>Conference Presentation: BCNU Nursing Practice' Vancouver, BC</td>
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<tr>
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<td>Attended Filipino Nurses’ Appreciation discussion: Rhizome Café</td>
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<tr>
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<td>VCC ethics approval</td>
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<td>Conference Presentation: 21st Canadian Bioethics Society Annual Conference, Kelowna, BC</td>
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<td>June 10, 2010</td>
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<td>June – November 2010</td>
<td>IEN Practice Readiness Project (CRNBC)</td>
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<td>FNSG workshop/nursing skills</td>
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<td>1st Advisory Group Meeting</td>
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<td>Recruitment Letters circulated; Recruitment Advertisement posted</td>
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<td>Presentation to English as Second Language Programs Department, VCC</td>
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<td>Conference Presentation: Health Worker Migration in Canada, UBC, Vancouver, BC</td>
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<td>Presentation to Multicultural Helping House</td>
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<td>Presentation to Victoria.Bayanihan Center; BCNU’s Workers of Colour Caucus Group Support Group</td>
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<td>Presentation to CIIP councillor</td>
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<td>Presented workshop, How to be RN in BC: MHH</td>
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<td>Presentation to Internationally Educated Health Professionals, Vancouver Coastal Health</td>
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<td>August 24, 2011</td>
<td>Meeting with educators, employers, and regulators at VCC re: developing supports for IENs</td>
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<td>Update email to Advisory Group</td>
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<td>Conference Presentation: 17th Qualitative Health Research (QHR), Vancouver, BC</td>
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<td>Conference Presentation: ICN, Melbourne, Australia</td>
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### Appendix C: Table of Participants

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**Legend:**

P=Participant; FG=Focus group participant
m= month; y= year
Au (Australia); ME (Middle East); UK (United Kingdom)

Blanks represent demographic data not collected. Before each interview participants completed the Data Sheet (see Appendix E). During the course of an interview additional data was sometimes collected.
Appendix D: Consent Forms

Consent Form

Primary Participants: Individual Interviews

Seeking RN Licensure and Employment in Canada: Experiences of Nurses from the Philippines

Principal Investigator: Dr. Patricia Rodney, Associate Professor
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

Co-Investigator: Margery Hawkins, PhD candidate
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

This research is meant to satisfy the requirement for a PhD in nursing for Margery Hawkins.

Purpose:
The purpose of this study is to learn from registered nurses (RNs) educated in the Philippines about factors influencing their experiences and/or decisions related to seeking RN licensure and/or employment in Canada. You are being invited to take part in this study because you have been educated as a RN in the Philippines; you are female\(^9\); you can converse comfortably in English; you have sought/or have considered seeking Canadian RN licensure and/or employment

\(^9\)Since female nurses make up the greatest percentage of RNs from the Philippines, I plan to focus my study on female RNs educated in the Philippines. However, to illuminate the experiences of these nurses, I will also solicit information from male nurses educated in the Philippines.
within the past 10 years; and you are willing to talk about your experiences and/or decisions related to seeking Canadian RN licensure and/or employment.

**Study Procedures:**

If you agree to participate in this study you will be expected to participate in 1 to 3 audio-taped individual interviews over a period of 6 months with a researcher from the University of British Columbia (UBC). The interviews will last between 1 and 2 hours and will be scheduled at a time and a location that you request.

Prior to each interview you will be asked to complete a data sheet indicating your age; the nature of your employment in Canada (e.g. home support worker, registered nurse); the length of time you have lived in Canada; and the nature of your Canadian immigration visa (e.g. Federal Skilled Worker Program, Temporary Foreign Worker Program, Live-in Caregiver Program). This information will provide context for researchers to understand your experiences. The data sheet will contain no individual identifying information and will be kept behind locked doors. Audio-tapes will be transcribed by a UBC based typist and your name will not appear in the transcriptions.

You may stop participating in this study at any time. If you choose to re-enter the study at another time, you will be able to contact the researcher to renew your consent.

**Potential Risks:**

Past research suggests that talking about experiences and/or decisions related to seeking foreign credentials and employment may cause upset. The researchers are aware of this and will direct you to some counselling services you may wish to access during or following your participation in the study.

**Potential Benefits:**

It is anticipated that participation in the study will provide you with an opportunity to discuss what has helped or hampered you in acquiring Canadian RN licensure and/or employment, or to discuss what has prevented you from seeking Canadian RN licensure and/or employment. As well, it is expected that
participation in the study will help you and your colleagues locate sites for potential change related to foreign RN credentialing and integration processes. On completion of the study you will be mailed a report of the findings and presentations.

**Confidentiality:**

Your confidentiality will be respected and your study records will not be made available to any agencies, or be made publicly available. All records will be identified only by a code number and your name will not appear in the transcriptions or in any reports of the completed study. Individuals who have access to data (clerical support workers and research assistants) will sign a confidentiality agreement prior to having access to data. The researcher will meet regularly with these individuals to discuss any concerns regarding confidentiality.

Members of a voluntary Advisory Group of nurses from the Philippines, who assist the researcher with recruitment of participants and the interpretation and dissemination of data, will sign a confidentiality agreement prior to participating in the research study and will only have access to data that has been stripped of any identification markers.

All information associated with this study will be kept behind locked doors or in secure computer files. Data will be kept secure for at least five years before disposal. After this time the audiotapes will be demagnetized, paper copies shredded, and data on computers erased. Although the researcher will share the results of this study at community presentations, academic conferences, and in publications, all information identifying you will be removed.

**Remuneration:**

You will not be paid for participating in this study. However, to compensate you for any transportation expenses, you will receive a $10 Gift Card for a local grocery store for each interview you participate in.

**Contact for information about the study:**

If you have any questions or desire further information with respect to this study, you may contact Dr. Patricia Rodney (xxx-xxx-xxxx) or Margery Hawkins (xxx-xxx-xxxx).
Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment, your education, or your ability to acquire Canadian RN licensure or employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________
Participant Signature  Date

____________________________________________________
Printed Name of the Participant
Consent Form

Primary Participants: Focus Group Interviews

Seeking RN Licensure and Employment in Canada: Experiences of Nurses from the Philippines

Principal Investigator: Dr. Patricia Rodney, Associate Professor
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

Co-Investigator: Margery Hawkins, PhD candidate
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

This research is meant to satisfy the requirement for a PhD in nursing for Margery Hawkins.

Purpose:

The purpose of this study is to learn from registered nurses (RNs) educated in the Philippines about factors influencing their experiences and/or decisions related to seeking RN licensure and/or employment in Canada. You are being invited to take part in this study because you have been educated as a RN in the Philippines; you are female94; you can converse comfortably in English; you have sought/or have considered seeking Canadian RN licensure and/or employment within the past 10 years; and you are willing to talk about your experiences and/or decisions related to seeking Canadian RN licensure and/or employment.

Study Procedures:

94 Since female nurses make up the greatest percentage of RNs from the Philippines, I plan to focus my study on female RNs educated in the Philippines. However, to illuminate the experiences of these nurses, I will also solicit information from male nurses educated in the Philippines.
If you agree to participate in this study you will be expected to participate in 2 or 3 audio-taped focus group interviews over a period of 6 months. The focus groups will consist of 3 to 5 other nurses educated in the Philippines who have also sought or have considered seeking RN licensure or employment in Canada within the past 10 years. The interviews will last between 1 and 2 hours and will be scheduled at a time and a location requested by the participants. The Co-investigator for this study and a research assistant will participate in the focus groups and work with participants to identify factors influencing experiences and/or decisions related to seeking registered nurse (RN) licensure and/or employment in Canada.

Prior to participating in the focus group interviews you will be asked to complete a data sheet indicating your age; the nature of your employment in Canada (e.g. home support worker, registered nurse); the length of time you have lived in Canada; and the nature of your Canadian immigration visa (e.g. Federal Skilled Worker Program, Temporary Foreign Worker Program, Live-in Caregiver Program). This information will provide context for researchers to understand focus group discussion. The data sheet will contain no individual identifying information and will be kept behind locked doors. Audio-tapes will be transcribed by a UBC based typist and your name will not appear in the transcriptions.

All focus groups will cover the ground rules of courtesy; respect for each other; and the importance of maintaining the confidentiality of focus group discussion. You may stop participating in this study at any time. If you choose to re-enter the study at another time, you will be able to contact the researcher to renew your consent.

**Potential Risks:**

Past research suggests that talking about experiences and/or decisions related to seeking foreign credentials and employment may cause upset. The researchers are aware of this and will direct you to some counselling services you may wish to access during or following your participation in the study.

**Potential Benefits:**

It is anticipated that participation in the study will provide you with an opportunity to discuss what has helped or hampered you in acquiring Canadian RN licensure and/or employment, or to discuss what has prevented you from seeking Canadian RN licensure and/or employment. As well, it is expected that participation in the study will help you and your colleagues locate sites for potential change related to foreign RN credentialing and integration processes.
On completion of the study you will be mailed a report of the findings and will be invited to attend presentations.

**Confidentiality:**

Your confidentiality will be respected and your study records will not be made available to any agencies, or be made publicly available. All records will be identified only by a code number and your name will not appear in the transcriptions or in any reports of the completed study. Individuals who have access to data (clerical support workers and research assistants) will sign a confidentiality agreement prior to having access to data. The researcher will meet regularly with these individuals to discuss any concerns regarding confidentiality.

Members of a voluntary Advisory Group of nurses from the Philippines, who assist the researcher with recruitment of participants and the interpretation and dissemination of data, will sign a confidentiality agreement prior to participating in the research study and will only have access to data that has been stripped of any identification markers. In some instances if participants request an Advisory Group member to be present during an interview, the Advisory Group member will sign a consent form and a confidentiality agreement prior to the interview and will be treated as a study participant.

Since you will be participating in discussions with other nurses from the Philippines, anonymity cannot be assured during focus group interviews. However, all participants will be asked to sign an agreement of confidentiality.

All information associated with this study will be kept behind locked doors or in secure computer files. Data will be kept secure for at least five years before disposal. After this time the audiotapes will be demagnetized, paper copies shredded, and data on computers erased. Although the researcher will share the results of this study at community presentations, academic conferences, and in publications, all information identifying you will be removed.

**Remuneration:**

You will not be paid for participating in this study. However, refreshments will be provided during the focus group interviews. As well, to compensate you for any transportation expenses, you will receive a $10 Gift Card for a local grocery store for each focus group interview you participate in.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Dr. Patricia Rodney (xxx-xxx-xxxx) or Margery Hawkins (xxx-xxx-xxxx).

**Contact for concerns about the rights of research subjects:**

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

**Consent:**

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment, your education, or your ability to acquire Canadian RN licensure or employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________________________
Participant Signature Date

____________________________________________________
Printed Name of the Participant
Consent Form for Secondary Participants

Seeking RN Licensure and Employment in Canada: Experiences of Nurses from the Philippines

**Principal Investigator:** Dr. Patricia Rodney, Associate Professor
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

**Co-Investigator:** Margery Hawkins, PhD candidate
School of Nursing, UBC
Telephone: xxx-xxx-xxxx

This research is meant to satisfy the requirement for a PhD in nursing.

**Purpose:**

The primary purpose of this study is to learn from female nurses educated in the Philippines about factors influencing their experiences and/or decisions related to seeking registered nurse (RN) licensure and/or employment in British Columbia (BC). You are being invited to take part in this study because you may be able to offer new insights into the context of the experiences of these nurses.

**Study Procedures:**

If you agree to participate in this study you will be expected to participate in an audio-taped interview that will last approximately 1 hour. During the interview you will be asked questions about your perceptions of the experiences of internationally educated nurses.

**Potential Risks:**
Past research suggests that talking about experiences and/or decisions related to seeking foreign credentials and employment may cause upset. The researchers are aware of this and will direct you to some counselling services you may wish to access during or following your participation in the study.

**Potential Benefits:**

On completion of the study you will be mailed a report of the findings and will be invited to attend presentations.

**Confidentiality:**

Your confidentiality will be respected and your study records will not be made publicly available. All records will be identified only by a code number and your name will not appear in any reports of the completed study. Individuals who have access to data (clerical support workers and research assistants) will sign a confidentiality agreement prior to having access to data. The researcher will meet regularly with these individuals to discuss any concerns regarding confidentiality.

Members of a voluntary Advisory Group of nurses from the Philippines, who assist the researcher with recruitment of participants and the interpretation and dissemination of data, will sign a confidentiality agreement prior to participating in the research study and will only have access to data that has been stripped of any identification markers.

All information associated with this study will be kept behind locked doors or in secure computer files. Data will be kept secure for five years before disposal. Although the researcher will share the results of this study at academic conferences and in publications, all information identifying you will be removed.

**Remuneration:**

You will not be paid for participating in this study. However, to compensate you for any transportation expenses, you will receive a $10 Gift Card for a local grocery store for each interview you participate in.

**Contact for information about the study:**

If you have any questions or desire further information with respect to this study, you may contact Dr. Patricia Rodney (xxx-xxx-xxxx) or Margery Hawkins (xxx-xxx-xxxx).

**Contact for concerns about the rights of research subjects:**
If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment, your education, or your ability to acquire Canadian RN licensure or employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

___________________________________________________  
Participant Signature          Date
___________________________________________________

Printed Name of the Participant
Appendix E: Data Sheet

Data Sheet

ID #: 

Age:

Nature of your employment in Canada (e.g. resident care attendant; home support worker, licensed practical nurse; registered nurse; dietary assistant; other):

Length of time you have lived in Canada:

Type of Canadian immigration visa (e.g. Federal Skilled Worker Program, Temporary Foreign Worker Program, Live-in Caregiver Program):
Appendix F: Interview Guide

Interview Guide

- Can you tell me how you came to decide to migrate to Canada?
- What prompted you to go into nursing in the Philippines?
- How did you prepare yourself to come to Canada?
- How has life changed for you since you came to Canada?
- Can you tell me about challenges you have encountered in Canada?
- Where have you found support along the way?
- What are your thoughts about your future?
Appendix G: Confidentiality Agreement

Focus Group Interview

Confidentiality Agreement

An important feature of focus group discussions is to maintain the confidentiality of the group members.

Your signature below indicates that you will maintain the confidentiality of the group members. That is, you will not reveal the names of the group members or the content of the discussion to others outside of the group.

Signature: _________________________________________

Date: ________________________________________________
Appendix H: Recruitment Advertisement

University of British Columbia
School of Nursing
T201-2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5
Canada

Recruitment Advertisement

Seeking Nurses from the Philippines to Share their Experiences Related to Acquiring RN Licensure and Employment in Canada

Margery Hawkins is conducting a research study to fulfill her requirement for a PhD in nursing at the University of British Columbia (UBC) under the supervision of Dr. Patricia Rodney, Associate Professor in the School of Nursing at UBC.

The purpose of this study is to learn from registered nurses (RNs) educated in the Philippines about factors influencing their experiences and/or decisions related to seeking Canadian RN licensure and/or employment.

The study also provides RNs educated in the Philippines with an opportunity to discuss what has helped or hampered them in acquiring RN licensure and/or employment, or to discuss what has prevented them from seeking RN licensure and/or employment in B.C. As well, it provides an opportunity for these nurses to identify sites for potential change related to foreign RN credentialing and integration processes in Canada.

Margery is seeking female nurses educated in the Philippines who have sought or have considered seeking Canadian RN licensure and/or employment within the past 10 years and who are willing to talk about their experiences. Participants will be invited to participate in 2 – 3 focus group interviews and/or individual interviews, each lasting 1 – 2 hours, over a period of 6 months.

She would be interested in hearing about your experiences if you:
- have acquired RN licensure and/or employment in BC;
- are seeking RN licensure and/or employment in BC;
- have not been able to acquire RN licensure and/or employment in BC;

Since female nurses make up the greatest percentage of RNs from the Philippines, I plan to focus my study on female nurses. However, to illuminate the experiences of these nurses, I will also solicit information from male nurses educated in the Philippines.
• have decided not to seek RN licensure and/or employment in BC.

For more information about this research project, or to volunteer to participate, please contact Margery Hawkins (telephone: xxx-xxx-xxxx).
Appendix I: Recruitment Letter

University of British Columbia
School of Nursing
T201-2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5
Canada

Recruitment Letter

Seeking Nurses from the Philippines to Share their Experiences Related to Acquiring RN Licensure and Employment in Canada

Margery Hawkins is conducting a research study to fulfill her requirement for a PhD in nursing at the University of British Columbia (UBC) under the supervision of Dr. Patricia Rodney, Associate Professor in the School of Nursing, UBC.

The purpose of this study is to learn from nurses educated in the Philippines about factors influencing their experiences and/or decisions related to seeking registered nurse (RN) licensure and/or employment in British Columbia (BC).

The study also provides nurses educated in the Philippines with an opportunity to discuss what has helped or hampered them in acquiring RN licensure or employment or prevented them from seeking RN licensure or employment in BC. As well, it provides an opportunity for these nurses to identify sites for potential change.

Margery is seeking female nurses educated in the Philippines who have sought or have considered seeking Canadian RN licensure and/or employment within the past 10 years and who are willing to talk about their experiences. Participants will be invited to participate in 2 – 3 focus group interviews and/or individual interviews, each lasting 1 – 2 hours, over a period of 6 months.

She would be interested in hearing about your experiences if you:

- have acquired RN licensure and/or employment in BC;
- are seeking RN licensure and/or employment in BC;
- have not been able to acquire RN licensure and/or employment in BC;

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96Since female nurses make up the greatest percentage of RNs from the Philippines, I plan to focus my study on female nurses. However, to illuminate the experiences of these nurses, I will also solicit information from male nurses educated in the Philippines.
• have decided not to seek RN licensure and/or employment in BC.

For more information about this research project, or to volunteer to participate, please contact Margery Hawkins (telephone: xxx-xxx-xxxx).
Appendix J: The Journey to RN Licensure in Canada

Ch. 5 Beginning the Journey: Seeking “Greener Pastures”

Deciding to Migrate: “We created a story”
Their dreams: “Land of milk and honey”
Structures shaping their dreams: “So I’ll go there”
“The salary is just too small for a family”
“Everybody was going away”
“So you’ve got to make a sacrifice”
“I’m sorta westernized in the American system”
“This is a chance for us”
“It was God’s plan us coming here to Canada”

Preparing to Migrate: Using “stepping stones”
Stepping stone #1: “Taking up nursing”
Stepping stone #2: Finding a “training ground”
Stepping stone #3: Immigration, “a lot of fees”
Stepping stone #4: “Parallel processing”

Ch. 6 Being a New Immigrant in Canada: “It’s Not For the Faint of Heart”

The Federal Skilled Worker Story: “They don’t accept us”
“What am I supposed to do to survive?”
“But in reality, it’s really very hard”

The Live-In Caregiver Story: The “countdown”
“The homesickness and loneliness, you name it”
“You have to budget”
“In the Philippines we’ve someone doing that for us”

Ch. 7 Being an IEN in Canada: “And One Block After the Other”

“It is so hard to pass the English test”
Preparing for an English language proficiency test
Taking an English language proficiency test
“I haven’t applied yet”
Untangling the complexity of the registration process
Fearing rejection
Considering family and financial responsibilities
Considering future aspirations
“I tried all the techniques that I know in preparing for the SEC”
Limited transparency
Preparing for the assessment
Waiting for the assessment
“I will not be taking anymore because you know we will go hungry”
Waiting to enroll in supplemental education classes
Meeting educational expenses
Accessing educational facilities
Contemplating usefulness of the re-entry program
“If only they will give me a chance”
Obstacles encountered finding an employer
Strategies used to find an employer
“When the time comes that we pass the exam they’ll say that we’re not in practice”

Ch. 8 Reconciling the Journey: “I Have to Move On”

“My main goal is at least to go back to my profession”
“But if it’s not for me, it’s not for me”
“You should always have an option”