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Indirect Pathways Into Practice: A Comparative Examination of Indian and Philippine Internationally Educated Nurses and Their Entry Into Ontario's Nursing Profession

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**Indirect pathways into practice: A comparative examination of Indian and
Philippine internationally educated nurses and their entry into Ontario's
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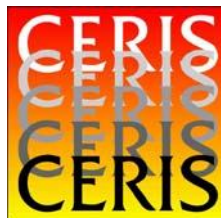
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Indirect pathways into practice: A comparative examination of Indian and Philippine internationally educated nurses and their entry into Ontario's nursing profession.¹

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Abstract: In Canada half of all internationally educated nurses (IENs) are employed in Ontario, and in 2010 the top three countries where new IENs had received their training were the Philippines, India and China. This presentation reports on preliminary results from an ongoing research project examining the experiences of IENs from the Philippines and India who intend to enter Ontario's nursing profession indirectly via temporary migration streams. The preliminary survey results will be presented, including differences in the characteristics and experiences of the two groups as they follow migration and occupational pathways to enter Canada and the nursing profession in Ontario. The preliminary findings will highlight some of the issues the data reveal in terms of specific settlement experiences, issues of effective conversion of pre-migration training into professional practice post-migration, and how policy shifts toward temporary and two-step migration may be shaping the nature of IENs' indirect pathways into practice.

¹ The authors would like to thank Sara Ahsan, Lindsay Blackwell, Jennifer Guo, Virpal Kataure and Lulu Marcelino for research assistance on this project, and the community collaborators, the School of Health & Life Sciences and Community Services Conestoga College, Waterloo and the Kababayan Community Centre, Toronto. The research was funded by a grant from CERIS-The Ontario Metropolis Centre.

Introduction: Gender, migration and global care chains

The international migration of health professionals such as nurses is not new, but the routes, patterns and pathways that internationally educated nurses (IENs) use to enter receiving country labour markets do change over time, and maintaining “positive practice environments”² (Adams and Kennedy, 2006) for IENs demands that the outcomes of policy changes are monitored and understood. In the case of Canada we want to assess any shifts in the main source nations IENs are drawn from, as well as explore the migration channels used for initial migration. Monitoring and assessing the nature of these shifts poses important questions not only about “positive practice environments” but also with regard to larger questions regarding how Canadian policies intersect with the ongoing feminization of labour migration. Feminization in this case is not just a question of female-dominated employment, but also about sectors of the labour market that become “feminized” in terms of working terms and conditions (Wright, 1997).

This paper begins to assess some of these shifts in the case of IENs from India and the Philippines who employ indirect pathways in order to enter the nursing profession in Ontario. Using case study research, we examine the characteristics of IENs from India, who enter Ontario as international students, and IENs from the Philippines, who enter via temporary worker streams. The share of total migrants entering Canada through temporary-foreign-worker streams has increased substantially in the last few years (Alboim and Maytree, 2009). This issue has significant policy relevance because indirect entry into the nursing profession adds complexity to a) labour force planning and practice in the health sector, b) ethical recruitment protocols for international health care workers, c) processes of migrant integration into the Canadian labour force and the deskilling of carework, and d) the assessment of macro-structural processes that shape and reproduce female migration as a form of state developmentalist policy.

² Based on the work of Adams and Kennedy (2006, 9) positive practice environments depend upon effective correspondence of a number of related issues including: “globalisation and international influences; migration; labour market and nursing shortages; immigration and society; diversity; cultural competency; and the experiences of international nurses.” Positive practice environments contribute to successful long term experiences of IENs, full utilisation of their skills and contribution to overall safe practices, meeting the needs of health care systems and patient needs.

The changing nature of migration policy toward temporary models represents a systematic yet relatively underexplored process, and raises a number of questions regarding the consequences of such policy changes for temporary workers and the related labour sectors in both sending and receiving nations. In particular, how will these pathways affect the labour market position and experiences of these nurses? What role do private sector intermediaries, and private and public educational institutions, play in this indirect system? In what ways are these pathways gendered and racialized, and what are the consequences for migrants navigating through these systems?

Using two case-study groups this research examines the experiences of nurses entering Ontario as temporary migrants through the live-in-caregiver program (LCP) and as international students who convert to permanent status and re-enter the nursing profession. In particular, what are the pathways (re-training, language training, etc.) these nurses take to gain re-entry into the profession? Finally, what are the impacts of this emerging “temp-to-perm” model of migration, on the nursing sector, and on immigrant social and economic integration?

Nurse migration and the internationalization of care

The migration of skilled females such as nurses is a growing dimension of international migration (Raghuram and Kofman, 2004; Kofman and Raghuram, 2006, Khaliq et al., 2008). It has been argued that in this context the use of IENs furthers the over-commoditization of care (Folbre, 2005), adds to the “churning” already present in nursing labour markets (Gordon, 2005), and further marginalizes the relative power of nurses within health care systems (Smith and Mackintosh, 2007). In addition IENs also face the challenge of overt workplace discrimination (Dicicco-Bloom, 2004). Migration thus exposes structural deficiencies in health systems globally (Buchan et al., 2003; Connell, 2008), and the indication is that the international mobility of nurses is set to continue into the foreseeable future (Hawkes et al., 2009). The migration of skilled female labour such as nurses is also reflective of the increasing use of migration as a form of economic development policy on the part of sending nations that increasingly take on the role of labour brokerage states (Rodriguez, 2008; Walton-Roberts, 2010; Connell and Stilwell, 2006).

To understand the global circulation of nurses we have to understand the nature of feminized labour migration in the care sector more generally. Using the lens of the “Global Care Chain”

we can conceptualize how female care migration might act as compensation for a “deficit of care” in developed nations, thereby acting as a form of “emotional surplus” transfer that is often channeled through the sphere of social reproduction (the home, domestic space), but is central to the operation of the formal economy (Ehrenreich and Hochschild, 2001; Misra and Merz, 2007).

In the case of nursing, the transfer of care is more formalized, since nursing credentials are managed by professional bodies, and nurses tend to be employed in institutional, rather than private, settings. However, as employment agencies and recruiters step in to help employers find overseas workers (as is the case for Canada’s Live-in-Caregiver Program), and poor working conditions overseas continue to produce a supply of trained professionals seeking an exit, the “nanny trade” has increasingly incorporated a growing number of medically trained professionals. As one such agency’s website aimed at Canadians advertises, “Looking to hire a nanny? Why not hire a nurse from another country?” (Gateways International Services Inc., 2009).

Furthermore, conditions of global uneven development lead many internationally trained nurses to see this as a viable migration pathway, as “grace hopefuls” posts on the ABCNannies Canada website; “I am a Registered Nurse Filipina 24 years old... and trustworthy, hardworking and willing to do anything.” (ABCNannies.com, 2009). The entry of nurses through the Live-in-Caregiver Program is not a new phenomenon. Several factors came together in the 1980s and 1990s to strengthen the network that has led to the growing number of Filipino nurses entering Canada through the LCP. In the 1980s nursing schools were established in the Philippines designed specifically for the export of nurses abroad, in line with a more broad-reaching labour export policy adopted by the Philippines at that time (Chang, 2000). Nursing shortages in Canada over the period led many to seek opportunities in Canada. However, since the Department of Citizenship and Immigration did not identify nursing as an occupation in demand (and so zero points were awarded for nurses under Canada’s point system at that time), this made it virtually impossible for foreign nurses to acquire sufficient points to enter as independent immigrants (Stasiulis and Bakan, 2005:110). For many Filipino nurses, the only available pathway to enter Canada was through the LCP.

More than three decades later, and after many changes to Canada’s immigration system, internationally trained nurses still face considerable difficulty in entering Canada as principal applicants for permanent, landed status. As Canada has moved toward selection criteria that put

greater emphasis on educational credentials, language skills, Canadian work experience and arranged employment, internationally trained nurses continue to face challenges in this competitive system of selection. Moreover, the chain migration network that has enabled the flow of Filipino nurses to Canada for decades continues to draw thousands.

Yet, IENs entering Canada as Live-in-Caregivers find themselves placed into the social organization of reproductive labour – carrying out devalued carework in informal, unregulated employment conditions, which encourages their deskilling in racialized and gendered work as they are drawn into what Pierrette Hondagneu-Sotelo calls the “New World Domestic Order” (2007). Using a global care chain approach allows us to construct both these sectors (domestic carework and nursing) as interlocking parts of a feminized global service sector (Yeates, 2009).

One important dimension of this research is to examine the routes IENs employ in order first to migrate and then to enter the nursing profession overseas. This can happen directly, through the nursing migration complex involving international testing and accreditation processes and through direct international overseas recruitment by health sectors (Yeates, 2009), or indirectly, via step migration, that is, moving through (and arguably up) different national health systems (Percot, 2007). However, there is also another two-step migration process that involves different forms of visa status in one place, where migrants enter under one class and then convert to another at a later date (Hawthorne, 2009).

This paper examines the intersections between distinct categories of migration, such as international student and temporary worker, recognizing that migrants will often move across numerous categories throughout their migration experience (Massey et al., 1998). As Khoo et al. argue, for many migrants from developing countries, “the dichotomy between temporary and permanent migration appear(s) to be a false one as the intention was always permanent migration” (2008: 221). Furthermore, as increasing numbers of migrants in the global care chain navigate more complex migration systems which involve two-step or transition processes, many will turn to the migration industry for assistance or services along the way, putting these migrants and their families at greater risk of exploitation and financial burden, particularly through the lack of federal regulation of recruitment practices in Canada (Hennebry, 2012).

One well-known example receiving significant media coverage was the case of Marivic Perlas Rivera, who was the first Live-in-Caregiver to win a court victory against a recruiter. She paid \$2,800 to Winlorfely Caregiver Providers to find her a legal employer for the Live-in

Caregiver Program and was offered a job that didn't exist from a "ghost employer". She was eventually awarded \$10,000.³ Further, Canada's federal government has strengthened language requirements and has essentially privatized the language testing and credential evaluation services, telling applicants that "CIC officers will not hold an interview to assess your language proficiency" and instructing applicants to "take a language test from an agency designated by CIC."⁴ This increased role for a range of legitimate and not-so-legitimate private agencies providing services to migrants (from consulting and recruitment to language testing) has served to bolster the migration industry (Castles and Miller, 2003) that surrounds and profits from the flows of foreign workers and students in Canada (Hennebry, 2008).

In the case of India this research was particularly interested in the intersections between education and migration, which are complex, extensive, and only just becoming central to the analysis of skilled migration globally (Hiebert and Kwok, 2004). Nursing, as a professional sector, is heavily shaped by educational processes and reflects the increasing intersection between domestic and international nurse training (Baumann and Blythe, 2008, Walton-Roberts, forthcoming). It is also one of the key sites where the sending nation becomes actively involved in the process of exporting trained personnel in terms of regulation and deregulation of the sector. Within India students migrate domestically for educational and work purposes (Nair, 2012), but there are also well-worn regional networks between southern India and the Gulf Cooperation Council (GCC) states, with onward migration to OECD nations (Percot, 2006). In addition, there appears to be an emerging capacity in northern India focused on markets in North America, Europe and Australia (Bhutani et al., forthcoming).

The analysis of current global migration circuits suggests that colonial legacies still mark the nurse migration system via the hegemony of English, which has created a preferential geographical circuit which includes Britain, Ireland, the USA, and the white settler colonies of Australia, New Zealand, South Africa and Canada (Valiani, 2012, Choy, 2003). Indian nurses, despite the dominance of the English language in their training, do not benefit from the same

³ "Nanny wins landmark suit after Star investigation" the Toronto Star, Wednesday November 25, 2009. Available online: <http://www.thestar.com/news/investigations/article/730445--nanny-wins-landmark-suit-after-star-investigation>

⁴ <http://www.cic.gc.ca/english/immigrate/cec/language.asp>

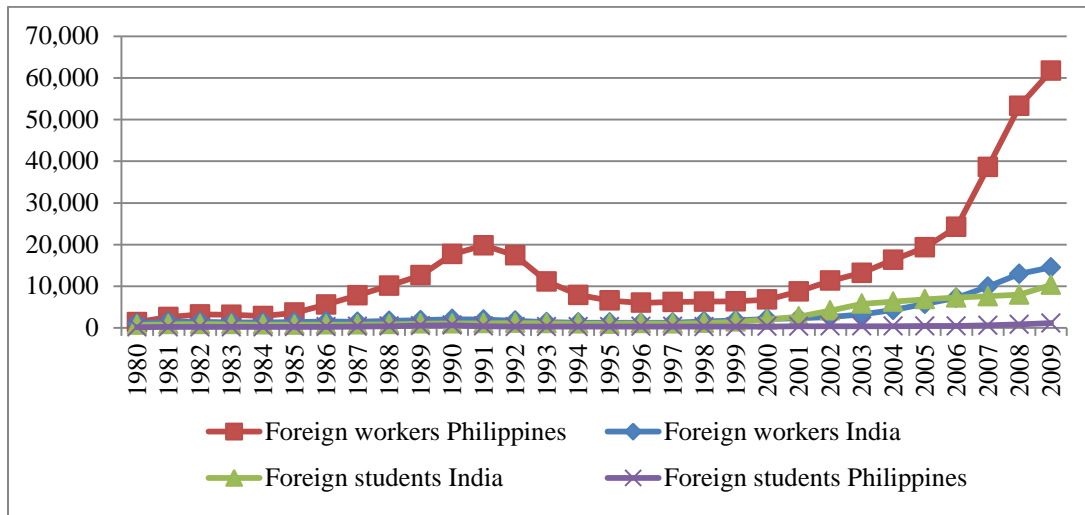
level of reciprocal recognition as those from other nations (i.e., between Australia and the UK, within Europe, between Australia and New Zealand). Indian nurses can enter the circuit and then seek registration in one of the preferential countries, and from there can engage in ongoing migration, but they will still likely be expected to take some form of language testing at each stage. Despite these barriers, international nursing opportunities have become an important focus for the Indian state (Khadria, 2007).

TFW entry into Canada: India and the Philippines compared

In the case of India and the Philippines the number of temporary workers and students heading to Canada has been increasing (see Figure 1). The profile of the two national groups shows a concentration of migration for Philippine TFWs in low skilled and semi-skilled categories as defined by Canada's National Occupational Categories (NOC).⁵ These include NOC C (occupations which usually require secondary school and/or occupation-specific training, which includes the live-in caregiver category), and NOC D (on-the-job training is usually provided for these occupations). In the Indian case the highest number of recent TFWs has been in NOC O (management occupations), NOC A (occupations that require university education) followed by NOC B (occupations that usually require college or vocational education or apprenticeship training). There is a clear bifurcation evident in the skill routes being used by Philippine as opposed to Indian TFWs, with Indian TFWs concentrated in NOC A and B (see Figure 2).

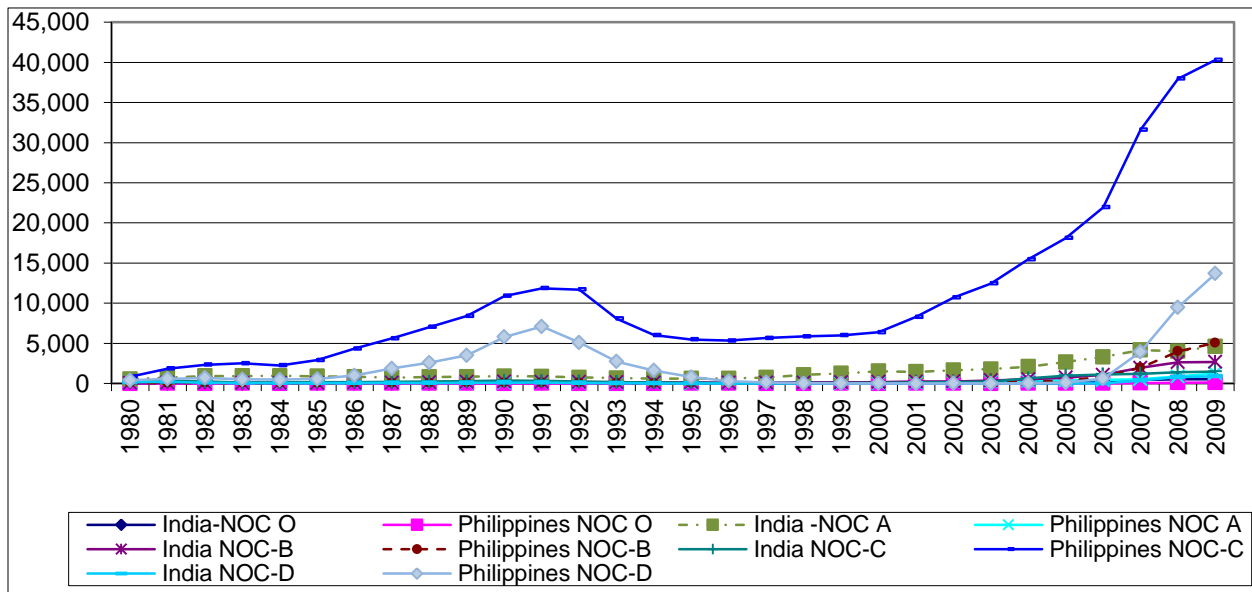
⁵ <http://www5.hrsdc.gc.ca/NOC/English/NOC/2011/Tutorial.aspx#8>

Figure 1: Temporary workers and students from India and Philippines 1980-2009.



Source CIC Facts and Figures, 2009

Figure 2: Philippines and Indian TFWs by National Occupation Classification (NOC)



Source: CIC data based on Facts and Figures, 2009.

Many internationally-educated nurses (IENs) enter Canada from the Philippines as temporary workers via the Live-in Caregiver Program (LCP) and Temporary Foreign Worker Programs (Pratt, 1999; Pratt and the PWCBC, 2008; Bakan and Stasiulis, 1997, Ball, 2004; PWCBC, 2001; Khan, 2009). In the case of India, however, the increasing number of nurses applying to register

marks the start of a widening of female professional migration beyond the traditional south India sending region.⁶ One route which seems to be developing as a mechanism for entry for these nurses is international student conversion (Hawthorne, 2009, 2008; Thomas, 2008; Walton-Roberts, 2010).

Pathways to professional registration (PR) for IENs

Certainly, all IENs can apply for entry to Canada through the economic class. For IENs who have entered Canada as international students, through the Live-in Caregiver Program or other streams of the Temporary Foreign Worker Program, there are very distinct pathways to permanent residency. The LCP has had a long history as a “transitional” program, providing what used to be thought of in policy circles as a “soft landing” approach to immigration. The Foreign Domestic Movement (FDM) of 1981 was the second incarnation of the current LCP, following the Caribbean Domestic Scheme program of 1955, and the more general 1973 Employment Authorization Program. The FDM laid new ground by providing access to permanent residency for eligible caregivers. In order to be eligible, caregivers had to meet a set of criteria which would qualify them as caregivers and as permanent residents, and could apply for permanent residency after a minimum of two years doing contract work as a live-in caregiver with one employer.

Since 1992, the LCP began to impose tougher entry requirements to guarantee better qualified caregivers - one outcome of which is that applicants are increasingly IENs. To qualify, applicants need either one year of paid experience (with at least 6 months with the same employer) or six months of training in a child-care related field and at least the Canadian equivalent of a high school diploma, as well as good knowledge of English or French. In order for LCPs to qualify for permanent residency they must complete 24 months of live-in caregiver work in a government-approved employer’s home or 3,900 hours of full-time employment (within a minimum of 24 months which may include a maximum of 390 hours of overtime), at

⁶ Personal communication with registration officials at the College of Nurses of Ontario and Walton-Roberts (forthcoming).

which point they can apply for status as a Permanent Resident.⁷ In December 2011, the federal government issued 14,000 open work permits to LCPs who met the employment hours to apply for permanent residency, which allows these caregivers to work outside of an employer's home and in the field they choose. As of December 11, 2011, all live-in caregivers who meet their obligations and submit an application for permanent residence are eligible for an open work permit while their applications are processed.⁸

Through the Canadian Experience Class (CEC), international students can apply for access to permanent residency after they have graduated from a Canadian post-secondary institution and completed at least one year of full-time (or equivalent) skilled work experience in Canada with a valid work permit. Additionally, applicants must provide results of an independent language test (from an agency designated by CIC) and demonstrate good knowledge of English or French.

Interestingly, despite the demand for caregivers in Canada, entries into the LCP have not shown a steady incline, with 4,369 entries in 2001, and 13,773 entries in 2007 (a peak for the decade), then falling to 8,394 in 2010. Comparatively, the entries of international students with work permits has grown relatively steadily, with 1,551 in 2001, followed by 3,106 in 2007 and peaking at 7,189 by 2010.⁹ Also, when looking at transition to permanent residency for the LCP compared to the CEC, the numbers of LCPs obtaining Permanent Resident Status are comparable to the numbers gaining access through the new CEC program. In 2009, in the first cohort of permanent residents through the CEC, just 1,775 principal applicants and 770 dependants, were granted permanent residency, and by 2011 this number had doubled, to 3,973 principal applicants and 2,054 dependants (a total of 6,027 entries in 2011).

Comparatively, while 6,157 principal applicants and 6,182 dependants gained permanent residency in 2009 via the LCP, by 2011 the numbers of principal applicants was just 5,033 (only about 1,000 more than those entering via the CEC). In the case of the LCP, the number of

⁷ The Live-in Caregiver Program: Who can apply? Citizenship and Immigration Canada, Online at: <http://www.cic.gc.ca/English/work/caregiver/apply-who.asp>

⁸ “News Release – Minister Kenney announces important change for live-in caregivers” Online at: <http://www.cic.gc.ca/english/department/media/releases/2011/2011-12-15.asp>

⁹ Citizenship and Immigration Canada, Facts and figures 2010 – Immigration overview: Permanent and temporary residents.

caregivers accepted as permanent residents generally corresponds with the number who came to Canada as temporary foreign workers (TFWs) a few years earlier (accounting for the roughly 5 percent in 2009 and 2010 of all permanent residents to Canada who were admitted through the LCP class). For instance, about 4,700 live-in caregivers entered the program in 2002, and about 4,500 permanent residents were accepted through the Live-in Caregiver Class in 2005. More than 7,200 caregivers entered the program in 2005 and about 10,400 individuals, including spouses and dependants of those caregivers, became permanent residents through the Live-in Caregiver Class three years later.¹⁰

Clearly, the majority of LCPs do in fact transition to permanent residency, while the numbers of foreign workers and students transitioning through the CEC remain a small proportion of the thousands of entries annually through these categories. While the CEC is a pathway of growing popularity, the LCP remains a more dependable transitional pathway, with access to permanent residency all but guaranteed once employment and language requirements are fulfilled. However, as will be discussed, though access to permanent residency is more dependable for LCPs, access to the nursing profession may not be as feasible or timely for this group compared with those entering as students and transitioning to permanent residency through the CEC or for those who have entered directly as economic class immigrants.

Table 1. Permanent Resident Entries by Category of Entry, 2007-2011

Category	2007	2008	2009	2010	2011	Total
Canadian Experience Class – principal applicants	–	–	1,775	2,533	3,973	8,281
Canadian Experience Class – spouses/dependants	–	–	770	1,385	2,054	4209
Provincial/territorial nominees – principal applicants	6,329	8,343	11,800	13,856	15,296	55,624

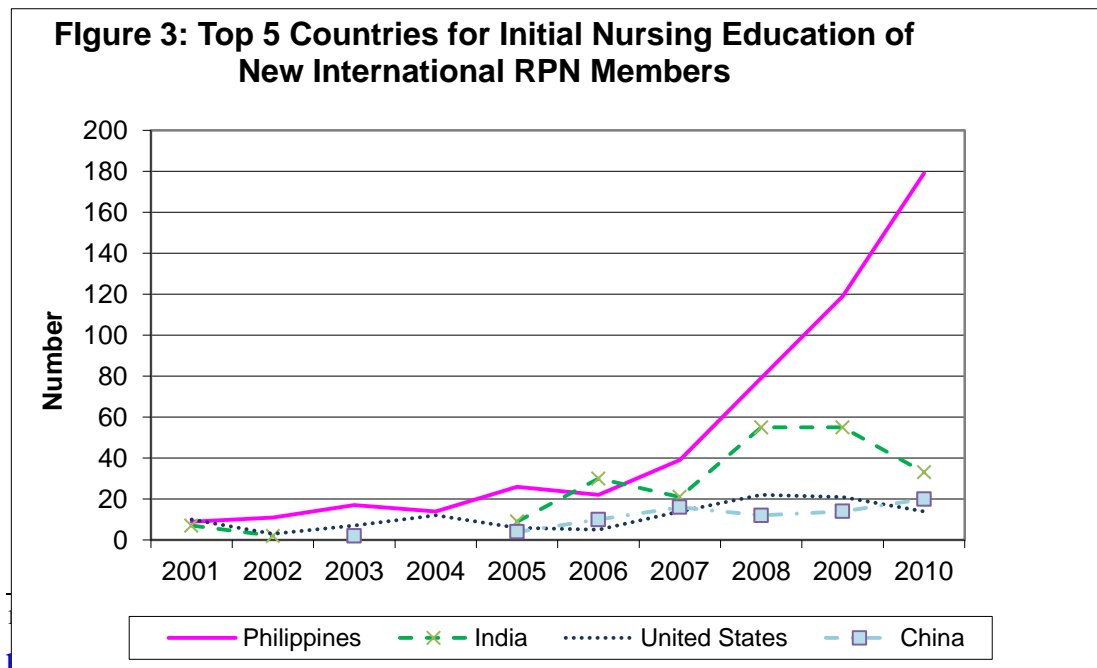
¹⁰ News Release – Minister Kenney announces important change for live-in caregivers” Online at: <http://www.cic.gc.ca/english/departement/media/releases/2011/2011-12-15.asp>

Provincial/territorial nominees – spouses/dependants	10,764	14,075	18,579	22,574	23,124	89,116
Live-in caregivers – principal applicants	433	6,157	6,273	7,664	5,033	28,560
Live-in caregivers – spouses/dependants	2,685	4,354	6,182	6,247	6,214	25,682
Total	23,211	32,929	45,379	54,259	55,694	211,472

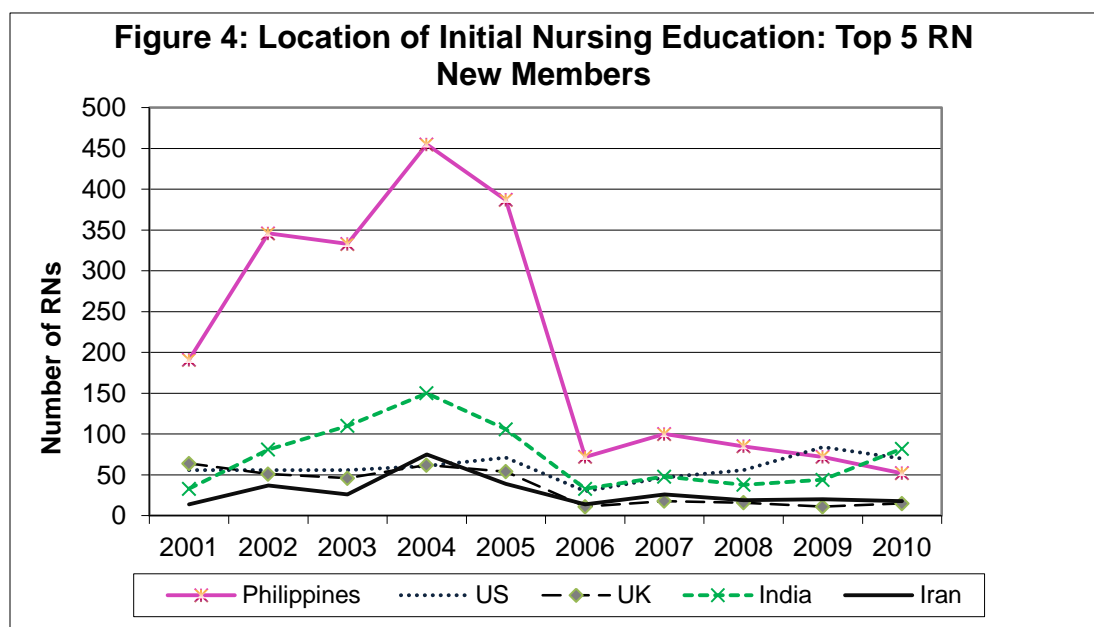
Source: Citizenship and Immigration Canada, RDM, Facts and Figures 2011 Data.

The flow of IENs into Canada

In Canada half of all internationally educated nurses (IENs) are employed in Ontario. In 2010 just over 30% of all new registration applications received by the College of Nurses Ontario were IENs, and 12% of new fully registered members were IENs.¹¹ In 2010 top source countries for new registered practical nurse (RPN) enrolments in the College of Nurses Ontario were the Philippines followed by India and China (see figure 3). For registered nurses (RNs) the top sources in 2010 were India, USA and Philippines (see figure 3).



Source: College of Nurses of Ontario "Trends in General Class new members 2010"



Source: College of Nurses of Ontario "Trends in General Class new members 2010"

The changing pattern of registration with the Colleges of Nurses of Ontario indicates a decline in numbers of RNs but increase in number of RPNs from the Philippines in the last few years, but the reverse is evident in the case of India, with an increase in numbers of RN applications, but decline in RPNs.

In seeking explanatory factors for the decline of IENs from the Philippines registering in Ontario (during a period when TFWs continue to enter Canada from the Philippines as figure 1 shows), it is useful to consider how the attraction of Canada's western provinces may be relevant. In Saskatchewan 238 Internationally Educated Nurse (IEN) applications were made in 2007, compared to 856 in 2008, and 718 in 2009.¹² In Manitoba there has also been an upward trend in IEN applicants, from 104 in 2006 to 532 in 2009.¹³ In Alberta, CARNA (College and

¹² http://www.srna.org/images/stories/pdfs/communications/annual_report/srna_annual_2009.pdf

¹³ http://cms.tng-secure.com/file_download.php?fFile_id=9387, p15.

Associations of Registered Nurses Association) received 3,306 new IEN applications in 2009, compared to 2,339 during the 2007 – 2008 year.¹⁴ The increase in enrollments in the western provinces may be drawing the interest of RNs from the Philippines; indeed the Philippines has signed bilateral MOUs specifically with Saskatchewan and Manitoba.¹⁵

Fair access to the professions

Recent years have seen many of the provincial professional associations meet the demands of fair accreditation practice, and nursing has been one of the more prominent sectors to meet the federal government's demand to address effective credential recognition for immigrants to Canada. The Canadian Nurses Association is the federation representing provincial and federal nursing associations. In 2005 the CNA published a report, "Navigating to become a nurse in Canada", which was funded by the Canadian government's Foreign Credential Recognition Program.¹⁶ Currently registration examinations have to be taken in Canada, but the CNA is conducting research on the feasibility of offering licensing examinations offshore.¹⁷ In Ontario the CNO has developed its website to make it easier for IENs to navigate the process of registration, and they also file an annual report with the Fair Registration Practice Ombudsmen that details statistics in terms of the number of application, levels of completion and successful entry. Figure 5 details the steps IENs are required to complete in order to gain registration with the CNO.

¹⁴ The number of IEN applicants in BC declined from 527 in 2009 to 252 in 2010.

https://crnbc.ca/crnbc/Documents/245_2010AnnualReport.pdf, p.16

¹⁵ See <http://aeei.gov.sk.ca/memorandum-understanding-sk-vietnam-philippines> and <http://news.gov.mb.ca/news/index.html?archive=&item=9747> accessed August 23rd 2012.

¹⁶ http://www.cna-aiic.ca/CNA/documents/pdf/publications/IEN_Technical_Report_e.pdf

¹⁷ <http://www.credentials.gc.ca/fcro/funded-projects.asp>

Figure 5: Specific Requirements for IENs to register with the CNO¹⁸

1. Complete an application and pay the fee.
2. Show proof of having completed an approved 4-year baccalaureate nursing program (for Registered Nurse category) or 2 year diploma practical nurse program (for Registered Practical Nurse category), or an equivalent to a current approved Ontario program.
3. Successfully complete the examination or an approved equivalent exam.
4. Show proof of recent safe practice.
5. Show evidence of fluency in written and spoken English or French.
6. Show evidence of eligibility for registration in the jurisdiction where the nursing program was completed.
7. Provide proof of Canadian Citizenship, permanent resident status, or authorization under the Immigration and Refugee Protection Act (Canada).
8. Show evidence of good character and suitability to practice.

In terms of IEN's labour mobility in Canada, the combination of the Ontario labour Mobility Act 2009, interprovincial labour mobility Bill 175 and incorporation of the interprovincial labour mobility provisions in Schedule 2 of the Regulated Health Professions Act Code (December 15, 2009) now means that once nursing registration occurs in one province it is recognized in another. This certainly encourages greater convergence in terms of how various provincial and territorial nursing associations deal with IENs, but as yet the processes are still variable. CARNA in Alberta offer a restricted temporary permit (RTP) that allows IENs to work while they complete their registration process.¹⁹ The CNO has a transitional class for some graduates, but this is not available to IENs.²⁰ The patchwork of regulatory provisions in Canada is also further complicated by the various pathways IENs employ to enter the Canadian system. In order to explore in some detail how these complex systems roll out for IENs from the

¹⁸ <http://www.cno.org/en/become-a-nurse/new-applicants/international/>

¹⁹ http://nurses.ab.ca/Carna-Admin/Uploads/CARNA_AR_2010.pdf

²⁰ <http://www.cno.org/en/become-a-nurse/new-applicants/international/classes-of-registration/>

Philippines and India, we developed a case study approach that surveyed Indian and Philippine IENs who had entered Canada under different entry schemes (LCP and international students); both schemes require conversion of temporary migration status and registration in order to enter the profession.

Methodology

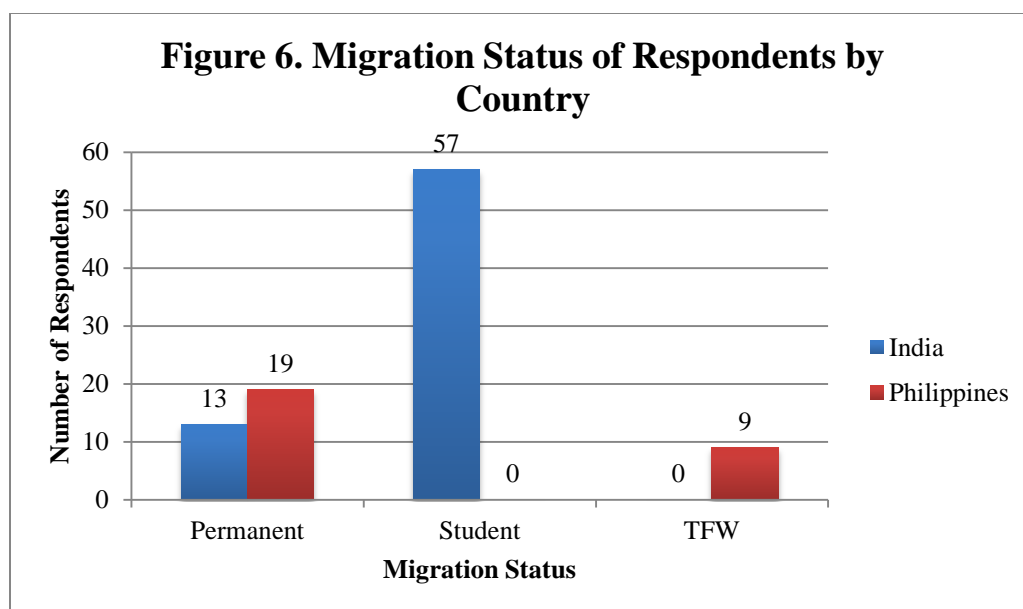
This research utilized both quantitative and qualitative sources of data. Two case study groups of internationally educated nurses in Ontario as temporary migrants were identified; a) nurses from the Philippines in Ontario under the Live-in Caregiver Program and b) nurses from India entering Ontario colleges as international students.

In the case of nurses from the Philippines, individuals trained as nurses who have entered Canada through the LCP were identified through collaboration with our community partners (primarily with the assistance of Pura Velasco and the Coalition for the Protection of Caregivers' Rights and Kababayan Community Centre, Toronto). In the case of Indian trained nurses we focused on a cohort of trained nurses from India currently enrolled in a specifically designed nursing course at Conestoga College, another community partner.

Surveys and semi-structured qualitative interviews were conducted in order to better understand respondent backgrounds and their efforts to convert, or their plan to convert, their temporary status to permanent status, and their experience of this process. Two community partners--Conestoga College and the Kababayan Community Centre in Toronto—have been actively involved in supporting IENs. Conestoga College has been actively involved with the case study of Indian trained nurses entering post-graduate professional courses. The college was involved in survey design, gathering data, and dissemination, and interviews and surveys with Indian respondents were conducted at the College. Kababayan Community Centre, Toronto, assisted in indentifying and accessing Philippine-trained nurses enrolled in the LCP and seeking to convert their status and reenter the profession.

Survey Results

Country	India	Philippines	Total
N	70	28	98



Migration Status: The sample’s Indian respondents were primarily in Canada under student visas (57), though some (13) were permanent residents (of these 7 were principal applicants and 4 were sponsored). Among Filipino respondents, most had permanent residency (19). Of these, most were principal applicants (12), and 6 were sponsored. Of those Filipino respondents who had temporary foreign worker status (9), all were LCPs.

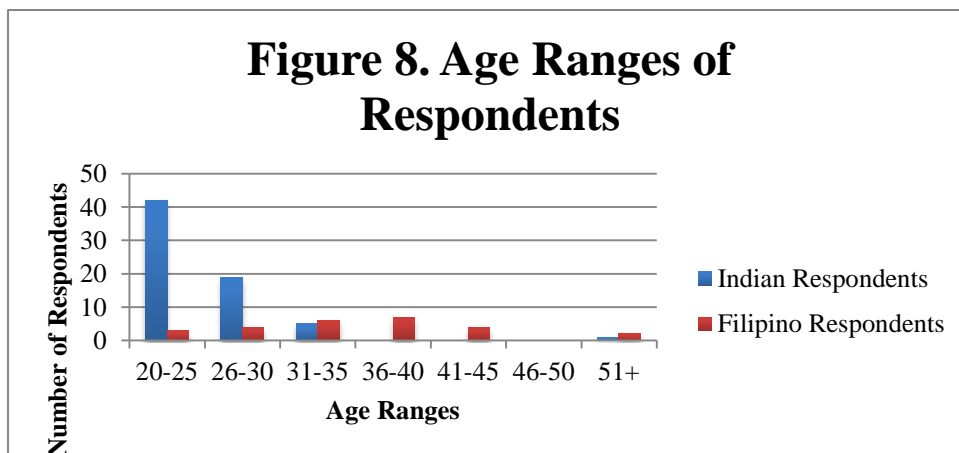
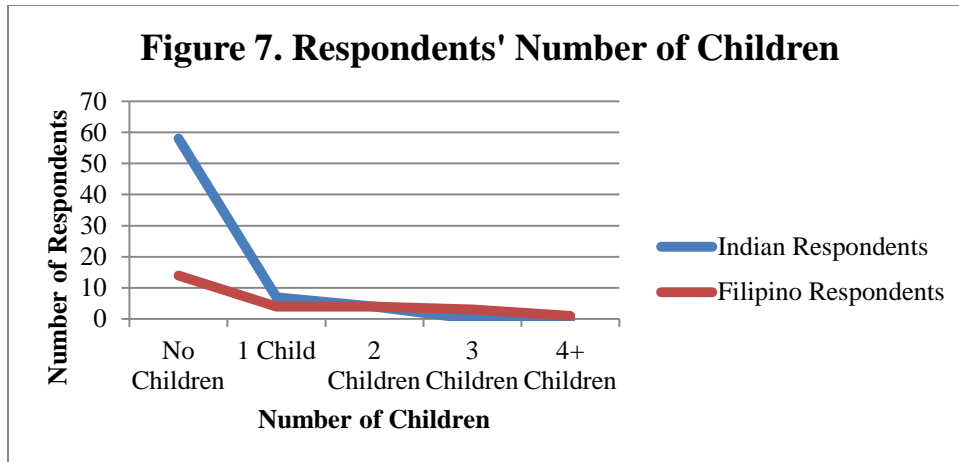
Length of time in Canada: Among Indian respondents, the average time in Canada at the time of the survey was 9.55 months (median, 5 months), whereas among Filipino respondents, the average was 19.54 months (median, 12 months).

Education: Most respondents had a BSc in nursing. Of the 70 Indian respondents, 55 had their BSc in nursing, one had a BSc in medicine as well as a BSc in surgery, and 9 held General Nursing and Midwifery Diplomas. Of the 28 Filipino respondents, 19 had a BSc in nursing. A few respondents held degrees at the master’s level; among Indian respondents, 1 held an MBA (in hospital management), and one held an MSc in nursing, and one attained a MA in nursing. Among Filipino respondents, 3 held MAs in nursing, and 1 held a Personal Support Worker Certificate (PSW).

Previous work and migration experience: The respondents from the Philippines had, on average, more work experience than those from India, with an average of 4.4 years compared to 2.4 for the Indian sample. Moreover Filipino respondents were much more likely than their

Indian counterparts to have worked in, and entered Canada from, a third country. 69 Indian respondents came to Canada directly from India, while the one remaining Indian respondent reported having worked in Australia previous to coming to Canada. 19 Filipino respondents came from the Philippines into Canada, five came from Saudi Arabia first, and one from each of the following: United Arab Emirates, Taiwan, Hong Kong and Singapore.

Children: Most of the Indian respondents did not have children at home (58 of the 70), whereas almost half of the Filipino respondents did (12 of the 28). This is probably caused by age differentials between the groups. Indian respondents were significantly younger (concentrated in the 20-30 age range) than their Filipino counterparts (who tended to be clustered in the 30+ range) (see Figure 8). The older the respondents, the more likely they were to have children.²¹



²¹ With regard to the Indian group, two respondents specified that their children lived back home in India, and 8 specified that children lived in Canada.

Gender and class position: Male nurses were fairly well represented in this sample, at 34.4% and 65.6% female. We asked respondents whether they had a family member in nursing as a proxy to determine if nursing was a new career option for those interviewed (in part through the opportunity it offers for international migration), or a continuation of family norms. 35 of the 98 respondents (36%) had a family member in the nursing profession, either a mother, sibling, aunt, or cousin. Respondents from India were more likely to have more than one family member (sibling, mother, aunt, or cousin) working in nursing than their Filipino counterparts.

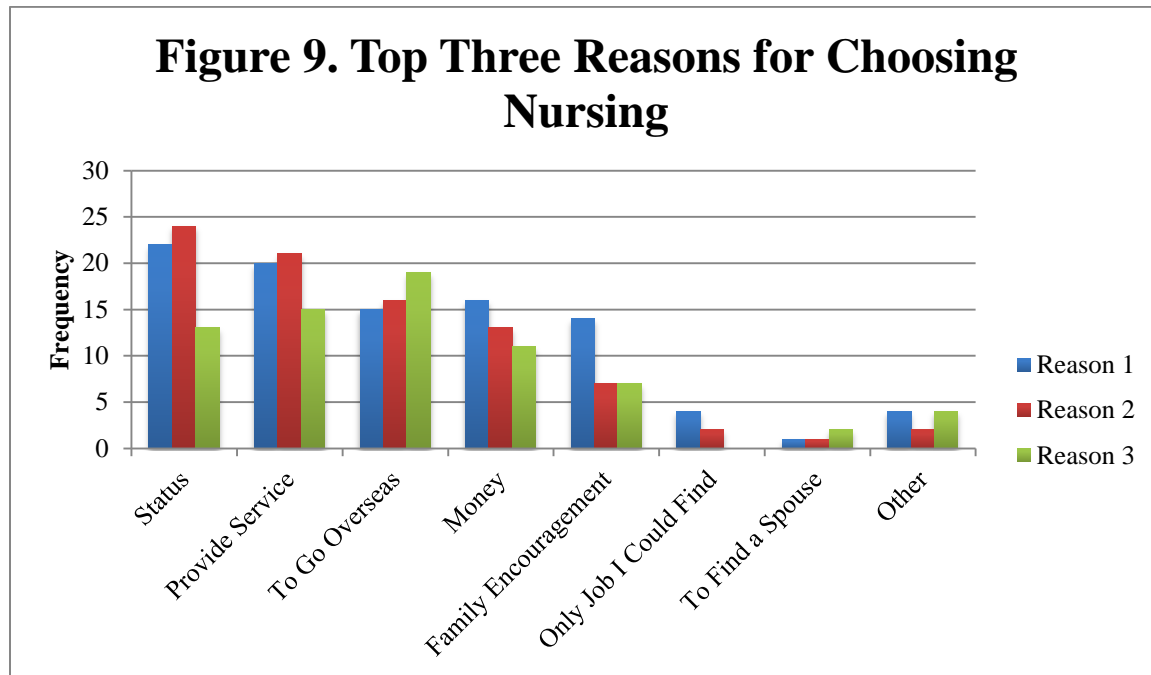
Marital Status: The respondents from India were mostly single 72.9% (n=51), 21.4% (n=15) were married and the remaining two were engaged. By contrast, the respondents from the Philippines were split more equally between single and married: 50% of respondents (n=14) were single; 42.9% (n=12) were married and a small portion were divorced. Of the 31 out of 98 respondents who were married or engaged, 54.8% (n=17) of respondents' spouses also lived in Canada. 9.7% (n=3) of respondents from India had spouses who lived in India, 16.1% (n=5) of respondents from the Philippines had spouses in the Philippines, 12.9% (n=4) lived in other countries and 2 respondents did not indicate in which country their spouse resided.

Intended migration pathways: On the subject of remaining temporarily or permanently in Canada, 56 out of 98 respondents indicated their intentions of remaining in Canada permanently. While respondents from both India (49 %) and the Philippines (79 %) were most likely to state a preference for living permanently in Canada (n=34, n=22, respectively), more respondents from India (42.0%) were undecided than their Filipino (21%) counterparts, (n=30, n=6, respectively).

Table .3 Respondents Who Intend to Remain in Canada Permanently

	India	%	Philippines	%
Yes	34	49%	22	79%
No	6	9%	0	0%
Undecided	30	42%	6	21%
Total	70	100%	28	100%

Choosing Nursing as a Profession:



Professional motivation: We asked respondents about their reasons for entering the nursing profession in part to explore the intersection of nursing with the growth of overseas opportunities and international migration. The literature is clear that nursing in western nations is attractive because of the increased salary, better status and more opportunities for advancement (Buchan et al., 2003, Connell, 2008). These factors ranked highly with respondents, including the explicit decision to enter nursing in order to emigrate overseas. The issue of providing service was still cited as important, despite the routes that nursing provides to live overseas. The importance of family input with regard to entering the nursing profession also indicates the nature of decision making being placed with the family, rather than individual decision making.

Financial support: We asked the international student sample to indicate how they had managed the costs of the program in which they were registered (not all respondents chose to answer). The majority of the students indicated that they borrowed in excess of 60% of the funds needed to live and study in Canada.

Table 4: Percent of Funds borrowed (international student sample only).

Percent of costs borrowed	n	%
0-15%	10	19.61%
16-30%	4	7.84%
31-45%	6	11.76%
46-60%	5	9.80%
61%+	26	50.98%
Total	51	100%

Conclusion

The preliminary findings provided in this paper indicate that the migration pathways for IENs are both complicated and diverse. This complexity may mean delays for entry into the nursing profession for some, particularly in the case of those entering through the LCP, but also for international students who need to complete their studies and fulfill requirements to practice nursing. This delay can also impact the families of these migrants as they may experience separation from children and spouses while they fulfill these requirements and wait for the application process. This is particularly the case for LCPs who do not typically have access to visitors' visas or work permits for family members. Also, since the majority of LCPs have children, this has a significant impact on families, with long-term consequences for integration as they deal with the emotional and financial impacts of this separation.

Additionally, this complexity also opens the door to greater propensity for exploitation and abuse from employers, recruiters, and others who might profit from these migrants while they attempt to navigate the system or complete eligibility requirements. In the case of LCPs, many will stay with undesirable or abusive employers so that they can complete the numbers of hours needed to qualify for permanent residency. These and other vulnerabilities to abuse and exploitation, as well as the deskilling of LCPs, have been well documented (see: Pratt, 2003). Yet, for these migrants, the pathway to permanency is relatively dependable, compared to the smaller proportion of students who have gained access to permanent residency. For IENs entering as international students the risks of not getting permanent residency are greater, and the emotional and financial costs may also be high, particularly since, as our research has shown, many borrow the majority of funds in order to help pay visa, tuition and immigration fees.

Despite these risks, it appears that the first cohort of the Indian sample of IENs coming through Conestoga College's program had a fairly successful pass rate in the College of Nurses of Ontario exam (71% for the first cohort of 14 who wrote the registration exam in 2011). For those who passed the registration exam, they then faced the challenge of getting their one-year work visa in order to then find a job. For this group preliminary reports suggest that they had to content with inconsistencies between the CNO's reading of a one-year post graduate visa as not being considered "proof of Canadian Citizenship, permanent resident status, or authorization under the Immigration and Refugee Protection Act (Canada)" as demanded by CNO requirements (see Figure 5). This suggests a discrepancy between CNO and CIC with regard to international student programs that are intended to create a coherent pathway from education to relevant labour market entry.²² These visa inconsistencies may eventually be worked out, but this sample's experience does indicate the complexities they will face in the process of visa conversion as they attempt to enter a highly regulated sector of the labour force.

Thus, both indirect pathways into Canada involve significant risk, delay permanent residency while work and/or study requirements are being fulfilled, and in some cases deter entry into the nursing profession. That being said, as current trends indicate, the development and promotion of the CEC and the continued access to permanent residency through the LCP will most certainly lead to greater numbers of IENs choosing this two-step approach in their endeavours to enter Canada and the nursing profession. Initial data indicate that Indian and Philippine migrants are using different channels to enter Canada: Indian immigrants have recently taken up the TFW and international student opportunities in categories that permit application to permanent residency through NOC O, A and B, while Philippine migrants continue to utilize the well-established routes of the LCP, as well as other opportunities that may not have such clear pathways to permanency.

How these routes have been structurally orchestrated by sending and receiving states has not been fully addressed in this paper, but it is obviously an important area of further research that contextualises international nurse migration. Clearly, both pathways (LCP and international student) involve stepping into the global care chain, though points of entry will have significant consequences for their mobility and eventual placement within the social and economic hierarchy of carework in Canada.

²² Based on personal communication with faculty at Conestoga College March 2012.

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CERIS – THE ONTARIO METROPOLIS CENTRE

Creating and sharing knowledge on the lives of immigrants and the policies that affect them

Who we are

Established in 1996, CERIS – The Ontario Metropolis Centre is a research network focusing on the resettlement and integration of immigrants and refugees in Ontario. We engage in comparative research, knowledge transfer, and policy development, and we work in a collaborative partnership that includes universities, community organisations and different levels of government. For our first sixteen years, we were funded by the Social Sciences and Humanities Research Council of Canada (SSHRC) and a consortium of 14 federal departments and agencies.

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CERIS trains a new generation of immigration scholars and researchers. Each year, graduate students receive funding to undertake their own research. We also provide support for students to present their work at annual conferences, local seminars, and graduate student workshops and conferences. We collaborate with our partners in the community and in government providing opportunities for them to participate in research projects and to learn more about research design and methods.

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Research has shown that immigrants and refugees coming to Ontario face increasing challenges. CERIS affiliates believe that good policy decisions flow from evidence-based research. We also believe that research must translate into action and we work to mobilise knowledge by getting it in the right hands at the right time.

Where we work

Our office is located at York University in Toronto, but our network extends across Ontario. Our research examines immigration issues in large and small cities as well as in rural areas across the province.