Health and New Zealand Health Services: A Latin American Perspective

By

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Attestation of Authorship

I hereby declare that this is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: _____

Dated: ___19th of November 2012___

For Margarita, Gala and Aroa,

With all of My Love

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Ethical approval to proceed with this thesis was granted by the Auckland University of Technology Ethics committee on 19th of June 2011.

Abstract

Introduction: The Latin American population in Auckland is small in numbers, but it has rapidly increased over the last decade. Quantitative studies regarding health needs reveal that this group of immigrants shows high rates of diabetes, asthma, and teenage pregnancy. This group is more educated than other similar immigrant groups, yet their income is reduced, and health indicators are closer to those of poor populations. There is no current qualitative information on why these phenomena could occur.

Research question: This thesis intends to answer the question, how do Spanish speaking Latin Americans, residing in the Auckland region, view health and health systems of their countries of origin and New Zealand.

Methodology: Eight participants (four men and four women) where interviewed, following narrative inquiry procedures. Participants had to be Latin American; aged 20 years or older; speak Spanish as a native language; have migrated to New Zealand between 2004 and 2010, and be resident within the Auckland region. Participants had to define health in their own words and tell personal stories involving health care usage in their country of origin and in New Zealand. A thematic analysis was performed on recurrent or relevant topics mentioned by participants.

Findings: Analysis of the participants' stories revealed that health was defined and viewed according to what participants experienced in their lives; it was also highly overlapped with trust issues. There were important differences among participants with low income (public service users) and those with high income (private service users), regardless of their country of origin.

Conclusion: This is the first qualitative study that explores Latin American individual views about health care in New Zealand, showing that they are deeply connected with participants' experiences, and their countries of origin are put into contrast against New Zealand as a reference. Future health care policies should take this into consideration when trying to reach small immigrant group populations, especially when they are vulnerable.

Immigration, Health, and Me

Since I have memory, my life has always gravitated around health and health issues. Health, as a concept, has been a very important part of my identity. I was born in a family dedicated to health: My father is a doctor, and my mother a retired nurse. My paternal grandmother was a nurse, and my maternal grandfather was a doctor. My parents worked at a rural hospital in the town where I was born (Chile Chico, located in the Chilean Patagonia, South of Chile). After my family moved to the capital, I kept visiting him at the different hospitals and private health care centres where he worked (my mother retired to raise my siblings and I). Many times, I was the patient in those hospital and clinics. I was a healthy boy, but a congenital growth disorder in my tibia required multiple surgeries in my adolescence and early adulthood. In total, I underwent five different operations to correct that abnormality (between the ages 11and 27). As a consequence, from a patient perspective, I became very familiar with how public and private facilities in my country worked. I was able to experience the abysmal differences between the private and the public sector regarding waiting periods, service quality, infrastructure deficiencies, costs, hygiene, and quality of the treatment (specifically, that the private sector had always better service, the only advantage of the public sector that it was cheaper).

After much deliberation I decided to study psychology, although it was very clear for me that I would not study clinical psychology; rather I would specialise in the industrial side of my profession. The irony is that I ended up working as an industrial psychologist in a public hospital, managing the area of Recruitment and Selection for Human Resources. This experience allowed me to know yet another side of the health system: that of the employees, unions, guilds, budgets, bureaucracy, and boards. I learned first-hand why some things work and others do not seem to do as well. During my employment, my interest regarding health care management increased, in particular the realisation that this area was mostly unexplored in my country, and that it had many possibilities for improvement. Public Health, in particular, seemed to be a new area of study.

I came to New Zealand in 2009, joining my wife after she won a scholarship from the Chilean government to study for a Ph.D. degree at the University of Auckland. This gave me the opportunity to initiate my studies at Auckland University of Technology, with

a diploma in Public Health, and then a Masters in Public Health. Being a Latin American immigrant in New Zealand, this study reflects many of my own ideas and experiences; I identified with many of the interviewees. For instance, my experience with New Zealanders has been quite positive; I was well received by many of them, being invited to their households and to share some of their activities. It also amazed me the range of green areas, parks, and free recreation available in Auckland, especially for a student couple with a limited income.

My experience with the health system, on the other hand, has been more bittersweet. Although we were planning to have a baby (and pay for the delivery, if that happened in New Zealand), when we realised that we were expecting twins, we had to make the decision to change our original plans and return early to our country, since the New Zealand government does not cover the birth of babies of people with a student visa, nor is it covered by our mandatory insurance. We had saved enough to have a single baby, but a multiple pregnancy was not foreseen, and would increase the risk of an early delivery, the use of incubators or other necessary items resulting in costs that would duplicate our original estimates. This came to us as a shock, but there was nothing we could do. Although the midwifery service was dedicated and helpful, there was not any way to bypass any of those costs.

The experiences made me realise the fragility of immigrants dealing with issues as delicate and essential as health. Many times, general results, often from large groups of people, such as the case of epidemiology and statistics, are provided; yet, by not observing inner thoughts or personal stories, we are restrained from the change of feel empathy and *feel* with the other. I became convinced that my thesis should involve the concepts of 'health' and 'person' simultaneously, and that the best way to reach to both was through hearing the stories of others; particularly, Latin Americans living in Auckland.

1. **Introduction**

Migration is a phenomenon that has been globally increasing over the last decades. New Zealand is no exception, and since 2000, has seen a rapid increase in the Latin American population. Though the Latin American population is still limited, it may increase significantly over the next few years, as has been the case in other developed economies. Thus, however small, Latin American migration has brought certain consequences to the New Zealand society in general, and for individuals and their families in particular. One such area where changes are noticeable is in individuals' perceptions of health and health beliefs.

The purpose of this study is to explore the perceptions of Spanish-speaking Latin Americans regarding health and health systems in both New Zealand and their countries of origin. The aim is to elicit deeper understanding of those Latin American immigrants' health background, as well as the similarities and differences between each other and the rest of the population. In other words, to analyse Latin American's meaning of health and health care following their migration process and the contrast between cultures, from the point of view of their personal stories and memories.

This study is important because of the lack of qualitative research in this specific area. Quantitative studies regarding Latin Americans in Auckland have only been able to speculate motivations and attitudes preceding certain general behaviours in relation to health care practice. This study aims to recognise some of those behaviours and underpinning personal biographic background. Thus, a narrative inquiry, involving personal interviews with eight Spanish speaking Latin American Auckland residents, was employed. A constructivist approach was considered used for analysis.

This research is divided into 7 chapters. In this chapter, I will discuss the importance of this study; then, conceptualise the research question of this research. Next I will summarise key concepts (Spanish speaking Latin Americans; immigration; immigration history in New Zealand and Latin American immigrants; health care; health care system, and health needs); before finally briefly discussing narrative inquiry.

1.1. **Importance of the Study**

The New Zealand government classifies the Latin American ethnic group with the African and Middle East communities (MELAA or Middle Eastern, Latin American and African group), since these three minorities represent a population too small to be statistically measured separately. However, the government is aware that these three groups are culturally very different; each one has diverse needs, religions, cultural beliefs and health outcomes. Even within each group there are numerous ethnicities[1], a fact that makes it difficult to address them as a whole. Perumal (2010) focused on the MELAA population in the Auckland region and concluded the following, regarding their health status.

First, Latin Americans have a comparatively higher rate for standardised mortality (mostly from chronic diseases), compared to other groups, but also the lowest rate for potentially avoidable mortality (Perumal, 2010). When dealing with health needs, the study detected specific uncovered areas in this group regarding sex education, family planning, asthma education, improvement of cervical screening in women, and better monitoring on diabetes (Perumal, 2010).

Secondly, the New Zealand medical system covers, in many ways, the health needs and demands of the MELAA population. Health services in New Zealand are divided into four types:

1. Primary health care services: provide basic services (i.e. not specialities). They are the most frequently visited and less complex services; meaning they usually involve only one doctor, a nurse and a receptionist, but in many cases, they involve other practitioners and services.

2. Public health services: provide the population with health protection services (water, sanitation, food, etc.), health promotion, prevention, immunisation and education. They are proactive in their approach to people and take initiative in their actions, instead of receiving patients.

3. Secondary and tertiary health care systems: include hospital, mental, and specialists medical and surgical services. Secondary care involves specialist and surgeons

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[1] Spanish-speaking Latin America was colonised by Spaniards between the 15th and 19th century, which produced a high mixture of different indigenous and European cultures, as well as African, since they were brought to America as slaves at that time.

providing ambulatory care. Tertiary care involves longer term surgery and hospitalisation. They are administered by district health boards and are mostly publicly administered, although there are community and private clinics too.

4. Social care: supports those members of society that may be disadvantaged or require greater daily attention to their health care. Includes some mental health services, disability support systems, care of older people, and strengthening families (French, Old, & Healy, 2001).

There has been considerable growth of the Latin American population in New Zealand since early 2000s (Perumal, 2010). This might be due to the fact that New Zealand migration policies have adopted a skill-oriented approach and New Zealand's stability and life quality presents itself as attractive to migrants that possess those skills. However, Latin American groups are still considered a small minority, and their personal experiences and motivations remain unexplored by organisations, even when there is specific information regarding their general health status. Social determinants become key issues to predict and address their needs, especially regarding their cultural background. Official information regarding the health of Latin American residents in Auckland has been provided in a quantitative format (Perumal, 2010), which describes general behaviour, but not motivations and psychosocial factors that might explain the differences both inside this group and contrasted to others. Causes were only hypothesised, but with no conclusive answers. There is, currently, at least one study involving Latin Americans in Auckland (Dürr, 2011); however, the focus was not on health; rather, the participants' experiences of integrating into New Zealand society. On the other hand, participants in that research were long-term residents, having migrated many years ago, which would miss all the changes Latin American health has undergone over the last decades.

In addition, aside from health research being primarily quantitative, including Latin Americans as part of the MELAA grouping is a limitation because, as much as it is understandable from a statistical point of view (since none of these groups is large enough to be measured as a unit); such grouping will not improve knowledge of a particular population. This is because each of the three groups is so culturally and socially diverse, it will not address the complexities of each one of them. Thus research is needed that

addresses each group's particular features, essentially focusing on their cultural and social context, and aiming to address their needs in a more personal way. It can provide a background that would eventually help build a more socially sensitive system and more efficient in terms of delivering services to the population, not only for them, but also for other small migrant communities, as well as future settlers.

The purpose of this study is to specifically elicit the experiences of members of the Spanish speaking Latin American community, to hear their personal stories and beliefs regarding their health. Furthermore, this study will help shed light on current understandings of a particular population.

1.2. **Research Question**

The question that I sought to address in this study is: How do Spanish speaking Latin Americans, residing in the Auckland region, view health and health systems of their countries of origin and New Zealand? To answer this question, the following aspects will be addressed:

1. How do Spanish speaking Latin Americans perceive and define health?
2. What is their experience when dealing with their country of origin's health system?
3. What is their experience when dealing with New Zealand health system?

1.3. **Key Concepts**

This study uses specific concepts such as Spanish speaking Latin Americans, migration, health, health beliefs, and health system. These concepts can be defined in more than one way; thus, to ensure that they are universally understood, they must be defined according to certain parameters; otherwise, the reader may make assumptions or conclusions that are not necessarily congruent in the context of this study. For this reason, these concepts will be defined according to the meaning I attributed to them during my research. This does not mean that my definitions are the 'correct' ones; it only means that those were the definitions I used for my analysis and that they are bound by this understanding.

1.3.1. *Spanish-speaking Latin American*

A Spanish Speaking Latin American is a person raised in a country or territory in Latin America[2], who speaks Spanish as a native language (or is the only language he/she speaks). Spanish speaking immigrants raised in other regions (e.g. U.S.A.) will not be considered for this study, since they may come from different social and economic backgrounds in their country of origin, even if they maintain the same cultural roots.

1.3.2. *Migration and immigration*

Migration is the movement of an individual or a group from his/her place of origin to a new country (Gadamer, 1995; International Organisation for Migration, 2011a); in this study, specifically from any country or territory in Spanish-speaking Latin America to New Zealand. Migration is considered one of the most important global issues of the 21st century shaping economies, environment and politics. Currently, one in 35 people on earth is a migrant, a proportion that is steadily increasing (International Organisation for Migration, 2011b). Although migrants are highly influenced by the economic and political context that surround them, these factors alone cannot explain the process of migration (Masey, 1994). A combination of receiving and sending factors (political, economic, religious, topological, climatic, environmental), combined with individual or group characteristics (economic necessities, life-cycle, family, perception of safety, political or legal issues) shape a response in people, perceiving a benefit (or a decrease in damage) in moving to a different place, at least greater than the perceived risk of staying in the same place (Greenwood, 2006). In Sassen's (1999) words, "international migrations stand at the intersection of a number of economic and geopolitical processes that link the countries involved; they are not simply the outcome of individuals in search for better opportunities" (p. 1). Over the years, in an attempt to control such phenomenon, migration policies have globally shifted, especially in developed countries. For example, in New Zealand, policies have changed many times since colonisation by Europeans in the 19th century to current practice.

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[2] Latin America is a region encompassing the following countries and territories: Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Uruguay, or Venezuela

Immigration is the process through which members from an outside community travel to a host community. In other words, immigration is migration from the point of view of the host, instead of the migrant population (International Organisation for Migration, 2011a). In this research, the process of immigration has to be made between 2004 and 2010: immigrants have to be recent, in order to have a fresh memory of their experiences before the migration; but not too recent, in order to have at least some experience of health issues during their stay in New Zealand.

1.3.3. *Immigration in New Zealand*

Settlement of New Zealand began with different East Polynesian cultures between the 9th and 13th century, importing their tropical economy and eventually becoming the Māori culture (Walter, Jacomb, & Bowron-Muth, 2010). This 'culture' was far from homogenous, and many conflicts persisted among the many tribes, especially because of the scarce availability of resources (Biggs, 1990).

The first European contact with the territory started in 1642, when Abel Tasman discovered New Zealand, and later, when James Cook discovered the islands in 1772. From that point, New Zealand began a process of settlement and colonisation by the British Empire, with the subsequent cultural and economic trade between settlers and Māori, and conflict. Years of conflict and negotiation between both parts, led to the signing of the Treaty of Waitangi in 1840, where the British Crown and the Māori people agreed on the rights and limitations to govern and develop British settlement from the part of the Empire, and to guarantee Māori rights as citizens. This did not, however, resolve disputes, and the interpretation of this treaty is rather conflicted. So, New Zealand is a territory very recently colonised, and all its inhabitants can be considered to be descendants of migrants, even among the native populations.

Since its beginnings as colony and then a member of the Common Wealth, New Zealand migration policies have appeared to be labour-and-demand oriented (Ongley & Pearson, 1995). By the end of the 19th century in the early 20th century, discriminatory policies regarding race were practiced (Ward & Masgoret, 2008); for instance, negative attitudes towards Asian migrants were enforced by legislation, such as a poll tax in 1881, and the 'blanket permit system' in 1920, in order to discourage the immigration of non-

Caucasians (requiring only them to have a special permit to enter the country) (Brooking & Rabel, 1995; Ip & Pang, 2005; Wah, 2002). Xenophobic attitudes persisted during the first half of the 20th century (including both post-war periods). Even though immigration was needed to improve productivity in the country; the huge diversification of immigrants the second half of the 20th century just was a consequence of the high demand of labour (Winkelmann, 1999).

By the 1970s, New Zealand's migration rates, in contrast with other similar countries, such as Australia, were very low. Negative attitudes towards immigrants persisted (much of the blame of the then current economic crisis and unemployment was placed into them) (Ongley & Pearson, 1995), but were starting to change. The government softened its policies, hoping to decrease discrimination based on ethnicity. Major changes were implemented in this period. The reasons were economic (after a long period of stagnation, the country was rapidly recovering) and cultural (recent events, such as the Vietnam War and the increasing unpopularity of South Africa's apartheid, increased a questioning of the status quo and the once general acceptance of the 'British superiority') (Brooking & Rabel, 1995). New Zealand had experienced unprecedented low unemployment and needed high skilled labour. As a result, immigration was subsidised (Winkelmann, 1999), employment and housing for immigrants became major concerns as part of a location strategy, following industrial needs (Brooking & Rabel, 1995; Colman & Kirk, 1974), and some de facto Pacific islanders residents received amnesty for their irregular status (Winkelmann, 1999). Then, for a time, no significant changes were made to migration policies; although New Zealand was gradually starting to accept racial, social and cultural diversity, in reality, immigration was still perceived with distrust from an important part of the population, and governments were not forced to make substantial changes.

Policy changed considerably in 1987, when the Immigration Act was signed. The major concern for that Act was to select people based on merit, rather than origins, which presented a new array of opportunities for immigrants coming from non-European and non-protestant societies. A system of points was designed, awarded according to qualification and experience (Winkelmann, 1999) and highly qualified professionals, especially from the developing world were encouraged to migrate to New Zealand, where their perceived income and life quality could be higher than their places of origin. In addition, the

government would stop criminally prosecuting illegal status immigrants, which made their situation more bearable and explicit (Wearing, 1993). In practice, it also meant that controls were tighter, as a response to the larger economic problems the country was facing at that time (Ongley & Pearson, 1995). This policy was reinforced in 1990 and 1991, when the criteria for selection became more specific (Brooking & Rabel, 1995; Nayar, 2009; Winkelmann, 1999). This system seems to have become fairer and more standardised (one of the most skilled-based in the developed world) (Glass, 2004). It was a new departure from the exclusive labour-market-oriented policy, creating niches for high-skilled and entrepreneur migrants (Ongley & Pearson, 1995). However, this system has not been without its problems, especially concerning immigrant integration with the society. Unemployment and underemployment, for instance, seem to be more common in immigrant groups, even though they are highly qualified, given the requirements demanded (Glass, 2004).

Recently, the government has started a new debate, in order to revise, again, the migration policies, focusing on the opportunities immigrants can bring to the population (Department of Labour, 2006). This, together with the New Zealand Settlement Strategy (Department of Labour, 2005, 2007), proves that the government is explicitly trying to see immigration in a positive light and to actively include and settle immigrants in New Zealand society. Although this policy has become less permissive in the last few years, it can be stated that New Zealand is a pro-immigration country.

It is possible that these policies might have changed over the years because of the increasing number of immigrants and descendants of immigrants in New Zealand. Studies (Ward & Masgoret, 2008) have shown that New Zealanders tend to have a positive and non threatening attitude to immigrants, especially compared to similar developed countries, such as Australia, England or United States. These features, together with stability, high incomes, education and benefits (e.g. working holiday schemes with Chile since 2001, and Brazil and Argentina since 2006), have made New Zealand an attractive place to migrate for Latin Americans (French et al., 2001; Perumal, 2010). That said, a bias towards Europeans in general, and British in particular, can still be perceived in practice regarding government policies(Winkelmann, 1999), and high English test results are still a major barrier to an entry to qualified labour marked.

1.3.4. *Immigration and Latin Americans*

The Latin American community has been present in New Zealand since the 19th century, as a consequence of the gold fever. However, it was a very limited population; only 80 Brazilian, Chilean and Peruvian were reported in 1874 (Perumal, 2010), and no more than 200 Latin Americans were living in Auckland during the First World War (Dürr, 2011). The population only increased in the 1970s, after many Chileans escaped from Augusto Pinochet's regime; this was not exclusive for Chileans, many Latin Americans sought refuge in other countries after most of their governments were ruled by dictatorships in the 1970s and 1980s. Some of them, a very small group, arrived in New Zealand (Morton, 2007). In the year 2000, the population of Brazilians has surpassed the Chilean population, mostly because of working holiday programmes. This is not exclusive of Brazil and Chile; the New Zealand government has also a working holiday agreement with Argentina, and is considering other countries. Since their application, the Latin American population is continuously growing at high rates (Perumal, 2010).

After Brazilians (579), Chileans (438), and Argentineans (216), there are smaller populations of Latin American residents: Peruvians, Mexicans, Colombians, Bolivians, Puerto Ricans and Uruguayans also present; each one of their populations is, in numbers, less than 200. There are even smaller populations, of approximately 20 individuals or less, representing Venezuela, Guyana, Guatemala, Honduras and Costa Rica (Perumal, 2010).

Latin Americans immigrants in New Zealand are, in general, highly educated (only 6% have no qualification, and 50% have post school qualification), but their perceived income is low, compared to other groups, especially Europeans (Perumal, 2010).

1.3.5. *Health*

Health is a complex construct that depends on a particular cultural, political, social, emotional, and historical context. According to the World Health Organisation (WHO), there are many plausible and accepted definitions of health, the first one, being "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 2006, p. 1). Health is established as a human right and an objective to be pursued for all nations and states. This definition, however, is not absent of criticism.

Advocates for he wellness model, for instance, critique this definition, in that it overemphasizes disease, and that it should be more focused on the positive dimensions, such as well-being, efficiency, energy, and productivity, and that personal feelings are much more important in the outcomes than they are credited. (Larson, 1999). Other issues criticized in this model are lack of consensus; dichotomisation and ambiguity when defining health terms; arbitrary priorities of some aspects over others, and, overall, its over theoretical and reductionist qualities (Breslow, 1972; Garner, 1979; Larson, 1999).

Whether these accusations are justified or not is a matter of debate. What is evident is that there is not a universally accepted or a 'correct' definition of health. It is not the purpose of this study to adhere to an a priori definition of the construct, since it should arise from the participants' point of view. Only this broader definition of health will be initially used, since it has been agreed by a majority of the global sovereign nations, and therefore, by different cultures. This constructivist approach has been criticised for its relativism, since its lack of frame allows an infinity of concepts and approaches, making any definition easy to question it and hard to achieve (Ong, 1996). To reduce this relativism, individual views will try to be joined in their similarities and from that starting point, differences will be addressed to express the richness and variety of those who defined them.

1.3.6. *Health care system*

In this current study, a health care system is defined as an organisation (planned or improvised) designed to meet the health needs of a particular population (Liverpool-ha, 2011).

1.3.6.1. Health needs

A health need can be defined as any individual, communitarian and/or social health determinant that requires to be specifically addressed in order to improve the health status of that individual, community and/or society. When a lack of positive health attributes, or an excess of negative ones, or a combination between both is presented, then a resolution of this particular combination of factors is proposed. That would be the operationalisation of a particular health need. Thus, a health need is not presented as a problem, but as a visualisation on how to resolve that problem (Rose, 2009). A health need can be felt

(individuals notice that their health needs to improve), expressed (individuals are actively pursuing an improvement in their health), normative (professionals determine the required standard to consider health to be improved), and comparative (two or more needs are contrasted in specific terms, such as priority, severity, cost, etc.) (Bradshaw, 1972; Rose, 2009).

A health need assessment is the active detection of health needs from a particular methodological perspective. There are two conceptual frameworks on how to address health needs: the first is the community-as-partner model, which assumes that a community system works as a mutually influential interaction among its core (the members of that community) and its subsystems (economical, educational, political, environmental, etc.), a fact that requires any assessment to be made at its core, reviewing its service providers. The second one is the ecologic model, which proposes that health is being influenced by the environment, and that detecting those influences is essential to determine any particular need (Nardi & Petr, 2003; Rose, 2009).

1.4. **Narrative Inquiry**

For the purposes of this research, a narrative inquiry has been utilised. A narrative inquiry is "the study of experience" (Clandinin, 2007, p. xiv). Thus, personal experience can be studied as a phenomenon by itself, wherein this 'experience' may be defined as the contents of a certain story, and/or the way this story is being told. It provides a broad and flexible methodology, rather than a specific or rigid technique, which allows the participants' stories to be the core of the research, with the researcher acting as a catalyser for the stories to be expressed (Stanley, 2008). A fundamental tool for narrative inquiry is the personal interview, which was the method of information collection for this research.

A narrative analysis is the process of induction and interpretation of the collected stories in a narrative inquiry. This is inevitably a personal interpretation, since participants and researcher are subjective beings. Hence, it is a process of "shaping" and "making sense" of understandings. It does not aim for objectivity, but for an approximation to the other and his/her view of the world (Josselson, 1995). Narrated individual stories are located in a broader context, making them interact with each other, constructing a "meta-

narrative interpretational overview" (Stanley, 2008, p. 436) that transcends the experience and translates it into a phenomenon.

In this research, analysis was focused on the personal stories told by eight adult Latin American immigrants living at the Auckland region, regard health and health systems in New Zealand and Latin America. A constructivist approach was used in order to facilitate the creation of concepts and analysis defined in the terms of the proper participants, rather than my own preconceptions (although these preconceptions will be explicit, since a constructivism inserts the researcher in the context of the research, in a horizontal or equal perspective). The reasons for choosing both narrative analysis and constructivist approach will be discussed in Chapter 3: Research methodology and methods.

1.5.   **Personal Interest**

This research is particularly important for me, not only as a researcher, but also as a Latin American immigrant in New Zealand. As a member of this community, I cannot isolate myself from my own cultural background: emotional and cultural issues arose during the interviewing and analysis process. Far from denying those issues, the most honest way to deal with them was to acknowledge and express them whenever I felt they were influencing parts of the research, in order to simultaneously construct a view of the world as yet another participant. My social sciences background (specifically psychology) was helpful as a tool to inquire about this subject, but I also acknowledge that it may be a limitation, since any professional formation inevitably includes certain biases that are not easy to overcome. Rather, I think it is important to contemplate the possibility that no background will make me completely free of bias and that the only way to combat it is to acknowledge that any point of view is personal at its best, and only works within this particular context. Any attempt to generalise the results presented here will only work in a hypothetical point of view and the research objectives only aims to raise discussions and attitudes regarding this perceived reality. There is no 'right' or 'wrong' way to see this reality.

1.6. **Overview of the Thesis**

This study will be focused on a group that shares and is joined by certain similarities that separates them from the rest of the population. However, I feel much more intrigued in the differences of their opinions, and how they shape their view of health in rather similar situations. The richness of experiences and thoughts are what makes us different (not only in this particular group, but in general). Those subtleties constitute the main interest of my research. After all, cases as theirs (and mine) however unique, are not unlikely to be similar to others, and in my opinion, a comprehensive health care system must be effective and efficient to deal with population, and needs to be prepared to have an open mind to 'abnormalities' and 'uniqueness'. In other words, and rather paradoxically, a holistic health care system must be prepared to be surprised. I think that we, as individuals, should too.

Chapter 1 has introduced the study to the reader; briefly defined the key concepts; introduced the kind of analysis utilised; declared my personal interest and opinions; and justified the need for this study. Chapter 2 reviews the literature regarding the studied subjects, including the phenomena of migration, identity, and Latin American culture. Chapter 3 explains the methodology used for this study and its philosophical approach, including methods and ethical implications. Chapter 4 will show the research findings, according to the interview: participants' lives will be summarised and their general health views explored. Chapter 5 will discuss the interviews, according to the research questions. Finally, Chapter 6 will summarise the conclusions, limitations of this study, and makes recommendations for future research.

2. Literature Review

A literature review is necessary to situate the reader in the context of information available regarding certain phenomena that will be essential in understanding its background and implications. This chapter will be divided into two sections:

1. discussion of health care, health beliefs, and identity, in relation to the Latin American culture; and

2. review of previous studies, addressing Latin Americans' interaction with health systems.

2.1. Health Care, Health Beliefs and Identity

2.1.1. *Health Care*

Health care is the way in which a population's health needs are being addressed. A health care system focuses on a population and its perceived needs, and tries to resolve those needs with the resources available in order to improve the performance of the system and the population's health. (Liverpool-ha, 2011). Health care is provided by those who have specialist training; these health professionals have specific responsibilities towards the general population, since health is considered to be a human right.

From the positivist scientific (medical) perspective, health care must respond to eight premises

1. Have a humanitarian purpose (to improve human beings life).
2. Be scientifically rational (evidence-based and rigorous).
3. Be as objective and measurable as possible (variables should be able to be isolated).
4. Emphasise physiochemical data over other sources of evidence.
5. Separate mind (psychogenic) from body (psychosomatic) symptoms, emphasising the latter.
6. View 'disease' as an entity distinguishable from others.
7. Be reductionist, in order to isolate variables that might make 'noise' when dealing with results.

8. Emphasise individual, rather than social, care. Focus on 'curing', rather than 'caring' (Helman, 2007).

As positivist as this model might sound, in practice, each doctor adapts it to his/her particular context, and many times doctors will use contradicting models when dealing with different patients, possibly proving that there is not an obvious 'correct' solution for health needs. Rather, health care is not an exact science and it depends enormously on a particular context. Moreover, health care it is not limited to a giver-taker phenomenon; rather, it is a transaction between both parties that generates a change in the status of the patient (and also the professional) as a result.

From the point of view of the health care giver, models tend to focus on five issues: a) aetiology, b) onset of symptoms, c) pathophysiology, d) course of the disorder or illness, and e) treatment. Health care follows an often tacit path for dealing with the patient, and although it aims for objectivity, it is not free of error and contradictions (Kleinman, Eisenberg, & Good, 2006).

On the other hand, populations are rarely passive entities; the recognition of the majority of health problems tends to happen, firstly, outside the health care system. People, in general, seek comfort and improvement of their health and, in many cases, they will not use the official system to solve those issues, instead opting for self-treatment, family care, religious support and/or unofficial 'healers'. The reason for this gap between need and care may be explained because of the different approaches from both sides of the system. While professionals treat 'sickness' or 'disease' (a scientifically measurable pathology), patients tend to suffer 'illness' (a state of discomfort and/or pain) (Kleinman et al., 2006); hence, there is a contraposition between a 'rational' answer to a 'personal' or 'emotional' need (dealing with threat, loss, significance and gain) (Kleinman et al., 2006). This topic raises many issues (some of which will be discussed later in this chapter). The first and most evident being that there is evidence that health care is not only limited to the medicinal field, it overlaps with other humanist approaches such as psychology, sociology, anthropology, and philosophy. Failure to address these problems from subjectivity has been a constant criticism of western medicine, and some (Kleinman et al., 2006) propose to include both perspectives in health care. A holistic multi-level focus (qualitative) might be needed to understand a phenomenon that has many sides and that can vary according to the

groups and individuals being studied (Larson, 1999; Mays & Pope, 2000). These levels of care will be discussed in greater depth when describing health beliefs in Latin America.

2.1.2. *Health care in Latin America*

Latin America health care systems tend to be perceived, in general, as middle-level in terms of budget and effectiveness, although there are exceptions from countries with the lower levels of health (such as Bolivia) (World Health Organization, 2000). However, since Latin America is a region with various types of governments, populations and political orientation, summarising its health care policies is a challenge. Moreover, many countries in Latin America have recently changed their policies to new systems, and many of those policies are in an experimental phase. To prevent this section being overly extended, a broad mention to these systems will be made, without much emphasis in one country in particular.

2.1.2.1. Two trends

Since the middle of the 20th century, there has been a strong dichotomy between Latin American countries with a Socialist background (i.e. Cuba, Nicaragua, Venezuela) and the so-called 'Neoliberal' (i.e. Colombia, Chile) countries. While countries with a left-wing vision of health pursued a centralised gratuitous system, on the basis that healthcare is a basic human right and it should be provided to anyone, neoliberal policies pursued a de-centralised system based on private health care providers and insurances, with the idea that competition among providers will increase health care and facilities services quality. Both policies produced benefits and problems for the populations. While in countries with a public health approach health care is slow and bureaucratic, with high expenditures from the state, in countries that fomented private care, the gap between quality among the poor and the rich increased, virtually segregating the population (Homedes & Ugalde, 2005). Through the years, neoliberal policies have decreased in Latin America, while unitary public policies only remain in Cuba and, to a lesser extent, in Venezuela. In general, countries in Latin America tend to follow mixed systems, including both managed and state-based health care (Stocker, Waitzkin, & Iriart, 1999).

2.1.2.2. Recent health care reforms

From the 21st century, many countries in Latin America are moving towards reforming health care systems more similar to align with what is perceived as a welfare state in developed countries. Results as yet too premature to be evaluated in longer terms, but different levels of goals and success have been reported in some Latin American countries. Chile, for instance, after the AUGE (Explicit Warranty Universal Care) reform implementation in 2006, has full economic coverage for all patients, if they suffer one of the 69 pathologies listed as priority (Cruz Saco & Mesa-Lago, 2009); Mexico, developed the SPSS (Health Social Protection System), in 2003, which aimed to increase coverage of the poor and decrease avoidable deaths by infection, childbirth, nutrition and transmittable diseases (Frenk & Gómez-Dantés, 2010). Other countries are reforming their systems, regulating nation-wide health care, de-centralising, or considering reforms in the future (Pan American Health Organization, 2008).

2.1.3. *Health care in New Zealand*

Health care in New Zealand underwent a series of reforms in the 1990s, trying to ration and make more efficient their administration. These reforms limited government funding, and private health care increased during those years. Co-payments were introduced for both inpatient and outpatient hospital treatment in the early 1990s. Health care centres also changed their criteria for prioritisation; instead of a first-come-first-served criterion, they switched to epidemiological and evidence-based data. In addition, certain high-volume and high-cost procedures were under a clinical priority criteria of assessment of booking systems. As a result, waiting lists and costs were significantly reduced for the government. On the other hand, these measures were not well received by the population, who saw their costs increased. Many of those measures were modified or reversed at the end of the 1990s (hospital co-payments were particularly unpopular and were removed in 1997) (French et al., 2001). Today, public funded health care provides many benefits to the New Zealand population. It is, basically, pro-natalist and anti-poverty, which means that it is focused on prioritising births and the low to middle income population. Ambulatory care is free of charge to anyone eligible for public funded health services (i.e. citizenship or

residency), including a maximum co-payment of pharmaceutical goods of NZ$15 for any items included in the Pharmaceutical Schedule. There are also concession cards, created in 1992, to provide health subsides to people of low to middle incomes. There are five programmes: the community services card (provides with health subsidies to people of low income); the high use health card (provides the same services as CSC, but for people with high demand in health); the free child health scheme (health is free for children under six); the pharmaceutical subsidy card (maximum co-payment of NZ$2 per item until 20 items; after that, items are free), and maternity services (most services are free for women, who can choose their provider; the government will pay for maternity hospitals) (French et al., 2001).

The health system is mostly public and visitors with a working visa are generally covered. This system is, nevertheless, not without its flaws. Immigrants without visas do not have access to health services (except for emergency situations). There are other reported ethnic disparities regarding access, poverty and education (Hefford, Crampton, & Foley, 2005). In the specific case of Latin Americans, only 51% of their population is enrolled with Public Health Operators (PHO), although the number is rapidly increasing. This can be contrasted with a high utilisation of emergency departments compared to other immigrant groups (Perumal, 2010). In general, people with lower income have reported difficulties in dealing with health care, even when its costs are mostly covered by the government (Schoen & Doty, 2004). This might be relevant in the Latin American context, considering the lower incomes they receive as a group.

2.1.4. *Health Beliefs*

Although health has been defined by many institutions, governments and individuals, it cannot be said that it is an objective and measurable construct. Much of what health constitutes remains personal and virtually unknown to the outsider. As was previously discussed in the Health Care definition (section 2.1.1.), there is a different 'scientific' approach from the health care provision treating 'sickness', or "abnormalities in the structure and function of body organs and systems" (Kleinman et al., 2006, p. 140), with the more 'subjective' patient need, addressing 'illness', "experiences of disvalued changes in states of being and in social function" (Kleinman et al., 2006, p. 140). These two

visions do not always overlap; illness can occur with the absence of sickness and an individual may carry a disease without knowing it, and in many cases treatment does not produce the effect the patient expects.

This lack of objectivity is normally described as the "Health Beliefs Model"; that is, "the patient response to symptoms and to compliance with prescribed medical regimens" (Janz & Becker, 1984, p. 2). The focus is placed on the individual's inner perception of his/her health (or 'illness') rather than on the identification of a particular pathology or disorder. The Heath Beliefs Model hypothesises that patients' behavioural responses are the direct consequence of the value patients put to a particular goal and their beliefs and attitudes that a particular behaviour will lead them to that goal. If that goal is wellbeing, the value to pursue will be to avoid illness, and the attitude will be the thought that certain paths will lead to the avoidance or prevention of that illness (Janz & Becker, 1984). According to this model, four dimensions frame the context of health beliefs:

1. Perceived susceptibility: whether someone sees him/herself as more or less sensitive to certain conditions.

2. Perceived severity: how serious does the patient sees his/her current state. It is an evaluation of the 'normalcy' of the situation and if it is or not bearable enough.

3. Perceived benefits: the disposition to take a risk involves that this risk must to have a high probability of improving one's condition (or reducing negative results).

4. Perceived barriers: involves potential negative direct and side effects and how they situate the patient in the future, compared to the current state; in other words, the higher the risks, the less likely to follow a particular behaviour (Janz & Becker, 1984).

These beliefs are not only constructed by individuals. Illness and health represent an important part of a society and culture, and certain responses or behaviours tend to be more socially or culturally accepted. Many aspects, such as language, gender, religion and social status condition, are an expected reaction from a certain person; hence, it can be said that health beliefs are also culturally (and sub-culturally) generated (Kleinman et al., 2006). This concept of approach is not completely new: since its formation in 1947, the WHO has included this social aspect; however, social health has been consistently less addressed than

physical or mental health (Larson, 1999). As a result, health care givers and patients tend to be separated by a different 'language', each one addressing the care and needs respectively (Helman, 2007). While health care givers are more prone to follow a positivist approach, patients may perceive it from a completely different approach. This lack of communication generates a gap that diminishes the effect of health care, independently of which one is more appropriate (since each model has its advantages and weaknesses). For instance, patients following the wellness model tend to be more suspicious of medical diagnostic and treatment, and seek alternative sources. It is also more common that those being more isolated from society's benefits (education, wealth, etc.) tend to look for alternative solutions (healers, self-medication, etc.) that the official health care cannot address as well as they perceive it should (Larson, 1999), increasing the gap between both sides.

2.1.5. *Latin American Culture*

Before dealing with each participant context, it is important to contextualise certain features of the Latin American culture as a whole. It may provide a background of certain common elements (or at least they are seen as 'common' by many analysts) in order to help the reader become closer to those individuals. It could be argued that these contexts could contaminate a more objective analysis with prejudices; on the other hand, a cultural context may raise awareness of these prejudices and isolate them from the comfortable 'familiar' or 'obvious' conjectures. In any case, it is important to be aware and careful of the uses and limits of using cultural background as a tool of knowledge.

It is hard to summarise Latin America as *a* culture, since it never had only one. The term is more an interpretation of certain shared cultural ways of thinking that are more a popular convention than an anthropological or historical concept (Alarcón & Pérez-Rincón, 2010).

A common definition of Latin America comprehends all American countries originally colonised by European Western Mediterranean empires, whose languages were a mixture of 'barbaric' dialects and Latin (namely, Spanish, French, and Portuguese) (Alarcón & Pérez-Rincón, 2010). It is not an exhaustive description, since there are exceptions, for example as the south of what is now the United States of America was originally colonised by Spaniards and Frenchmen, and the French legacy in Canada is

officially recognised to this day. Those areas are not generally considered part of Latin America; it tends to be a way to differentiate the United States and Canada from the rest of the continent. On the other hand, states such as Belize, Aruba, Guyana and Suriname are occasionally described as Latin American; however, their official languages are not Latin-based (English and Dutch), and could not be accurately described as such.

Others prefer to use the term "Ibero America", to specify that the dominant languages in the region are Spanish and Portuguese (the Iberian peninsula), excluding French and other Latin-based languages (Italian and Romanian, for instance). It is a term more commonly used among Spanish scholars than in other countries. Even more specifically, the term "Hispano America" is used only for countries in America that use Spanish as their official tongue (or one of their official tongues). This term is also popular among Spaniards (Alarcón & Pérez-Rincón, 2010).

In general, it cannot be said that one term is more precise than the others, and its use might be more political than anything else. Among people from the United States, the term Latin America could be more used because it differentiates them (who call themselves "Americans") from the rest of the continent (they also use the plural form for that, "the Americas"). The fact that French Canada and the South of the United States (e.g. South California, Texas, Arizona, New Mexico) is not usually included, might be for geographical reasons (South from U.S.A.) or to separate 'developed countries' from 'third world economies'. Some Latin American scholars reject the term precisely because it looks derogatory to them. Meanwhile, Spaniards prefer one of the other terms because it denotes the importance of Spain and Portugal in the history of the area, which is the main reason why other scholars refuse to be referred as such too. This is not universal, however, and many take a sense of pride in either of those definitions (Alarcón & Pérez-Rincón, 2010).

One of the many peculiarities of the term is that it is rather unusual among non-migrants. People will refer to themselves as Latin Americans only when they are in a non Latin American country. In their homelands (and in Latin American in general) they will be Peruvians, Colombians, Mexicans, and Cubans. Only in Europe, North America or other countries will they say "us Latin Americans", acknowledging that they belong to a common culture and history (Alarcón & Pérez-Rincón, 2010). Rivalries can be ignored and people can take care of other '*Latinos*', '*Chicanos*', or '*Raza*' (race)" (Jones-Correa & Leal, 1996).

Although Latin America does not comprise one nation, state or culture, there are many similarities among its population. They can be more accentuated in some places more than others, but in general a Latin American would in general identify him/herself with those aspects. It can be said that Latin Americans share a common history, languages, cultural background, and religion.

2.1.5.1. Latin American health perceptions

Even in this globalised era, culture plays a fundamental role in how health is perceived, administrated and delivered. How each culture understands terms such as health, sickness, pain or illness is essential to how health care strategies are designed. This is clear when analysing state policies, but especially when dealing with different forms of 'traditional' or 'alternative' medicine.

In the case of Latin America, health is viewed from at least two polarised perspectives: The first one is the 'allopath' or 'western' medicine, which is scientific and reductive, and is officially accepted by all governments; the second one is the 'alternative' medicine, much more based in traditions, the spirit and cultural perceptions of health.

It is important to notice that both health conceptions do not exclude themselves. In most cases, both are seen as complementary, or are used when the other one fails. For instance, a patient with incurable cancer might seek advice from a herbalist when chemotherapy does not seem to work, or a mother will go to a paediatrician when the advice from the healing woman does not produce any change. Both forms coexist in all the population (regardless of race, social status or origin), and each has its own place, depending on the case The only difference seems to be that the more educated seek a specialist first and then a healer, and the less educated tend to do it the other way. (Ortega-Lopez, 2006).

An important figure for Latin American health is the 'healer' (he/she has many names depending on the origin, but it is usually referred as '*curandero*'). Healers perceive their mission as to help people to be both physically and spiritually healthy (mind and body are inseparable, from their point of view) (Spector, 2000). Many of the pathologies' origins are attributed to an imbalance, lack of self-confidence or faith, lack of 'good spirits' or excess of 'bad' ones, to a 'work' ('*trabajo*') of witchcraft, or '*mal de ojo*' (the 'evil eye') of

an enemy or rival. But most healers do not attribute metaphysical origins to everyday problems. Healers tend to diagnose them on rare occasions, and many of them do recommend their patients go to an allopath doctor. They, in general, do not *replace*, but *complement* medicine, and are perceived as charlatans if they behave otherwise (Ortega-Lopez, 2006). One of the most common causes attributed to unknown sources is the 'evil eye', which is some harm done by another person because of envy (Spector, 2000). This is an interesting concept, because in Latin America, progress and success is many times perceived with resentment and bitterness. People who abandon their place to find success in other cities or countries is perceived as uppity and/or a traitor. People will talk behind their backs (every culture in Latin America has a word for that), and the person will be scolded form forgetting his/her roots and/or using other (illegitimate) means than those claimed. As a result, progress is very hard in Latin American families, and people tend not to brag about their achievements, fearing envy from others.

The most important function of the healer is to give sense to a certain illness, not to diagnose. Patients want to be heard and acknowledged, and go to the healer to receive support and empathy. There is also a very spiritual relationship between healer and patient, and many religious figures are used for the therapy, both Christian and non-Christian. They incorporate many cultural elements, sometimes borrowed from traditional Eastern medicine (e.g. massages, reiki, acupuncture) or from Western's 'new age' interventions (e.g. aromatherapy, Bach flower remedies), depending on the cultural background of both healer and patient. This versatility allows them to work on every educational or social level. The can also be 'specialists' or 'generalists', depending on the time they dedicate to the activity (part-time or full-time). Although they are rewarded by their activity, it is expected for them to place more emphasis in the spiritual world than the material one (Spector, 2000).

Healers receive their 'gift' by three means: being born a healer (very common in indigenous communities), which is determined by somebody else; being an apprentice, learning from another healer, until it is determined that he/she has the qualities required; or receive a 'calling' from a vision, dream or epiphany (normally during a very traumatic event), from a religious figure, ancestor or symbol (Spector, 2000).

2.2. **Current Understandings of Latin American Health Perceptions**

The relationship between Latin Americans and health perceptions has been previously explored by many other authors, although few have done it in the New Zealand context. On the other hand, given the size of the Latin American population in the United States, and the increasing proportion of Latin Americans in the American population, there are many qualitative studies focused in their migration status, and how they cope with issues such as occupation, health, discrimination, and language. Some studies have acknowledged the paradox that first-generation Latin Americans in the U.S. have better health than other Americans, considering their income and social status, but this situation decreases in the next generation, where Latin Americans' health status is paradoxically lower than their contrast group. Some (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999; Scribner, 1996) have hypothesised that a phenomenon called 'acculturation' is the cause of this decrease, arguing that individuals tend to imitate unhealthy host habits that were not present in their original culture (e.g. junk food, smoking, dirking, sedentarism), to which they are not fully prepared. Others have critiqued this hypothesis for being centred on individualistic choices, omitting other variables, such a hostile environment. It assumes that cultural traits would be inherent to groups, devoiding them from the complexities that contribute forming that particular subculture. In a study by Viruell-Fuentes (2007), this idea was put to test through interviews with 40 female Mexican immigrants in Southwest Detroit. Half of them were first-generation, and the other half was composed of American citizens who were either born of Mexican immigrants in the U.S., or who migrated to U.S. before the age of 12. The study concluded that second-generation women reported more often experiences of "othering". That is, the perception of being treated differently (humiliatingly, aggressively or ignored) by other groups, for traits perceived from their ethnicity. This was more common in the second-generation group, since they had to interact more frequently with members outside their community, while members of the first-generation group were more isolated and persisted in living similarly to their country of origin (keeping costumes, language, etc.). Experiences in the second-generation group were often recalled with negative feelings, such as anxiety, fear, sadness, or impotence. The author concluded that, although the results of this study could not be not generalised, it was evident that the process of change in these women was not a simple swap of lifestyle; rather

a forced minimisation of ethnic traits in order to 'survive' in an environment that sometimes was hostile for the mere fact of being perceived as different. This did not mean that acculturation was inexistent but, instead, that other phenomena might play an important role.

Another analysis, based on the same research (Viruell-Fuentes & Schulz, 2009) focused on the same participants' social ties, which they experienced inside and outside their community. First-generation women described isolation at the moment of migration, which was a source of anguish, and valued secondary social ties (such as church organisations) as vehicles for integration and help in general. Second-generation participants also valued secondary social ties, but these were different, and long-term generated (i.e. friendship). The authors also noted that these ties were racial in their context, instead of being focused on the process of migration. Narratives were explicit here to point out that participants were closer to other Latin Americans, either because they felt more comfortable with them, or that they felt rejection from other ethnicities. Another difference between groups was the amount of transnational ties (distant relatives and friends). While first-generation participant maintained strong emotional connections with them, these connections were almost lost in the second generation, although they still valuated it. This, according to the authors, would be another key element to understand deteriorating health experienced by second-generation women. Health care access would also play a major role in the long term, which may derive of the institutionally forced isolation in both groups (since their legal status tends to be delicate). Both studies (Viruell-Fuentes, 2007; Viruell-Fuentes & Schulz, 2009) are useful to understand the migration phenomenon, especially among large migration groups, and their relationship to health, beyond simplistic explanations. The authors appear to be supportive of the idea that behavioural changes in the long term tend to be a consequence, rather than a cause, of deteriorated health indicators in second-generation members.

A similar study, conducted by De Fina and King (2011) used narrative inquiry based on in-depth semi-structured interviews with 13 Latin-American immigrants with a contingent legal status (and often, no legal documentation), in the greater Washington DC area. Participants described conflicted situations based in the use of Spanish, and lack of English proficiency. Narratives were classified in three groups: (1) an antagonist uses the

protagonist lack of competence in the language (English or Spanish) to harm or humiliate her; (2) lack of competence is only mentioned by the antagonist to produce the same result, and (3) the lack of language skills is ignored, also with the objective of harm or humiliation (i.e. the protagonist does not understand the content of the humiliation until after the situation has occurred). Participants recalled many of these situations as traumatising, and they learned from these experiences as a source of self-marginalisation. Effects in health were not addressed as much as in the previous study, but there are noteworthy similarities in the conclusions to address that consequences might be very similar, especially in the long term. For instance, those participants who had better language skills were more often able to identify verbal aggressions than those who only speak Spanish, which gave them a sense of more awareness of discrimination or "othering", as the other mentioned studies suggested.

The issue of discrimination of immigrants and its repercussions in the work environment and health system is addressed in a study by de Castro, Fujishiro, Sweitzer and Oliva (2006), conducted through interviews at the Chicago Interfaith Workers' Right Center, a non-for-profit organisation in Chicago, providing services and assistance to workers, regardless of their legal status. A great majority of the workers were Latin Americans. Participants came voluntary to seek for assistance regarding what they perceived as abuse and discrimination from the employer's side. They were told to narrate their experiences, and data was analysed using grounded theory methods. The study expressed concern for the amount of abuse regarding unpaid or underpaid extra hours, discrimination against other groups, unsafe environments and absence of security measures, high rate of accidents and indifference to their problems (e.g. pregnancy, absence because of accidents). Employees usually responded to complaints by ignoring them, retaliating or even terminating their jobs. As a result, workers expressed symptoms of stress, exhaustion, impotence, anger, and other mental issues. They were also more prone to accidents. This is a valuable study, since it views illegal migration more as a problem to the immigrant than to the host country. Workers performed useful—albeit cheap—work for the society, getting very little in response. The major problem this study has is that it was mostly passive: participants had to take the decision—and risk— to visit the centre in order to express their complaints. Therefore, it is hard to know the rate of this abusive behaviour among immigrant workers; numbers could be much greater (as employees could be fearful of

repercussions), or the sample was of an atypical group (only the very few who were being abused might have reported their problems). Nevertheless, the undeniable element of this research is that immigrant workers are in a very vulnerable occupational position, contrasted with the local population, which is the problem with immigrants in any region, including New Zealand.

The topic of illegal immigrant workers is also explored in a review by Clark (2011), but from the point of view of immigration and health government. This study uses discourse analysis approach through a review of arguments, policies from the U.S. press releases, discourses, and other public opinions, described as narratives, both supporting restriction or expansion to health services. The author analysed the language used by different commentators, focusing on how certain words chosen indicate an implicit support of a particular position. For instance, those in favour of restrictions often used terms that indicate an active or intentional conduct from illegal immigrants, which produces harm in citizens (often described with a positive trait, contrasted with the first group). The term 'illegal immigrant' is, many times compared or adjacent to terms such as 'criminal', thus making a parallel and a strong association between both terms, which are legally different.

Those advocating for increased access focus on the vulnerable side of immigrants (many times referring to their children, who, by all means could not be guilty of their parents behaviours), and that they do, in fact, contribute to society, receiving the worst part of the deal. Passivity is preferred in these arguments (expressing that one does not 'choose' to have an accident or get sick), which elicit a sense of compassion and empathy. There are two issues in this review: The first one is that it explicitly picks a side (favouring immigrants), and argues in favour to it, using a more aggressive vocabulary when dealing with other visions. Since it is not a qualitative or narrative study, it does not invalidate it, but it makes it difficult to become persuasive to those who have a different opinion. The second issue is that, as said earlier, it is not a narrative study in the original sense. Comments and opinions expressed in political or journalist circles are subject of many careful editions, and tend to supress more unconscious thoughts. Ideas are more defensive and carefully conducted than in interviews. However, it is interesting to notice that, in spite of all these defences, language and narrative uncover underlying thoughts that inevitably affect the conclusions of different narrators.

It is important to note that there are major difference between U.S. and New Zealand realities, especially in the Latin American communities, in terms of size, proportion, history, background, and regional policies. However, some elements might be shared by both Latin American communities.

In a context closer to New Zealand, many studies have been conducted in Australia. Although both Australia and New Zealand share some similitudes, Latin American population is greater in numbers there, which has encouraged research among their population.

Cohen (2003) examined the statement "*No somos indios*" ("We are not Indians") made by several Latin Americans residing in Adelaide. This declaration is made by people who advocate for indigenous rights and history vindication in various areas in Latin America, which at first seems contradictory to the author. He further explores the subject, analysing the context of language of these and other cultural expressions (such as poetry, arts festivals and the like), in order to understand the basis of Latin American indigenous and *mestizo* cultures in the Australian context, especially contrasting it with the experience of Aborigines in the country, since American Indigenous seem to share some similarities with them regarding colonisation, subjugation, racism and deprivation of land and culture (although through very different ways and historical contexts). The issue of multiculturalism is addressed by the way of integration, but also the understanding and tolerance of difference. He concludes that the apparent contradiction in the original statement is an oversimplification of Latin American indigenous vindication: it is actually "an engagement with indigeneity" (Cohen, 2003, p. 41), by revealing a history of perception of otherness and self-perceptions[3]. Also, there are many differences between what each social context describes as indigenous, and generalisations tend to distance from the purpose of integration and understanding, as well intended they might be. This study is useful, not only as precedent to future qualitative research involving immigrants in New Zealand, but also as a statement of how Latin American groups in this area of the world might differ from non-migrant Latin Americans or Latin Americans in other regions. For instance, in my experience, vindication of indigenous rights is far less generalised in Latin America, and in many places, racism is not only accepted, but it actually has been

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[3] The term *Indio* is pejorative when used in indigenous people in Latin America; it is also inaccurate, since actual Indians are native to the South of Asia, a confusion caused by Columbus mistake.

perpetuated by politics and mainstream media (e.g. television, newspapers, marketing), only recently becoming more politically incorrect, after globalisation has gradually permeated different views of the world over the last decade.

A narrative research in Australia was made by Dawson and Gifford (2001), involved interviewing 25 Chilean and 25 Salvadorian immigrant women in Melbourne, regarding health education, and behaviours concerning STDs, pregnancy control and other related issues. Both groups came from different backgrounds (Salvadorians came from rural and less educated situations, while Chileans were originally from a more urban and middle-class background). Authors observed that, regarding sexual health, both groups were considered vulnerable even before entering the country, mostly because of religious and cultural aspects. Machismo played an important role in this vulnerability; the authors described the male population as being encouraged in engaging in pre-marital sexual relations and marital infidelity, while women were repressed from these behaviours, in order for them to be pure and faithful to their husbands. Sex education was almost non-existent, since sex was a taboo among women. Further, all participants were raised by a strong Catholic culture, with an emphasis on feelings of guilt and humility. The use of prophylactics was seen with distrust, and abortion was invariably condemned. As such, both groups were extremely vulnerable to exposure to STDs from their partners and to have unwanted pregnancies. The main difference the authors noted between both groups was that Salvadorians felt proud of their cultural heritage and continued those beliefs, while Chileans tried to distance themselves from those ideas, absorbing as much as they could from the Australian background. Some of them even said they had renounced their faith, after being disappointed by their experiences with religion. While they reported it was hard to distance themselves from such a strong cultural background, they had hopes that the next generation of women, raised in this new reality, would do it easily. This study serves as an example for a more voluntary acculturation, at least from the part of Chilean immigrants. Whether this acculturation will be positive for them is hard to predict, but it seems to have given them a sense of empowerment that the other group lacks, at least referring to sexual health. These results may be very illustrative to understand certain participants' visions in the current research, especially in women. Since sexual health was not directly addressed in the interview, unless the participant mentioned it, omissions could also play a significant

role in that regard as well (although they naturally cannot be inferred from the interview and, therefore, no generalising conclusions can be made from them).

Finally, it is worth mentioning other interesting views on narratives, such as a study made by Furman (2004), who explores the narrative value of poetry made by Latin Americans from poetry workshops in different nations, some with a suggested topic, others with no prior instructions. Some of them had experienced immigration issues (which were occasionally addressed in their poems). This approach shows a strong potential; although it eliminates spontaneity, it encourages richness of language and a greater introspection from the participant's part. Unfortunately, the study only offers a set of examples, and refrains from making interpretations or analysis. It would have been interesting to see a restorying process, and its potential in a more homogenous population, such as a group of Latin American immigrants in a particular context.

Qualitative studies made in New Zealand regarding Latin Americans tend to be scarcer than in Australia, probably because their population is too small (although, as noted before, increasing). However, research could be increasing over the years; recently, Dürr (2011), used ethnographic methods (semi-structured interviews, participant observation and narrative accounts), and followed 24 Latin Americans over a period of eight months. Most of the population observed had migrated to New Zealand in the 1970s and 1980s, for political or economic reasons. She observed an emotional attachment to the new country, a sense of belonging that did not undermine their identity as Latin Americans, but that reflected that home, for them, was not their country of origin anymore. Participants admired New Zealand society, not only in terms of economic development, but also its environmental status, stability and biculturalism, especially regarding the Treaty of Waitangi (although some of them expressed doubts that the government respected as much as Māori allegedly would deserve). Although this study was focused in a population with 'older' immigrants than the current research, it is very interesting in terms of contrast. Past immigrants came from a different reality than the current ones, and their motivation was quite different, even when a society as stable as the New Zealand one has not changed that much (e.g. almost all Latin America consists of democracies today). It would be interesting to see if immigrants in the present differ from the optimistic view of those in the past, at least regarding health, which is where the current study was focused.

The aforementioned studies deal with an issue that is inherent to qualitative research: the reliability of testimonies. Are narratives a source that can unveil information that is coherent with reality, or are they prone to be manipulated by the participants, in order to obtain certain benefits, or by mere social desirability bias (e.g. by victimising their position)? Qualitative studies must acknowledge that this may be the situation in some cases, and methodology should be careful to avoid manipulation from the side of the participant, as well as from the side of the researcher. For instance, in the case of the study by de Castro et al. (2006), participants would receive benefits if their claims had merit (e.g. legal advice). Narratives had to be contrasted with the employer's position, but, since their mission was to defend the participant's rights, it necessarily meant that they would take their side. This bias is less evident in the other studies; nevertheless, it is a delicate issue, and cultural differences between researcher and participants might increase this problem.

From the constructivist point of view, this is not necessarily a reliability problem, since there is not an 'official' truth, and both participants and researcher's perceptions are a key ingredient in the expression of results. Moreover, this particular study does not intent to 'prove' the reality of Latin Americans in New Zealand, but to address the social expression of what they perceive as reality, or at least how I translate this expression to others.

Although this statement appears to reduce the scope of the analysis, it is important to address that there are many similitudes to other studies addressing the same issue, and that conclusions can serve as a point of contrast to them, as well as providing with new information that can be relevant for future studies or policies regarding similar or the same population.

2.3. **Summary**

In the present chapter, information considered relevant for this study was analysed and compared, in order to provide a reliable background to develop the later analysis. Although this information was useful to contrast its objectives with other, similar contexts, the results can still be relevant, since there are differences with all of them regarding geographic region, type of population, background and research objectives. In conclusion,

this study can serve as another layer of depth for issues that seem to be relevant worldwide, regarding health, the Latin American population, and New Zealand.

3.   Research Methodology and Methods: Narrative Inquiry

This chapter will discuss the choice of a qualitative methodology and narrative inquiry. Then, the methods used to obtain and analyse data will be set out and finally, the ethics implications and scope of this design will be presented.

3.1.   A Narrative Inquiry of Latin American Perceptions of Health in New Zealand

Qualitative data is useful for eliciting viewpoints and perceptions from individuals, sometimes helping discovering new or unusual phenomena. Furthermore, qualitative data provides a rich source of information from each participant (Furman, 2004; Houser, 2009). Hence why a qualitative design was chose; that is, a study about individual Latin American migrants' perceptions. While there is some health-related information regarding Latin Americans in New Zealand (Perumal, 2010), there is little in-depth information from the point of view of the participant to the researcher. A qualitative study allows the understanding of a particular context (in this case, Latin Americans residing in Auckland), in which participants act and interact. It helps understand the influences between the perception of that context and their actions. It situates individuals in their reality, without dissociating either of their components (Houser, 2009).

The research question of this study is: How do Spanish speaking Latin Americans, residing in the Auckland region, view the health care systems of their countries of origin, compared to New Zealand? It was intended that this study would focus on the different stories of a small number of people and their individual opinions regarding health and health care in New Zealand. For this reason, a narrative study was considered a suitable choice (Creswell, 2007); that is, an empiric collection of personal context and experience and resulting opinions, from a holistic point of view, through the means of interviews. Narrative inquiry was developed as a tool for knowledge management in organisations (Cleveland, 1989). The idea was to transmit information and experience from the expert to other members, by analysing the underlying processes and thoughts behind each told story. The resulting information of this process (and others) was known as "knowledge transfer"

(Corbett-Etchevers & Mounoud, 2011). Eventually, this form of data gathering evolved to other areas, such as social sciences and health, since it is flexible enough to be applied to many different kinds of participants, regardless of their cultural, social or individual background.

Narrative methodology sorts the information and, at the same time, reveals and interprets that information, exploring the core of the subjective nature of the narrator and helping define the narrator himself/herself (Patton, 2002). Narrative is based on the epistemological assumption that individuals try to make sense out of their experiences, even though those experiences might appear to be of random nature (Bell, 2002). By studying and analysing stories, the researcher becomes aware that there is an underlying chain of thoughts that provide meaning, revealing at least part of the nature of the storyteller, his/her environment and his/her priorities (Bell, 2002). Narrative aims for certain processes and practices that are not *a priori* apparent: they can only become explicit through the person's story. It proposes that, in order to understand the person's background and perspective, it is necessary to listen to him/her telling it and how he/she tells it. The story is a matter of interest in itself and in its form. It tells the language, the cultural elements, the perceived social world of that person, and its limits. It is subjective and incomplete, but it also tells about the subjectivity and incompleteness of the narrator. (Chase, 1995).

The narrative approach was considered more suitable for this research, since it aims to explore personal experiences and opinion. This contrasts with a simple recollection of events (e.g. through a survey). The importance the participant attributes to each episode and action creates a framework of explicit or implicit views and feelings that can, in some cases, be interpreted and analysed by the researcher. How someone understands a health system will have repercussions in how that system is used. Since people live according to what makes sense, the built story regarding that health system (or any other perceived experience) can become a pathway to lead their actions and ultimately their lives (Sparkes & Devís Devís).

3.2. **Philosophical Understandings**

Narrative's hermeneutical approach, "the way interpretative understanding is achieved" (Gadamer, 1995, p. 266), relies on at least three philosophical paradigms: post positivism, constructivism, or critical perspective. Each of which will now be discussed

Post-positivism proposes that truth is, more or less, stable in a particular context, and that a researcher can distance himself/herself from that particular context to analyse it. However, no knowledge is superior to others or immune to be challenged. Rather than knowledge regarding certain things, there are *conjectures*. Certain theories are warranted by certain evidence, but anything can be contradicted in light of future investigation. Researchers can theorise according to their particular scientific contexts, if they explicitly limit themselves to those bounds (Philips & Burbules, 2000).

On the other hand, from the critical point of view, there is reciprocity between the identities and the object of that research; in other words, there is no distinction between 'subject' and 'object' of research. Researcher and narrator cannot be separated, since a reality is shared by both, being their conversation also general and non-guided, requiring an enormous amount of involvement from the 'researcher' part, building long-term and relationships with the 'participants' (Hollingsworth & Dybdahl, 2007). Yet constructivism, a middle ground between the post-positivism and critical, requires certain frames to work, but they are not as defined as in the post-positivist model; instead, the exchange between participant and researcher is explored by both, providing feedback before moving to the next planned stage (Hollingsworth & Dybdahl, 2007).

This research followed a constructivist approach for the following reasons:

a) I am also a Latin American immigrant in New Zealand, which puts me in a position where my personal beliefs and experience have direct and close similarities with those of the participants. These conceptions cannot be objectively suppressed during this research.

b) There are conceived topics that must be addressed during the interviews (e.g. health, health services, migration); therefore, interviews must have a particular guidance and a structure, although flexible in nature.

c) I am not an 'authority' in those subjects. Rather, I must assume a humble and powerless position of openness and learning. A semi-structured interview will help

create — for participants and researcher alike — a particular vision and relationship of that new knowledge.

The constructivist approach has the epistemological suggestion that 'truth' (or rather, the different experiences and perspectives of subjects; the 'many truths' that cohabit in the universe) is unstable, and has to be viewed in a particular context. Considering this, its theoretical position on power is that it has to be co-constructed to maintain the intentions of narrators, being shared by both; regarding the relationship between researcher and narrators, it is unstable, varying through the interview according to the contents of the interview(s); and finally, the identity of the researcher must be considered in the design, since he/she cannot be separated from it (Hollingsworth & Dybdahl, 2007).

Constructivism does not dichotomise or isolate the researcher/participant relationship, but encourages a horizontal way of focusing on the creation of a reality; that is, both sides are equally responsible for constructing a world view from that particular topic. This allows the research to more organically express its subjectivity, and upholds a more democratic power structure from both parts. Thus, the researcher acknowledges that objectivity is not only impossible, but neither necessarily, a desirable state (Helman, 2007; Hollingsworth & Dybdahl, 2007). It is necessary to also acknowledge that the analysis is a complex process and its success is rather limited to the parameters and backgrounds in which the researcher has had an experience or knowledge; hence, this research is not meant to present results as a 'truth', but as a personal approach to what a few members of a particular group express as their experienced reality, through the meaning of the stories told by them.

In the case of this study, this is situation evident, since I share many similarities with the participants, to the degree that I could have been another participant as well. Self-reflection was unavoidable during all interviews and analyses and was used as an instrument to situate myself in their particular contexts. In other situations, self-experience was used as a contrast to what the participant narrated, to highlight the different experiences and points of view. In other words, interview and analysis were not only an exercise of empathy and understanding, but also a self-reflection (and questioning) of the researcher's position on that particular subject. Therefore, I needed to be aware of my own pre-conceptions (and prejudices) in order to accept to co-construct a new vision of reality

from a joined perspective. This involves active feedback of thoughts during both interviewing and analysing.

One major obstacle to overcome when dealing with constructivism is to be aware of relativism; although there are certain subjective 'truths' in this construction, an analysis must keep being critical of them. After all, awareness of prejudices is not a justification for them. As Bruner (1990) puts it, "(a)sking the pragmatist's questions –How does this affect my view of the world or my commitments to it? – surely does not lead to 'anything goes'" (p. 27).

3.3. **Research Design Methods**

Two instruments were developed to obtain the necessary information to conduct this research: a small questionnaire to situate the participant's general status; and the interview, which was set to answer the research question through narrative inquiry.

3.3.1. *Questionnaire*

Once consent had been given by the participant, a questionnaire was provided at the beginning of the interview, to obtain demographic data that would help situate the participant, for example: district of residence, age, gender, marital status, age and gender. A full copy of the questionnaire can be found in Appendices A (English) and B (Spanish). This information was crossed with the results of the interviews, in order to provide a context to contrast the information in terms of each interviewee's status.

3.3.2. *Interview guidelines and interview procedure*

Interviews were semi-structured. A set of open questions were asked of the participant, in order to obtain information regarding the subject matter, set in a way that helped participants recall personal stories regarding migration and health care. Interviews were set to be semi-structured (see appendices C for interview questions in English, and D for interview questions in Spanish) to allow the participant to explore the topics suggested through his/her own memory, with minimal opinion or judgement from the part of the researcher. A minimal level of guidance was necessary to focus the interviews on the

required issues (health experiences in Latin America and New Zealand, migration experience, etc.). Participants were encouraged to tell, as a story, their experiences and views.

The structure of all interviews was organised according to the following criteria, in order of importance:

1. The first questions were designed to be generic and broad to help the participant contextualise himself/herself in the situation.

2. Every topic was meant to be completely explored before moving to the next one. The interview was organised in four topics: Health, community, country of origin and migration. Each topic had a set of questions arranged to cover each one.

3. Questions made to elicit a biographic recollection were ordered in chronologic order (e.g. "why did you decide to come to Auckland?" came before "how was the adaptation process?"). The purpose of this was to facilitate the recollection of memories and avoid confusion from both participant and researcher. It helped the creation of a coherent story and avoided contradictions.

In general, participants had no problems understanding or answering the questions. In some cases, the conversation flowed naturally and some questions did not need to be answered, since the participant talked about the topic without being asked. For instance, participants were asked to narrate the immigration process. After that, they were asked to describe how adaptation was in New Zealand and what positive and negative issues they faced during that adaptation. In general, participants did not need any guidelines, since they narrated both issues as one story, without need to be interrupted.

3.3.3. *Eligibility criteria*

Participants had to fulfil certain criteria in order to be able to be interviewed.

1. Be older than 20: The research required participant to be adults and to be able to answer the interview without another person's authorisation. Also, it was more likely that they would have more recollection of experiences in health systems if they were adults.

2. Be born and raised in Latin America: It was essential that participants considered themselves as members of the Latin American community to be part of this study. The only way to ensure that was to interview people who spent their childhood and adolescence in Latin America.

3. Speak Spanish as native language: This criterion was required to have the interviews in Spanish, the native language of the researcher. Cultural expressions (such as idioms, slangs, proverbs, etc.) would be made more explicit and understandable if both parts speak the native tongue.

4. Have immigrated to New Zealand between 2004 and 2010: This criterion was selected for participants to have a fresh memory of their immigration, but enough time living in New Zealand to have had health experiences in the country.

5. Currently reside in the Auckland Region: Namely, Auckland Central, North Shore, West Auckland, Mid-Auckland and Howick. This was required in order to be more accessible by the researcher in order to do the interviews.

3.3.4. *Approach*

This study was conducted at the Association for Latin American Cooperation (ALAC) offices, located in Onehunga, Auckland. In case it was not possible for participants to attend there, they were offered to be interviewed in a place of their convenience. Community leaders were contacted through social networks and organisations (concretely, ALAC, Inc., an NGO focused on addressing the needs of Latin Americans in Auckland). All community leaders were professionals (doctors, social workers, paramedics, nurses). At first meeting community leaders were informed of the project consisted in a meeting. The content of the interview was discussed with them and feedback received regarding the interview schedule and their view about the community perspective (Green & Mercer, 2001). All material was presented, including the interview schedule (see appendices C and D), informed consent (see appendices E and F), and demographic data (see appendix A and B). They agreed with the material and no modification was made to it.

In general, community leaders showed great interest in the research and its results. They were offered a presentation with the general results (omitting names and other ways to identify individual participants), by the end of the research. This meeting was conducted

on 16th of April, 2012. During this meeting, an abstract or other general written work was offered when the study was over.

3.3.5. *Accessing the Field*

After the researcher approached community leaders, the nature of the research was then explained to them. This was accomplished by:

1. Visiting community facilities: ALAC Inc. headquarters was approached by me.

2. Explaining to community leaders (people in charge of the NGO), the nature of the research, showing them its objectives and methodology. The contents of the interview were then discussed and revised with them.

3. Submitting information: An envelope containing a written invitation letter (see appendices G for English version and H for Spanish version) was delivered to participants. An open invitation to all potential participants was published at the NGO's bulletin board (see appendices I and J).

4. Public meetings: With the aid of community leaders, I invited potential participants to join a meeting at the facilities of the NGO (ALAC Inc.), where I introduced myself and presented relevant information regarding the study. Potential participants were invited to join the research. Additional printed information was delivered to them (e.g. participant information sheet, see appendices G and H). Additionally, I provided them with his contact details (in form of business cards), in order to be accessible for them. This approach was not effective, since none of the participants who attended to those meetings had the requisites for being interviewed. The strategy had to be replaced. For this reason, members of the NGO provided me with a list of potential participants, whom I contacted.

5. Interviews: Those agreeing to participate were contacted and interviewed by me, after reading and signing the consent form. If a participant did not give a response after two weeks, it was interpreted as a refusal to participate and was removed from the list of potential candidates. Eight initial participants responded to the invitations to the interviews, but two declined to participate (in both cases, the explanation given was that they did not fulfil the requisites for the interview).

6. Snowballing: After each interview, envelopes were handed to each participant, inviting others to join the research. The participant was encouraged to hand those envelopes to people they know and that might be interested. Two further participants were contacted this way.

Information about the project was given in form of a written letter (appendices G and H). Participants were contacted by phone and e-mail, in case they still had doubts or concerns about the research. ALAC Inc. headquarters were used to present the objectives of the research to potential participants, previously invited by community leaders. A translated consent form in Spanish (appendix F) was provided to those who could not speak fluent English. This form was independently translated back to English by a third person to warranty its fidelity to the original.

3.3.6. *Selection*

This study does not intend to represent the whole population of Latin American residents in Auckland. Instead, it focuses on the richness of each particular experience and opinions; for this reason, the number of participants was relatively low and selection was based in community leaders' criteria and participants' availability.

3.3.6.1. Purposive selection process

It was the most utilised method. Purposive selection process consists of using a particular knowledge or expertise when trying to reach participants. Individuals are selected considering particular characteristics of them in the population. These characteristics are the main reason each participant is selected (Berg, 2009). In this case, participants were selected on the criteria of being recent immigrants (having arrived in New Zealand between the years 2004 to 2010), Latin American adults (older than 20), and residing in the Auckland region.

Members of the NGO committed themselves to provide a list of possible candidates (that fulfil the desired criteria) and to publish an announcement in English and Spanish (see appendices I and J) on their bulletin, to promote the participation in that research.

Following these criteria, the researcher tried to make the group as heterogenic as possible, in order to focus on the differences between participants and verify the similarities. Six participants were located by this way of sampling.

3.3.6.2. Snowball selection process

Snowball selection process consists of reaching a limited number of initial participants and expanding that number by direct referral from them. It is recommended, especially, when dealing with sensitive issues (Berg, 2009). In this study, once participants were interviewed, they were asked to further collaborate with the research by handing interviews' advertisement to them. This part of the recruitment was necessary, since the researcher could initially interview only people within the scope of the NGO–that is, if the NGO did not have information about certain people, they could not be interviewed. By indirectly providing information through a third party, the possibilities to interview people that did not have any relationship with the NGO increased; thus, making the research more varied. The reason this method of selection was used was because there was the possibility of potential participants afraid to approach any institution or organisation, because of their irregular migrant status. Two participants were located this way.

3.3.7. *Participants*

In total, eight people participated in this study. Four men and four women participated. Three of them were Chilean; one was Uruguayan, one Colombian, one Peruvian, one Guatemalan, and one Argentinian. Ages went from 34 to 70. These conditions constituted a highly heterogeneous group, considering the limited number of participants. Participant's demographic data can be found in appendix K.

3.3.8. *Gathering data*

Before the interview commenced, the informed consent was read aloud and discussed (see appendices E and F). One copy had to be signed by the participant and kept by the researcher, and the other one was kept by the participant.

Data was documented using digital audio recordings, and a journal was kept to support additional information (observations, personal opinions or ideas of the researcher, non-verbal communication interruptions and relevant emotional response) (see appendix L). The researcher remained able to be contacted via phone or e-mail by the interviewees to answer questions or if participants wished to elaborate further on their interview.

Interviews took place at ALAC headquarters, participants' households, places of work, and another community centre. In most cases, interviews were made in an isolated room; the only exceptions occurred at the household of two participants (they were taking care of their children), and in the workplace of another one. Regardless of that, interviews were only occasionally interrupted, and all of them were conducted in one session, from 40 to 75 minutes.

After the interviews, information was a) transcribed in Spanish; b) then translated to English; c) Nvivo program was utilised to label and sort the information (potential categories included emotional feedback, moral opinion, personal story, positive response, etc.); d) collected data was sorted individually to chronologically and causally make sense to the reader (without altering the contents of each story itself, in a process called *restorying*), and how they socially convey in that particular group (Creswell, 2007); to e) finally contrast and compare them with the other interviewees' stories, creating patterns according to differences and similarities within the community.

3.3.9. *Data Collection*

Participants were encouraged to talk freely about each suggested topic and to be as specific as they could. In other words, this research was aiming for quality of information, more than the amount of data gathered. No interview was suspended or cancelled, although sometimes it was necessary to pause it when a participant was interrupted (in two cases, the participants were taking care of their babies or small children). In order for the participant to feel more comfortable, bottled water and a small snack was given to them before the interview.

3.3.10. *Data Analysis*

After the interviews, the following steps occurred:

1. Interview recordings were transcribed in Spanish. To keep the information untouched and maintain the richness of the language, interviews were made in Spanish and transcribed in the same language, to only then be translated to English and analysed.

2. Transcribed data was translated to English by the researcher. To ensure the accuracy of the translated transcript, both copies were kept to be compared by an independent source, in case there might be doubts about accuracy of the translation.

3. NVivo, a computer programme for handling qualitative data, was utilised to label and sort the information, according to emerging topics, for example trust, inequality, access to health, monetary issues, eating habits, physical activity. These categories often overlapped where one paragraph included two or more identified topics. Topics merited labels when they either where common among participants, they provided a relevant or interesting angle to the discussion topics, or both.

4. Each individual collected data was sorted in chronological order, according to the narrative theory (e.g. first infancy, then youth, then adulthood), regardless of how it was narrated by the participant, to causally make sense to the reader (without altering the contents of each story itself, in a process called *restorying*), and to see how those stories socially convey in that particular group (Creswell, 2007).

5. Finally, information obtained through that recompilation was reviewed through thematic analysis. Thematic analysis is a research method known for its flexibility, which focuses on reporting certain patterns in the obtained data, which then is interpreted according to established philosophical paradigms (which, in thematic analysis, can be chosen by the researcher) and the research objectives (Braun & Clarke, 2006). It proposes that some relevant elements will be more frequent and similar among participants, and these themes can be abstracted and analysed through a particular way of interpretation. However, frequency was not directly proportional to relevancy; in some cases, certain

topics were only covered by a few participants, but they were relevant to the overall understanding of those participants' point of view, hence they were analysed at the same level as other more common topics. By this method, individual stories were contrasted and compared with the other interviewees' stories, creating patterns according to differences and similarities within the community. For instance, a relevant subject was the difference between private and public health in Latin America. While the private experiences tended to be narrated as positive or satisfactory, public health experiences were narrated as annoying, frustrating or even traumatising.

Since this particular research follows a constructivist approach, inductive reasoning[4] was required to translate expressed statements into themes and their relationship between each other, together with common patterns and conclusions. This means that a bottom-up process was required to generate conclusions: first, patterns were detected individually; then, they were contrasted with other similar patterns found in the same participant or others (for instance, lack of access tended to be mentioned at the same time with inequality in many participants' stories). At this point, I tried to explain these consistencies and inconsistencies, and relate them to other topics; to finally conclude and propose theories based on these findings through latent interpretation[5], according to my personal conclusions and theories proposed by others. There were no a priori suppositions over how data would be presented; instead, certain focus or domains expressed by available literature were set in order to provide a framework to work on the information obtained by the interviews (Thomas, 2006).

A constructivist level of analysis also involves theorising over socio-cultural contexts and cultural conditions, expressed through individual stories. Experiences were not considered 'trivial', since they express a certain background through language (verbal or

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[4] Inductive reasoning is a cognitive exercise by which a premise provides information to support a probable truth or theory in conclusion. In the best of scenarios, the premise is so solid, that the conclusion is unlikely to be false and the theory is not only *possible*, but also *probable* (Internet Encyclopedia of Philosophy, 2003). It is worth noting that there is never absolute certainty in inductive reasoning (as there is in deductive reasoning, which is based in axioms or self-evident propositions), but this does not prevent the researcher to propose explanation to certain phenomena.

[5] Latent interpretation involves exploring the underlying content of data. This involves assumptions and conceptualisation of expressed and omitted content (Braun & Clarke, 2006).

non verbal) and ideas. The fact that certain stories were better remembered than others is already an indicator of their view of reality (Braun & Clarke, 2006).

3.4. **Ethical Considerations**

Ethics approval (number 11/128) was granted for this study on 19th of June 2011 by the Auckland University of Technology Ethics Committee. The details are as follows.

3.4.1. *Avoidance of conflicts of interest*

I assured confidentiality of the content of the interviews at all times; both recorded and written (original and translated) copies of the interviews were accessed only by the researcher and supervisors. I also protected the identity of the participants; only I knew who was going to be interviewed and who was not (since I contacted them myself). A summary of the findings was presented to the community leaders, and pseudonyms were used to protect participants' identities.

3.4.2. *Voluntary Participation*

I recruited participants through written invitations and seminars. Those seminars were coordinated with the community leader at ALAC, who has previously worked with many of the potential participants. This meant he could be in a position of power with them. To avoid such influence of this, he was not included in the selection process of those who participated, or in the interviews. If participants met the required criteria for the interview, I contacted them privately, having their contact numbers and/or e-mail addresses from a wider list, and interviewed them the same way, without the community leader involvement at that stage.

Participants were able to refuse an interview (explicitly or by omission of response), and they were informed that they could refuse to answer any question or suspend the interview at any point, without any consequences.

3.4.3. *Informed Consent*

Two copies of the written consent were given to the participants that they had to sign. One copy was given to them and the researcher kept the other one. Consent forms were available in Spanish and English. Before they signed, the researcher read the form out loud and asked if there were any doubts or observations (in practice, no comment, observation or critic was received). After the participant agreed and signed, the interview commenced.

3.4.4. *Avoid Deceit*

All information regarding the study was openly discussed with the participants, including its purpose, objectives and subject matter. Participants were also free to discuss anything they were uncertain of. I did not have any reason to withhold information from participants, with the exception of the identity of other participants, to warranty confidentiality.

3.4.5. *Confidentiality*

Given the characteristics of the research, participants could not remain anonymous. They had to be contacted and interviewed by me. Further, personal information provided was essential for the objectives of this research. To avoid privacy issues and confidentiality, names to be transcribed were replaced with a pseudonym. Information of a personal nature (e.g. town or date of birth) not essential for the results of this research was omitted. Only I and my supervisors have access to the transcribed information, which was kept at AUT facilities. After the results are presented, all information will be destroyed or erased, according to AUT protocols.

3.4.6. *Risks and mitigation*

Since the nature of this research is to reveal personal information, there is some risk of personal vulnerability. To minimise these effects, only open questions were asked. When I sensed that the information provided was too sensitive and not necessary for the purposes

of this research (e.g. a previous criminal record, traumatic experiences, sexual behaviour or preferences), I would ask the participant to stop that part of the interview. If a participant found any question to be inappropriate, he/she was free to omit an answer or to stop the interview completely, even to decline his/her approval to consider that particular interview. Both situations did not occur during the interviews.

AUT counselling was offered as a free service to those who require it (See appendices G and H for support letter). For counselling in Spanish, the participants could contact Catholic Family Community Services. I would incur the cost of the counselling. To this date, there has not been any report of a participant asking for counselling because of the interview.

3.4.7. *Koha*

A NZ$20 commercial gift card (to use The Warehouse store) was handed to each participant at the end of the interview, as an acknowledgement of their participation in the research. I did not previously announce this, in order to avoid pressure or unnecessary persuasion to the participant.

3.4.8. *Treaty of Waitangi*

This research was undertaken according to the ethical principles defined by AUT (2011). The Treaty of Waitangi principles served as guidelines for this research as a way to ethically address a cultural minority. There were many similarities between Latin American and Māori communities, besides the obvious — being a minority population; for instance, both consider the community in general and the family in particular to be essential for their development, and both are socially cohesive groups, discussing their problems within the community. This research considered ethical aspects of the Treaty, including:

1. Partnership: leaders of the Latin American community (e.g. religious, social, etc.) were be involved in consulting and revising the interview questions before commencing the interview.

2. Participation: this was one of the main objectives of this research; to hear the participants' stories and experiences and consider a personal and holistic view of their situation in relation to future health care decisions and research. With

the support of communities, participants were encouraged to be involved. I interviewed each participant individually, hearing them without time restrictions.

3. Protection: this research adheres to the principles of confidentiality and anonymity to prevent undesirable consequences because of their collaboration (such as distress or discomfort). Participants' identities were protected at all times (Waitangi Tribunal, 2011).

3.4.9. *Framework and Methods for Promoting Rigour*

Rigour can be described as the adherence to any particular methodology planning, in order to aim for excellence and accuracy (Twycross & Shields, 2005). It is the main requisite for any scientific research. Since the nature of this research is qualitative, certain specific elements must be present in order to warrant a desirable amount of rigour. Although their presence does not necessarily warrant scientific rigorous quality (Barbour, 2001), the absence of them would certainly damage the study's credibility. These methods differentiate from the 'traditional' quantitative ones, such as validity and reliability (Nelson, 2008).

The constructivist paradigm proposes that a complex phenomenon such as "quality" cannot be pre-specified by a simple set of rules; instead, certain guidelines can help the researcher advance through an intellectual path, through a debate that encourages awareness of issues, and appropriate ways to recognise and face them (Seale, 1999). When these issues are not explicit through the methodology, the reader is forced to make assumptions and interpretations, which derive in the risk of misunderstandings or errors beyond the inherent subjectivity of a qualitative study (Hoddinott & Pill, 1997); therefore, it is necessary to make each precaution explicit and detailed.

3.4.9.1. Verisimilitude

Qualitative studies cannot be accurately proven 'true' or 'false'. However, they can reach an amount of general acceptability, which is based in certain conventions of

coherence (Bruner, 1991). Verisimilitude does not validate a study, but its absence can invalidate it.

In the case of this study, participants' narratives were interpreted according to what the researcher understood of them. The conclusions of the analysis were based in the verisimilitude between what the researcher saw as a coherent 'plot', according to the interaction between both researcher and participant. Since this interaction and the resulting narrative made sense to both parts (otherwise, the dialog could not have been made possible), the conclusion is that narratives had at least a minimal amount of verisimilitude.

3.4.9.2. Authenticity

Authenticity is an attribute of information quality that can convince the reader that the story is honest, serious and 'true' (Webster & Mertova, 2007). The only way to achieve it is by providing the reader with enough detailed information in every step of the study.

In this case, information was provided with transcriptions of segments of the interviews, which suffered little change (with the exception of translations) in the analysis. Unfortunately, certain language idiosyncrasies were not easily translated. In those cases, they were explained in parenthesis, footnotes or in the analysis itself.

3.4.9.3. Familiarity

The human mind processes things at different levels. When certain conceptions become self-evident, routine or automatic, they tend to disappear from our conscious mind. The ways we reach for our conclusions are so 'obvious' that they cease to become apparent. By this way, contradictory, damaging, needless or useless information become isolated from criticism (Webster & Mertova, 2007).

Cultural bias was a major issue for both participants and researcher, but in this case, it might become more apparent for an external viewer than for the researcher himself. With his natural subjective limitations, I tried to avoid this information isolation, and every concept from the narratives was put into test, whether it seemed obvious or not. Information was not self-explanatory nor taken for granted, even when it appeared to be this way to me. By this way, information that was familiar became subject of question and analysis; i.e. transformed into unfamiliar (or critical) information.

3.4.9.4. Credibility

Credibility is the amount of recognition that external viewers attribute to a particular study. One of the unavoidable risks of dealing with reportable events is that they are, by definition, remarkable or unusual, which could mean that the more reportable an event is, at the same time, the less credible it is (Labov, 1982).

If qualitative data represents an accurate description of a certain human experience, other individuals, sharing similar experiences, will also be able to relate to that data (E. Thomas & Magilvy, 2011). Several strategies help develop a certain level of credibility, some of those were used by the researcher:

1. Reflexivity: the amount of awareness or insight the researcher has of his/her own knowledge, relevant characteristics, limitations and biases. In Mays and Pope's (2000) words, it is the "sensitivity to the ways in which the researcher and the research process have shaped the collected data" (p. 51). Whether the researcher manages to overcome those elements to present a rigorous study is a matter only the reader can decide, but it is the first step to present results and conclusions in a transparent way.

   In this case, I must clarify that, being Latin American residing in Auckland himself, the amount of similarities between him and the participants were so many that trying to distance himself from them would be artificial and deceiving. Personal opinions and experiences appeared in the analysis, not as conclusion, but to add information or speculate about implicit statements. They were indicated as such, avoiding any indication that could be interpreted as conclusive or definitive.

2. Fair dealing: To incorporate different perspectives of analysis, having multiple points of view (Mays & Pope, 2000). Quotes from different participants and reviewed literature were used for that purpose. Due to the length limitations of this research, not all of them could be used in the proper context, but all participants were granted, at least, the opportunity to be heard.

3.4.9.5. Transferability

Qualitative studies aim for transferability, which is "the range and limitations of the study findings, beyond the context in which this study was done" (Malterud, 2001, p. 484). This means cases cannot be generalised in a broader context, since there is no 'true' interpretation, but they can be compared to others, in a case-to-case transfer. Each story is in itself a subjective point of view that can be similar or different to others; thus, creating a triangulation of information that aims to interpret those similarities and differences within a particular context (Tobin & Begley, 2003).

Transferability is the measure by which a particular study's results shares similarities or relates with other settings in the same field; in other words, if the case in particular is applicable for others. This requires the researcher to provide enough description and detail to form a view that can be interpreted and used in other setting with shared characteristics (Twycross & Shields, 2005). Comparisons between interviewed participants (from different background) were used for that purpose. It is important not to confuse transferability with generalisation; the fact that many opinions were shared by participants does not mean that they can be applied to a majority of Latin Americans, but that they can be related to others, even considering the differences between populations.

3.4.9.6. Dependability

Dependability refers to the possibility for other professionals to "follow the decision trail used by the researcher" (E. Thomas & Magilvy, 2011, p. 153). To achieve this, the researcher must be able to:

a) describe the specific purpose of the study; b) discuss the selection of participants; c) describe the data collection; d) explain the analysis of that data; d) discuss the interpretation of that research; and d) communicate the specific techniques used to achieve credibility (E. Thomas & Magilvy, 2011, p. 153). All these steps were intentionally followed in order to achieve a desirable level of dependability.

3.4.9.7. Confirmability

Confirmability requires that the researcher represents the reality in the context of the study (Holloway, 2008). It could only be achieved through a certain level of neutrality, and the avoidance of bias (de Witt & Ploeg, 2005). It can only occur when credibility, transferability, and dependability have been established (E. Thomas & Magilvy, 2011).

From a constructivist point of view, this level of rigour is only subjectively obtainable, since reality is both a construction of researcher and participants (and, hermeneutically, the reader); it is not *the* reality which is represented, only *a* reality. Neutrality is not possible under constructivist terms. Under that premise, the researcher acknowledges that results might be subject of discussion, and should not try to represent the *true* nature of the issues discussed.

3.4.10. *Conclusion*

This research aimed for methodological rigour. In order to show coherence with its paradigms, transparency was essential to portray the results in a way that could validate this study from a third party perspective. Having discussed the research methodology and associated methods, the next chapter presents the findings of the study.

4. **Findings**

This chapter deals with the information obtained from participants' interviews through methods explained in Chapter 3, Methodology. This chapter starts by summarising participants' biographies; after that, the findings related to participants' beliefs and behaviours, and their relationship with health, are considered.

4.1. **Participants' Biographies**

The following section describes participants' main biographical events and personal characteristics. In reporting participant information, pseudonyms have been used.

4.1.1. *Camila*

Camila is a 34 year-old Chilean. She lives with her Kiwi boyfriend in his parent's house. She completed her tertiary education in Chile, obtaining a degree as an English teacher. This, however, was not the first time she studied; having previously trained as chef. She comes from a family of professionals. Her father is a veterinarian and her mother a kindergarten teacher. She remembers that she was not wealthy in her childhood, even though her grandparents had a good income. She grew up in the South of Chile and studied in the North of the same country, where she experienced different lifestyles. She had the opportunity to travel to Europe, where she discovered she loved to be in different places. This was the main reason she wanted to study English. She did an internship in Minnesota, USA, to improve her language skills. This was not a pleasant experience to her, both academically and personally; she had little time to practice English, since the school she was assigned was an all-Spanish one; the climate was very harsh and she did not like the people there. She met her boyfriend and decided to join him living in Auckland, New Zealand. She considers herself happy, and has many friends in Auckland (mostly Pākehā and Latin Americans). She became very close to Latin American NGOs, partly because of the opportunity to share with Spanish-speaking people.

4.1.1.1. Health

Regarding her medical history, she describes her childhood as very problematic. She had typhus, to the point of almost dying. She spent long periods at the hospital, and became very thin and prone to other diseases. After her childhood, she says she has become a more healthy person, and after her migration to New Zealand, she has changed her habits, becoming more disciplined in her sport activities, and quitting smoking, which she attributes to a "bohemian life-style" (she likes to party and hang out with her friends until very late). She thinks she eats at irregular intervals (sometimes too much, sometimes nothing).

4.1.2. *Carolina*

Carolina is a 70-year-old Uruguayan paramedic, although she has spent a significant part of her life in Argentina. She left her country when she had her second child, for political reasons, since the country was governed by a dictatorship. She and her husband had to put their careers and lifestyles on hold and start a new life in the neighbouring country. They lived there for almost three decades, until a severe economic crisis desolated the country. All of her children went to live overseas, and she followed them to New Zealand. She felt very depressed by this decision, since she had to give up to her old lifestyle again and she had problems with the language. However, she found a new passion dedicating herself to helping others and creating different social services for the Latin American community in Auckland. She currently divides her time between social services and raising her grandchildren.

4.1.2.1. Health

Carolina defines her childhood as pleasant, although when she turned 18, she had a serious disease that prevented her to studying medicine, her career choice. Instead, she studied paramedicine, against her doctor's wishes, who recommended a quieter career. In the end, she did not have significant problems choosing to work night shifts. Carolina claims to have not been sick for years. She feels she has not take care of her health as she should; specifically, by being inactive. This has lead to obesity problems. In New Zealand,

since the health system forces her to routinely consult physicians, she has prevented problems escalating.

4.1.3. *Arturo*

Arturo is Chilean and 43 years of age. He grew up in the south of Chile, and has dedicated his life to teaching and trying to be healthy (i.e. physical exercise)and promoting healthy habits. For academic reasons, he went to study in Auckland with his wife and two children, to work in his PhD. He chose Auckland because his similarities with the south of Chile (Canada, the other option, was too cold for him). He is very busy and says he has little social contact with other people, academic situations aside.

4.1.3.1. Health

Arturo claims to have been a very healthy person when he was young; in his own words, he "was indestructible". He practiced many sports during his adolescence and early adulthood. He currently lives a rather active life, although more sedentary than it used to be, because of his studies. He says he has had complications because of risks factors: in particular, his cholesterol is high and he had kidney stones, which were removed in New Zealand.

4.1.4. *Andrea*

Andrea is Chilean. She is a social worker, and has lived in the south of Chile all her life, where she worked in rural areas. She moved to New Zealand with her husband and child, because her husband was offered an internship in Auckland. Since migrating, she dedicates her time both as a housewife and as a volunteer to assist other Latin Americans living in Auckland in adjusting to the New Zealand society. She also organises sporting events for the community.

4.1.4.1. Health

Andrea saw herself in the past as a lazy person, generally because she did not do much exercise. She did not, however, have any serious problems in her youth, besides some accidents and measles. It was after moving to Auckland that she decided to become more

active, and that she realised she had "skills". Her favourite activity is to run on the spinning machine, since she can do it at home, without leaving her children alone or neglecting other duties. She has had some respiratory issues in Auckland, which has led her to visit doctors.

4.1.5. *Claudio*

Claudio, aged 36, is Guatemalan He currently lives in Howick with his wife and children. He worked as an agronomist in his homeland before moving to New Zealand, mainly because of the violence and lack of safety Guatemala has been experiencing. His brother was studying in Auckland and invited him to live in his house until his family could manage. He currently works in a completely different field (providing customer service for Spanish speakers), and he misses both his life and family in Guatemala; however, he feels lucky, since he managed to quickly find a job and move from his brother's house.

4.1.5.1. Health

For as long as he can remember, Claudio thinks he has been a healthy person. He describes himself as an energetic person—or at least with the capacity to do normal things—and he loves to ride his bicycle, although the climate in Auckland is rather uncomfortable for him. He says he has to fight sedentarism, especially in a job that forces him to be seated for long hours, without much time to eat something healthy. He was sick at the time of the interview. He thought he had the flu, but he was not planning to go to a GP, even when he spent the weekend in bed.

4.1.6. *Daniel*

Daniel, aged 35, was born in West-Colombia. He was very poor in his youth and decided to join the Colombian Army to bring economic support to his family. In Colombia, after an armed confrontation against the guerrillas, he was kidnapped. He was rescued and moved to Ecuador, where he stayed at a hospital. Unfortunately, he was kidnapped again. He stayed isolated for four days, and was rescued again. This time an international NGO relocated him to New Zealand, as a refugee. His stay has been very difficult, since it is hard for him to trust anybody. He tries to avoid contact with other Colombians, but he has met

other Latin Americans and Kiwis. One of them is his actual partner, with whom he has a daughter. The three live in One Three Hill. Daniel performs casual work to bring support to them, as well as his family in Colombia.

4.1.6.1. Health

Daniel has, mostly, relied on family medicine and friends' advice to deal with diseases and other conditions. His economic and educational background has not allowed him to have access to the health system in Colombia, so he has had to cope with health issues himself. Even when he had an appendectomy, it was not covered by the institution, because he had just resigned after his kidnapping. In New Zealand, he has had more medical problems (paralysis and other symptoms), and he has visited hospitals. Currently, his major worries and priorities have been to his daughter, who was born premature in New Zealand, and has had hearth and vision impairments.

4.1.7. *Felipe*

Felipe is a 54-year-old Peruvian Christian theologist, He spent his early childhood in a small town in the Andes, but had to migrate to a large city, because of poverty and lack of opportunities in rural areas. Since the economic crisis, he left Peru in the 1980s, looking for a better life quality in Europe. He moved to England, where he stayed for a year studying English as a foreign language. When his visa expired, he travelled to the Netherlands, where he lived for more than a decade. He got married to a Dutch woman and had a child. However, he marriage did not work, however, and again he moved, this time to USA for a while, and then Spain, where he studied geriatric care. His work situation did not improve, especially during the last recession, so he decided to move to New Zealand. It was here that he met his current wife, who is also a migrant from Zimbabwe.

4.1.7.1. Health

Felipe believes that he is a healthy person, since he has put so much care into his eating habits. This has not always been the case; when he was very young and poor, his mother could barely afford to eat him, much less give him healthy food. It was enough to have something on the table. He tries to be healthier now that he has the means to it. He has

had some prostatic problems that might require surgery (which he says is odd for his relatively young age). His wife is just recovering from a cancer that she had before they got married.

4.1.8. *Josefina*

Josefina was born in Argentina, where she dedicated herself to work as a paramedic for the Presidential Residency. She defines herself and her family as travellers, "like Gypsies. With her first husband and children, they sailed around the world in a customised boat. She educated her children while travelling, and never spent too much time in one place. When she decided she had had enough, a conflict started between her and her husband, which ended with them separating. Josefina remained in American Samoa for many years, until she met a Kiwi, who convinced her to live in New Zealand permanently. She was, at that time, without a job, and so agreed. He is currently her partner, and both live with the remaining children of the first marriage in Mount Albert. She is currently 61, works part time as a housekeeper, and is planning to continue travelling, this time by means of a caravan they are reconditioning.

4.1.8.1. Health

Josefina was asthmatic until her early teens. Other than that, she says, she has not had any major health problems, and she sees herself as a very active person for her age, although she has started to feel she is not as energetic as she used to be. In particular, she has started to have headaches, which sometimes end in nausea and vomiting. Nevertheless, she claims that she is always in good spirit and gives advise to younger people, who seem to be in worse condition than her.

4.2.   **Participants' Perceptions, Beliefs, and Behaviours in Relation to Health**

Having provided a brief introduction to the participants, in this section, participants' personal thoughts regarding their health and health issues are discussed. The following themes will be discussed in depth using quotes from the participants' interviews to highlight the overall analysis: family, social networks, and their relationship with mental

health; eating habits, physical weight and cholesterol; trust issues; self-medication and natural medicine; and finally, participants' change of health related habits during their stay in New Zealand.

Participants were asked about their behaviours regarding health, and how much they have changed in their personal lives. They had to respond by remembering situations and actions, without necessarily judging them. From these behaviours, certain beliefs were either explicitly addressed or implicitly deduced. Even when these ideas do not necessarily represent the general thought of the population, participants shared many similarities despite their different backgrounds.

4.2.1. *Family, social networks and mental health*

Family is presented as a source of support, both affective and material. Arturo, for instance, remarks on the essential role of a network, which is exacerbated in an unknown environment:

"Yesterday I read in the newspaper here they found a man who had died a year ago. I mean, […] it's shocking when… […] What about the neighbours? What about family? Nobody realised that this poor man died and stayed there. […] That is, even the smell of decay of the body […] The visit of close family, friends, or... The guy lives... He lived alone, completely alone. And I think if we do not recover that value, community, living together, […] We're going there, we will die, we will die alone and abandoned! And say, it was shocking. It made me think, […] So there, now. Ok. We came here to improve our status, our domains, our income, have other relationships, other friction. But why? […] We are never satisfied.." (Arturo)

Other participants also mentioned this topic, remembering their own experiences.

"The decision was from my husband, to follow our daughter [moving to New Zealand]. It didn't make any sense to live in a country where we didn't have any children. We had formed a family, we were a very tight family, we had three children…" (Carolina)

Carolina talks about the need to tight family connections, to keep the family together as an important source of health. Claudio, on the other hand, remarks how important family is to a balanced life, over other material things.

"[Do] not put your heart where material things are. Because, from what you know here, well, you left all you had behind, and… It's over, right? So, we know that, in the end, the most important thing is the family and not so much the things you have. […] Material things come and go. And now, among the more negative things, I'd say... Maybe the most difficult thing is that, you know? Family and distance. Yes. That it's harder to make a bond with… Like the one you have with your family, your fiends, your country." (Claudio)

Family is also an objective of support, as well as a source, especially in those who are to provide for them. In this case, it can be a source for self-perception of achievement and competence, as well as an additional burden of responsibility and stress, which does not mean that they do these activities with displeasure. Sometimes, it can be both simultaneously. For Camila, distance from family does not decrease responsibility:

"[M]ore than anything, my concerns go to my parents and to... They are greater regarding my family. They are over the sixties, and, of course, things start to happen, and... I'm a little bit obsessive with that, besides, because I'm far away." (Camila)

But the absence of personal contact is a limitation. In the case of Carolina and Claudio, duties are much more evident when taking care of relatives (or being taken care of them) when they live together:

"I take care of my grandchildren; I have a grandson that I take care since he was three months, and I take care of him every day, except one, when I come to the library. The rest of the time, I take care of him all day, at least 10, 12 hours. Sometimes he spends the night and his mom works the night shift, and I have the energy to deal with him like... Like a much younger woman." (Carolina)

"Well, I think it was relatively simple. In the sense that we had my brother here, he received us in our house, we were there, more or less, like five months living with him, […] and we started to look for jobs, from... We managed to spread or wings. […] A bit complicated. Especially with the children. Because... there were different educating ways, and… Starting to take other spaces, ours as much as theirs, in our family dynamics. So, yes. It was a bit complicated. That part." (Claudio)

Carolina reveals her duties regarding her grandson's health, while Claudio mentions that he and his family were objects of care. In the case of Claudio, it is revealing that the sense of lack of independency and spaces become a source of stress, while in the case of

Carolina, who *provides* with care, it is a source of confidence and self-validation. It seems that being a voluntary care provider is less stressful than a care receiver. Andrea sums it up, when referring to healthcare and childbirth: "[M]y son is not a disease, hey. A baby is a blessing, […] And, the better it's taken care of, the better yet." It would seem being able to take care of loved ones is a blessing, especially if they are healthy and without problems.

In some cases, there are not enough close social networks on which to rely. In these cases, participants feel a powerful need to create a new one, by looking into other networks and organisations:

"Unlike, perhaps, many of the people you're going to interview, because, as we have tickets, for free, we have four tickets per year. Then I say, the first year we came in May, for one week. After that, we moved in June to 'live', […] but in September we were in Chile […] Again. […] So we have never spent more than six months that I've been outside Chile. I have not had the time to be homesick. […] That has helped a lot. So, from making the decision, to saying 'we're going to emigrate', because it is not emigrate and then return in five years […] and that has been easy, comfortable. […] I didn't work the first years; I worked, exclusively, for him. […] Then I started working [as a volunteer], […] halftime. I worked there a lot, three years. […] We have not had to have extra work or strenuous days. […] I'm a very sociable person, I make friends easily. So, that has helped us a lot too. Uh... Always, in our house, there have been people…" (Andrea)

Even though Andrea has the opportunity to frequently travel by plane, unlike the other participants, she felt the need to attach herself to the local community, to provide care to others and be cared for. Other participants revealed an even more powerful urge.

"Just before coming to New Zealand, I had a very cloistered life. We live well within the family, very 'to us'. Here we have tried to be a bit more sociable. We tried to have more contact with others. A bit motivated by the fact of being alone. That we are definitely a family. In Chile, in the end, you have a close family, relatives, something you do. But not here, then... A little to remedy that... The rest of the family, one can find the rest of the Latin Americans, and generate a sort of small community or supplement that the family did not have. And being more sociable, too, makes us to... Or led us to take certain behaviours that we had lost, because that thing of communicating or making things, uh... Thinking together and doing things together". (Arturo)

"I... […] became desperate. I looked for on the internet, which was as when I came to Minnesota, to this Chilean community, and I found them and came, finally, here. "Hey, I am alone, you know? I need to share with someone."(Camila)

"They took me to a restaurant called Mexican Cafe, which is in the city. […] There is Latin music and all... […] For so many problems that I came and after so many things, one Friday I went over there and... And I told her, who was going to be my partner: 'Shall We Dance?' But I did not speak English and she spoke no Spanish. Nothing. […] And I pointed out and made signs and so on. So we keep talking, I invited her home, share a cool weekend, and we started dating. […] We were together for dating, started, but it was something different, because... Just by being in New Zealand, a country that speaks English and you have no culture, because culture is a totally different culture here, I began to talk to her with a dictionary […] I wanted to say a word and I had to get the dictionary and showed her, and she looked at it and laughed and vice versa. […] It was our first communication. […] She, then, little by little by little, began to learn, learn, learn and learn Spanish. […] If you do not surrender, you will never have the opportunities you want." (Daniel)

However these social networks are perceived, the common thread is that there is an undeniable link between networks and participants' mental health, to the point that they should not be viewed separately.

4.2.2. *Eating habits, physical exercise, weight and cholesterol*

Food, eating habits and diets, was the most popular topic, discussed by all participants and seemed crucial to their descriptions of health, having a healthy attitude, and being a healthy person. Physical exercise, weight and cholesterol were often related to eating, as complements, but there was no doubt that, for participants, eating habits were one of the main focuses regarding health perception. It certainly was more important for some of the participants than others; however, there is no denying that this topic had a central role when defining health issues:

"A healthy person... Must eat well, right? Must eat well, the best way possible. And do exercise. Right? Be active." (Felipe)

Eating well is mentioned first in this case, and is also associated with physical exercise and being active; however, in his speech, these factors are secondary to the most important one: eating. Eating well or balanced is also present in other participants:

"I try to control, a bit, my eating habits, […] eating healthy food, eat vegetables, not so much fat (Claudio)."

"I control my diet. I try to do exercise: to walk. […] I have a disposition to high cholesterol, or... Prone. My cholesterol by ingestion is normally low. But... It's genetic, so it's high. But, in many ways, I changed my breakfast. I used to have these commercial cereals. Now, oats. Uh... Fruits. I try to avoid cheese, all things... Avoid things that I know will affect me. And… And well, but also for the rest of my family, I try to cook healthy. Vegetables…" (Josefina)

Others claim to be less successful in pursuing their goal:

"I try to eat well, more or less balanced, I eat vegetables, with meat, fish. I try not to eat much junk food. Uh... I don't like fried food. I enjoy it, of course." (Andrea)

"If it's a weekend, we try to have a meeting with friends, where we are supposed to eat. During that week, we try to eat healthy. Or with normal portions, not abundant," (Arturo)

"I try to chew food well, not swallowing it. Because, simply, many errors... You can make many errors by swallowing food. Not chewing it well. So, if you don't chew well, there is no good... These elements are not going to be that effective, I think. And well, water... Well, water is almost always... […] No. I used to drink Coca-Cola. Not now. I don't know, and when I drink... Just once in a while. So... A glass or two, and that's it." (Felipe)

For the three participants there is an inherent contradiction; Andrea claims that she does not like fried food, but immediately admits to enjoying it (it could be interpreted that she enjoys food in general, but this comment is made immediately after mentioning fried food, which implies that she still has it in mind); Arturo, on the other hand, mentions that he takes care of his eating during the week to prepare for the weekend, when food will be more abundant and probably less healthy. This can also be interpreted as an "enjoyment". Once per week, they will enjoy food, instead of just ingesting meals. Finally, Felipe, who is very descriptive of the process of eating and how it would affect the general result, claims to have dropped his habit of drinking soft drinks and opting for water — but then accepts the fact that he sometimes does it anyway. He follows the same pattern again:

"In the measure of possibilities, trying to eat well, balanced, at my hours, which are five. Five times. At my hours, no cravings, and if I do, I do it just once, but not... Not always." (Felipe)

These three commentaries reveal an important feature: Apparently food can be healthy or enjoyable, but it is very hard to combine both. "Delicious" would be a rare feature in healthy food.

Other participants found it harder to succeed in having a healthy diet, even though they were aware of its benefits and wished to change their behaviour:

"I highly believe in making life healthy, having a healthy diet, and prevention. But I'm not particularly careful of these things. Others have to take care of me." (Carolina)

However, she adds later that she does pursue a healthy diet:

"I eat very healthy. Uh... Not in quantity, but in quality. I eat, exclusively, Mediterranean food. I eat only olive oil, not much salt, a lot of fruits, a lot of vegetables, meat [beef] once per week, chicken twice per week... My diet is very varied. Very rich, very healthy. Maybe I eat too much cheese... And bread, that is why getting thin is so difficult for me. don't eat anything that isn't absolutely healthy. And I don't eat much by... Outside, because, in general, I don't like much the food here. And, besides that, I prefer to eat at home." (Carolina)."

Camila, on the other hand, admits that she is very irregular when eating, and that she has tried to change it:

"I have the defect, which I told you at the beginning, that I'm very irregular to eat. [...] I have the capacity, that is why... I get fat, and that is very unhealthy... My older sister always scolds me, because [...] I have the characteristic that I can spend two days just drinking coffee, as I can eat a full bowl of lasagne without any difficulties. [...] Of that people that can't eat for three days, as much as eating like an animal. Which is very harmful. And I have tried to change it for a while. [...] That worries me: Like having lunch, make breakfast, doing all those exercises, like eating at proper times, and eating, like, healthy and that. I have tried to change it a bit; it's not an issue of losing or gaining weight, but it is unhealthy, at the end, to spend the day just drinking coffee." (Camila)

But this thought does not satisfy her enough. She feels there might be internal issues that could be affecting her health beyond her behaviour:

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"I don't know what's wrong. I don't know. Something like gluten, that... That there is something wrong. So, I eat some things and they make me ill. But it is not serious. It is something I have to handle.[…] I feel, sometimes, that dairy milk makes me feel a bit odd, then I have thought to changing to soy milk…" (Camila)

Felipe, to whom food plays a very important role in his health (almost a third of his interview revolved around this topic), says he is very conscientious regarding his eating, and he seems to recriminate himself when he does not follow his own patterns:

"Between four or five months, normally. But no... No. I think I am not making any mistake. […] I analyse my food a lot. […] Last two weeks, I've had... A lot of butter, which is not good. The butter I'm eating is not good. Mostly, I eat the light one, the soft one. The one without cholesterol. Because, if I eat that, and some other things, I can make it... I get fat. And getting fat, for me, means high cholesterol. So, I try to stay... In that sense, like... Like I'm not having water. Things like those." (Felipe)

There seems to be a current motif in all these claims, which is to associate food to an amount of guilt, although it was never directly declared. Food-related stories always start with an ideal, and later they seem to deflate in the reality that these ideals are much harder to obtain than originally thought.

Enjoying food and caring about health are seen as hard to combine, and the fact that eating requires a relatively small amount of time and control from the part of the person could be perceived as a failure to commit to certain goals.

There is, probably, a major cultural component behind this feeling of uneasiness., which could explain why some participants are very critical of their cuisine:

"With my mother, I ate well and... I was very active, too. I had activities. Sure, I ate well regarding... I mean, in what I did, right? If I had my children right now, I wouldn't give them the food I had... Being able to have. Say, my food would be more balanced, right? With their schedules. More vegetable, for instance. […] It was... We eat a lot, in my area... Much rice. Much rice and fish. That's the meat we had. […] Yes, that is what we had. Always what we had. Always rice." (Felipe)

Felipe remembers his childhood and judges that he was not properly taught by his family to eat well (even though he initially states precisely that), mostly because he comes from an impoverished background, where food variety was lacking in general, and quantity was more important than quality.

Others are much more critical to their countries' foods.

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"[W]e [Latin Americans] don't eat balanced, we don't eat well. That makes you rise your cholesterol level, uh... Sometimes, obesity or overweight, etc." (Andrea)

"I had the opportunity to be in South America ... I think that, generally, no ... no ... We don't have a balanced meal. We don't have a balanced meal. And we don't eat at the proper hours. Within hours, right? At the times indicated. I believe that ... We swallow ... I use the word because there is no better word ... Swallow what is not chewed well. Let's put it that way". (Felipe)

"Because I don't know, maybe it's not a habit, right? Do not chew well and... Now, ... In many cases the food is repetitive, right? For me ... I like it, right? It's nice to eat. I eat stew all day at home, right? Chicken stew, beef stew, pork stew. Rice, rice, rice. And maybe, […] A little lettuce, right? But that's not enough, right? Of course, they taught me there to... To eat more... […] I think that I, that Latin Americans ... Generally, we don't eat balanced meals. And the water, well, we don't even look at it. In many cases. Right? But ... Always Coca-Cola, Coca-Cola and Coca-Cola. And... Things like those." (Felipe)

Carolina approaches this topic from a different angle, claiming that, in spite of poverty and lack of access, Latin Americans, in general, at least have access to food and that greater problems (malnutrition, famine) are avoided. She makes a clear contrast with other areas of the world.

 "I don't know if it is they take care... Or it is because our countries don't have big problems... They don't have famine problems, they have poor people, but they don't have famine epidemics, they don't... People, for better or worse, have enough to eat, even when they are very poor, […] Brazil has its poverty slums, but in that country, with that climate, people at least can eat bananas. Therefore, they don't have health problems like other countries." (Carolina)

Carolina clearly makes a contrast to rate Latin America's eating habits: Instead of "good" versus "bad", she resorts to "better" versus "worse". If this conclusion is added to the previous ones, the general speech would be that Latin Americans are suffering from first-world problems regarding food (at least, the problems of socially-deprived people in developed countries), instead of third-world ones.

It is worthy to note that physical exercise was mentioned, during these conversations, by most of the participants. Exercise was very closely associated with eating, to the point of being considered a part of the same topic.

The only exception to this relationship was made by Arturo, to whom exercise had a more pivotal role than the rest:

"I try to keep a permanent physical activity state. […] I try to develop physical activity during the day, I try to change my ... um ... sedentary state, I try not to be over an hour and a half, two hours sitting, I stand, I'm trying to apply the concepts I am trying to introduce, as ... healthy elements of myself". (Arturo)

Sports have always been important in his life, and he uses a language that identifies him much with physical activity. He remembers that he used to be a very active young person, but a sport injury led him to be more careful:

"I used to practice sports a lot... I suffered a lesion. I realised I was frail. And I started to be careful. But not major cares, I just tried to avoid new risk situations." (Arturo)

For the other participants, exercise was recognised as important, but it was mostly mentioned as complement of diets. The definition of physical activity varied from person to person, too. Depending on the age and physical status of the participant, it was viewed differently; for Carolina, who is 70, walking and avoiding too much sedentary life is considered exercise. The same happens to Josefina, who is 61: "I try to do exercise: to walk."

For younger participants, a specific activity is referenced when making an example of physical exercise.

"But sports at home. I bought a bicycle to do some spinning, that was what I always did in Chile. I go swimming twice a week; I bought some dumbbells for my arms, but nothing, no discipline…" (Camila)

"On the bicycle, I rod the bicycle a lot. Here, instead, I don't... I try to do it, but it is... It requires more will because of the weather."(Claudio)

"My children are Permanently doing sports activities. Because I, particularly believe and... Since I work in that area, that exercise I s a good antidote to all that kind of trouble." (Arturo)

It is also remarkable that changes in behaviours and attitudes regarding sports and physical activity were, in general, the most mentioned ones, compared to all the others

changes (See section 4.2.5.). In this sense, physical activity had a larger influence in participant's life after they moved to New Zealand than dietary behaviours.

4.2.3. *Trust*

Trust is a very delicate issue for some of the participants, not only in their daily life, but also when dealing with illness and treatment. There seems to be the idea that trust is a rare gift, which can only be given to a few. Daniel is probably the most dramatic case of lack of trust. Since he has had a traumatic past, it is very difficult to trust others, especially his fellows:

"The conditions I arrived, well, I didn't know anyone... I came here scared, because it's a country where I didn't know where it was, And if the... It is pretty far away from society. We are far away from everywhere. But it's a country that I appreciate a lot, because at the beginning it was hard. And everything, because little by little they gave me the chances to live another experience, another life quality, for instance. Uh... Living a little more quietly. That they [the guerrillas] are not looking for me, that I don't have to look everywhere when I go downtown. What I always have is a little of caution to mix with the Colombian community. Because you never know where they come from. I have Chilean, Mexican, Peruvian friends, but no… Colombians." (Daniel)

He ends with a happier note, indicating that he is learning to open himself up a little more. His case is extreme compared to the others, but this underlying distrust is apparent in to varying degrees in all participants when dealing with unknown people. This is not directly addressed, but, in health situations, they appear to reveal certain apprehensions, like in this example:

I remember that this time, when I put the antibiotic to the vein, this young doctor started looking for the vein in the arm, she butchered me. She left the arms purple. And after the third search of the vein, I said 'oh, if you can't, I will go and get the nurse'. Then I stared with mad face and said: 'see my arms, why didn't you seek the nurse?' Then she says 'no, the thing is that...' 'But who is doing this procedure? Is it the nurse or the doctor, here in New Zealand?' Then she looked at me and told me that either. 'But who is the specialist in the vein, anyway?' You know? Because, 'Why are you practicing with my arms?' Then the gall realised I was upset, then I said: 'Sorry, but in my country, the person who makes this procedure is the nurse.' Then, she is the one who can do with more proficiency, actually. And she doesn't miss as

much as the other. Then, 'yes, but the thing is...' 'But I didn't authorised you to train with my arms', I said. 'Look how you mistreated them.'" (Camila)

After feeling pain when being shot a couple of times with a syringe, Camila claims to have been "butchered". She immediately asks for the professional's credentials, and is not satisfied to hear that she is not a nurse. The logic behind this behaviour would be that not all health professionals are trustworthy to do even simple procedures, and since she seems to be failing at that, it is probably because she is not qualified. She demands someone else to do it, since trust in the professional has been broken.

Trusting appears to be a rare gift. So much so, that participants tended to listen more to people they knew, rather than specialists. This happened transversally, but there was one major difference: Non-professionals and less educated participants listened to the advice of friends, relatives and acquaintances.

Daniel, for instance, after being sent to a hospital with a heavy migraine, being treated and ending with a paralysis in his legs, decides that he will stop trusting doctors anymore:

> I didn't come back after that. So I started with my therapies myself, and... They told me that... They said... That worked. They said 'climb a high place, to receive the wind. A strong wind will help you, it makes you crumble, and it helps you.' But it was already at night, and in the night we went to One Tree Hill, and we were at the top and, I don't know, suddenly, it took me in a bad standing, shook my crutches and took me in a bad standing. And I fell down. I fell in my buttocks, and... […] A friend told me. […] A friend, a Chilean friend. He told me that. He told me that a strong wind scares you and like stretches the body, and like helps. And I listened to him, but... […] It didn't work and... The wind was so strong, that I fell sitting, and I think that is what worked, because at the next day, after that hit, at the next day my leg started hurting." (Daniel)

Daniel follows the advice of some friend, and, even when he does not get the desired results, he thinks it was a good advice: since his legs start hurting, it means he is being cured. He assumes causality and believes it was his friend's advice which helped him. The doctor, on the other hand, was, according to him, the cause of the whole problem. Felipe shows another example from his perspective:

"I also went through to learn more, online. Chatting with adults, learn a bit before, because they ... In Spain you learn a lot, because adults will explain, right? Water, for example, I did not even do much to inform me. Just a little, right? The basics ... But it was an old man who told me: 'do not forget, Felipe,' he says, 'when taking food... The water '. I say, 'I drink lots of water!' He says, 'But remember, at the end of the meal.' And then, on the radio (Felipe)...[…] A Spaniard. Yes, when I was in Spain. He... That advice, I took it. Then he said 'it will be good for your digestion, because as we eat, we have to evacuate.' And if there is water, there are less chances of constipation. And if there is constipation, you can't evacuate. So true. And you analyse and... And then evacuated with ease..." (Felipe).

Felipe uses the word "adults" in his to this story. The term implies maturity and seriousness, which might be what he intends with the moral of this story. He does not talk just to anyone he knows, but an "adult", or an "old man": somebody with wisdom, who deserves his trust. He becomes an 'informal expert', somebody within the social circle who can be believed and consulted. In some cases, the participants themselves become 'informal experts'.

"We were here at a friend's house. I wasn't even there, and when I returned, [my partner] was in pain and I started to look and say: 'love, what's wrong' and she says: 'I'm in pain.' So I said: 'stand in front of me' and took her hands and we started to bend our legs, up and down together, as to avoid some contractions. And down... Then nothing, and she laid in bed. Nothing. I said: 'no, love. These... These... These are labour pains.' And we went to the hospital." (Daniel)

In this case, Daniel uses his own advice to prevent his partner to going into labour (she was 25 weeks pregnant), but the exercise does not seem to have any results. But, since he is her partner, and he loves her, this advice could not be bad, and he does not question it at any moment, much less discuss it with a professional. They finally go to the hospital, because the birth is inevitable.

Felipe, on the other hand, likes to share his thoughts about diets to others:

"Many people, here, ask me how to lose weight and all... I say: 'it has 12 steps'. Because I've lost weight. I have my own methods, my own tips that work. I recommended it to two friends and they have lost weight. And they are happier. They eat healthier, have lowered the fat. But they have to have willpower." (Felipe)

Participants with professional background and those with a higher income also expressed more trust in members of their social network, except they made the condition that these family and acquaintances were health professionals:

"Supposedly, the GP was going to make the contact with the hospital to give us the appointment. But, on the other hand, she gave us a prescription, and we went to do that exam privately. That same day, with those results, we went to consult some friends of ours, some doctors. We told them what was it about and they thought it was weird. It seemed more serious than we could see. To our knowledge, it was just a spot in an x-ray. But the doctor said: 'no, there is something else'. And they asked a specialist, a cardiologist, and said 'no, this can be serious, so go to emergency immediately.'" (Arturo)

"I said 'hey, would this not be a fungus?' And […] he went to the doctor, who prescribes pills for fungi, without prior exams. I know about the subject […] because my sister is doctor and my dad is diabetic. Well, my dad has had, for a long time, fungi in his toenails. And it turns out (clears throat) that he goes to a diabetologist […] because it turns that is the best for diabetics, and it turns he cannot have... Diabetics cannot have, is anything that damages their liver. […] And one of the remedies he cannot have ever, are anti-mycotic drugs, because they are very strong and with hepatic compromise. And it called my attention that this GP gave [my boyfriend], like 'take these pills' without any hepatic test, so I called my sister and: 'What happens is that [your boyfriend] has […]...' 'No', she told me. 'That stuff, […] Forget it, they have to test him hepatically before, during the process and at the end.' […] I'm sure, because my sister is always aware of..." (Camila)

Camila goes further, by claiming that being related to a doctor gives her more access to medical information. For this reason, New Zealand's health care system is not suited for her.

"I think [New Zealand health care] is good. Avoids waste of time. You know? Departing from this question that the people, 'ah, I feel bad, my guts hurt, I'll go to a gastroenterologist,' and that, in fact, may have nothing to do with it. Eh... But I think it is for people who have no biological education. You know? But someone who has biological education, who is close to medicine, who knows a little... I trust more a urologist, when I have a urinary tract infection, than a GP. You know? So... That... I feel like I've lost a Little of the freedom I had in Chile. I said: 'Ah, I'll go to the gynaecologist, I will ask her, I don't know, […]' In short, I'm paying the consultation... I have to attend, do you see? So, I feel it helps, for people who have no biological education, to say it in one way, closer to medicine, to be able to use that sieve alone... Right? That, for the active population is helpful, because there must be 10% of people who knows where to go, who has a sister, as I have, or a cousin to ask. Isn't it? But for me it is not comfortable." (Camila)

In a way, she would be implying that her proximity to her sister would make her an expert too. This conception does not only apply for friends, but also for friends of friends:

"I went to my sister, who ... is in sports. She's, uh… International tennis court judge, and has tennis academy, and it is closely related to the people of sports. She said 'look, do not return [to the orthopaedic surgeon] unless I take you a... To see a... A doctor friend of mine, a traumatologist'. I almost got twice having surgery, and he would check me and not let me have a surgery." (Carolina)

"[B]efore I came to New Zealand, uh... I had a pain... A pain here, down there, in my chest, at the top of my stomach. The first thing I did was to call a friend who is, uh... gastroenterologist. So I told him what I had and so... so I said by telephone, he... That certainly there were gallstones. And he recommended me directly to... A specialist. I believe those who see this are... Oh, I don't remember. I forgot the name of the specialty. But hey, I was recommended directly to a... A surgeon, who does these operations." (Claudio)

For both Carolina and Claudio, the amount of trust is given by a prior direct or indirect relationship with the other. The only difference is that those who have had tertiary education (and therefore could be described as "more educated") added professional knowledge to the equation, but this was only secondary to familiarity.

However, lack of confidence in the expertise of health professionals is not necessarily irrevocable. For participants, there are certain elements that can help returning their trust. The most important seems to be the behaviour of the health professional. If he she exhibits an authority figure, then it substitutes familiarity. The lack of authority figures in medicine was highly criticised by participants.

"The vaccine issue is just starting here and is not mandatory. Then they say 'Please vaccinate your child, it is important,' I don't know. But it is not compulsory, as in Chile, which is good because it is a health issue... in the end, and, for example, in the case of my son. He has no follow-up he will is going to be three years now... Some time ago, about a year, I think it was when he turned two years. I can't remember. With that I say everything. And I went asking, since I moved from my house, if... when did he have the next appointment, and they said: 'when he is three, if you like, you can bring him, because, actually, when they are three it is a very busy time for the parents, they start bringing their children to kindergarten, uh... So 'don't worry, it's up to you. If you want to bring him, you bring him. If not, you don't'. So, these are extremely important times when moms or dads are teaching them things, especially if it is the first child." (Andrea)

"I think it's a bit more informal. […] I think here it is a bit more informal. […] Uh... that is provided by the specialist. If you go to a gynaecologist, who is a specialist, with a gynaecological stretcher, with artefacts to... But here, you go to have a gynaecological exam, with an ordinary stretcher, with a GP, so it's less... Uh... That same reason, say, I feel it's less... Serious, to put it somehow?" (Camila)

"And another thing we do that is worth emphasising here, in health, is that doctors do not research you and you're used to that... As in Colombia or South America, I don't know, you're used to the physician, he is accustomed to look, to see what you have... But the doctor here, when one starts telling... And he begins to write: Ta-ta-ta-ta, on his computer. And that kind of gives you uncertainty, because the doctor is going to you and a doctor only does... In terms […] of he himself to prescribe anything to you. Without touching you. […] But that is what you see one here. […]There is no contact, so you say... but, how does he knows if I have that, if he hasn't touched me, he doesn't know where it hurts? He is there, writing at his computer […] So it is something I have seen in general, generalised. […] In an emergency, at the hospital, they research you, to see what you have. But with appointments, I've realised that... No" (Daniel).

The gravity of a medical personal's actions and omissions varies, according to each testimony. What they all have in common is that health care professionals take an approach that does not coincide with the participant's vision of what a health care professional should do, whether it is being more empathic, treating the patient, having the proper equipment or touching the patient. In other words, the doctor is not behaving with their vision of a good doctor's behaviour, by being relaxed, apathetic or indecisive. It seems that these participants miss some sort of vertical authority. A doctor should be sure about his/her work, and for them, the way to show this confidence is by showing certain attributes that could be perceived as pedantic. This verticality seems to be in league with the lack of trust in strangers. It could be argued that what they perceive as confidence translates in professionalism and substitutes the lack of knowledge to that particular professional.

Not all participants agree with this vision. In some cases, they prefer this more friendly and accessible approach, which makes patients easier to discuss issues with professionals. Being humble, flexible or soft-spoken with patients is seen as an improvement to health care in Latin America for some participants. Arturo, for instance, sensed that he could trust doctors more in New Zealand for this reason:

"I thought it was interesting, or called my attention, when the doctor said: 'well, if there is surgery to be made, I'll try to do it tomorrow'. When he saw me with all that pain, he said 'we are going to move it to today, tonight, now'. I mean, he had a

disposition to treat my relief, to look for a... To diminish ailments and pain, and to solve the problem." (Arturo)

I think there is a relevant aspect regarding patient service. I see here a better care for the patient, everything is guided by ethical protocols and even for a routine shot, they ask you please and then apologise if it hurt you. We don't see that very often in Chile. Doctors are a godlike authority, and pity those who dare to contradict them. I see also a better rigour in procedures, and a control system that forces doctors to follow established protocols and better follow-ups." (Arturo).

Carolina also shares this view. She sees medical professionals as attentive, and the fact that they make efforts in doing follow-ups on her is, in her opinion, gratifying. Like Arturo, she also values certain protocols as positive.

"There is supervision. Not there [in Latin America]. Neither supervision, nor follow-up. Otherwise, I wouldn't spend ten years without having a Papanicolau. When I came and said to the doctor, she told me 'Oh, didn't you have it for ten years?' 'No.' 'Oh, well...' I mean... She wasn't impressed that I didn't go. Meanwhile, here, if I don't go in three months, I receive a letter from the nurse, the doctor, my GP, telling me: 'you are someone that has a... high pressure, and you can't have medication twice, if you come every three months, and, besides, you, since you have diabetic potential, have to do the analysis every...' If it happens one day, they call me, because they sent the letter, so it is impossible not to take care of you." (Carolina)

Felipe makes a more affective judgement when talking about his doctor:

"The doctor is a doctor from Iraq. And the... Well... He treats me well. Yes, they treat me very well. And they inspire... they inspire me confidence. It inspires that you could be listened as a friend. To the patient." (Felipe)

In a way, this doctor has broken the barrier of familiarity, and Felipe feels listened "as a friend". Therefore, he can trust him in difficult times.

4.2.4. *Self-medicating and natural medicine*

The issue of self-medicating arose among several of the participants, especially when talking about Latin Americans:

"[W]e self-medicate. Uh... Especially us Chileans. I don't know, I don't know much about the other cultures, but... In Chile, any pain is quickly hidden, And that is not good, because sometimes you don't get to the bottom of the problem." (Andrea)

"Oh, yes, in the case of Guatemalans, health is pretty much 'someone told me this pill works for that thing'. Between... So keeps on moving, everybody tries to cure themselves with what someone else gave him". (Claudio)

"Much of the household remedies are homemade in Guatemala . Yes. […] It can be because of the culture mix, right? Because there is much... Guatemala is very influenced by the indigenous culture, which is the majority of the population, so, indigenous, in general, they, like, take... natural medicine. So, between, like, mestizos, this has kept on going. There is much... Much more of that thing". (Claudio)

In some cases, participants described their own behaviour and gave signs of self-medication, although not identified as such. Some mentioned generic drugs to ease pain or ailments:

"I drank Paracetamol tees, when I was very, very decayed. I drank Paracetamol tee and coughed, nothing else. Besides, I'm allergic to anti-cough syrups. When I have coughs... [gestures of holding them]" (Claudio)

Others mentioned natural medicine as an alternative to other kinds of treatment.

"[W]hen you tell someone that you are sick, people tell you 'Oh, you have to take these pills you have to make this little infusion, this tea'. Much of the household remedies are homemade in Guatemala." (Claudio)

"If you had stomach-ache, [my mom] made you an infusion of lemon balm... Or a *tote* infusion. Tote is a very white plant, very good for... Or, when you are sick, the headaches... She put potato in your head... Peeled. She put potato in your head." (Daniel)

There appear to be two reasons as to why participants use their own medicine: first, as already described in the previous section, there seems to be a lack of trust in conventional medicine and health professionals; second, some of the participants have stated (as seen in section 5.1.1.) that they have a more holistic vision of health, and that nature seems to be a good complement for their health. In a way, eating habits could be considered a part of this natural medicine. Several kinds of food are used by some participants as natural remedies for ailments.

"When I was 12, with the help of my mother, that... She prescribed me a house remedy... […] Honey and onions (laughs). […]She grated the onion, and...after grating, she removed the juice. And mixed onions and honey, and gave it to drink it every day. […] And, until a few years, I saw honey and smelled onions (laughs) […] Well, I don't know if that… Well, when you study, both… Both are, uh… Onions are rich in vitamin C, and honey… Yes. It has a logic, right?" (Josefina)

"Sometimes… I`m always trying to… to influence or… Something that might benefit you, pass my knowledge, right Uh… I have a friend who suffers from… From… kidney stones, and he is always suffering. Then, whenever I'm… annoying him… 'Drink your water, take this, take… Cranberry juice, drink what helps you.'" (Josefina)

Organic food is also a concern especially for Felipe:

"I tried to… I'm more natural. And if possible, if I can, in the country, when I go somewhere in the north, there were many people who sell organic food. Yes, I prefer organic food. Because organic food is better, healthier."

This concern has made him grow his own vegetables:

Well, the issue of ... of ... of fruits and vegetables, which are being irrigated with ... With some chemistry, right? Some chemical that ... […] protect it from insects and other things, but ... As I heard, that are being sprayed with certain ... Certain, these... Powders. Or liquids containing certain ... That can damage health. […] I had a vegetable garden ... […] and I tried to make it more natural. With things... The river, with bones... Bones of the goat ... Or the cow, put them on earth, there, right? […] The waste from the cow. […] I didn't put chemicals. Because... I read it, right? And affected... […] In the short and in the long run, they affect you. So here comes the idea of... From … What do you call? […] To have products that have no powder or anything. Spray, whatever. And vegetarian. […] Here I've gotten into this matter. As I had the opportunity to […] have tomatoes and stuff, uh ... I, myself ... […] I'm getting closer to that matter. I see it's healthy. Healthier. I'm not a fanatic." (Felipe)

Interestingly, there is not much mention of "cure" to diseases or disorders by this behaviour. Participants' main focus seems to be to improve the immunologic system, tease pain or illness, or simply to avoid possible complications by dealing with unknown substances.

4.2.5. *Change of habits*

All the previous behaviours, attitudes and beliefs reported only indicate a particular moment, as perceived by the participant, and not necessarily a permanent stance on health. Indeed, participants claimed that they had changed, more or less, in recent time.

All of the participants noted having changed some of their habits, either for necessity, or by their own choice. The main reason for this change of behaviour was the process of migration. For some, physical activity decreased, since they changed their jobs and routines. Weather too seems to be an important factor.

"I try to develop physical activity during the day, I try to change my... um... sedentary state, I try not to be over an hour and a half, two hours sitting, I stand, I'm trying to apply the concepts I am trying to introduce, as ... healthy elements of myself. And in that sense, I have changed." (Arturo)

"[I]n Chile, I did a lot of sports, many years. I stopped and now I started again." (Camila)

"Yes, I think I do less exercise here. […] Um... On the bicycle, I rod the bicycle a lot. Here, instead, I don't... I try to do it, but it is... It requires more will because of the weather." (Claudio)

For Andrea, on the other hand, the amount of outdoor areas and activities has encouraged them to become more active and pursue a healthier life.

"New Zealand urged me to do exercise. I never had done it before, in my life. Except when I was at school, and forced to do it, to have my marks. […] But I realised I had skills. It's impressive. Well, to start, with my husband we organise the Latin Marathon. […] It is a little activity that has been growing, that we organised the same year we came. We arrived in May, and we did the first one in October, and... We saw so many people in the park, so much outdoor activity, such a good weather, that, sometimes, we went with our kid, our biggest kid, that had the same age [points her two-year-old child]... And a park, we ran, and... I liked it. So, once in a while, I go out running, or to do Sumba once a week... So I try to have a quiet life, in the middle of this... So, if I have the time, the children... I do stuff (Andrea)."

For Claudio and Andrea, seeing the same factors, the results are the complete opposite: for Claudio, a Guatemalan, the weather is too hostile for outdoor activities; for Andrea, who comes from the South of Chile, the weather is not only nice, but it urges her to go out with her family. She became so motivated that she started organising sports events.

In the end, a subtle difference between both backgrounds causes a complete change of behaviour.

Pursuing a better life seems to have changed the use harmful substances, such as alcohol and cigarettes for Camila.

"I was a smoker. I am... was a smoker... That I hope I will never be again... But very. Since I came to live here in a small flat, we went together with my partner, […] and [he] just stopped smoking at that time. Then, I started feeling this sensation... I, stinking as a cigarette, he wasn't... it wasn't nice. And it was like this: I said 'I won't smoke anymore, I won't smoke', and never more." (Camila)

"[H]ere, at four o'clock, I don't want to have a beer. I'm nocturnal, so I don't drink there. I could even say that in Chile I was a social drinker. I wasn't a drinker... But of course I drank more than here. I don't drink anything here. Barely... Nothing. I mean... I can spend months without even having a... I open one beer and I drink half […] And wine, I don't know... I think wine here is very bad.... Uh... No." (Camila)

The last sentences have more meaning by the way she pronounces them than by the content itself. They are expressed as a gesture of unpleasantness and an irrevocable decision. Her intention appears to be to be made clear that there is no possibility she will return to this behaviour again. She does, however, seem to contradict herself:

"I said 'I won't smoke anymore, I won't smoke', and never more. No... I mean, the only time I have smoked this year and a half, was when I went to Chile and... Right? A marathon with my girlfriends... Drinking and so... I couldn't even speak, […] I can't smoke anymore. It makes me ill. I hate the cigarette smell... [She is asked whether she needed any help by quitting smoking] Nothing, no, no, like this, '*tak*'. I found out that I was... I insist: I mean, even today, I think it is a pleasure to smoke. I like it." (Camila)

Apparently, she has smoked again, but in minimum quantities, and only in specific social occasions, compared to past habits. It certainly is an improvement, but she did briefly return to her habits. There is also ambivalence in her comments; although she says that returning to smoking with her friends felt unpleasant, she admits later that smoking is a pleasure. This contradiction seems to come from a cognitive dissonance. It is later implied that she does not seem to have a high opinion of those who claim that it is hard to stop smoking.

"I even think about it and how I would love to have some cigarette. But... That's why I think it is a lie that... I don't know. Well… It's a psychological thing. But it's a lie when people say that... No. No, you can. I mean, I was a heavy smoker. During more than 15 years. And I dropped it. Never more." (Camila)

She seems to imply that people who say that it is impossible to stop smoking are lying, but stops right before making that conclusion. Camila refuses to be included among those people, even after admitting that she smoked again not too long ago, when she was visiting Chile. She, then, reaffirms her identity by making it clear that she never smoked again. She uses "never more (*nunca más*)" twice to remark her achievement and to distinguish herself from the group.

Daniel experiences an important change, this time regarding mental health:

"I have a less stressful life. I have a completely different quality of life. I want to learn how people live here. We can ... That is not done in South America, for example. In my country, it is not done. And that helps a lot. Because it is not only necessary to work anymore. But in Colombia, you work, work, work, and you never have (Daniel)."

According to Daniel, New Zealand's lifestyle has a different pace and lets people enjoy their life better. Daniel's approach comes from a disadvantaged position. He has trouble explaining himself, but concludes that "in Colombia, you work, work, work" (Daniel). No matter how hard he will work, he will only have the minimum. There is a clear implication that this lifestyle is affecting his mental and physical health:

"In Colombia, one thinks and thinks and thinks and emotionally, and personally seeing it affects overall health. Because one is more concerned about the job. By working and thinking, but you do not worry yourself. In contrast here, since you only work as needed. Say, one has a more relaxed life. No one cares if tomorrow you will have or don't have. There are different things and with that, then I feel a little calmer." (Daniel)

Again, he uses repetition to stress an unhealthy behaviour. In this case, he seems to refer to worries, anguish, fear, fixed ideas, or other negative thoughts ("thinks and thinks and thinks") that undermine his mental health. Not being able to let his mind go from his job is a clear symptom of unrest, burnout, and probably post-traumatic stress disorder[6].

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[6] It is important to remember that he worked in the Colombian army, and not only he witnessed terrorist attacks, but he was also kidnapped twice by the guerrillas.

He is unable to enjoy, because life is dedicated to work, but work is not dedicated to life. He perceives he has been only surviving, instead of living. He wants to learn from New Zealand's lifestyle, which could be interpreted as learning (or re-learning) how to live, a chance he seems to have been denied in his home country.

These changes of attitudes and behaviours are not trivial. They involve great levels of accommodation, which can be stressful by themselves, even when they are made willingly or when they are considered as improvement to their previous life. In fact, it would be possible to hypothesise that many of those changes may be responses to the need to a better self-perception, in order to cope with changes that might be negatively affecting their health.

4.3. **Summary**

In this chapter, participants' lives were briefly exposed, especially regarding their migration and health issues. Five key components of how health is experienced and perceived were revealed: family and mental health, diet, physical exercise, trust, self-medicating and natural medicine, and behavioural changes in New Zealand. In the next chapter, I address participants' health issues by answering the research questions made in section 1.2.

5. Discussion

The purpose of this Chapter is to explore views of the participants regarding health and health systems in their countries of origin and New Zealand. Information provided by the interviews in the context of the research questions proposed in chapter 1.2. (how do Spanish speaking Latin Americans perceive and define health?; what is their experience when dealing with their country of origin's health system?; what is their experience when dealing with New Zealand health system?) will be analysed, and hypotheses to these explanations with relevant literature will be formulated. The following analyses will attempt an explanation through cultural and behavioural theories proposed by other authors, although no definitive answer can be provided by any means, given the inherent subjectivity of participants' thoughts' nature.

5.1. Participants' Perceptions and Definitions of Health

5.1.1. *Definition of health*

The first topic in the interview was to define health. Participants were given the opportunity to define health themselves, without resorting to ideas that might have come up in the conversation or other influences. Health definitions were similar among all participants: six of the eight participants used the words "state" to define health.

"It is the state of a person… Not to have serious physical or psychological problems. It's wellbeing, at the end." (Andrea)

"Health is a state of equilibrium between all components that allow your wellbeing." (Arturo)

"I imagine it is… the state of feeling… Of human beings of feeling… in good conditions." (Camila)

"It is the best way to… The best state to live, also, better. Health is essential to life. When you lose it, you die." (Carolina)

"You always try to keep yourself in a state of… feeling, of all that, right?" (Daniel)

"It is the perfect physical, mental and economical state of the individual." (Josefina)

According to participants, health as a state can involve certain unchanged attributes. It is not the way to obtain certain things, but the result or product of something. Health can be, then, aspired to or, better yet, achieved. Carolina departs from this vision to go as far as to implicitly define it as life itself, "when you lose it, you die". The suggested dichotomy would be, then, to either be healthy, in the best state possible, or to die. The remaining participants were more cautious in their definition. Felipe went also defining health as something to aspire:

"Health is… wellbeing. Wellbeing of the body, right? Being free to… enjoy. Uh… Enjoy… A good body function, without diseases." (Felipe)

However, he did not use a static definition. "Wellbeing" can be momentary or permanent. It can be an end, or the means to an end, or even both. He assimilates it to enjoyment, body functions and the absence of diseases, but the similitudes remain ambiguous. Is health all those things? Or the way to which those things are achieved? Since he did not use the word "state", it is less clear than the other examples. Claudio is clearer. He defines health as a "condition", instead of a "state":

"Being healthy would be the… physical condition that human beings have, how they physically and mentally feel." (Claudio)

Health is not, then, something to aspire, but a series of characteristics that one possesses, which can be good, bad, both or neither. He uses a more mundane definition, like asking, "how is your health?" to another person, contrasted with the idealised vision of the other participants. For Claudio, health does not have a connotation per se. It is just the sum of many traits. But he seems to be the exception here. The sense that health is equivalent or directly involved with wellbeing is shared among the majority of participants.

But what would compose this wellbeing? The above quotes already mention the absence of problems or diseases, (Andrea, Felipe) and even death (Carolina). Mental health is often mentioned, not only in Andrea's, Claudio's and Josefina's quotes above:

"Physical and mental. I skipped that one. And mental. […] And without mental ailment, I mean, without the feelings of mental disorders." (Camila)

"Not only… uh… physical health, but also mental health. They are two 'healths' that cannot be dissociated. Because, if they are dissociated, they won't fuse themselves". (Carolina)

"[I]t is important to the mood of everyone, health." (Daniel)

Arturo, who does not mention mental health at this point, uses equilibrium and balance to rephrase or deepen his conceptions:

"[W]hen things are balanced, to my understanding, you find yourself in a healthy state." (Arturo)

Participants tended to have a quite holistic initial view of health. They were aware of the importance of mental and psychological conditions. This was consistent with how they later told their personal stories.

However, there were also important differences. When asked to expand their definitions, two new concepts arouse: energy and performance. Energy was more often mentioned or addressed by the women:

"[W]hen you have energy. When you are eager to wake up in the morning […] Above else, having energy. Having the will to live". (Andrea)

"I had an energy that… nobody would have though." (Carolina, talking about her youth)

"If you have good health and good conditions, you can, err... irradiate to those who surround you […] Joyful. […] Energetic." (Josefina)

Only Arturo and Claudio mention energy; Arturo, when referring to his youth, although he first uses the word "vigour" instead:

"When I was younger, all the support was in function to my […] Vigour that youth gives. I was indestructible." (Arturo)

Claudio, on the other hand, makes a strong link between energy and performance: "I feel energetic, with strength to perform my normal activities."

For men, the term "performance" or similar concepts (the idea that health is essential to fulfil certain duties and or the attribute of being healthy would include to be able to perform) was more common:

"For me, [health] is important. Because it allows us to develop other activities and to use other components that also help that equilibrium when we, basically, are trying to have a better life. […] If I'm not fine, I won't be able to reach my goal, in the destined time I have for that." (Arturo)

"Being healthy is… Both not having any ailments, feeling good, feeling in a good shape, to feel satisfied with your body and its performance. […] It's very important, because it allows you to […] disarm all daily activities in a normal way." (Claudio)

"To be able to do anything. […] If you don't have health, you are not able to do anything, uh… Different to read, work, whatever." (Daniel)

"To me, it's important. Because it's the body the one that mobilises you in life, right?" (Felipe)

Andrea is the only woman who uses performance as a concept for health. She seems to define health at a more pragmatic level, like male participants, although her ideas, in general do not seem to be considerably more pragmatic than for other women:

"When you develop all your basic needs without any help, uh… you can eat yourself well, you can mobilise, uh… without pain or illness." (Andrea)

The term "energy" seems to have a connotation of mood, spirit, life. "Performance", on the other hand, appears more focused on doing things and getting results. It could be said that both are necessary for the other to occur, but the emphasis is rather internal in the first case, and more external in the second. This different focus was crucial in the storying of men's and women's narratives.

5.1.2. *Health self-perception*

According to their definitions, participants were asked to rate their own health. In general, they responded positively. Most of them saw themselves as healthy people, even though they might have certain illness:

> "All basic stuff that, for me, re important in a woman, above all else, I think they are fine. I have great teeth, for instance, I'm obsessed with that subject, uh... I hope it remains like that, say... […] And I am a concerned person. […] I go to the dentist twice a year, and all that stuff, and... Great. I haven't been sick since a long time ago, I never get sick of anything serious in many years, I've been operated once from appendicitis, which I think is very simple... […] I catch the classic cold once a year... I don't have any feminine ailment. Say, the things... I have none." (Camila)

The absence of disease is established here as a standard of health. Colds are disregarded as anything serious, and described as an ordinary thing. Appendectomy is seen as a "simple" procedure too. Camila mentions, specifically, her dental health, which she describes as very important for her, and "feminine ailment", to which she seems to be implicitly inferring about her menstruation cycles and other gynaecological conditions. Since those two things are the important ones, they are more crucial in defining her health. Therefore, she concludes, she has a good state of health.

> "I have much energy, my life may not be according to my age [70]... I take care of all things at home, uh... I take care of my grandchildren; I have a grandson that I take care since he was three months, and I take care of him every day, except one, when I come to the library. The rest of the time, I take care of him all day, at least 10, 12 hours. Sometimes he spends the night and his mom works the night shift, and I have the energy to deal with him […] Like a much younger woman. […] Besides that, I sleep very few hours, that since I'm available at nights, I spend three, four hours at night navigating on the internet, informing myself, reading, and so on. And having a relationship with many friends […] and relatives that I have around the world. I think that, if I didn't have... I couldn't be healthy, I couldn't do it." (Carolina)

Carolina uses the term "energy" (and implicitly, performance) to rate her health condition. As mentioned in the previous section, she attributes all the external results as only examples or manifestations of her internal energy. She does not mention diseases, but her age is an important point of contrast: Considering she is a 70 year old woman, her energy to do things that younger people cannot do implies that her health status would be relatively good. Carolina also mentions the ability to contact friends and relatives as

another expression of her energy. However, she does not express the direct benefit of having a social life in her health, yet.

Claudio offers a similar perspective of energy and performance and also mentions social life (although restricted to his family):

"I don't have many diseases, I feel energetic, with strength to perform my normal activities and being able to share with my family in a good way" (Claudio)

On the other hand, Arturo provides an opposite approach to the same situation:

"I feel I'm capable of... Doing all of my... necessary things, say... I have enough independence to be able to do all necessary activities for my daily development. […] And also, […] the fact that I'm able to provide some sort of... Support. Well, in this case, my family. Therefore I, because of that, in that sense, feel healthy. Although I know... Because I have some... […] Complications regarding... Some risk factors". (Arturo)

Arturo defines himself as "capable" of doing things. What makes him capable is not important; it could be a 'black box' that allows him to do it. The important thing is that he can do his activities, and therefore, he is healthy.

He later doubts his declaration and concedes that there might be complications arising. There are risk factors that can complicate his status. But, since he is observing his present time, he can safely say that he is healthy.

"[…] I never had any serious disease, […] I had an accident when I was two, the only time I went to a hospital. After that, my two children were born, […] and nothing else, I mean... A couple of contagious diseases, hat every kid has… and nothing else". (Andrea)

The lack of diseases and accidents seem to be fundamental for Andrea. To be away from the hospital is also used as a good sign (having a baby seems to be an exception, since it is not associated with lack of health).

Josefina is briefer and only counts an allergy as ailment. "I... suffer an allergy, but... I control it and I don't let it affect me". Since there is only one thing and she can control it, by logic she would be healthy. Felipe initially uses the same strategy:

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"I think of myself as a healthy person. […] Because… There are some little things, like, for instance, the bones. They say that... In their middle age, men... Also have bone problems, right? They have to do exercise. And sure. I've that, yes... By walking, for instance, my foot feels bad, and... I've had a problem with my ankle in England." (Felipe)

He is more ambivalent than the rest. His first impulse is to rate his health positively; after he starts enumerating his "little" problems, which seem to be associated with his age (54), he does not seem so sure as he initially was.

Daniel, in contrast with Felipe and the rest of the participants, openly states that his health is not good:

"Because one has... There are always inconveniences in life, you know? And, somehow, you are always with a virus, with something... […] Many headaches, […] Sometimes... I don't have the flu. It's more like headaches. What is most common. And, according to that, the mood is always down. It's always down." (Daniel)

He seems to be describing the same situations as the rest (occasional illness, pain in certain areas), which were discarded by them. Yet, he concludes that his health is not good enough. The difference here appears to be his mood. He feels always "down", which might be indicative of someone depressed or sad. Implicitly, he seems to be lacking the "energy" that others described.

Intuitively, the participant's abstract definitions of health become more holistic when applied to their daily life. They manage to self-reflect their status with the notion discussed and their response not only becomes more pragmatic, but also richer in this combination. Their health stories, which will be described later, will tend to be congruent with those initial visions.

It should be noticed that in many cases, health self-rate tended to orbit around food and eating habits in general. It was implied that much of it had to do with weight and cholesterol, but the significance of food went beyond that. In some cases it was a measure of the standard of living, and it had a deep relationship with not only physique, but also mental health. In Latin America, cuisine used to have a very important role, since it allowed everyone to participate in community activities during the fiesta (not only through consumption, but through preparation and bringing ingredients). Food is considered an important source of health by tradition, especially among 'healers'(Spector, 2000). Latin

American food tends to be high in carbohydrates (potato, rice, corn, beans, tomato), although obesity levels are considered low compared to the developed world. Nowadays, these customs seem to be altered by fast food and a more sedentary way of life (urban population has increased over the years in most countries). Obesity levels are getting higher, especially among the poorer population, where health is also considered a synonym of healthy (McArthur, Peña, & Holbert, 2001).

5.1.3. *Health model and elements*

Several elements influenced the general conceptions on how health is perceived. The diagram in appendix M shows, as a summary, the main problems and concerns indicated by the participants regarding health (acute illness, accidents, cholesterol and weight, mental health problems and trust issues) and means to solution those problems, with the objective of being healthy (natural medicine, self-medication, eating habits, doctor appointment, family and physical activity). These behaviours were intended to be put in practice when consulting healthcare services, but they did not work at the same level: physical activity, for instance, worked more indirectly with eating habits, and so did natural medicine; A doctor's appointment immediately was followed by other behaviours (medical check, and medicine prescription, treatment and/or surgery), and trust, while not a behaviour in itself, was connected with family support and doctor/patient interaction.

5.2. **Participants' Experiences when Dealing with their Country's Health System**

In this section, stories regarding health in the country of origin will be examined, summarised and analysed. Topics were separated according to clusters set by the researcher, according to his own perceptions regarding these stories.

5.2.1. *Traumatic events*

When participants were asked to recollect past events, they tended to access those that had a more lasting impression in their life. For this reason, these events were, in many cases, traumatic. This is delicate in many ways: first, traumatic events may be perceived as

exaggerated way by the storyteller, since he she is appealing to strong emotions; second, the nature of the information itself is delicate, since it deals with painful, unpleasant or stressful events that are generally concealed in their memory; third, these events could overwhelm the general appreciation of one's life history, adding a general note to the whole life, instead of being merely events that could, in some cases, be considered as exceptions or, at least, just some examples. However, there is a reason why participants chose to tell these events and not others, and is evident that these events played an important role in how they perceive health. However, regardless of the existence of positive events associated, overall it would seem health care systems in Latin America do not hold positive memories for participants, which is revealing in the context of the purposes of this research.

Camila, for instance, has very strong memories regarding her hospitalisation for typhus when she was three years old. Since she was attended in a public hospital, her memories shaped the way she perceives public health care to this day:

"My only contact with the public system was when I was little and I caught that damn typhus. […] I have bad memories. Very bad. Bad attention. Sort of... like aggression, in fact. [It is] a super-sensitive issue. […] That image is what I have from the public system, 30 years ago. […] I think I suffered some […] 'aggressions'. I mean, what happens is that, to a child, is an aggression." (Camila)

In the case of Felipe, his memories of health care in his country of origin seem to limit only to childhood, especially when he was hospitalised in Lima:

"I was taken to a hospital, which ... […] It was a very poor hospital, right? It was poor and people were yelling, not everyone was well treated. We are talking about many years, from '73. […] No, you weren't treated well and… […] And there I stayed for a month. […]They yelled because of the... The queue, right? The line, the queue. 'Don't get in here!' Thinks like that. And... And the other thing was they were having a disease. And the doctor, well... Nervous, and people, nervous, because there were too many people crowded. And waiting for long hours, long queues... That was... At that time." (Felipe)

It is hard to tell whether their traumatic perceptions were, at least in part, based in their short age, and that being hospitalised would have been traumatising for any child. Nevertheless, these memories of trauma prevailed through the years. Although participants tend to think that health in their countries has improved, traumatic events persist to illustrate Latin America's health system.

5.2.2. *Corruption*

Corruption was, in many cases, directly or indirectly mentioned as a part of the health care system in Latin America. The most common form of corruption reported was nepotism: To know someone of importance inside the system gave the person certain benefits that he/she would not have obtained otherwise.

"I think that... there is corruption... […] At some amount, equivalent, designated by the public service or the medical services... But there is corruption…" (Josefina)

"They are little corruptions that they make inside the system. […] That, here, I don't think it could happen. I don't think it could happen. Let's say it is a part of society that... A society that does those things." (Carolina)

This system seems to work regardless of the participants' awareness. However, in some cases, participants admitted to have been benefited from corruption, or to have used in their advantage.

"I worked in medicine [...] in Uruguay, and worked at the star laboratory […] of Uruguay, very good, […] I worked with all great professors, I was a person... say, with good contacts with the medical environment and recognised in Uruguay. Then, when I was pregnant and I have to receive attention in Argentina, once one of the directors of the lab called to the highest grade of ... one of the five-grade doctors, this ... obstetrician and gynaecologist in Buenos Aires. Then he says: 'Look, I have here a woman who has been my right hand for 12 years', and, well, I'll have to go to have it there... Because they wanted to pay for my attention and I declined. […] I went to his private practice, he treated me excellent, did not charge me, and [...] I was admitted to have my third child at the hospital. But, of course: I arrived and there was a huge queue of people. When he said who he was, they made me pass. So they interned me, gave me a room, alone, with a suite bathroom." (Carolina)

In other cases, participant made indirect references to, situations in which certain rules were broken or bypassed to obtain a personal benefit. In these cases, it was unclear how the participant viewed corruption, or even if he/she recognised as such. In any case, no conflict was reported to obtain benefit from the situation.

"[B]efore I came to New Zealand, […] I had a pain... […] here, down there, in my chest, at the top of my stomach. The first thing I did was to call a friend who is, uh ...

gastroenterologist. So I told him what I had and so ... so […] he recommended me directly to ... A specialist." (Claudio)

"I went to my sister, who […] is closely related to the people of sports. She said 'look, do not return unless I take you a... To see a... […] doctor friend of mine, a traumatologist, for I almost got twice having surgery, and he would check me and not let me have a surgery." (Carolina)

Yet, in some cases, corruption was referred as something negative that has almost no redeeming quality, and that only benefits those of power or criminals. This was the case when mentioning high-level corruption in health care systems. These cases were a source of instability, fear, inequality and other factors that could affect health and wellbeing. In fact, this was one of the reasons why Daniel was forced to leave his country and remains unable to trust others.

"There is an insurance that right now is... being implemented, for social middle classes. Middle and lower. That is called SISBEN. It's like ... an insurance that covers ... consultations, medicines, and covers the operation of the patient. Yes, everything you need at that time. And yes, it's something, well, that's useful, because for an operation in Colombia, it is super expensive. And it's a ... One thing the government is doing. Not very good, because ... Until recently, they discovered the theft of health; someone stole a lot of money and... And that ... Right now is the scandal they have in Colombia. The theft of health. Invested many billions of pesos, and that caught by the CPS, but never... Never went there. It was a money that stood there." (Daniel)

Unlike in particular situations, this general diagnostic was not defended by the participants in any way. It could be proposed that there is a double standard here; i.e., that participants were ambiguous when some form of rule-breaking benefited them, but inflexible when the high levels were involved. In one way or another, participants felt very ambivalent towards corruption. Even if they referred of this phenomenon as negative, they expressed, on many occasions, a lack of respect for normatives they saw as inconvenient. They also valued knowledge of contacts, and viewed it as being resourceful, as a catalyst for improving conditions in a generally hostile and incomprehensible environment. They did not express remorse on asking for personal favours, and some felt that it would be silly not to use personal contacts to resolve health problems.

It should be said that, in Latin America, while the level of corruption can vary from country to country, in general, some level is tolerated, even accepted in most of Latin

American cultures, which has undermined their institutions and possibilities of development (Husted, 2002). Bribes (any kind of payment or favour inducing unethical behaviour and reciprocity in the other part) (Sanchez, Gomez, & Wated, 2008) are common in both governmental and private institutions. While bribery is generally perceived as negative and passively endorsed by citizens of some nations, nepotism (*'compadrazgo'*) is more widely acknowledged as positive or at least an effective way to avoid unnecessary *'papeleo'* (red tape) (Crist, 1968). This attitude has its base in a collectivist culture, where group interests have more value than the official law, where solidarity to the own group is better viewed than individual consequence (Sanchez et al., 2008). Those who refuse to follow the unofficial patterns set by the surrounding culture are perceived as naïve, stubborn, or *'tinterillos'* ('ink-bottlerists'): supporters of bureaucracy and enemies of getting results (Crist, 1968). Treaties and legislation have been signed to stop this in most of the countries (Husted, 2002), but this has little meaning, since laws are often ignored. Latin American cultures tend to be Particularist instead of Universalist, which translates in exceptions for rules when dealing with members of the same group (friend, relative, member of the party, etc.) (Sanchez et al., 2008).

5.2.3. *Hygiene*

Hygiene was often mentioned as a source of annoyance or trust. The quality of facilities was, in many cases, contrasted with that of New Zealand, and words such as dust, filth and cleanliness were used to illustrate this contrast. Carolina describes her stay at a public hospital:

"Everything incredibly filthy. My mother began to mourn when she saw where I was.[…]The room. It was dirty. […] It was... how hospitals normally are. […]
And all furniture was scratched, uh.... they were made of metal, marked, scratched.
The toilet... Pipes had never been polished. They just took he dust out." (Carolina)

"[Health care centres in New Zealand] are simpler, they don't have that much... sometimes, all those ornaments, and [...] it feels cleaner. Cleaner and prolixity, that, maybe, with other things, I don't know... They are very simple here. They don't have signs... They don't, besides those that they put in... Many signs, but no... accessory things." (Carolina)

"If we go through those things. In terms of hygiene, [...] They look cleaner, they look […] better cared. In terms of sanitisation. Which in Chile is the same, they are permanently cleaning. Here you notice it more." (Arturo)

5.2.4. *Lack of Access*

Certain sectors of the population, according to some participants, could not access health care systems. They were often poorer, less educated, and lived in rural areas.

"Eight years ago, there was an explosion in Colombia, close to Medellin, killing 65 people only. For a bomb... At that time, was a bomb. We arrived: One, there was no adequate ambulances to carry everyone. Then, we took all the people in taxis, private cars... Arrived at the hospital now because... At the hospital they did nothing. There was no necessary help. There were no machines, no medication, there were no people who wanted to help people, or people in charge at that time. Doctors or nurses. They were not trained for any event as strong as that day, for example." (Daniel)

"Well... [health care centres] were very precarious. Also, depending on where you live. If you came from an impoverished area, well, they were very precarious, right? And, if it was in a more arranged zone, were more well-off people lived, well, it was much better, because you pay more, too. At the area where I lived. It was in Lima, but in an impoverished area, because, basically, it was an area where... We, coming from the mountain…" (Felipe)

Participants with higher educational and economic levels seemed to underplay this situation, since they did not have the experience:

"I think the Chileans here have pretty much the concept of 'Oh! Chile!' Come on. Chile is not Pakistan. Well, that's my ... I know people who use the public system to have babies here. Of course, this is a developed country, with money. Chile is still underdeveloped, but that does not mean it's Pakistan, it's the same with people in the public system, the people I know who has had babies, they have been well received, your baby is born in good conditions and you paid 250,000 pesos [NZ$627]... Nothing. Because in Chile you have to think we pay half the taxes that are paid here. Then I feel they also complain a bit while being full." (Camila)

By comparing Chile to Pakistan, a country she seems to perceive as underdeveloped, she makes a distinction that, in her view, favours her own county, although acknowledging that it has limitations. This contrast works only in relative terms

(better than others, but not necessarily good), but it helps her improve her view of the country, accept *status quo* and minimise criticism.

Only those who worked in social areas tended to be more aware of the magnitude of this problem, at least as reflected by them. Andrea, for instance, describes her experience as a social worker in a rural health care centre:

> "It's a rural area, certainly, but that problem I'm talking about was equal or... worse in poor urban centres. In poor areas, for instance, of Temuco or Santiago, when we gathered with colleagues at some meeting, [...] They told us, I mean... Endless queues, from early in the morning, to have an appointment…" (Andrea)

5.2.5. *Inequality*

The conclusion of many of the participants is that quality health is only accessible to those who have contacts, money, education and or power. If a participant was lacking any of these conditions, at some point in his/her life, he she would have experienced the 'bad' end of the system.

> "The doctors were the same. Actually, if you go to a hospital, they have, in general, the same doctors than paid societies had. It's not that doctors' care... A hospital doctor is as good as the other doctor... I mean, doctors... What differs is the hosteling. The sanatorium and all that kind of stuff. In Argentina too. It has much to do with your earning power." (Carolina)

> "I believe that, in general, the public system is very bad. There are many deficiencies. Because... the lack of funding. […] Now, regarding private health,
> […] There are very good doctors. I mean, he who has money, can access to an almost five-star health system, because, normally, people has specialisation overseas, with great reputation... Many of them are the ones that operate in USA too. In large hospitals." (Claudio)

5.3. **Participants' Experiences when Dealing with New Zealand's Health System**

This section summarises the many stories told when seeking health in New Zealand, and adapting to the new healthcare system. Chronologically, these stories shared many similarities.

Appendix N shows a diagram indicating how behaviours initiated from problems and progressed through several instances. Although eight participants were interviewed, each one of them told more than one experience of health in New Zealand. In total, 20 stories were narrated involving these contents. 15 of them were, according to participants, resolved (or were in way to be resolved) within the New Zealand health system, and five were not resolved that way, for one reason or another: either they were solved in a different country, solved through a different method (i.e. not healthcare), or remained unsolved until the moment of the interview.

In this diagram, red squares represented an emerging problem. There were two general kinds of problems mentioned in participants' stories. First, acute symptoms (17 cases), or perception of intense pain or urgency, caused by a condition, disease or accident; second, chronic conditions (2 cases), or a perception of an on-going set of symptoms and/or diagnoses that did not necessarily require an urgent treatment, although they required to be constantly checked in order to maintain or improve the health status.

While both individual chronic problem situations were addressed through a GP by way of enrolling, the situation was different with acute symptoms. Either the participants went directly to an emergency room, or they contacted a GP without enrolment. In just one occasion, a participant went to the GP she was already enrolled, and occurred after several consultations without enrolment (i.e. paying the full price). There was one occasion in which the participant went directly to the specialist. According to her story, Josefina preferred to pay more and to have the problem immediately resolved; also, she was without insurance, and she and her partner had some money saved.

After entering the system, the process went more uniformly: The doctor inquires about the problem; then, he/she treats the patient; in most cases, the doctor prescribes with medication; if it is an accident, x-ray or other scanners are performed; if the case is more serious, hospitalisation is required. This seems to reveal that the system has already established unifying protocols and professional (GPs, emergency doctors or dentists) rarely deviate from them.

Finally, participants have to pay for their consultation (indicated with green squares). In one case there was an ACC full return of the payment, and in four cases, there was one form of co-payment. However, in the rest of cases, patients had to pay full prize for their consultation, probably because the lack of enrolment or insurance.

It should be said that in some cases, participants decided to abandon the system in one way or another or skip a step in the process. In two cases, participants preferred to ask friends for advice before deciding to continue the treatment. In one of those occasions, the participant decided to abandon treatment.

Although participants tended to follow more frequently the expected process of seeking health care, in many cases, this was done after a considerable amount of trials and errors, until accommodating their behaviours in a way more suited for the New Zealand health system.

Next, a brief summary of behaviours will be presented in order to explain the final results exposed in the model.

5.3.1. *Getting a GP appointment*

Most of the participants consulted a GP at some point, although it came more as a last resource in terms of dealing with health issues. They tried different things when they felt ill or had an accident, for example resting, self-medicating, using natural medicine or advice from friends. It was only after these experiences that they enrolled to a health care centre.

In general, there seems to be the conception that going to a doctor happens only when one is in acute pain. Even then, other remedies are sometimes tried. This happened even when participants had health insurance.

Moreover, when the situation became too painful or unbearable, some of them went immediately to the emergency care unit or bypassed the GP to consult a specialist. This was common amongst participants who had private insurance in their home country.

Most of the participants were not aware of the system's focus on prevention, or did not understand the concept. Only those who had spent more time in the country or were older in age, had notions on how prevention checks work, and that GPs remain in contact with specialists. In general, consulting a GP was often seen as annoying, unnecessary or time-consuming. Money was an issue too. Since participants did not know how the system worked, they did not enrol in health care centres, instead paying full price for appointments.

5.3.2. *Language barrier*

Language was an important issue to participants. The ability to understand and being understood — both aspects do not necessarily go hand in hand — was a major obstacle in order to access to the features their new life was offering them.

Language in the context of health was not an exception; even more, it was an instance were precision was a must, but vocabulary was — in general — very limited. Even more, pain or illness tended to be an additional obstacle, which made communication even harder. This, in some cases, decreased the chances of consulting a GP when in pain, even when they were aware that there are translators available in hospitals.

> "I have to admit that the first two years we had a GP who spoke Spanish. Because it helped us a lot. When we arrived, no English, um ... I was terrified;
> suddenly, the child is sick and I do not knowhow to explain the doctor what is happening." (Andrea)

5.3.3. *Mental health*

Mental health problems are brought up, but do not seem to be properly treated. Many participants mentioned —explicitly or implicitly — the change in mood, sadness, longing, altered sleep cycles, anger, stress, and anxiety, but only a few addressed them as health issues. Overall, participants tried to keep a positive attitude when facing setbacks and conflicts (health-related or other), regardless of their psychological situation. This appears to be a defence mechanism against an already turbulent reality; either they endure difficulties with an optimistic attitude, or they fail to recognise the problems they mention as such. In men, there can be cultural issues involved; mental problems might be perceived as 'weaknesses', since they do not have a physical manifestation. The exception in this study was Daniel, who concluded that he felt ill, and mentioned mental issues as a symptom.

5.3.4. *Enrolment, co-payment, insurance*

All participants mentioned monetary issues when dealing with health care. Participants believed, in Latin America, one is only as healthy as one can afford it. Health

is seen as expensive. Daniel believes that this commercialisation explains, in part, the quality of health in Latin America:

"[H]ealth, in itself, well... Speaking honestly… It is low. It is very bad, because people only care about money. The medicine... Bought the medicine and they charged it too expensively, and… It's useless; they care more about money than the quality of the medicine itself. It's very unregulated. I don't think it's able to reach the 50%, most of the time." (Daniel)

In some cases, when people learned how to use the system in New Zealand or had insurance, they were amazed at how much there was coverage there was. In some cases, they still thought expensive, but were relieved when these expenses decreased.

"The coverage is only ACC, it's all the accidents. Then we were covered. Say, a person visiting New Zealand is covered, but when it includes treatment of these characteristics, which are not effect of an accident. You have to pay for the service. So, I took the bill and sent it to the insurance company, and the insurance company finally paid the hospital." (Arturo)

Perhaps the greatest advantage that participants saw, compared to Latin America, was the prize of medication, subsided by the state (with a maximum of co-payment). In the case of Arturo, he is impressed by this system and sees it as a source of preventive care:

"The final cost of prescript medicine is JUST $3!!!, incredible. This subside to medicine extremely draws my attention, since they are not necessarily generic and they are equally subsided. And regarding laboratory exams, better yet, ZERO cost, at least in those of blood and urine, which are the ones I have taken. It shows that the prevention policy is implemented by the state, a preventive vision instead of a curative one, with the aggregated saving to the country." (Arturo, in a written e-mail sent after the interview, adding extra information)

Some also expressed surprise that the dosage was exactly as the doctor's prescription indicated[7]. This is the case for Carolina:

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[7] In Latin America, pharmacies tend to sell medication in sealed boxes, with a fixed number of doses, which means a considerable amount will be thrown away or reserved for future occasions (which increases the risk of self medication, sharing medication and consumption of expired medicine).

"[A]nother thing that draws my attention here is the good management they have with medication. Patients are never without medication, because you do not... Do not get the... They cut it to you, but you get just what you need. I take medicine every day, three times. I get ninety pills. I finish the medication when I go to the doctor. No packages left. And they are monodrugs. The vast majority. And almost all are subsidised by the state. So... and when they are not subsidised, they give them to you anyway. They subsidise you."

There seems to be a consensus in praising this system and avoiding private pharmacies for prescript medication. Co-payment of GP's services receives less unanimous praise, although this might mean, in some cases, that participants are complicated in how the system works.

"[A GP] explained me a bit about the system. She told me: 'The thing is that here, with family doctors, like in Spain, you have to come here so I can refer you to another doctor". She explained me about the tree of formation here, and kindly, the receptionist told me, 'Ah, but you have come here like five times.' I had left them a huge amount of money, and she told me, 'I'm going to enrol you.' And there I stuck. So, I pay in that place, even when I'm not resident, I pay the same [my Kiwi boyfriend] pays, because he goes there." (Camila)

In the end, monetary issues were highly relevant to participants, since many of the participants were in a delicate financial state. Knowing how the system works resulted to be a tremendous help for them, and this area is where they welcomed information the most, whether they agreed with the system or not.

5.3.5. *Lack of specialists*

Participants accustomed to the private system expressed disappointment with the lack of availability of specialists. Some of the participants believed that they know what is happening to them, since they know their body. For this reason, they sought specialists to deal with their particular ailment. A GP was considered less qualified or incompetent.

"I preferred the Chilean system. I preferred the alternative, in Chile, to say 'Hey, you know what? We'll see this stuff, I've been too long like this, I'm going to the urologist. Or I'll see.' Yes. I like it better." (Camila)

"[E]verything goes directly to the specialist. In fact, doctors that stay being GPs, in most cases only work for the public... for the public system or in rural areas. Because,

if he is a surgeon in a clinic, it doesn't, no... They wouldn't have much field inside the private area, so to speak. Because everyone is accustomed to go to specialists." (Claudio)

There might be many reasons as to why this happens. In first place, in Latin America, GPs are tended to be seen as second-class physicians, mainly because they cannot apply to a speciality, are too young and inexperienced, or simply perceived as incompetent. Claudio described how doctors practice in Guatemala:

"[I]n Guatemala there are very good doctors in general. They have lots of experience and already students in third, fourth year, literally have lives in their hands and they must decide ... What guidelines are patients who have more chances, right? Well, so have told me my friends who are doctors. But that's a strength that there are very good doctors."

It is inferred in this description that doctors practicing in public health care centres do so without the necessary knowledge, and that, through trial and error, they become better. A private clinic doctor is a former GP that learnt from his experience and managed to apply to a speciality, which means that the public system 'filtered' those better qualified.

Second, patients receiving private health care are seen as 'customers', which means they have rights beyond what is traditionally perceived as universal in Latin America (i.e. being treated politely and on time, instead of just being treated). If they were unsatisfied with the doctor's attitude, they often complain to supervisors or the clinic. Patients in public health do not feel entitled to those rights, and sometimes endure mistreatment because of it.

"Sure. I mean, if you compare the private system with the private one in Chile, that joke, I can assure to you, in a clinic would not have happened. I mean, the doctor... no, no, no, no. I'm sure. And she would have offered me all the proper apologies, if she gave me bruises." (Camila)

Third, those who seek private health care in Latin America tended to be more educated, and many of them knew doctors first-hand. This gave them the impression that they knew more about health, and therefore, seeking a GP was unnecessary.

"I said: 'Ah, I'll go to the gynaecologist, I will ask her, I don't know, […]' In short, I'm paying the consultation... I have to attend, do you see? So, I feel it helps, for people who have no biological education, to say it in one way, closer to medicine, to be able to use that sieve alone... Right? That, for the active population it is a help, because there must be 10% of people who knows where to go, who has a sister, as I have, or a cousin to ask. Isn't it? But for me it is not comfortable." (Camila)

5.3.6. *Prevention*

Whether explicitly or implicitly, prevention was seen as 'tedious' by some participants. They mentioned behaviours to keep being healthy, but by and large this did not include seeing a professional. They did get appointments from doctors, but only after suffering particular conditions. The exception seems to be in the case of older participants (who had certain chronic disorders) and infants.

"Well, I think prevention... For instance, what they do... I can say it from what happens to me. That they send me to the doctor every three months, that they do me analyses, and that ... routine controls are done to me every year, that they made me do some annual mammographies and Papanicolaus, until I was 70 and I don't have to do it anymore. I'm a bit happy that I turned 70 and don't have to go every month, all that. That is prevention. Because they are detecting […], primarily, any problem you might have. If you don't go to these checks, and you get sick, once you get there, you will probably be in a terminal state, in a different ill detection status. […] They don't do that in other countries. I haven't seen it... At least, I haven't heard from it." (Carolina)

5.3.7. *Criticisms to professionals*

Professional health care was mentioned, in stories, as a last resource to pain and illness, which meant participants would not go to the doctor unless it was urgent. As a consequence, some participants suffered with their illness for a long time before seeking health care; thus, increasing the chances of worsening their condition and decreasing effectiveness of treatment.

On the other hand, participants had a high opinion of friendship and personal relations for issues related to health, indicating that they would follow advice and instructions that way, especially when dealing with preventive care (for many, this will almost be the definition of health prevention). As a result, it is likely that, in early cases of

illness or discomfort, alternative medicine and self-medication will increase, which can alter results after consulting a professional (e.g. combination of medication, therapies, exercises, etc.).

The differences between those participants coming from a public background and those who had insurance were so significant in their stories that they became better predictors for behaviours and beliefs. Latin America seems to consist of two major health care systems: the public one and the private one. Since each group has their own expectations about the system, in practice they become two different populations.

Stories regarding the quality of health professionals mentioned, in some cases, a lack of "seriousness". This was, in fact, one of the major criticisms involving health care in New Zealand.

"If you go to a gynaecologist [in Latin America], who is a specialist, with a gynaecological stretcher, with artefacts to... But here, you go to have a gynaecological exam, with an ordinary stretcher, with a GP, so it's less... That same reason, say, I feel it's less... Serious, to put it somehow?" (Camila)

"[I]t's too natural, let's say... Uh...You are not accustomed to that. I mean, you expect your doctor to give you orientation, counselling and good auscultation, and... Because he is a professional, and that is why he studied. So, I feel they take it a little bit lightly…" (Andrea)

Participants' low opinion of 'doctors who do not act as doctors' may have strong implications in the follow-up of treatment. The fact that most physicians they will encounter are GPs decreases the respect for the professional. Those of higher income will probably go to a physician when visiting or returning to their country, which also decreases the chances of opportune treatment in New Zealand.

In some cases, there is some sort of ambivalence. For instance, Daniel, after telling two stories — one where he felt he was poorly treated, and another one where he was very grateful towards the medical personnel who saved his daughter's life — he has a conflicted vision. He concludes that he can trust child health care, but that the adult health care system, in general, was unsatisfying:

"When I came here, health, to my criteria […] is very good for children, but not for grown people. I have the experience that wen I came here, I went to the hospital in

Mangere because of a headache, that I had passed out, and they took me in an ambulance."

5.3.8. *Improvement of opinions*

In general, for participants, after learning how the system works, their opinions regarding health care in New Zealand improves. When participants interacted longer and took more advantage of health care benefits, they seemed to dismiss their old beliefs and concluded that, in general, it is far better than what they had in their countries.

"If you want a specialist immediately, you can do it, but you have to pay a lot. If you want to, if you are in the health system, you want to be inside that health system and have free care, and not being outside the system, you have to wait for them what they understand is reasonable. In his case, he had to wait for three months for a consultation with a specialist, he waited and nothing happened. They were right, it wasn't urgent. These are things that are hard to understand for us (Carolina)."

5.4. **Summary**

Stories, beliefs and behaviours were strongly related in interviews. This would imply that, behind certain behaviours, omissions and decisions, there are certain underlying attitudes, which pre-empt individuals to act more often in in accordance to their principles, costumes and habits, instead of simply randomly reacting to stimuli set by the environment. Several authors in social psychology have analysed this phenomenon; the theory of planned behaviour, for instance, proposes that attitudes towards behaviours interact with social norms and perceived social control, forming an intention, which becomes a predictor for the resulting behaviour (Ajzen, 1991). The liberty of taking decisions — and, in the long term, stories — might be limited by each participant background, but only to a certain amount. Eventually, much of each participant inner self could be inferred in how they viewed the situation and navigated through the story. This section connects between the story and the person, inducing prevalent attitudes to conflicts related to health, and their possible consequences.

In the particular case of the participants in this research, explored attitudes and beliefs tended to be formed by their Latin American background. Health care was perceived in contrast of how they remember to be treated in the past; their expectations were set in

accordance to that experience. Traumatic events, corruption, hygiene, lack of access and inequality were key issues explored here. If experiences were satisfactory (such as the users of Lain American private health care system), participants wanted the new model to replicate the old one; if experiences were unpleasant or traumatic (such as public health users), participants had no expectations, and their view of the new system had less to do with the past and more with the present. Getting an appointment, breaking the language barrier, coping with loneliness and other mental problems, overcoming monetary issues, and understanding the different dynamics when dealing with a new style of health care became the major concerns at this stage. However, these views were not static, and the more they spent living in their new background, the more they evaluated the system under new terms. This usually meant an improvement of opinions regarding the new system.

6. Conclusion

The research question I sought to answer was: How do Spanish-speaking Latin Americans, residing in the Auckland region, view health and health systems of their countries of origin and New Zealand? Three objectives came out of this question:

1. Inquire how do Spanish-speaking Latin Americans perceive and define health.
2. Examine their experiences when dealing with their country of origin's health system.
3. Examine their experiences when dealing with the New Zealand health system.

These questions were applied in a qualitative context, focused on what participants' narrated.

6.1. Latin Americans' Health Perceptions and Definitions

All participants had pre-conceived ideas of health and considered it an important aspect of their lives, if not the most important. It seems that, in spite of their diversity and individual differences, participants shared many similarities in how they perceived health and health care, both in Latin America and in New Zealand.

Health, as a concept, had different overtones, but it was seen as necessary, and as a source of care. If it did not work well, it affected other areas of their lives. The most recurrent features of health mentioned were eating habits, weight, mental health, energy (mostly in females), performance (mostly in males), natural medicine, and self-medication. Visiting a doctor was seen as another resource, but rarely as a preventive measure. Seeking attention was mostly associated with pain, accidents, acute illness (e.g. vanishing), and emergencies (e.g. labour). There were, however, exceptions, and they were more common in people living longer in New Zealand. Overall, preventive care was mostly inferred when talking about the very young (pregnancy and infancy) and the very old.

6.2. Participant's Experiences in Their Countries of Origin's Health Systems

Stories, in general, tended to be charged with emotion, and they were very vividly told, sometimes changing the tone while quoting other actors. As a unifying concept, stories

linked themselves with issues of pain, fear, disorientation, and trust. Trust resulted to be a very important issue, especially when other people were involved in those stories.

Health in Latin America was perceived from the personal experience, rather than information from media or other sources. Those who had better health experiences (mostly using insurance and seeking specialists in the private system) rated health in their particular country in positive ways. On the other hand, those with less income and less access (mostly using public health care) rated it as poor and sometimes useless. A common trait in participants was the mention of using personal contacts to improve access to health (by referring personal favours or "knowing people"). Participants' attitudes toward these situations tended to be ambivalent. They sometimes regarded it as a form of corruption, but also as necessary to overcome an unrealistic or bureaucratic system.

6.3. **Participant's Experiences in New Zealand's Health System**

All participants had had at least one experience regarding health in New Zealand and seeking consultation. While they expressed concern in some of the ways they were treated (and, in some cases, they completely lost trust in GPs), most of the participants improved their perceptions of the health system after knowing how the system works and 'understanding the logic behind it', even if this opinion was not better than their experience in Latin America. A common complain regarding health professionals in New Zealand was the lack of vertical authority; some participants complained that doctors did not appear as such, which increased their distrust in them, as they perceived this feature implied a lack of confidence. But even this assumption was not shared by all of them, and some participants appreciated that professionals were more accessible and flexible.

Overall, there is a sense that participants — each one in his/her own way — adapted to the new system and learned new behaviours and habits in the process. This shows a high contrast with the previous studies discussed in section 2.2 of the literature review. Participants felt the system was new to them and hard to comprehend, but they generally felt embraced by health care staff. None of the participants reported discrimination, and attributed lack of service quality to other factors, such as the quality or expertise of health professionals. Participants also showed a disposition to change behaviour in order to adapt

to the new system, which could be perceived as acculturation, but many of them emphasised the value of their own culture and the idea that perhaps New Zealand could also learn from them. Although this topic was not explored in the depth of Cohen's research (2003), findings showed similar results in terms of cultural pride. There is, however, a chance that this optimism is related to the fact that all participants had recently migrated, and that their cultural exchange with the New Zealand society was still limited, in contrast to participants interviewed in the studies by Viruell-Fuentes (2007) and Viruell-Fuentes and Schultz (2009). Nevertheless, they declared to feel accepted by the population in general, and in particular, the more they knew about New Zealand health system, the more their view about it improved in most areas, especially compared to Latin America.

On the other hand, participants' stories revealed that they had limiting understanding of what to expect from the NZ health system; they also had great difficulties navigating the system adequately. Lack of information and cultural differences were the main causes of these initial difficulties. Once participants realised of the system's benefits, they improved their handling of their health issues to a certain point; nevertheless, most of them could keep increasing their benefits and fit them to their lifestyle if they adventured to learn more about it. It is clear that to improve Latin American health participation, the New Zealand health care system should take these issues into account. Perhaps more information and less fear (or distrust) to consult could increase Latin American immigrants' knowledge of the system and general health statistics, which could be achieved through a more proactive education. Perhaps the same Latin American communities could participate in this education, interpreting the New Zealand regulations in a language and method relevant to them.

6.4.   Comparison of health care systems

Health care systems in the different countries mentioned in the interviews revealed that, although Latin American countries share some similarities, there are differences in the way they deal with health issues; however, it is difficult to rate these differences, since the number of participants was reduced and their socio-economic and educational background was more revealing than their country of origin. This could be an indication of health care

systems in Latin America depending greatly on the income, insurance and education of the person, rather than of the policies of that particular system.

It is also remarkable that, although participants recognised many of these issues as negative, they tended to be accustomed to them and sometimes preferred their country of origin "problems" rather than the New Zealand system "solutions". This could be an indicator of the power of Latin American customs (that Latin American countries address better than New Zealand), as well as the fear or inconveniences of change; even when participants recognised New Zealand as a more inclusive country than their own, their cultural priorities were not met the way they expected.

There is no easy answer to these problems, even in the most developed and inclusive health care systems in the world; however, the New Zealand health care system could increase coverage by addressing where the differences lie and increasing their effort in reducing or clarifying them, in order for users to easily adapt and take advantage of improvements. Nevertheless, even when taking these considerations into account, personal, cultural and social background will always become an obstacle to adapt, and both parts should be patient when addressing differences.

6.5. **Implications**

The first question that this study implies is whether the NZ health system was able to successfully address and resolve Latin American health problems. It could be said that, economically, it solved or relieved many of their issues. The fact that they enrolled and became part of the system facilitated a more comprehensive understanding of their health records and health conditions. In terms of processes, it was difficult for them to adjust to the many steps required to receive diagnosis, and the lack of verticality or "paternalism" from the medical staff resulted in distrust and objections that sometimes affected their adherence to treatment, but gradually they accommodated to these new demands and behaviours. Those who did it more successfully received more health benefits from the system than those who did not. Difficulties to adapt depended highly in the education and experience of the participant. In conclusion, the system was effective in addressing most of their health issues, but failed to provide a more comprehensive care regarding their culture,

language and costumes. These limitations raise doubts into the true extent of the success of the system.

Regarding immigrant qualities, although each group has its own particular characteristics, there are many common traits amongst immigrants in general. For instance, all of them travel to a particular culture and society to which they have to adapt. In this particular case, the differences between health care systems were explored, showing that the more knowledge participants had of the system, the more they were aware of their responsibilities and rights, and the more they could benefit from the system in general. This is especially significant when health care systems from developing countries are contrasted, against systems such as the New Zealand one.

For Latin Americans, specifically, the emphasis on prevention and the multiple layers of care (primary, secondary, tertiary) seems hard to understand or to value. Once participants understood the purpose of protocols they realised the benefits of the system. For instance, many of them tried to contact a specialist immediately, but when they realised that information was shared among professionals through a database, they saw the sense of this approach and increased their trust in the system. This is hard to understand for patients who have been treated in facilities and professionals that work autonomously and are blind to other external care, and it was a source of anxiety for them. Once trust in the system increased, they became more prone to follow protocols and avoided skipping them.

For this reason, it seems that providing immigrants with clear information in their native language is essential to increase health care and make it more efficient to both parts (patients and professionals). In the case of Latin Americans, ALAC has started educating programmes with Latin American immigrants; these programmes have been very successful in terms of their expectations, but their resources are limited and it is hard for a small NGO to reach an increasing immigrant population. Programmes like this should be applied to a larger community and to other vulnerable populations, which is also an opportunity to receive feedback from individuals whom the system has limited information.

It is advisable for the New Zealand government to continue supporting these initiatives and to increase their scope, since it not only facilitates prevention and treatment for the most vulnerable; it also incorporates new individuals inside the health care system, including their health stories. This could be helpful to areas such as epidemiology, since government and researchers would have specific information available regarding patient's

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history, behaviours and beliefs, instead of only "hard" data regarding pathologies and symptoms.

6.6. **Limitations to current study**

While a qualitative review — and more specifically, a narrative inquiry — has its limitations when dealing with groups, it can be said that participants had the opportunity to express their thoughts, beliefs, and behaviours regarding health and health care, by reviewing personal experiences and re-constructing significant episodes in their lives. As such, health is seen as a relevant issue and there are topics that have shaped their views.

The content of stories told, and the way they are told, reveal many elements that somehow shape how they feel, and which elements are sensitive to them. While this study never intended to show the 'Latin American view on health', it cannot establish anything beyond subjected individual perceptions; however, it can help revealing that members of this particular demographic group may have relevant things to say regarding their place in health and healthcare. The final purpose of this study was, beyond generalising, to stress that a few subjective opinions can be relevant, especially when a particular group is unable to make itself heard.

Due to the nature of this research, many significant issues were not covered. For instance, sexual health, which turned to be an important aspect of Latin American immigrants in New Zealand, was barely mentioned (beyond a few comments regarding pregnancy care, and some social comments). Even this omission could be relevant, since topics were only generally suggested, and there might be cultural issues involved.

6.7. **Further research**

This particular study intended to reflect certain aspects, and future studies could expand and improve this vision adding more participants, using a different approach (e.g. ethnography), or use completely different means. Hopefully, this one could set up one of many bases to start new research involving this minority, or other minorities similar as this one.

On the other hand, the high importance of food and eating in health has an interesting connotation, when Latin American immigrants in New Zealand have shown problems involving obesity, diabetes and cholesterol.

Perhaps the most relevant issue to be discussed and further researched is the nature of trust. This seems to be very important when involving attitudes toward health care and follow-up of professional advice. The lack of knowledge in the system seems to play an important part in this. Social education regarding the New Zealand health system and the nature of preventive care appears to be essential to improve this issue, albeit education would not be sufficient enough in itself.

6.8. Conclusion

In general terms, it could be said that participants are highly aware of the importance of health in their lives, and that they have strong opinions about it. It should also be mentioned that participants' numerous and different health experiences shaped the way they perceived health. Also, moving to a different country changed, in many ways, their perceptions of what to expect when receiving health care, not only for them as individuals, but also for their families and others. Moreover, these new experiences made them reflect on their position in society and question what was taken for granted. Some individual opinions shared common traits and others were exclusive of some of the participants, and it is impossible to generalise them — even more in a more global context; however, it can be said that health is not a concept that leave people indifferent when inquired about it. National health care providers should consider these and other issues when implementing new policies with this population in mind.

This research contributes to the understanding of Latin American immigrants' health beliefs and attitudes in a New Zealand environment. This is the first study that provides a qualitative exploration of the topic and brings another dimension to the few studies that have previously been done on Latin American's health from a quantitative perspective. This topic will become more relevant as the Latin American immigrant population increases, as it has been the case over the last decade. Overall, it should be said that Latin American voices could contribute in improving health care, especially to the

more vulnerable populations. It is recommended to explore them more in further qualitative studies.

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Appendices

Appendix A: Demographic Data Sheet (English)

Demographic Date Sheet

Date: ___ / ___ / _____

Address (district only): _____

Age: _____

Gender: _____

Civic status: _____

Number of people living in household (indicate relation and age): _____

      Spouse / Partner: _____

      Children: _____

      Siblings: _____

      Parents, Grandparents, Parents-in-law: _____

      Other relatives: _____

      Other: _____

Country of origin: _____

Cicizenship: _____

Second citizenship (if any): _____

Spoken languages: _____

Date of first migration to New Zealand: ___ / ___/ _____

Lives in NZ since (uninterrupted): ___ / ___ / _____

Other countries of residence: _____

Highest education degree: _____

Profession / Occupation: _____

Current activity: _____

Does anyone at your household:

      Smoke? ____ How many? _____ How much? _____

      Have a chronic condition? ____ Who? _____

Appendix B: Demographic Data Sheet (Spanish)

Hoja de Datos Demográficos

Fecha: ___ / ___ / _____

Dirección (sólo distrito): _____

Edad: _____

Género: _____

Estado civil: _____

Número de personas viviendo en el hogar (indicar relación y edad): _____

      Cónyuge / pareja: _____

      Hijos: _____

      Hermanos(as): _____

      Padres, abuelos, suegros: _____

      Otros familiares: _____

      Otros: _____

País de origen: _____

Nacionalidad: _____

Segunda nacionalidad (si la hay): _____

Idiomas hablados: _____

Fecha de primera migración a Nueva Zelanda: ___ / ___/ _____

Vive en NZ desde (sin interrupciones): ___ / ___ / _____

Otros países de residencia: _____

Grado más alto de educación: _____

Profesión / Ocupación: _____

Actividad actual: _____

¿Hay alguien en su hogar que:

      Fume? ____ Cuántos? _____ Qué cantidad? _____

      Tenga una condición crónica? ____ Quién? _____

Appendix C: Interview (English)

You agreed to participate in an interview regarding perceptions of health by Latin Americans. It will take you about an hour of your time and will be digitally recorded. The contents of this recording will be transcribed, but your name and more personal details will be omitted. After transcription, all recorded data will be erased.

You are free to decide whether or not to participate, it won't affect you either way. Fo you have a question? Do you agree to participate? Can we start now?

I. **Health**

1. What do you understand as health? How would you define being healthy?
2. How important is health in your life? How often do you think about it?
3. Do you consider yourself as a healthy person? Why? Has it been different in your infancy and adolescence?
4. What do you do to be healthy?
5. Do you have any other behaviours or habits that may affect your health (e.g. alcohol, smoking, etc.)?
6. Do you remember the last time you were sick? What did you do?
7. How would you define the health of your family?
8. What do you do to protect the health of your family?
9. Do you remember the last time someone was sick in your family? What did you do?

II. **Community**

1. What characteristics would define Latin Americans?
2. How would you define Latin American's health?
3. How do you think it would differentiate from New Zealanders (Pakeha and Maori)?

III. **Country of origin**

1. How would you define health in your country of origin? Why?
2. Have you ever seek attention at a hospital, clinic, PHC or emergency room in your country of origin? Could you describe one of those situations?

IV. **Migration**

1. Why did you decide to come to Auckland? When and how did you take that decision?
2. How was the adaptation process? Could you enunciate positive and negative aspects?
3. Have you been sick in New Zealand? What happened?
4. Have you seek attention in PHCs, clinics, hospitals, emergency rooms, etc. in New Zealand? Could you describe one of those situations?
5. What differences have you noticed in such centres, in contrast with your own country? Could you name some examples?
6. What differences have you noticed in your own health and self-care? What elements of contrast have been positive or negative? Have some of those habits changed?

Appendix D: Interview (Spanish)

Vd. Ha accedido a participar en una entrevista sobre las percepciones acerca de salud por latinoamericanos en Nueva Zelanda. Le tomará cerca de una hora de su tiempo y será digitalmente grabada. Los contenidos de dicha grabación serán transcritos, pero su nombre y detalles más personales serán omitidos. Después de la transcripción, todo dato grabado será borrado.
Es libre de decidir si participar o no, no lo (la) afectará de manera alguna. ¿Tiene alguna pregunta? ¿Acepta participar? ¿Podemos empezar ahora?

I. **Salud**
10. ¿Qué entiende Ud. por salud? ¿Cómo definiría el estar saludable?
11. ¿Qué importancia tiene para Ud. la salud en su vida?
12. ¿Se considera una persona saludable? ¿Por qué? ¿Ha sido distinta en su infancia y adolescencia?
13. ¿Qué hace para estar saludable?
14. ¿Tiene otras conductas que cree podrían afectar su salud (ej. fumar, beber alcohol, etc.)?
15. ¿Recuerda la última vez que estuvo enfermo? ¿Qué hizo?
16. ¿Cómo definiría la salud de su familia?
17. ¿Qué hace para velar por la salud de su familia?
18. ¿Recuerda la última vez que alguien estuvo enfermo en su familia? ¿Qué hizo?

II. **Comunidad**
1. ¿Cómo definiría la salud de los latinoamericanos?
2. ¿En qué cree que se diferencia con los neozelandeses (Pakeha y Māori)?

III. **País de origen**
3. ¿Cómo definiría la salud de su país de origen? ¿Por qué?
4. ¿Se ha atendido alguna vez en algún hospital, clínica, centro primario de salud o urgencia en su país de origen? ¿Podría describirme alguna de esas situaciones?

IV. **Migración**
7. ¿Por qué decidió venir a Auckland? ¿Cuándo y cómo tomó la decisión?
8. ¿Cómo fue el proceso de adaptación? ¿Qué aspectos positivos y negativos podría enumerar?
9. ¿Ha estado enfermo en Nueva Zelanda? ¿Qué sucedió?
10. ¿Ha estado alguien de su familia enfermo en Nueva Zelanda? ¿Qué sucedió?
11. ¿Se ha atendido en consultorios, clínicas, centros primarios de salud, urgencia, etc., en Nueva Zelanda? ¿Podría describirme alguna de esas situaciones?
12. ¿Qué diferencias ha notado en dicho centros, en contraste con su país? ¿Podría nombrar algunos ejemplos?
13. ¿Qué diferencias ha notado en relación a su propia salud y autocuidado? ¿Qué elementos del contraste han sido positivos o negativos? ¿Han cambiado algunos de sus hábitos?

Appendix E: Informed Consent (English)

Consent Form

Project title: **Health and New Zealand Health Services: A Latin American perspective**

Project Supervisor: **Dr. Shoba Nayar**

Researcher: **Alvaro Perez**

○ I have read and understood the information provided about this research project in the Information Sheet dated 10th of June, 2011.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one):

Yes○ No○

Participant's signature:

....…………………………………

Participant's name:

....…………………………………………

Participant's Contact Details (if appropriate):

…………………………………………………………………………………..

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Date:

Approved by the Auckland University of Technology Ethics Committee 19th of June 2011 AUTEC Reference number 11/128

Note: The Participant should retain a copy of this form.

Formulario de Consentimiento

Título del Proyecto **Salud y Servicios de Salud en Nueva Zelanda: Una Perspectiva Latinoamericana**
Supervisora del Proyecto: **Dra. Shoba Nayar**
Investigador: **Álvaro Pérez**

○ He leído y entendido la información provista acerca de este proyecto de investigación en la Hoja de Información fechada el 10 de junio de 2011.
○ He tenido la oportunidad de hacer preguntas y que éstas hayan sido respondidas.
○ Entiendo que se tomarán notas durante la entrevista y que el audio será grabado y transcrito.
○ Entiendo que puedo retirarme o retirar información que haya proveído para este proyecto en cualquier momento previo a la finalización de la recolección de datos, sin sentirme, en ningún modo, perjudicado(a).
○ Si me retiro, entiendo que toda información relevante, incluyendo grabaciones y transcripciones, o partes de ella, serán destruidas.
○ Estoy de acuerdo en participar en esta investigación.
○ Deseo recibir una copia del reporte de esta investigación (por favor, marque su preferencia):
Sí○   No○

Firma del (de la) participante:..……………………………
Nombre del participante:
....…………..
Detalles de contacto del (de la) participante (si corresponde):
…………………………………………………………………………………..
…………………………………………………………………………………..
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Fecha:
Aprobado por el Comité de Ética de la Universidad Tecnológica de Auckland (AUT), en 19 de junio de 2011. Número de Referencia de AUTEC 11/128.
Nota: El (la) participante debe retener una copia de este formulario.

Participant Information Sheet

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Date Information Sheet Produced:
9th of May, 2011

Project Title
Health and New Zealand Health Services: A Latin American perspective

An Invitation
My name is Alvaro Perez and I am a Master in Public Health student, preparing my thesis. I address this letter to invite you to help me by participating in my research, which will only take one hour of your time.

Be sure that your participation is voluntary and that you may withdraw at any time prior to the completion of data collection without any adverse consequences. If you choose to participate or not will neither advantage nor disadvantage you.

What is the purpose of this research?
To explore how Latin American immigrants residing in New Zealand (specifically, the Auckland Region), and how they view health in the context of the local health system and in their country of origin. This information is very relevant to understand the needs of their community, and if they are being addressed or not. It will be useful for the whole Latin American community living in Auckland.

How was I identified and why am I being invited to participate in this research?
You have been reached by representative members of your community, who have selected you, among many others to participate, because you fulfil the requisites of this research: to a) be over 20 years old; b) speak Spanish as a native tongue; c) have migrated to New Zealand between 2004 and 2010, and d) currently be reside in the Auckland region (namely Auckland central, North Shore, West Auckland, Mid-Auckland and/or Howick). I believe that you will be able to offer insights into accessing the health system here in New Zealand and its differences with your country of origin.

No other information has been provided, and your identity has remained confidential.

What will happen in this research?
You will be interviewed between one and two hours, at a place of your choice (preferably ALAC offices). The contents of that interview will be digitally recorded and transcribed, but your identity will remain anonymous and no one but me will have access to the recordings and transcriptions. If, for some reason, the interview is interrupted, we may need to make another time to continue it. It is possible that, during analysis, some information you provided may need to be clarified. In that case, I will try to contact you to make sure I understood the context of your answer.

What are the discomforts and risks?
Please be advised that, although it is not the objective of this research to cause discomfort, the interview might, unwittingly, deal with intimate or uncomfortable issues. If you feel uncomfortable at any moment during the interview, please feel free to let me know, decline to answer the question in particular or ask to be withdrawn from the research. Your wishes will always be respected with no positive or negative outcomes for you.

How will these discomforts and risks be alleviated?
If you have felt, in any way, that your rights have been violated, or that you suffered negative consequences as a result from the interview, feel free to contact Health, Counselling and Wellbeing office (09 921 9992, City Campus; 09 921 9998, North Shore) at AUT without any charges. Counselling is offered at AUT health clinic for a maximum of three sessions.

What are the benefits?
This study might be relevant to your community in general and to you as an individual. It addresses the health needs of the Latin American community and will be a good occasion to hear the voice of Latin Americans (and you in particular).It may help improve their relationship with government policies and NGOs.

How will my privacy be protected?
Interviews will be recorded, but your name will not be written in any form (including the transcription of the interview). Your identity will remain confidential (if a name is required, yours will be changed to protect your identity). If your name is mentioned during the recordings of the interview, it will not be transcribed.

Only I will have information regarding your identity. Personal information (such as age, gender, country of origin) will be recorded in written form, without any indication of your name. Your address, contact numbers or other ways to reach you, will not be written. Such demographic data will be reported, but not associated with your identity.

All data containing information regarding the interview will be kept in a safe place until after the publication of this thesis. After that, data will be destroyed and recorded information erased.

The person who contacted you will not know whether you were selected to do the interview or not. A summary of the findings will be handed to him, but without your real name. Only you and I will have that information.

What are the costs of participating in this research?
It will take approximately one to two hours of your time.

What opportunity do I have to consider this invitation?
You have up to two weeks to consider this invitation from the moment you receive the letter.

How do I agree to participate in this research?
You will contact me (by e-mail or phone) or the community member that gave you this letter. When we meet, you will have to sign two copies of a consent form. You will keep one of those copies.

Will I receive feedback on the results of this research?

Yes, if you wish to do so. You will have to provide me with a contact detail (preferentially your e-mail address) to send you that information. You can also contact me or my supervisor.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Shoba Nayar*, shoba.nayar@aut.ac.nz*, T: 921 9999 ext. 7304.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext. 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Alvaro Perez
wrm0036@aut.ac.nz

Project Supervisor Contact Details:

Dr. Shoba Nayar
shoba.nayar@aut.ac.nz
T: 64-9-921-9999 ext. 7304

Approved by the Auckland University of Technology Ethics Committee on *19th June 2011*, AUTEC Reference number *11/128*.

Hoja de Información para el Participante

Fecha de Producción de la Hoja de Información:
9 de mayo de 2011

Título del Proyecto:
Salud y Servicios de Salud en Nueva Zelanda: Una Perspectiva Latinoamericana

Una Invitación
Mi nombre es Álvaro Pérez y soy un estudiante de máster en salud pública, preparando mi tesis. Dirijo a Ud. esta carta para invitarlo(a) a ayudarme participando en mi investigación, que le tomará aproximadamente una a dos horas de su tiempo.

Esté seguro de que su participación es voluntaria y que puede retirarse en cualquier momento antes del término de la recolección de datos, sin consecuencias adversas. Si elige participar o no, no le acarreará ninguna ventaja o desventaja.

¿Cuál es el Propósito de esta Investigación?
Es el explorar el cómo los inmigrantes latinoamericanos en Nueva Zelanda (específicamente, la región de Auckland), ven la salud en el contexto del sistema de salud de local y del país de origen de cada uno. Dicha información es muy relevante para entender las necesidades de la comunidad, y si éstas están siendo atendidas o no. Será de gran utilidad para la comunidad latinoamericana viviendo en Auckland.

¿Cómo es que fui identificado y por qué estoy siendo invitado(a) a participar en esta investigación?
Ud. ha sido recomendado(a) por miembros representativos de su comunidad, quienes la han seleccionado, entre muchos otros, a participar, debido a que cumple con los requisitos para esta investigación: a) tener más de 20 años; b) ser hablante nativo de español; c) haber migrado a Nueva Zelanda entre 2004 y 2010, y d) residir actualmente en la región de Auckland (específicamente Auckland Central, North Shore, West Auckland y/o Howick). Creo que Vd. Podrá ser capaz de ofrecer una visión del acceso al sistema de salud de en Nueva Zelanda y las diferencias con su propio país de origen.

Ningún otro tipo de información me ha sido provista acerca de Ud. y su identidad ha permanecido reservada.

¿Qué pasará en esta investigación?
Será entrevistado(a) por entre una y dos horas aproximadamente, en un lugar de su preferencia (idealmente las oficinas de ALAC). El contenido de dicha entrevista será grabado digitalmente y luego transcrito, pero su identidad permanecerá anónima y nadie más que yo tendrá acceso a las grabaciones y transcripciones. Si, por algún motivo, la entrevista es interrumpida, podríamos necesitar completarla en otro momento. Es posible que, durante el análisis, alguna información provista por Vd. necesite ser clarificada. En tal

caso, intentaré contactarlo(a) para asegurarme de que entendí el contexto de su respuesta.

¿Qué riesgos / incomodidades podría acarrearme?

Es mi deber informarle que, pese a que no es el objetivo de esta investigación el incomodarle, la entrevista podría, involuntariamente, tratar temas que puedan resultarle íntimos o incómodos. Si en cualquier momento se siente incómodo(a) durante la entrevista, por favor siéntase libre de hacérmelo saber, declinar a responder la pregunta en particular o solicitarme retirarse de la investigación Sus deseos serán siempre respetados, sin consecuencias positivas o negativas para Ud.

¿Cómo se aliviará esa incomodidad?

Si Vd. siente que, de alguna manera, ha sufrido consecuencias negativas a raíz de la entrevista, siéntase libre de contactar a la oficina de Health, Counselling and Wellbeing (09 921 9992, City Campus; 09 921 9998, North Shore) en AUT, sin cargos, por un máximo de tres sesiones.

Para ayuda en español, sírvase contactar a Malia Moeno-Kolio, Catholic Family Community Services (e-mail: cfcs@org.nz; fono 09 378 9650).

¿Cuáles son los beneficios?

Este estudio puede ser relevante para su comunidad y para Vd. Como individuo. Está dirigido a las necesidades de salud de la comunidad latinoamericana y será una buena ocasión para oír la voz de los latinoamericanos (y a Vd. en particular) Podría ayudar a mejorar la relación de éstos con políticas de gobierno y ONGs.

¿Cómo se protegerá mi privacidad?

Las entrevistas serán grabadas digitalmente, pero su nombre no será escrito en forma alguna (incluyendo la transcripción de la entrevista). Su identidad permanecerá confidencial (si la investigación requiere de un nombre, su nombre real será cambiado). Si su nombre es mencionado durante las grabaciones de la entrevista, no será transcrito.

Sólo yo tendré información en relación con su identidad. Cualquier información personal (tal como sexo, género, país de origen) será anotada sin indicar su nombre. Su dirección, números de contacto u otras formas de poder localizarlo serán omitidos. Se reportaran dichos datos demográficos, pero sin ser asociados con su identidad.

Toda información en relación a la entrevista será guardada en un lugar seguro hasta después de la publicación de mi tesis. Luego de ello, los datos serán destruidos y la información grabada eliminada.

La persona que la contactó no sabrá si es que Vd. fue seleccionado(a) para ser entrevistado(a). A dicha persona se le entregará un resumen de los resultados, pero su nombre habrá sido cambiado. Sólo Vd. y yo tendremos dicha información.

¿Cuáles son los costos de participar en esta investigación?

Le tomará aproximadamente una a dos horas de su tiempo.

¿Qué oportunidad tengo de considerar esta invitación?

Tiene hasta dos semanas para considerarla desde el momento en que recibió esta carta.

¿Cómo accedo a participar en esta invitación?
Ud. me contactará (por e-mail o teléfono) o contactará al miembro de su comunidad que le pasó esta carta. Cuando nos reunamos, deberá firmar dos copias de un formulario de consentimiento. Puede quedarse con una de las copias.

¿Se me retroalimentarán los resultados de esta investigación?
Sí, si así lo desea. Deberá proveerme con detalles de contacto (preferentemente su dirección de correo electrónico) para enviarle la información. También puede contactarme o a mi supervisora.

¿Qué hago si tengo mis reparos respecto a esta investigación?
Cualquier reparo en relación a la naturaleza de este proyecto debe ser notificado en primera instancia a la Supervisora del Proyecto, la Dra. Shoba Nayar, *shoba.nayar@aut.ac.nz*, T: 921 9999 ext. 7304 (sólo habla inglés).

Cualquier inquietud respecto a la forma en que esta investigación se ha llevado a cabo debiera ser notificada a la Secretaria Ejecutiva de AUTEC Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext. 8044 (sólo habla inglés).

A quién contacto para tener más información acerca de esta investigación?
Detalles de Contacto del Investigador:
   Alvaro Perez
   wrm0036@aut.ac.nz
Detalles de Contacto de la Supervisora del Proyecto:
   Dr. Shoba Nayar
   shoba.nayar@aut.ac.nz
   T: 64-9-921-9999 ext. 7304

Aprobado por el Comité de Ética de la Universidad Tecnológica de Auckland el *19 de junio de 2011*, Número de referencia de AUTEC *11/128*.

WOULD YOU LIKE TO PARTICIPATE IN A RESEARCH?

An Invitation

My name is Álvaro Pérez. I'm a psychologist doing my MPh thesis *"Health and New Zealand health services: A Latin American perspective"*. To perform this research, I need to interview Auckland residing Latin Americans.

This interview will deal with health issues from your own point of view and your own personal experiences, and can be useful to know New Zealand residing Latin American's real needs. All information you give to me will be confidential and your identity will never be revealed.

It is important to point out that you will not receive monetary benefits for collaborating, but you will be part of a project that aims to address the needs of our community.

Location: ALAC offices

45 Cardwell St.

Onehunga

Length: 1 - 2 hours

Requisites: a) To be a native Spanish-speaker; b) to live at the Auckland region; c) to be older than 20, and d) to have arrive to NZ between 2004 and 2010.

Image 1

Appendix J: Bulletin Board Poster (Spanish)

¿Desea participar en una investigación?

Invitación

Mi nombre es Álvaro Pérez. Soy psicólogo, realizando mi tesis de magíster *"Salud y servicios de salud en Nueva Zelanda: Una perspectiva latinoamericana"*. Para llevarla a cabo, necesito entrevistar a latinoamericanos residentes en Auckland.

Dicha **entrevista** tocará temas de salud desde su propio punto de vista y su propia historia personal, y puede ser de utilidad para poder conocer las verdaderas necesidades de los latinoamericanos residentes en Nueva Zelanda. Toda la información que me entregue será confidencial y su identidad no será revelada.

Es importante señalar que Ud. no recibirá beneficios monetarios por colaborar, pero habrá sido parte de un proyecto que pretende acercarse a las necesidades de nuestra comunidad.

Lugar: Oficinas ALAC
             45 Cardwell St.
             Onehunga

Duración: 1 - 2 horas

Requisitos: a) ser hablante nativo de español; b) vivir en la región de Auckland; c) ser mayor de 20 años, y d) haber llegado a NZ entre 2004 y 2010.

Image 2

Appendix K: Participants' Demographic Data

Name	Date of the interview	District of residence	Gender	Age	Civic status	Country of origin	Lives in Auckland since…	Highest education level	Profession / occupation
Camila	04/08/2011	Panmure	Female	34	Cohabiting	Chile	2010	University complete	English teacher
Carolina	04/08/2011	Papakura	Female	70	Married	Uruguay	2004	Technical complete	Paramedic
Arturo	02/09/2011	Milford	Male	43	Married	Chile	2008	Ph.D. student	Physical ed. teacher
Andrea	07/09/2011	Glen Eden	Female	40	Married	Chile	2006	MPh. complete	Social worker
Claudio	08/09/2011	Howick	Male	36	Married	Guatemala	2008	MBA complete	Agronomist
Daniel	13/09/2011	One Tree Hill	Male	35	Cohabiting	Colombia	2007	Technical incomplete	Hostelling
Felipe	17/09/2011	Epson	Male	54	Married	Peru	2010	Technical complete	Theology (non Univ.)
Josefina	17/09/2011	Mount Albert	Female	61	Married	Argentina	2008	Technical complete	Paramedic, instrumentalist

Image 3

135

Appendix L: Personal journal for Interviews

Date: ..../......../......... Time of the interview: ..... : ...... am/pm

Non verbal communication
(.... : ....' .....'') ....
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Interruptions
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General observation
Description of place of interview: ....
....
Suggestions made by the participant: ....
....
....

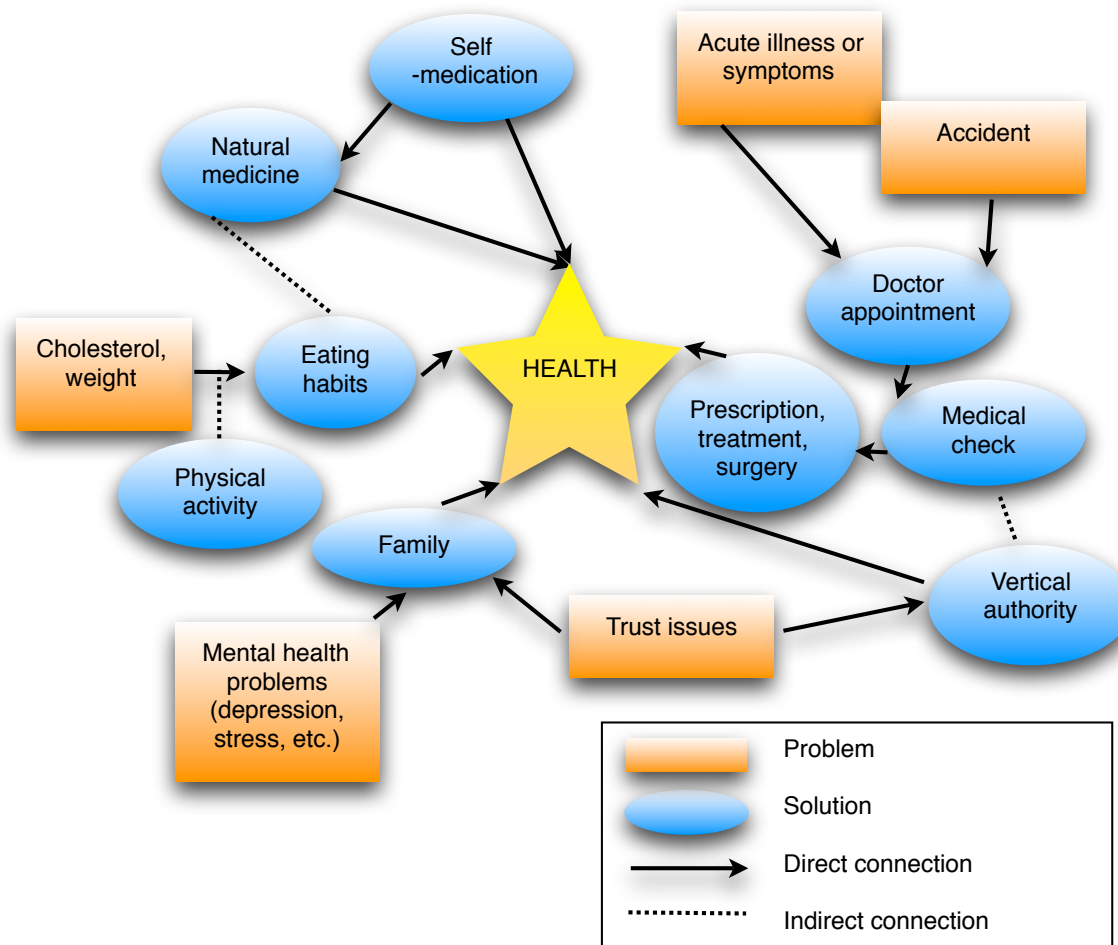# Appendix M: Main Problems Concerning Health, According to Participants

Image 4

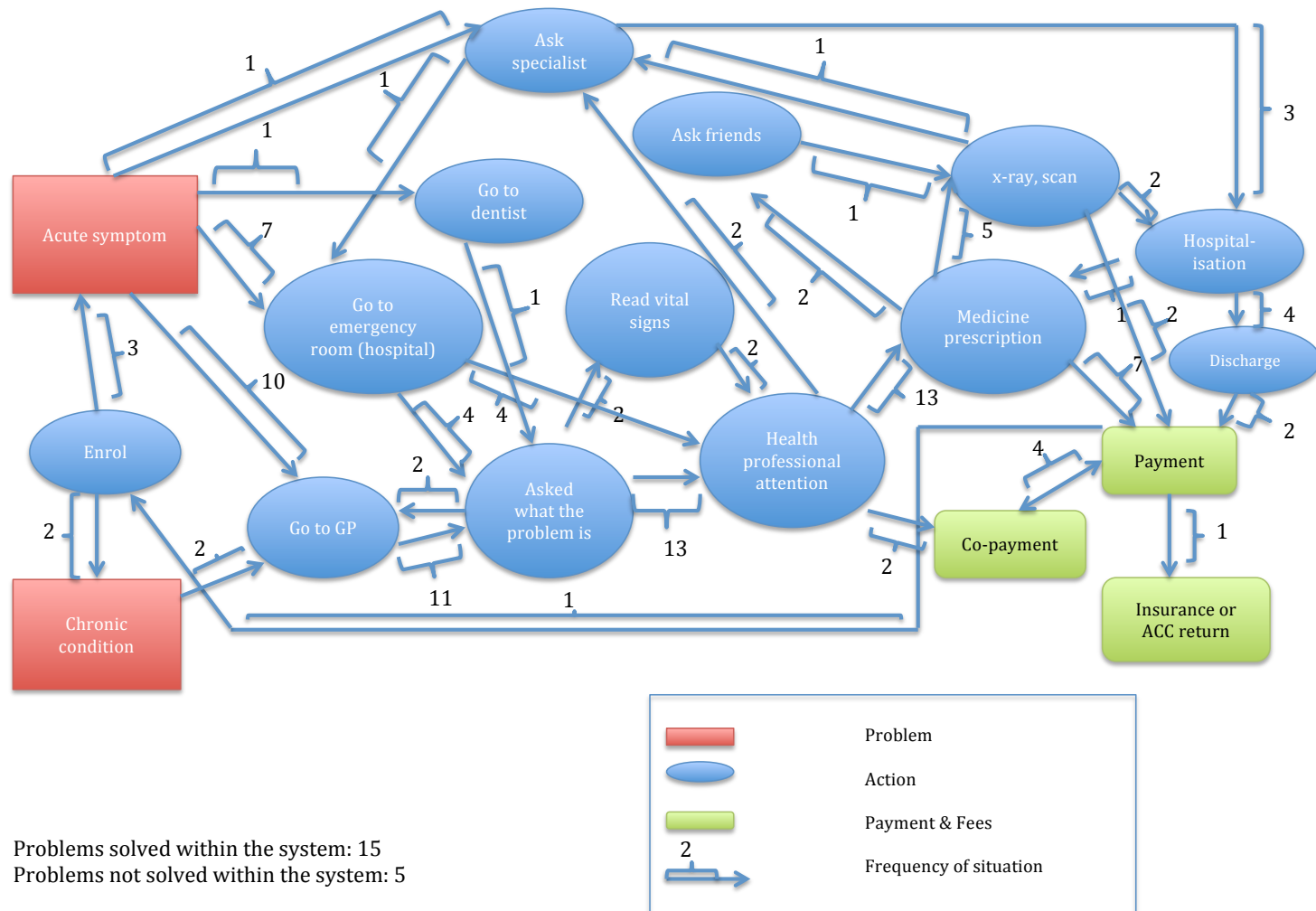# Appendix N: Flowchart of Health Care Usage for Participants

Problems solved within the system: 15
Problems not solved within the system: 5

Legend:
- Problem
- Action
- Payment & Fees
- Frequency of situation

Image 5