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Communication Research and Practice

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/rcrp20

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To cite this article: Pooja Jayan, Mohan J. Dutta & Jagadish Thaker (17 Feb 2025): ‘I am not complete without my family’: a culture-centred exploration of meanings of health and well-being among migrant Indian nurses in Aotearoa New Zealand, Communication Research and Practice, DOI: 10.1080/22041451.2025.2456397

To link to this article: https://doi.org/10.1080/22041451.2025.2456397

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Published online: 17 Feb 2025.

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COMMUNICATION RESEARCH AND PRACTICE
https://doi.org/10.1080/22041451.2025.2456397

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'I am not complete without my family': a culture-centred exploration of meanings of health and well-being among migrant Indian nurses in Aotearoa New Zealand

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ABSTRACT

In Aotearoa New Zealand, the voices of migrant nurses are often overlooked and marginalised despite being visible in the economy. This manuscript uses a culture-centred approach to centre the voices of migrant Indian nurses on understanding their meanings of health and well-being. Contrary to the Western models, which position health as individual accountability, the thirty in-depth conversations with migrant Indian nurses point towards the importance of collective in maintaining health and well-being. The dialogues with participants revealed three main themes: the family and community as interwoven to health and well-being, migration and the hidden health cost of family disconnection, and the significance of culturally appropriate food in maintaining health. This study contributes to health communication theory and practice by providing insights into the health and well-being meanings of migrant nurses, centring their voices as replacements to neoliberal, dominant paradigms of health.

ARTICLE HISTORY
Received 11 August 2024
Accepted 17 January 2025

KEYWORDS
Migrants; New Zealand; health communication; nurses

Introduction

Nursing shortages worldwide have steered unprecedented international migration, especially to developed countries (Kingma, 2018). This drift is particularly apparent in the healthcare sector of Aotearoa New Zealand, where migrant nurses play a central role in filling skill gaps (Gultiano, 2022). According to a recent New Zealand Nursing Council report, around 42% of the nursing workforce comprises migrant nurses (New Zealand Nursing Council, 2023). Many of these nurses come from lower-wage countries like the Philippines and India, and their migration is often forced by economic necessities (Brush & Vasupuram, 2006). However, research indicates that their migration journey has various challenges (Jenkins & Huntington, 2015). From negotiating unfamiliar cultural norms to overcoming difficulties in acquiring appropriate employment, migrant nurses often face impediments that affect their health and well-being (Collins, 2020). Despite their indispensable role in healthcare delivery, the challenges encountered by migrant nurses,

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particularly concerning their health and well-being, remain under-researched and insufficiently addressed in policy and practice (Alwan, 2022).

Moreover, in Aotearoa New Zealand, the government generally leads public health planning and policy changes, with contributions from related experts and stakeholders (Came, O'Sullivan, & McCreanor, 2020). This top-down approach has limited involvement of the concerned groups like migrant nurses. These migrant workers from the Global South, at the bottom of the care economy, negotiate hyper-precarious work within healthcare without adequate protections and security and are erased mainly from public discursive registers around healthcare (Wise, 2015). For example, Howe, Charlesworth, and Brennan (2019) highlight that New Zealand's reliance on temporary care workers obscures the underlying employment issues and lower pay. Moreover, as highlighted in a study by Harvey (2022), the feelings of 'otherness' among migrant nurses have led to marginalisation and exclusion from opportunities that local nurses may access. Such erasures of nurses from the discursive spaces lead to their perceptions and experiences not being fully reflected in the policies and programmes developed for them (New Zealand Nurses Organization [NZNO], 2020). Hence, it is vital to listen to the voices of migrant nurses when forming programmes and policies that directly affect them.

Furthermore, existent literature on migrant nurses' experiences in Aotearoa New Zealand has focused mainly on acquiring professional registration, staffing (Hogan, 2014), assimilation into the healthcare system (Choi, Cook, & Brunton, 2019), cross-cultural training (Brunton et al., 2020), upskilling (O'Connor, 2019) and the challenges they confront in their work environment (Walker, 2010). However, there is a dearth of peer-reviewed research on migrant nurses' health in New Zealand centred on their voices and culture. Several organisational and health communication researchers have highlighted the need to listen to community members at the margins in creating solutions affecting them (Airhihenbuwa, 2007; Dutta, 2008; Pal, Cruz, & Munshi, 2023). Moreover, Ashwell and Croucher note how research using frameworks of the Global North can aggravate the difficulties confronted by communities from the margins of the Global South rather than extending alternative pathways to raise their voices and define their development. To address this gap and comprehend the health meanings of migrant nurses in New Zealand, a culture-centred approach (CCA) was employed, highlighting the significance of centring the voices and experiences of migrant nurses in health research and policy development (Dutta, 2018). By providing communication platforms for migrant nurses' voices to emerge, we try to explore the everyday meanings of health and well-being held by migrant Indian nurses in Aotearoa New Zealand.

Migrant nurses in Aotearoa New Zealand

In the past few decades, the world has noticed an unparalleled rise in global migration, driven by globalisation and the widespread execution of neoliberal economic policies (Dutta, 2008, 2016). Neoliberalism as an ideology supports the unrestricted movement of goods, capital and labour through deregulation and privatisation strategies. The globalisation of trade has created an increasing need for inexpensive and low-skilled labour. Aotearoa New Zealand is no exception to this phenomenon; it has a long history of accepting migrants, with the country robustly attracting skilled workers and professionals to its economy and society (Iqbal, 2017). New Zealand's

population recently increased substantially, with a net migration gain of 133,800 migrants (Stats, 2024), with Indians, Filipinos and Chinese being the leading three migration suppliers.

Moreover, a noteworthy trend in New Zealand's migration model is the influx of migrant nurses to improve the country's healthcare staffing needs (Chalmers, 2020). The health workforce in Aotearoa has one of the highest proportions of migrant nurses of all the Organisation for Economic Co-operation and Development- OECD countries (OECD, 2016). In Aotearoa, migrant nurses represent 27% of the overall practising nurse workforce (NZNO, 2023) and are increasing in number (Rebecca Mowat & Jarrod Haar, 2018), with nurses from India and the Philippines being the fastest-growing group (Tsujita, Hisaya, & Rajan, 2022). The colonial legacy of utilising India as a labour pool continues in Commonwealth countries like New Zealand, with Indian nurses often placed as essential yet undervalued workers (Ramsamy, 2006). Researching Indian nurses could highlight how colonial discourses continue to depict migrant labour, framing it as a resource to be employed rather than a community with agency and rights (Dutta, 2016).

Following the easing of COVID-19 pandemic restrictions in 2022, about 50% of the migrant nurses who received work visas were from India (Blessen, 2023). Also, the Indian High Commission has warned Indian nurses planning to come to New Zealand, as many nurses registered with the New Zealand Nursing Council struggle to find jobs (RNZ, 2024). Lately, news reports highlighted how the management of a public hospital directed Indian nurses to stop using their language in any public space at work, leaving the migrant nurses threatened and undervalued and thus emphasising the cultural marginalisation often experienced by these migrant nurses (Pennington & Xia, 2024). Even though there are studies based on nurses from other ethnicities like China (Song & McDonald, 2021), the Philippines (Hernandez, 2019), etc., research focusing on the health and well-being of migrant Indian nurses centring on their culture is limited. The working settings of these migrant Indian nurses in Aotearoa New Zealand, are influenced by intersecting systems of immigration policy, labour market, and healthcare organisational structures.

The migrant Indian nurses are offered visa pathways to New Zealand such as the Accredited Employer Work Visa and the Occupational Registration Visitor Visa Category (Immigration New Zealand, 2024). Recent reports have noted the exploitation of migrant Indian nurses under the Accredited Employer Work Visa, which binds migrant nurses' residency status to work while restricting their negotiating power and reinforcing their dependency on employers (Tom, 2024). Moreover, the Nursing Council of New Zealand requires a credentialing process and competency assessment, which has proved expensive and time-consuming for many migrant nurses (Arora, 2024). Studies have highlighted that migrant nurses often endure challenging accreditation and recruitment processes (Niven, 2023) and high fees charged by recruitment agencies (Tsujita, Oda, & Rajan, 2023). Although advocacy organisations such as the New Zealand Nurses Organisation (NZNO) are crucial in advocating against the systemic barriers nurses face, they are limited by structural barriers. For instance, NZNO has noted that the Health New Zealand (Health NZ) boards lack representation for nurses and have no clear union presence (NZNO, 2021). This lack of the nurse's voice at the decision-making tables, especially migrant nurses, signifies the silencing of health workers within the healthcare hierarchies of Aotearoa, New Zealand.

Additionally, it is noted that in Aotearoa, New Zealand, migrant nurses often perform physically and psychologically draining tasks while experiencing discriminatory policies and behaviours within health organisations (Jenkins & Huntington, 2015). For instance, Healee and Inada (2016) note that migrant nurses struggle at personal and professional levels and finding a voice is imperative for them to thrive in the working environment. This lack of representation constrains their capacity to express their lived experiences in the healthcare sector. As Harvey (2022) noted in his study, there is a need to uplift the status of international nurses by reducing the perception of 'otherness' and acknowledging and respecting their healthcare experience. For this to happen, listening to their voices authentically is necessary.

Challenges to migrant nurses' health

In 1938, Aotearoa New Zealand was one of the first countries to achieve its goal of universal health coverage; however, since that time, the healthcare system has undergone significant restructuring and change (Goodyear-Smith & Ashton, 2019). Compared to other countries, New Zealand, from the late 1980s to around 2000, has gone through the highest number of healthcare system restructures globally (Gauld, 2016). These changes were due to the decisions made by consecutive governments, who had contrasting political agendas and made various changes to funding and planning systems. Still, ongoing inequities exist in access and outcomes for Māori, Pacific Island, and other ethnic populations, reflecting the whiteness of healthcare organising in settler colonial Aotearoa (Goodyear-Smith & Ashton, 2019). Moreover, much literature argues that these inequitable healthcare outcomes stem from colonial racist policies that have contributed to the continual decline of the Māori language, and an increase in race-based discrimination and social exclusion practices (Came, 2014; Chin et al., 2018). For example, the life expectancy of Māori is 7.1 years shorter than Pakeha, and they have a greater probability of confronting health issues and illness (Sheridan et al., 2024). New Zealand's health care system privileges Western world views and ethical understandings (Durie, 2011), reflecting the overarching values of the dominant white culture and is biased in the organisation and design of policy, procedures, health services, care, and treatment (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). More importantly, as Brown and Bryder (2023) demonstrate, predominantly bio-medical healthcare systems do not accommodate cultural and ethnic differences, and there is an imminent need to recognise different cultural pathways to improve health. This matter warrants attention, given the high proportion of migrant nurses in the workforce of Aotearoa New Zealand.

Furthermore, migration poses several challenges as individuals adapt to new social and physical surroundings (Williams, 2010). Research across the globe suggests that difficulties associated with moving away from home, together with social isolation and injustices, cause decreased emotional and mental well-being among migrant populations (Dutta & Jamil, 2013). Similarly, in Aotearoa, New Zealand, Choi, Cook, and Brunton (2019) highlight acculturative stress faced by migrant nurses and the need for reciprocal supportive leadership rather than solely resting the responsibility on the shoulders of migrant nurses. Additionally, migrant nurses in Aotearoa, New Zealand, face racism and other inequalities. Gultiano (2022) highlights that such encounters of bullying and racial discrimination faced by migrant nurses pose a risk of losing these skilled professionals

despite the existence of organisational policies intended to care for their health and well-being. As suggested in his study, there is a need for migrant nurses to lead solutions to address the issues they face.

Overall, the challenges faced by migrant nurses in Aotearoa New Zealand, not only relate to the physical and mental adversities of moving to and settling in a new country but also stem from discriminatory treatment in institutional settings. We can observe the symbolic marginalisation of migrant nurses through the absence of their voices in discourses within the healthcare infrastructure. For example, in her study, Clubb (2022) highlights how channelling migrant nurses experienced in acute clinical settings to unfamiliar aged care clinical settings during the Competency Assessment Programme[1] (CAP) course was unsettling and left the migrant nurses feeling deskilled. While addressing the challenges migrant nurses confront in New Zealand, it is essential to steer away from a top-down problem-solving model that presumes migrant nurses' passivity, as doing so could unconsciously sustain the marginalisation of migrant nurses (Dutta, 2008, 2015). To address the erasure of migrant nurses from discursive spaces in Aotearoa, New Zealand, we adopt a culture-centred approach that allows the voices of the migrant nurses to emerge from the margins.

Culture-Centered Approach (CCA): voice infrastructures

Evolving from postcolonial and subaltern scholarship, the CCA engages with subaltern groups who have been suppressed by or are absent in dominant theories and models of health (Dutta, 2011). Privileging 'dialogues' with the participants of marginalised communities, CCA emphasises the relationship of culture, structure and agency in examining how meanings of health are created at the grassroots (Basu & Dutta, 2007). As Dutta and Kaur-Gill (2018) note, culture is seen as dynamic, a way of meaning-making based on the lived experiences of people, and shapes all facets of life, from how people behave and speak to how they think. Structures are institutional norms, frameworks and roles in mainstream society that often control and limit the options of living a healthy life for marginalised people. Meanwhile, agency signifies people's capacity to access the structures that govern their lives. CCA exposes those structures and communicative practices that constrain marginalised communities and offers a framework for 'listening'. In doing so, this approach can amplify voices against those structures, disrupt them, and centre the marginalised in communication research, theory, and practice.

The narratives from the margins aim to subvert the dominant paradigms of health and wellbeing by foregrounding the structural contexts of health (Basu & Dutta, 2007). CCA seeks to challenge hegemonic structures fostering marginalisation through dialogue and community participation. Here, the lived experiences of migrant Indian nurses serve as entry points to defining their meanings of health and articulating solutions. Earlier, interventions anchored in the CCA have amplified marginalised voices, establishing the culture's role in shaping health experiences (Dutta, 2011). In this study, the CCA creates avenues for listening to the voices of migrant Indian nurses in the context of precarious care work within healthcare in meaningful ways that matter to decision-making and evaluation of existing structures of healthcare organising (Dutta, 2021). We ask: What are the meanings of health and well-being held by migrant Indian nurses in New Zealand?

Data collection and analysis

Using the framework of CCA, the study drew upon in-depth interviews to co-create robust voice infrastructures in partnership with migrant Indian nurses. The study design was peer-reviewed and deemed a low risk under the University ethics guidelines. Thirty migrant Indian nurses who have practised as registered nurses in New Zealand for at least six months were engaged in the study. In order to secure a diverse range of viewpoints, we used purposive and snowball sampling to select participants for interviews. These face-to-face interviews followed a semi-structured format, permitting open and honest conversations. The open-ended questions and listening to their voices formed the foundations of recognising the challenges faced by the migrant nursing communities in New Zealand. The interviews began with an open-ended question about the meanings of health, 'What does health mean to you?' and then emerged as a back-and-forth dialogue. Interviews were conducted in English with an average duration of one hour and focused on health and well-being issues based on the lived experiences of the migrant Indian nurses.

After organising thirty interviews, we saw that we were not collecting any new information or insights, indicating data saturation. The data collection process was specifically challenging during the COVID-19 pandemic due to limitations on in-person interactions and the greater stress levels among participants. Therefore, we temporarily paused in-person interviews and only continued them once restrictions were lifted, and the migrant nurses felt more at ease.

Grounded theory was used for data analysis (Charmaz, 2000; Strauss & Corbin, 1990). The grounded theory seeks to develop midrange theories (Charmaz, 2006; Corbin & Strauss, 2008; Cresswell, 2003) about matters of significance in people's lives (Glaser, 1978; Strauss & Corbin, 1998). It is attained through a data collection process often described as inductive (Morse, 2001), where significant issues emerge from narratives that the participants share with the researcher. The researchers examined data by constant comparison, firstly comparing participant data and then evaluating their explanations by organising them into codes and categories. The first step is the line-by-line analysis of the interviews, in which open codes are created. A second researcher analysed the open coding in this case. The correlated codes surfaced in open coding and were grouped into conceptual clusters using axial coding. This then led to selective codes that represent the key themes of the study. Like previous CCA studies, this study used ethnographic notes that articulated our reflections as co-participants in the interview process.

Findings

The analysis revealed themes that subvert the dominant meanings of health and well-being in the context of migrant labour in healthcare – health as interwoven with family and community, migration, disconnection from networks and health challenges, and the importance of culturally appropriate food for better health. Migrant Indian nurses' narratives reveal that their everyday meanings of health are located within the structures of Pākehā[2] whiteness determines cultural understandings of health and the distribution

of resources. The voices of the migrant nurses point out their everyday struggles in negotiating health within the healthcare sector of New Zealand.

Family and community: interwoven pathways to health and wellbeing

The participants expressed the notion of health as intertwined with their work, constructing it as an individual state and a collective state shared with family. According to Stephy[3], 'Health is just not my health, the health of my family as well. If the health of my family is affected, my health is affected. Obviously, I am affected. I mean, mentally, I don't feel good'. This association of health as linked to family and community is a theme that reverberated throughout the in-depth interviews. Migrant Indian nurses spoke about responsibility to their families and fulfiling family expectations. Most of them voiced their discontent with having no time and energy to spend quality time with family, who are their only support in the foreign land due to organisational structures. Consider, for instance, the following narrative by Reeja:

> I do afternoons, and so the afternoon shift starts at half past two, then it finishes by quarter past eleven. Sometimes, I will be back here only by midnight. Then my kids will definitely be in bed. I will go to bed by one o'clock or half past 1:00 in the morning; then I wake up by 9:00 or 10:00, and then my kids will go to school. I mean, in terms of relationships it is affecting my health as well and also the health and well-being of the family.

Similarly, many nurses working on shifts voiced shift work as a key element isolating them from their families and adversely impacting their health. They reported that workplace timings, determined from the top down, often led to isolation and stress. This is well narrated in the following depiction by Julie:

> I was feeling isolated. Like, you know, every time work, work, work. No actual interaction between the people. Yeah, I did not have. Because, like most of the time, my husband used to take the weekend off. I will be working, and he will be staying at home. He used to do all the mornings, and they put me all PM[Shift]. So, it is a disconnect.

Rebecca supported this, who reiterated, 'We need some time with family sometimes. We came here to make some income. It's not just for money. It's for the family too. So really, if you're not getting time with us family, that's not a great thing'.

The meanings of health by migrant nurses shift from individual health frameworks within the biomedical model to accentuating connections and family dynamics. The narratives reveal that the experiences of migrant nurses, evidenced by challenges correlated to work-life balance, irregular shifts and isolation, negatively impact their health and well-being.

Migration: the hidden health impacts of family disconnection

Participants shared their meanings of health linked to experiences of isolation articulated in narratives of separation from left-behind families in India. For many participants, this separation meant being disconnected from the necessary support that shaped their experience of physical and mental well-being. For instance, Ancy, who had to stay away from her children because of the COVID-19 border closure, explains how being disconnected from family affects her overall health and well-being.

> I would like to say that is not only the physical care, but we should be emotionally stable, mentally stable, then really, we can be physically stable. So, when you talk about holistic well-being, this that relates to the health of your extended family back in India, you know, your health is connected to them. I would definitely say it is because I'm a person who has been away from my family for 17 months. So, I have two kids, five and three years old. So, if they are sick, I won't be able to work like what I expected in my work.

Furthermore, the conversations with migrant nurses revealed how the adjustment to a new country is further complicated by the lack of support from the extended family system that they relied on in their countries of origin. A number of participants pointed out that employers may not recognise how sociocultural context, such as family life, may affect the health of migrant Indian nurses. For instance, Rinto explained how being away from family puts him under much stress.

> What I was expecting when I came in, maybe after two, three months, I could bring my family . . . because staying without families, you know, it is like, we are not emotionally stable. Always our mind is behind our kids and what they're doing. I am talking about health. Yeah. So when I came, I was thinking like I would be able to take them within a few months, but then things changed because of the COVID.I was really frustrated. I am not complete without my family.

The voices highlight that migrant Indian nurses struggled to balance their family and work lives because they lacked the support they would have had in India. Moreover, some participants recognised that although in their home countries they would have been able to rely on the extended family, in New Zealand, these extra resources were not available to them. For instance, Anita narrated:

> We are far away from our own home. For me, it is hard to raise a family without any support; that is the first thing, that gives me lots of stress. As well as you need to work otherwise you won't be able to live in here. So, the work pressure and family are like, you need to fight each other to carry on with your life. So that gives me lots of stress.

The above comment by Anita highlights an alignment with the neoliberal framework, where migrants are supposed to manage independently, relying on their own resources and where health is a personal responsibility. The narratives highlight that the lack of emotional support from close family members often intensifies the stresses of working in high-pressure healthcare settings.

Disconnection from the community and health impacts

For migrant Indian nurse participants, the meaning of community is tantamount to health, healing, building trust, creating bonds, forging connections, communicating for support, alleviating pressure, learning health information, and caring for each other. Here, the lack of such community interactions due to working hour patterns affected their health, as revealed by Tessa:

> I just have a plan to resign from the workplace. Because of the stress. I'm working in a mental health facility. We have some physical, you know, the dangers of being attacked or something. I have just been attacked by one of the clients and have had to take sick leave. So, in such a scenario, you know, we have to compromise mental health as well as physical

> health, and we won't get many chances to just vent that with others. Like, although we have our own community here, the chance to interact with others, it's very minimal.

Working in a high-stress environment with threats to their physical health, Tessa needs community support to heal. The work hours, however, prevent her from connecting with the community and drawing support from community members. Similarly, several other participants also pointed to the extreme hours of work, which prevented building connections with the community. Furthermore, these accounts of migrant nurses portray that shift work impacted connecting with community networks, which in turn affected the psychological well-being of nurses.

Moreover, migrant Indian nurses reported that the lack of networking due to workplace timings often leads to isolation and stress. These accounts of migrant nurses portray that shift work had an impact on connecting with community networks, which in turn affects their psychological wellbeing. This was also mentioned in the following commentary by Jismy:

> What troubled me was the support of the social network. Where I come from, we have a lot of family support you know we can rely on. Here you are a sole fighter and we just have to take everything. So really it is a great challenge.

Another nurse, Charles, mentioned how he had to move from his workplace as he felt alone and disconnected from his community, stating:

> I was really alone there. It was so rural. . . only 1000 to 2000 people, I think. It's so rural, and to see other people [from the community], I had to travel across and over the hilly areas. So, I was really alone there. It was not at all interesting in the end. So, I just moved to the hospital.

What becomes evident in these narratives is that migrant nurses associate the emotional/psychological effects that stem from a lack of social connectedness, shift work, separation from family in the country of origin and lack of networking opportunities with the physical indicators of stress on the body. This loss of potential community connection is the price the migrant nurses pay for their responsibilities related to work, and these narratives subvert individualistic framings of health within the neoliberal context of migrant labour. In addition, workplace retention is an issue, as several participants noted how their experiences also affected their decision to transition to other areas.

Untangling the meanings of health through culturally appropriate food

Migrant nurses narrate health meanings through various discourses about culturally appropriate food. Employment laws in Aotearoa New Zealand dictate that nurses can have a certain number of breaks and unpaid meals within a given workday. However, some of the migrant Indian nurses said they could not have culturally relevant food at work, which in turn affected their health and well-being. In Sherma's narrative, food is marked as absent in the workplace. She says, 'People would say, "you smell like an onion", and to be honest, I mean, I do have showers, and I do not eat too many onions. Those kinds of things, it is not easy to deal with it'. In another instance, Lissy commented, 'When we have Indian food, I can't microwave it because it's a strong smell of curry that I make and then the patients keep smelling it, or my colleagues. It's just a challenge that

Indians face in the workplace'. These narratives demonstrate how Lissy and Sherma's ability to eat culturally appropriate food is compromised within the workplace.

The participants' experiences reveal that they go through 'unmanageable workloads' without food and proper breaks. Also, the individual narratives of migrant Indian nurses' attribute to the physical experience of pain/discomfort. For instance, Sherin recounted:

> Personally, by the end of my shift, I get high blood pressure. Essentially, I have got hypertension, but it is by the end of the shift, because of the tight schedule that we are exposed to. So, I had to get a combination of two medications to have my blood pressure under control.

This quote by Sherin is interesting as it highlights how some migrant nurses have to cope with the after-effects of stress on their bodies, which in turn can be linked to an absence of health. Moreover, migrant Indian nurses reported their inability to buy fresh produce, which Ancy reflects on.

> We used to eat lots of green leafy vegetables. But here, we tend to buy more frozen vegetables, which I find maybe less healthy. Okay, and because of the workload, we tend to buy more junk foods and fast foods. I think that's also another thing that doesn't allow us to live a healthy lifestyle.

Here, the above comment by Ancy emphasises how the lack of customary and culturally relevant foods can lead to feelings of food insecurity and dependence on inexpensive, less nutritious choices among many migrant Indian nurses. Overall, this section has provided a succinct look at some of the more pertinent factors affecting migrant Indian nurse's well-being, and the following section discusses these in more depth.

Discussion

As mentioned earlier, this manuscript draws on the CCA to foreground the lived experiences of migrant nurses, who form one of the lower ranks of precarious care work in Aotearoa's neoliberal healthcare economy (Schilgen, Nienhaus, Handtke, Schulz, & Mösko, 2018). Interrupting the emphasis on cross-cultural and communication skills training directed at immigrant healthcare workers, this work addresses the everyday meanings of health articulated by migrant nurses. The location of the nurses at the margins of the healthcare economy plays out in their precarity and everyday erasure experiences. The lived accounts of health offered by the participants in this project point to the politics in the global division of labour, the raced nature of this politics, and how raced constructions of transnational care work constitute the experiences of precarity among workers (Boese et al., 2013). As demonstrated in the previous section, the participants in this study articulate health in the language of relationships, connections and access to culturally appropriate food, thus fundamentally disrupting the hegemonic approach to cultural sensitivity training that imposes a deficit model to develop educational training in the backdrop of a racist healthcare system.

The participants reveal a profound disconnection from their communities and families, considerably challenging their health and well-being. Konno (2006) noted that this lack of a supportive network aggravates feelings of loneliness and reduces their ability to manage the pressures of their job and daily life. Participants refer to structures of

immigration hindering their lack of access to care resources from their families. The voices of migrant nurses challenge the universalised biomedical model that considers health as an individual paradigm and stresses individual-level decision-making. Throughout the narratives, we see the dynamic relationships among individual, familial, community-based, and societal aspects of health. What this means for reforming migrant health is that rather than creating tools for communicating with particular cultures based on deficit models, the experts must be prepared for dialogic engagement and listening, focusing on people's voices and culture.

Additionally, the lack of access to culturally appropriate food surfaced as a concern affecting the health of migrant nurses. As Parasecoli (2014) highlight, food is a significant characteristic of cultural identity and well-being, and the lack of ability to access familiar and culturally significant foods can lead to reduced satisfaction with life. Participants in the study recognise that organisations may not comprehend how sociocultural contexts, such as culturally appropriate food, affect their health. The voices suggest that they mostly rely on unhealthy frozen foods due to heavy workloads. Together, these findings point towards the need for a holistic approach to healthcare that values and incorporates the cultural, familial, and community contexts of migrant populations.

Culture and community are often seen as subjects that need fixing by applying Eurocentric frameworks (Dutta, 2021). Simultaneously, the cultural backgrounds, the community's capacity to adapt, and the agency of individuals are often overlooked. Solutions are usually imposed on communities using a top-down approach by outside professionals who often lack an understanding of the community's specific challenges. In contrast, participants of this study point towards the necessity of grounding solutions in the lived experiences of migrant nurses to develop viable solutions. The migrant nurse's voices in the study point towards moving from individualistic framing of health to collective frameworks, recognising familial and community networks, better integration support, the need for family visa considerations and access to culturally appropriate food.

Based on the migrant nurses' voices, we propose actionable recommendations, such as culture-centred training for healthcare organisations to promote dialogue and attentive listening to migrant nurses to identify migrant nurses led solutions. The participant voices also highlight the potential of existing community networks and communal activities. Funding approaches should acknowledge these informal community organising efforts as essential for health and wellbeing solutions.

The study also offers practical implications for immigration policy reform and healthcare infrastructure. Policymakers must examine restricting visa policies and bureaucratic practices that perpetuate vulnerabilities for these migrant nurses. Also, immigration reforms that promote long-term stability, such as residency pathways for families and improved reunification systems, could improve the well-being of migrant Indian nurses, as mentioned in the study. The narratives of migrant Indian nurses in New Zealand can also be linked to debates on how global health structures depend on racialised labour to support healthcare delivery, placing them in precarious situations (Syed, 2016).

Furthermore, this article adds to the existing scholarship on the CCA by portraying how culture impacts the health and well-being of migrant nurses. The article interrupts the deep-rooted Eurocentric preconceptions innate in theoretical contexts of communication and the Whiteness of the literature on

migrant nurses in Aotearoa New Zealand, questioning the racist impressions of cross-cultural adaptation that underlie this literature. The mounting importance of culture within Aotearoa New Zealand, points towards developing a meaningful theory and practice to best comprehend how culture may be mobilised for health purposes.

The insights presented in this study could more broadly inform the challenges faced by other migrant nurses in Aotearoa New Zealand. Even though the study reports valuable insights of the lived experiences of migrant Indian nurses, the results may not fully mirror the diversity of challenges confronted by other migrant healthcare workers in Aotearoa New Zealand. Future research could investigate more deeply into how factors such as gender, marital status, age, and socio-economic circumstances intersect with migration and work experiences to influence the health and well-being outcomes of migrant nurses.

Notes

1. Migrant nurses from countries like India are required to complete a Competence Assessment Programme (CAP) before registration in New Zealand to display his or her ability to satisfy the Nursing Council of New.
   Zealand's competencies.
2. Pakeha is the term for white or New Zealander of European descent.
3. Pseudonyms to ensure anonymity and confidentiality of participants.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

No funding was received for this research.

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