UNVERSITY OF HULL

MOTIVATIONS, MIGRATION AND EXPERIENCES OF BLACK AFRICAN

NURSES IN THE UNITED KINGDOM

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By

Gloria Likupe BSc(Hons) University of Humberside

MSc University of Hull

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ABSTRACT

This thesis explores experiences of black African nurses from sub-Saharan Africa in the UK. The exploration starts with motivational factors which cause black African nurses to migrate, as it is argued that migration trajectories have an influence on nurses' experiences. Managers' experiences are also explored to obtain their perspectives.

A qualitative approach was used as a methodological framework. Focus groups and individual, semi-structured interviews were used to explore experiences of black African nurses working and living in the UK. Semi-structured interviews were used to collect data from managers working with black African nurses. The data were analysed using Spencer, Ritchie and O'Connor's framework. In total 30 black African nurses were interviewed, comprising 4 focus groups and 15 individual interviews. The number of managers interviewed was 10.

The results indicate that black African nurses move to the UK as a result of historical, political and economic factors. However, the main factors are immigration policies and practices of the British government. Migration trajectories of black African nurses indicate that black African nurses are recruited to a subordinate position in the British National Health service; as a result, nurses are stereotyped and experience prejudice, racism and discrimination. Managers' accounts largely echo black African nurses' experiences.

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CHAPTER 1

INTRODUCTION TO THE THESIS

1.1 Background to the Study

This study explores motivations for black African nurses who leave their countries and move to the United Kingdom (UK). It describes their experiences once they arrive and are working in the UK. Experiences of ward managers who work with black African nurses are also Investigated to gain managers' perspectives on their perception of the experiences.

The impetus for this thesis originates from my own background as a black African nurse who moved to the UK in the 1980s. At that time there were very few black African nurses at the hospital where I worked. I noticed that most of the time I was treated differently from my white colleagues in terms of work allocation, training and promotional opportunities. I wondered whether this phenomenon was similar for other black African nurses working for the National Health Service (NHS) in the UK.

The 1990s and early 2000s saw unprecedented recruitment of nurses from overseas to the UK, to work both in the NHS and in the private sector. The recruitment campaign was a result of nurse shortage throughout the UK, which was caused by a combination of factors: an ageing population, skills shortages, increased health care demand (Buchan, 1999 and 2002), and the reduced role of the family in caring for older people (Bueno de Mesquita and Gordon, 2005).

Although data on overseas nurses working in Britain show that the main source countries were the Philippines and India (Buchan, 2002), a substantial number also came from sub-

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Saharan Africa. For example, Buchan, Jobanputra and Gough (2004) found an increase in the number of African nurses being recruited to London hospitals. South Africa contributed 17% of the nurses, followed by Nigeria (6%) and Ghana (3%). Nurses were recruited actively by employers and agencies or passively where nurses applied for jobs directly to NHS hospitals. Allan and Larsen (2003) reported that nurses from South Africa, Zimbabwe and Nigeria contributed a large number to their focus group interviews on the experience of internationally recruited nurses. Data from the World Health Organisation (WHO, 2006) indicate that nurses and midwives trained in sub-Saharan Africa and working in Organisation for Economic Co-operation and Development (OECD) countries represented 5% of the workforce. In the UK, there was an increase of nurses on the Nursing and Midwifery Council (NMC) register coming from South Africa, Zimbabwe, Nigeria, Ghana, Malawi, Kenya and Botswana (NMC 2005). However, there is variation between countries, with Uganda contributing 0.1% and Zimbabwe contributing 34%. During this time interest grew from nurse academics in researching motivation for overseas nurses relocating to the UK and experiences of overseas nurses in the UK, as a consequence of the increased numbers of overseas nurses in UK hospitals.

The main debate in the literature so far has been concerned with the effects of the brain drain on the services of the sending countries, and the ethics of recruitment and regulatory policies (Hardill and Macdonald 2000, Buchan 2003, Deeming, 2004 and Bach, 2007). Some investigated experiences of internationally recruited nurses in general (Allan and Larsen 2003 and Matiti and Taylor, 2005), while others have described black and ethnic minorities as a homogeneous group (Daniel, Chamberlain and Gordon, 2001, Lemos and Crane, 2001, Shields and Wheatley Price, 2002, Alexis and Vydelingum, 2004, Gerrish and Griffith, 2004, Alexis and Vydelingum, 2005, Taylor 2005, Alexis, Vydelingum and Robins, 2006, Smith,

Allan, Henry, Larsen and Mackintosh, 2006, O'Brien, (2007 and Alexis, 2009). Some studies have researched nurses from particular countries, like the Philippines and sub-Saharan Africa, from countries such as Zimbabwe, Ghana and Nigeria (Withers and Snowball, 2003, McGregor 2006 and Aboderin, 2007), but none has captured the experience of black African nurses as a group.

Kenny and Briner (2007) concluded, in a review of British literature on ethnicity at work, that minority ethnic groups in Britain come from a range of different backgrounds, face different forms of stereotyping and display differences in class and cultural backgrounds. These factors are likely to impact on the way different ethnic groups are treated within the workplace, and may account for the differences in the levels of workplace discrimination perceived by different ethnic groups. They state that existing research fails to explore these potential differences. Kenny and Briner (2007) recommended that as well as recognising the diversity within ethnic groups, researchers should be conscious of the potential differences between ethnic groups in the way ethnicity is experienced from within organisations. I therefore decided to investigate migration factors and the experiences of black African nurses in the UK for three reasons: firstly, to raise awareness of historical and political factors that influence black African nurses from sub-Saharan Africa to migrate to the UK, and secondly to investigate how these factors affect experiences of these nurses in the UK. The third reason was to raise awareness of discriminatory practices in the National Health Service (NHS) experienced by this group of nurses. Such knowledge could be key to implementing anti-discriminatory practices to enable a more integrated NHS workforce that could be beneficial to patients.

Hence in this study I decided to examine migration motivations, as these would shape nurses' experiences in the UK. I also decided to examine professional and social experiences of nurses, as these cannot be divorced from each other in the way they impact on the nurses' lives. Managers' experiences of black African nurses were sought to explore their perspectives on the issue. The research questions posed were: What are migration motivations for black African nurses who move to the UK? What are their experiences once they have arrived and are working in the UK? What are the experiences of their managers?

A qualitative approach was used to gain an insight into black nurses' motivations for moving to the UK and their lived experiences once in the UK. Individual Interviews and focus group discussions were used as tools for black African nurses and their managers to express their lived experiences.

The aims of the study were:

1. To explore why black African nurses move to the UK.

2. To explore the professional experiences of black African nurses in the workplace.

3. To explore whether black African nurses are aware of equal opportunities policies in the workplace.

4. To explore whether managers were informing black African nurses of equal opportunities policies and implementing them.

5. To explore the social experiences of black African nurses in the UK in general and the effects these have on their families and their effectiveness at work.

Previous studies (Beishon,Virdee and Hagell, 1995, Lemos and Crane, 2001, Shields and Price, 2002, Allan and Larsen, 2003, Alexis and Vydelingum, 2004 and Taylor, 2005) among others have reported racism and discrimination against ethnic minority and black nurses in the NHS. These experiences continue among black and ethnic minority nurses, despite equal

opportunities legislation (particularly Race Relations Act, 1976, amended in 2000 and 2004). It is not clear why discrimination and racism continue in the NHS despite various legislations. However, it is apparent from the literature review in the present study that researchers have often described experiences of black ethnic minority nurses in the NHS without investigating the cause. It can be argued that anti-discrimination legislation could be regarded as treating the symptom and not the disease in this case.

I argue in this thesis that black nurses from sub-Saharan Africa are motivated to move to the UK for a variety of reasons which are embedded in historical, political, economical and social relationships. These reasons include the effects of colonialism, which resulted in unequal development of countries (Wallerstein, 1974). The emergence of globalisation in this context has meant that rich countries like the UK can exploit poor countries like those in sub-Saharan Africa for labour. Colonialism also created conditions which are favourable for nurses from sub-Saharan Africa, including use of a common language and similarities in education and networks, which can facilitate migration. However, all the above reasons are dwarfed in comparison to the UK immigration policies and practices which determine who can be allowed into the UK, and when, and for what reason. Chapters two, three, and nine demonstrate that immigration of nurses was encouraged by the Labour government from the late 1990s to 2007 in order to boost the number of nurses in the NHS so that the government could fulfil its promise of the NHS plan (DoH, 2000).

I therefore argue in the thesis that black African nurses experience racism and discrimination as a direct result of recruitment policies and practices of the UK government. I argue that, by stating that foreign nurses were recruited to relieve nurse shortages temporarily in the UK while home nurses were being trained, the government legitimated the recruitment of foreign

nurses to a subordinate position which was made worse by the organisation of the nursing hierarchy in UK hospitals. All nurses from sub-Saharan Africa interviewed in this research were recruited to grade D in the nursing hierarchy, which is the lowest possible grade for a qualified nurse. This grading did not take into account any qualification of past experience that nurses had in their own countries prior to moving to the UK. This, together with historical factors, exposed black African nurses to various forms of exploitation, racism and discrimination.

1.2 Organisation of the Thesis

The thesis is organised into 9 chapters, including this introduction. Chapter 2 reviews the literature on factors that motivate nurses to leave their countries and want to move and work in the UK. Chapter 3 reviews the literature on experiences of overseas nurses in the UK. Chapter 4 outlines the framework which is used to analyse factors which motivate black African nurses to migrate to the UK, and how their migration trajectories influence their experiences in the UK. Chapter 5 discusses the approach which was used to investigate black African nurses' motivations for moving to the UK, their experiences in the UK and experiences of ward managers working with black African nurses. Chapter 6 explores motivations of black African nurses and their expectations. Chapter 7 discusses professional and social experiences of black African nurses in the UK. Chapter 8 explores experiences of managers working with black African nurses. Chapter 9 is a discussion of the study findings and implications for practice. It also concludes the thesis and puts forward suggestions for further research.

CHAPTER 2

LITERATURE REVIEW ON MOTIVATIONS OF INTERNATIONALLY

RECRUITED NURSES IN THE UNITED KINGDOM

2.1 Introduction

This chapter reviews the literature on factors that motivate nurses to migrate from their countries to the UK, and also reviews requirements for overseas nurses to work in the UK. The review is organised into personal and professional themes as motivational factors that motivate nurses to relocate to the UK. Theoretical concepts and social consequences in the country of origin and country of destination, professional issues, colonial ties, globalisation, as well as political and economic influences are discussed in the review.

The late 1990s and early 2000s saw unprecedented recruitment of nurses from overseas to the UK, to work both in the NHS and in the private health sector. Data from the NMC demonstrated a steady increase on the register of nurses from Zimbabwe, Nigeria, Ghana, Malawi, Kenya and Botswana (NMC, 1998-2008). Table 2.1 shows the main source countries of nurses to the UK register from 1998 to 2008 in terms of actual numbers recruited from those countries. However, numerical analysis of numbers entering into the UK NHS system Does not provide evidence of the nurses' experiences as this thesis will demonstrate.

Table 2 1: Main Source Countries to the UK Nurse Register 1998-2008

Country	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
Philippines	52	1,052	3,396	7,235	5,594	4,338	2,521	1,541	673	249
India	30	96	289	994	1,833	3,073	3,960	3,551	2,436	1,020
South Africa	599	1,460	1,086	2,114	1,480	1,689	933	378	39	32
Australia	1,335	1,209	1,046	1,342	940	1,326	981	751	299	262
Nigeria	179	208	347	432	524	511	466	381	258	154
Zimbabwe	52	221	382	473	493		311	161	90	49
New Zealand	527	461	393	443	292	348	289	215	74	62
Ghana	40	74	140	195	255	354	272	154	66	38
Pakistan	3	13	44	207	172	140	205	200	154	42
Kenya	19	29	50	155	152	146	99	41	37	19

Table 2.1 continued										
Zambia	15	40	88	183	135	169	162	110	53	51
USA	139	168	147	122	89	141	105	98	21	35
Mauritius	6	15	41	62	60	95	102	71	27	19
Malawi	1	15	45	75	57	64	52	41	0	3
Canada	196	130	89	79	52	89	88	75	0	24
Botswana	4	0	87	100	39	90	91	44	0	2
Non EU total	3,621	5,945	8,403	1,5064	1,2947	1,4122	1,3608	1,0985	8,673	2,309
(EU)	1,413	1,416	1,295	1,091	764	1,033	1,753	1,193	1,484	4,830

Source NMC 2008

The main debate so far has concentrated on the effects of the brain drain on the services of sending countries, and the ethics of recruitment and regulatory policies (Hardill and Macdonald, 2000, Buchan, 2003, Deeming, 2004, and Bach, 2007), but none has captured the motivation and experiences of black African nurses as a group.

2.2. Literature Search Methodology

A search of the literature was undertaken throughout the study using the following electronic databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Pub Med, and Applied Social Science Index (ASSIA). Key words used to search the literature included: nurse migration, United Kingdom, experience of nurses, sub-Saharan Africa, black African, racial discrimination, recruitment agencies, equal opportunities and exploitation. The search was not limited in terms of year of publication because of the scarcity of literature in this area. The search yielded the following: CINAHL 49, MEDLINE 228, Pub Med 6, and ASSIA 2 articles. However, some of the articles found were repeats, and after eliminating these only under a 100 articles were found by this method.

Additionally reference lists of articles were scanned for additional items; new releases of key journals were also individually searched for recent published studies. The internet was searched for professional organisations and government websites for unpublished research studies, discussion papers, media releases and action reports relating to nurse shortages, nurse migration and nurses' experiences.

All documents not written in English were excluded, as there was no access to a translation service and it would have proved expensive to hire one. All empirical studies were included, as well as government and organisational reports which related to nurse migration in the UK and the experience of these nurses. This evidence was useful, as there are limited empirical studies in this area. It also ensured a high level of quality, and thereby promoted validity of the overall findings and conclusions.

2.3. Requirements for Working as a Nurse in the UK

Before discussing what motivates nurses to come to UK it is necessary to outline the process which potential immigrant nurses must undergo in order to be registered by the NMC so that they can practise nursing in the UK. The NMC is the regulatory body for nurses and midwives practising in the UK. Applicants with general nursing qualifications from European Union (EU) or European Economic Area (EEA) have the right to practice in the UK because of mutual recognition across EU countries; however, they need to register with the NMC through the European Community Directives. Nurses from outside the EU/EEA must apply to the NMC for verification of their qualifications in order to be admitted to the register. From September 2006 all nurses wishing to register with the NMC from outside the EU/EEA must go through the Overseas Nurses Programme (ONP).

Under the ONP programme all applicants are required to attend a compulsory 20-day period of protected learning, and where appropriate a period of supervised practice. In addition, applicants have to pass the specified International English Language Test (IELTS) before they can apply for the ONP. Before September 2006, the NMC made decisions on an individual basis. Some nurses were registered without having to do an adaptation or supervised practice, while others were required to undergo a period of adaptation or

supervised practice, usually lasting between three to six months. This was confusing to overseas nurses as the previous registration body, the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) had no published criteria on which to base these decisions. Almost all nurses from outside the EU need to apply for and be granted a work permit in order to take up paid employment in the UK.

2.4 Motivation for Working in the UK

Currently there is little research on what motivates nurses to migrate to the UK (Allan and Larsen, 2003). Some studies (Buchan, 2002, Hardill and Macdonald, 2000, Kline, 2003 and Allan and Larsen, 2003) reported that overseas nurses are motivated to move to the UK by personal, professional, and financial and social reasons. The financial motive according to these authors is most prominent among nurses from developing countries.

2.4.1 Personal, Professional and Financial Reasons

These issues are closely interrelated and can be viewed as a response to shifts in the global market and socioeconomic conditions in countries of origin (Smith, Allan, Henry and Larsen and Mackintosh, 2006). Nurses in Allan and Larsen's (2003) study of experiences of internationally recruited nurses in the UK stated they moved to the UK to experience another culture and a different way of life. Nurses also said that they expected professional development and exposure to high levels of nursing practice, and that financial rewards from their employment would allow them to meet their social obligations in their country of origin. However, the Allan and Larsen (2003) study is unclear in citing which countries these nurses came from other than the Philippines and South Africa. Smith et al (2006) found similar results in their mixed sample of overseas nurses.

Allan and Larsen (2003) and Smith et al (2006) used mixed samples from both developed and developing countries. Motivational factors for nurses are therefore varied and do not form a particular pattern. Therefore it is difficult to see how the researchers could conclude from this limited data that the financial motive was most strongly represented among nurses from developing countries.

Although Allan and Larsen (2003) acknowledge that overseas nurses' motives for moving to the UK are often interwoven in complex ways, and that strategies and motives for individual nurses tend to change over time, there is no attempt in the study to separate motives according to place of origin, sex and age and to analyse these accordingly. The study ignores the importance of other factors that motivate nurses to move to and work in the UK, such as availability of jobs, availability of information on job vacancies through employment agencies and the internet, and the importance of networks. Emigration policies in sending countries are also ignored, as are political factors such as the ease and constraints placed on nurses entering the UK.

Aboderin (2007) used a qualitative approach to explore Nigerian nurses' motives for migrating to the UK and found that nurses' decisive motives were to gain financially, with a view to achieving material standards for themselves and their children in Nigeria. This study comprised of nurses in both the UK and Nigeria, which strengthens its validity. However the generalisation made by the author that, without the economic motive nurses would not migrate needs to be taken with caution, as this study was limited to older and middle-aged Nigerian nurses, and a younger population could yield a different result.

There are particular causes for migration (see chapter 4). For example, Neo-Classical Theory explains that migration is caused by differences in supply and demand of labour and capital. Workers move from low-wage countries to high-wage countries. Wage differentials in some instances can be up to a factor of 30 times greater, with enhanced career prospects, continuing professional education, better working conditions in general, political and economic stability in the destination country attract immigrants. In addition the existence of social networks created by previous migrants, which may reduce the psychological as well as financial cost of migration, and the rise of private sector agencies specialising in skilled migration may reduce search costs and encourage people to migrate (Bueno de Mesquita and Gordon, 2005).

Buchan, Parkin and Sochalsik (2003) developed a typology of push and pull factors for internationally recruited nurses in the UK. Buchan et al (2003) suggested that African nurses are motivated by economic factors and career moves, while nurses from countries like Australia, Canada and New Zealand are motivated by opportunities to travel. According to this typology nurses who are motivated by economic reasons tend to make a permanent move, while those who are motivated by travel tend to be temporary migrants. This seems to be a generalisation by the authors using limited quantitative information. Social research on migration indicates that migrants in general are motivated by a combination of factors as outlined above (Massey, Arango, Hugo, Kouaoci, Pellegrino, and Taylor, 1993, and Hollifield, 2000). Buchan et al's (2003) typology is rigid and should be interpreted with caution. For example, a nurse may migrate to the UK for economic reasons but at the same time be attracted by career opportunities, or a nurse may come as a student, and may opt to stay for economic reasons. Some nurses coming to the UK for a holiday find partners and decide to stay because of opportunities in the UK.

Chikanda (2005, 2008) revealed that nurses from Zimbabwe are motivated to move to the UK by economic, political, professional and social reasons. Some economic factors cited by nurses in this study include the desire to save money quickly for later use in Zimbabwe or the desire to receive better remuneration in the country of migration. Political factors include the high levels of crime and violence in Zimbabwe. Professional factors include lack of resources and facilities within the health care system in Zimbabwe, heavy workloads and insufficient opportunities for promotion. Social factors cited by nurses include the desire to find better living conditions and family-centred reasons.

2.4.2 Globalisation

Bauman (1998) uses the metaphors of the 'tourist' and the 'vagabond' to depict two different types of immigrants. The tourists travel because they want to, while the vagabonds travel because they have no other bearable choice. Bauman (1998) further explains that the tourists inhabit the first world or top of society while the vagabonds inhabit the second world or bottom of society. In Bauman's view there are two perspectives to international migration. Firstly, the global perspective represented by individuals in the elite segment of the population who can move freely between countries and continents, and secondly, the local perspective represented by the less privileged segment of the population, individuals bound within their native environments with limited life opportunities. Using Bauman's (1998) framework on globalisation, Larsen, Allan, Bryan and Smith (2005) explored overseas nurses' motives for moving to the UK.

The Larsen et al (2005) study showed that nurses' motives for migration, although conforming somewhat to Bauman's framework, were more complex; as nurses from

developing countries indicated they migrated for financial and professional development reasons, while nurses from developed countries such as Australia and Canada cited working holiday and adventure as reasons. However, Larsen et al (2005) pointed out that motivations often overlapped and were liable to change over-time. Moreover, not all third world migrants are motivated by financial factors. Some have the same intentions as travelling migrants from developed countries. This study acknowledged micro and macro factors contributed to nurse migration; however, their emphasis was on the micro (individual) level with less exploration of the macro factors (such as political factors) that motivate nurses to migrate.

2.4.3 Policies of the World Bank and the International Monetary Fund

 Global exploitation and the relative financial power between nations which often results in devaluation policies on developing countries, imposed on them by the International Monetary Fund (IMF) or World Bank is mentioned in the literature, but not explored in detail.   In the mid 1980s Africa began its public sector reform process as a result of the Structural Adjustment Programmes (SAP) imposed by the World Bank and the IMF in their call for downsizing or zero growth in public sector (Hahnel, 1999).

Adhering to the IMF's insistence meant that developing countries increased their interest rates to stabilise the value of the local currency. This led to increased levels of taxation to reduce the government budget deficit. At the same time the government service provision contracted and encouraged the development of privatisation of public enterprises. The final step in this process to secure-financial liberalisation was the removal of restrictions on the inflow and outflow of international capital, as well as the restrictions on what foreign businesses and banks were allowed to buy, own and operate (Hahnel, 1999). These conditions were imposed upon African governments by the IMF so that further loans could be provided

to prevent default of international loans and avoid bankruptcy. The IMF and the World Bank

then arranged restructuring of the countries' debt among private international lenders,

imposing a pledge of new loans (Kingma, 2006).

In Cameroon, for example, the government reform initiated in the early 1980s under SAP

resulted in suspending recruitment in the health sector, strict implementation of retirement at

50 or 55, and limiting employment to 30 years. It also resulted in suspension of any financial

promotion, reduction of additional benefits such as housing and travel expenses, and two

salary reductions totalling 50% and a currency devaluation resulting in effective income loss

of 70% in 15 years (Hahnel, 1999). In addition, training for nurses and laboratory technicians

was suspended for several years and schools were closed. The situation was similar in other

> sub-Saharan countries (Liese and Dussault, 2004). According to Colgan (2002):
> the past two decades of World bank and IMF structural adjustments in Africa have led
> to greater social deprivation and an increased dependence of African countries on external
> loans. The failure of structural adjustment has been so dramatic, that some critics of the
> World Bank and the IMF argue that the policies imposed on African countries were never
> intended to promote development (p. 3)

Colgan (2002) asserts that the World Bank and IMF policies have impeded Africa's

development by undermining Africa's health, causing deterioration in health and healthcare

services across the African continent.

In 2005 finance ministers of the G8 countries agreed to write off more than $40 billion of

debt owed by 18 highly indebted countries to the World Bank and stated that 21 more

countries would be eligible if they met targets for fighting corruption and continued to fulfil

structural adjustment conditionalities. Most of these countries are in sub-Saharan Africa and

the insistence by the World Bank and the IMF that debt relief is linked to structural

adjustment conditionalities has meant that they have ignored the devastating consequences of

their imposed policies on African countries' infrastructures. The impact of these unintended

consequences on health services provision has been profound in the last two decades, and it is

difficult to assess whether the debt relief will eventually improve health systems, especially

as there has been an exodus of skilled trained nurses to developed countries. Yet the

expectation seems to remain that there will be a continuance of nurse migration from poor to

rich countries.

The World Health Organisation (WHO) added in 2006 that in many countries health sector

reform SAP was responsible for capping public sector employment and limiting investment

in health worker education, thus drying up the supply of young graduates. These political,

financial and social factors have affected the countries' healthcare infrastructure, and these

(coupled with global inequality) have all contributed to the deterioration in health services

and help to explain reasons behind nurse migration. Also economic policies, such as bilateral

agreements, are designed to facilitate nurse migration in periods of critical nurse shortages.

For example, the United Kingdom and other countries placed nurses under a list for

preferential treatment and easier immigration process, making it easier for nurses to

immigrate (Kingma, 2006).

2.4.4 Colonial Ties

Colonial ties are not only responsible for connecting countries through a common language

such as English; they are also responsible for the development of governments and

institutions which either enhance economic development alongside quality healthcare

provision or impede economic development leading to weaker infrastructures and, in the case

of this thesis, impact upon the provision of health service systems. Acemoglu, Johnson and Robinson's (2001) empirical investigation reported that differences in colonisation policies in different colonies had a strong correlation on the type of institution that developed after independence.

Acemoglu et al (2001) based their study on the fact that there were different types of colonisation policies which created different sets of institutions. At one extreme, European powers set up 'extractive states' (an example being Belgian Congo). These institutions failed to provide checks and balances against expropriation to protect private property. The main purpose of extractive states was to transfer as much resources as possible from the colony to the coloniser. At the other extreme, Europeans migrated and settled in a number of colonies Creating 'Neo-Europes' (Crosby 2005). These settlers replicated European institutions, with emphasis on private property and checks against government power. Examples include Australia, New Zealand, Canada and the United States. According to Acemoglu et al (2001) the colonisation strategy was influenced by the feasibility of settlements. In places where the disease environment was not favourable to European settlements the creation of extractive states was more likely.

Acemoglu et al (2001) suggest that Africa is poorer than the rest of the world not because of pure geographical or cultural factors but because of defective institutions set up by colonialists which persisted after independence. These malfunctioning institutions contribute to the development of poor health systems, and in turn are a causal factor in migration decisions.

Smith et al (2006) reported that African nurses in their sample were all from ex-colonies, and tended to migrate directly from their home countries to the UK. They noted that this is connected to the fluency in the English language of highly educated people in most colonies. There are professional linkages between these countries and the UK in medical and nursing curricula, educational institutions and colleges.

2.4.5 Compatibility of Nurse Education

Colonial ties influence the choice that nurses make as to which country they would like to migrate. Most studies on nurse migration ignore this factor, although it is acknowledged that communication is important for nurses to be effective in their jobs (Withers and Snowball, 2003, Allan and Larsen, 2003). Most sub-Saharan countries use English in educational systems, and curricula are based on the English system. Dodani and LaPorte (2005) assert that these colonial ties are important in nurse migration because of similarities in language recognition and professional qualifications.

The majority of formal nurse training programmes in Africa started in the 20th century and intensified during the colonial period, when most hospitals engaged in nurse training programmes. In Anglophone Africa, this trend changed when nurse training gradually became associated with nursing colleges and university training in the 1970s (Munjanja, Kibuka and Dovlo, 2005). Professional nurse or registered nurse training required completion of high school (12 years of basic education) and three years of professional training, encompassing a higher level with more depth of theory and science. Now these universities offer four-year direct entry degrees and two-year post-basic degrees. This is equivalent to UK nurse training and in some cases exceeds UK requirements, making sub-Saharan nurses attractive to the UK NHS. Table 2.2 shows nurse training requirements and qualifications in

selected sub-Saharan countries. It is easy to ascertain why these nurses adapt easily to the British nursing system.

Table 2.2 Training requirements and qualifications in selected sub-Saharan countries

Country	Nurse type or category	Basic schooling	Basic nursing education	Comments/remarks
Malawi	RN Diploma	12 years	3 years	Upgraded to BSc in 2000
Nigeria	BSc	12 years	3 years	
South Africa	BSc	12 years	4 years	
Zambia	RN	10-12 years	3 years	
Zimbabwe	BSc	12 years with 2 A-level sciences	4 years	

Munjanja, Kibuka and Dovlo (2005)

2.4.6 Asylum Seekers

Iredale (2001) describes five typologies of categorising professional migrants: 'forced exodus'; 'ethical emigration'; 'brain drain'; 'government induced'; 'industry led' (p 16). He cites the example of oppressive regimes as a consistent factor in the flight of the well educated. Winkleman-Gleed (2006) also highlighted the role of conflict in migration, noting that the UK has historically offered refugee sanctuary to people in crisis, and some nurses entered the UK through this route. However, factors that influence people seeking asylum in

the UK are complex and includes language, colonial ties, economic and political factors. Among those granted asylum status are nurses that want to practice their profession. However the issue of asylum seekers although a factor and therefore mentioned is not the focus of this thesis.

2.4.7 The Brain Drain

The tendency for skilled and educated professionals to leave their countries in search of better returns for their investment is referred to as the 'brain drain' (Iredale, 2001). Although 'brain drain' was formerly used to describe the loss of valuable skilled personnel from developing to more developed countries, it is now also used to describe the loss of skilled human resources from developed countries. Nevertheless it is in developing countries where the phenomenon has more adverse effects.

Government induced brain drain refers to the selection policies that governments use to select permanent immigrants, such as the policies used by Australia, Canada and New Zealand. The UK has recently introduced the highly skilled migrant scheme, which is intended to attract highly skilled professionals to work in the UK. Initially the UK government placed nursing on the list of shortage occupation in order to ease immigration rules for nurses. However UK health policies promoted an increase in internal nursing numbers which has now decreased this shortage and hence placed restrictions on non EU nurses' immigration to the UK. From September 2006 only nurses achieving band 7 (senior nurse with 2-3 years' experience) can apply for a work permit, and this effectively excludes all band 5 non-EU nurses. This is important to appreciate as all nurses from non-EU countries are initially employed at band 5 (which is the equivalent of a newly qualified nurse) when they move to the UK, regardless of their qualifications or experiences.

2.4 .8 Gender Issues

It is well known that nursing is a female-dominated profession. Winkleman-Gleed (2006)
asserts that women constitute three quarters of the UK NHS workforce. This trend is
replicated world-wide; hence, the likelihood is that the majority of migrant nurses to the UK
are female. Yet nursing research has not explored the issue of migration and gender fully.

Migration literature often assumes that migrants are men (Raghuram, 2004, Mahler and
Pessar, 2006) with women migrating to join men. This form of migration, called family
reunification migration, was common in the 1960s and 1970s as a consequence of a
predominantly male-led labour market. Significant numbers of migrants came to UK from the
Indian sub-continent and the Caribbean to take up jobs in the unskilled sectors of the labour
market. This view can no longer be supported in the case of nurses, as often nurses are the
lead immigrants in their families. Nurses are regarded as skilled migrants in the UK and
significant numbers immigrated to the UK since nursing was placed on the shortage
occupation list by the Labour government in the late 1990s. However, nursing and migration
literature has paid little attention to the fact that the nature of family migration must also
therefore be changing.

In a system where migration was dominated by male unskilled labour, particularly from
former colonies, male labour migrants were often disadvantaged in two of the social
categories: race, class and gender. Migrant problems were therefore regarded as those of
social integration rather than professional integration (Raghuram, 2004). Women migrants
are disadvantaged in all three. Current trends toward female migration have included
unskilled as well as skilled migration in the caring and domestic sector (Anderson, 2000).
Women are primary migrants in these sectors and present a different set of problems that

these women face and therefore require further research. Nurses in the current study reported being overworked as they tried to be both bread-winner and housewife as their partners were reluctant to help with house work. House work is considered women's work in sub-Saharan Africa and is often delegated to maids if both husband and wife work outside the home. For some nurses, however, migrating to the UK was a way of coping with separation or divorce from their husbands while for others it was a way of gaining independence from their husbands.

2.4.9 The Role of Recruitment Agencies

Migration may be industry-led when employers are behind the selection of skilled immigrants. In the case of the UK, nursing agencies operated both abroad and in the UK to recruit registered nurses. The Government acted a 'lubricator' to ensure fast-track mechanisms and speedy entry (Iredale, 2001). Recruitment agencies played an important role in source countries where they sometimes enticed nurses with unrealistic salaries and working conditions in the destination country. Mahler and Pessar (2006) state that:

> Demand-induced migration turns assumptions about migration and migrants on its head. It questions the assumption that people migrate merely because they envision a better quality of life. Quite conversely, most migrations do not begin with individuals' cost-benefit calculations but with enticements made to people with no intention of migrating. These enticements alter the very basis for cost-benefit calculations that migrants use, introducing a foreign element that is rarely if ever acknowledged in the neoclassical theoretical accounts. (p. 47)

Recruitment agencies in the UK were accused of providing inaccurate information to overseas nurses in order to entice them to move and work in the UK (Allan and Larsen, 2003; Withers and Snowball, 2003; Bueno de Mesquita and Gordon, 2005; Mensah, Mackintosh and Henry, 2005).

2.4.10 The Push-Pull theory of Migration Factors

Migration is the result of the interplay of various forces at both ends of the migratory axis. Some of these forces are political, social, economic, legal, historical, cultural, or educational (Mejia, Pizurki, and Royston, 1979). Push factors are generally present in donor countries, while pull factors are present in receiving countries. Both forces must be operating for migration to occur. In addition, facilitating factors must be present as well, such as the absence of legal or other constraints that impede migration usually controlled by governments. In agreement, Kingma (2006) explains that determining why nurses migrate is a complex matter and no one theory has yet captured all the forces that influence an individual to move. For instance, the traditional economic theory does not help us to understand why relatively highly paid nurses are found working in other countries with less pay.

The influence of transnational communities on migration is increasingly being recognised by migration experts (Kingma, 2006). As well as factors like political forces, poverty, and the age of the migrant, past colonial and cultural ties and existing immigrant population in the destination country will play a significant role in the decision to migrate. Other factors such as an increasing global economy, the international standardisation of educational systems, the availability of cheap international flights and skill shortages in the health care sectors of the developed countries are also responsible for increased nurse migration (Larsen et al, 2005). Governments may influence how demand for international health professionals is generated through policies such as relaxed immigration regulations and reduced investment in local nurse training (Dovlo and Martineau, 2004). Castles and Miller (2003) state 'the idea of individual migrants who make free choices…is so far from reality that it has little explanatory value' (p.25). Relaxing of immigration rules by the UK government between 1998 and 2004

allowed more nurses from African countries to find employment in the UK, while the policy

of the Conservative government (of reducing nurse training places) in the previous decade

was contributory in creating the nurse shortages (Bach, 2007). At present international

recruitment has declined because of the governments' sensitivity to accusations of poaching,

and easing of nurse shortages in the NHS. The coming to power of a Conservative/Liberal

coalition government, with its commitment to cutting public spending has almost halted

international nurse recruitment.

Push and pull factors often mirror each other (Kingma, 2001, 2006, Bach, 2003, Buchan et al,

2003, Dovlo, 2004, Kline, 2003, Padrath, Chamberlain , McCoy, Ntuli , Rowson, and

Loewenson, 2003, Buchan and Calman, 2004, Dovlo and Martineau, 2004, Dodani and

LaPorte, 2005, Mensah, Mackintosh and Henry, 2005, and Thupayagale-Tshweneagae,

2007), so that a nurse who has a relatively low salary will be pushed out of his/her country

and pulled toward a country where there are relatively higher salaries. Pull factors include

high remuneration, job satisfaction, a safe work environment, better-resourced health care

systems, or professional development opportunities. Political and economic stability, travel

opportunities, and the chance to take part in humanitarian assistance would also draw or pull

nurses to a particular location. One of the main push factors for nurses from sub-Saharan

Africa is said to be the HIV/AIDS epidemic, while a major pull factor is the shortage of

nurses in the UK (Thupayagale-Tshweneagae, 2007).

Nursing increases the risk for infection, and the nursing workload expands as the HIV/AIDS

epidemic grows and colleagues get infected, become sick, die or migrate (Padrath et al, 2003,

Buchan and Calman, 2004, Munjanja, Kibuka and Dovlo, 2005). The rate of infection varies

across countries, with southern Africa reporting the highest rates. Malawi and Zimbabwe, for

example, report higher rates than Ghana (Padrath et al, 2003, Ogilvie, Mill, Astle, Fanning and Opare, 2007). Padrath et al, (2003) reported that AIDS is responsible for five to six-fold increases in health worker death rates. Tawfik and Kanoti (2003) estimate that 19-53% of all government employee deaths in Africa are due to AIDS.

Research by Dovlo (2007), using focus groups, found that nurses and doctors in Ghana were concerned about the state of the health services in that country and cited this as a reason for migrating abroad. Areas of concern raised by nurses include the unproductive labour relations and negotiations with governments for several years without agreement. The research also highlighted poor career progression, low salaries (making it difficult to acquire personal resources such as housing and personal transport), poor retirement benefits and government policies perceived as favouring doctors, were seen as push factors for nurses. Doctors, on the other hand, cited lack of job satisfaction, poor career and professional opportunities, and a strong sense of government bureaucracy as push factors.

Dovlo (2007) observed that nurses' expectations reflected other causes of migration. Nurses felt they had no opportunities for educational and career advancement, which made it difficult for their training and experience to be recognised for university courses. They expected that leaving Ghana would give them the opportunity to train and enter courses. They also expected to earn more money, and this outweighed the perceived disadvantages.

In comparison an earlier study by Withers and Snowball (2003), in a study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospital NHS Trust, found that nurses had expectations of earning more money, having a higher standard of

living, and gaining professionally. Daniel et al (2001) found similar results in their study on the expectations and experience of newly recruited Filipino nurses.

McNeil-Walsh (2004), in a study of South African nurses, reported three dominant discourses on nurses' migration from South Africa: the 'push /pull discourse, the 'brain drain' and the 'ethics' discourse. The push/pull discourse has already been discussed above, but push factors specific to South Africa include HIV/AIDS, personal safety, and deteriorating working conditions. The pull side of the equation includes the availability of jobs and financial incentives.

The 'brain drain' discourse concerns the South African government and its health service. It focuses on skills depletion as an outcome of the increasing migration of health care professionals, and the corresponding fear of skills depletion within South Africa has shifted with the levels of conflict that have characterised the political climate.

Van Rooyen (2000) identifies four waves of migration during different periods of South Africa's political turbulence: the implementation of apartheid in 1948, the political unrest in the 1960s, further unrest in 1976 and the mid 1980s when the states of emergency were declared; and finally, the period when the ANC came to power in 1994. The rate of migration has been increasing since then, and the brain drain discourse concentrates on the impact of this migration on the social and economic fabric of South African society and strategies needed to stem it.

The ethics discourse is seen in the context of increasing recruitment of health care professionals by the UK while South Africa has a shortage of its own. McNeil-Walsh (2004)

widens the South African nurse migration discourse to include aspects of postcolonial theory, to highlight important ways in which the migration of South African nurses is shaped. As a colonial power, Britain reshaped the fabric of South African society in many ways. After independence, Britain's continuing relationship with South Africa meant that Britain was inevitably engaged with the process of racial stratification that served to provide privileged spaces for British migrants within the South African labour force. In later years, Britain's implementation of sanctions played a role in the unravelling of the apartheid system. During the post-apartheid era the white population of South Africa have had an advantage because of the immigration act of 1971, which favours patrials to come into Britain without restrictions. This has meant that many white South Africans can come into the country to work without a complex procedure of work permits. McNeil-Walsh (2004) says that any analysis of current migration cannot ignore this historical context. She further explains that there is still the presence of the empire in South Africa and an understanding of the migration experiences of South African nurses should take this into account. South African nurses' deferring positions in history have been deeply shaped by race and empire.

2.4 .11 Social Demographic Changes

Sociology of migration needs to take into account local and global social dynamics, as well as their complex interactions (Castles, 2003). Recent shifts in migration patterns are related to cultural shifts affecting household daily routines as well as socio-economical organisation of society. In this regard Ehrenrich and Hochschild (2002) cite the example of women in developed countries who are increasingly joining the paid workforce with a corresponding increase in immigration of female workers from developing countries. Of the estimated 120 million legal and illegal migrants, about half are women and they are typically more affluent and better educated than male immigrants. This is in agreement with Van Hear's (1998)

suggestion that, while it is important to understand the macro political economy that surrounds migratory order as well as the policy dimensions of the migratory regime, it is equally important to understand the micro aspects of the migrants' perspective.

2.4.12 Discussion of Chapter

This chapter has reviewed the literature in relation to what motivates overseas nurses to move to the UK. There is a tendency in the literature to categorise all overseas nurses as one homogeneous group, and only a few studies have attempted to study overseas nurses in terms of the geographical areas from which they come. The literature indicates that nurses are motivated to move to the UK for various reasons which are interrelated. These are financial, personal and professional development. These factors have been classified as push and pull factors, where push factors are conditions which exist in the sending country and motivate nurses to migrate. Pull factors, on the other hand exist in the receiving country and attracts nurses to emigrate. Low wages, poor working conditions, lack of professional growth, heavy work load, as well as the increase of AIDS/HIV patients in African hospitals have been cited as push factors. The high wages paid to nurses in the UK in comparison with African countries, a better standard of living, better working conditions have been cited as pull factors.

However, the literature has often neglected the influence of the state in changing immigration policies and practices to suit its needs. The influence of emigration policies in the sending countries is also often not discussed. The UK has changed its immigration policy and practice concerning nurses each time there has been a nursing shortage in this country. To achieve this, nursing was put in a shortage occupation category. However, the UK government has recently reclassified nursing and now allows only senior nurses to emigrate, thereby

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effectively excluding all nurses from sub-Saharan countries who are initially employed as newly qualified nurses. By doing this the Government is seen to be responding to ethical recruitment and fending off any accusation of poaching nurses from developing countries. Moreover, most NHS vacancies can now be filled by British-trained nurses, and the shortage of nurses in some specialties appears to have abated. Table 2.1 demonstrates that the increase in overseas nurse recruitment has declined significantly as a direct result of the UK government expansion of nurse training in the late 1990s and the easing of shortages at entry-level nursing posts. International nurse recruitment was already on the decline from 2006 because the UK government removed nursing from a shortage occupation list. Currently in 2011 international nurse recruitment has virtually ceased as a result of the coalition government policies on skilled immigration, which has introduced an immigration cap.

The role played by employment agencies has also been explored in the literature and it is clear that this shapes the experiences of nurses when they relocate to the UK. Little has been written about the influence of gender yet nursing is a female-dominated profession which means that women are often the primary migrants, with men and children following them. This is in contrast to earlier migrations in which women followed men as dependants. As there is little research on what motivates nurses to migrate, there is need for research into this area. The current investigation will partly address this question by asking black African nurses currently working in the UK what motivated them to move to the UK. The next chapter will review experiences of overseas nurses in the UK.

CHAPTER 3

LITERATURE REVIEW ON EXPERIENCES OF INTERNATIONALLY RECRUITED NURSES IN THE UNITED KINGDOM

3.1 Introduction

This chapter reviews the literature on experiences of internationally recruited nurses in the UK. The previous chapter discussed various factors that motivate overseas nurses to relocate to the UK. Among these factors are historical, economic, social, political and personal factors. It would seem logical that nurses' motivations for relocating to the UK would shape their experiences. Experiences would also be shaped by different routes taken by the nurses to move to the UK, and by social, political and working conditions in the UK as well as culture and ethnicity.

It has been pointed out in the previous chapter that a major factor in international nurse migration to the UK, especially from sub-Saharan Africa, is the UK's immigration•and recruitment policies and practices. Mobility of nurses is firstly influenced by regulatory frameworks of the UK, by training and deployment policies. Secondly, the UK government is responsible for rules that govern the issue of work permits, nurse registration standards and border control policy.

Bach (2007) explains that labour market institutions play an important role in influencing government immigration policies. He asserts that employers are not only responsible for generating employment; they are also responsible for structuring jobs in particular ways that may be conducive to employing migrant labour. Governments then organise recruitment to fulfil employer requirements. More often, employers employ migrants in low status jobs

which are difficult to fill. Employment agencies are included in labour market institutions, as they are influential in the flow of migrant labour.

Nurses from sub-Saharan Africa were recruited as part of a recruitment drive by the then-Labour government in order to boost the number of nurses in the NHS (DoH 2001). The Labour government was able to develop rules and infrastructure that resulted in an unprecedented increase in the number of overseas nurses moving to the UK. The Labour government was able to influence the professional body responsible for nurse registration, the NMC, by its delegated authority so that more nurses could be registered. For example in 2004-2005, the NMC was frequently recommending overseas applicants to undertake 3-6 months clinical placement for adaptation courses (NMC, 2005). This decision influenced the number of nurses who were available to work. Long waiting periods for placements would discourage nurses from moving to the UK, as most had to meet their own cost of living in the period leading up to registration and finding a job.

3.2 Social Experiences

Social experiences for black African nurses are shaped by their migration motivations and trajectories. Most nurses come with their families and, according to the social exchange theory of migration (chapter 4), this should affect the gender roles of husband and wife and the equilibrium of the family as a whole. Nurses will also be affected by factors that are associated with moving to a new environment. These factors are discussed next.

3.2.1 Negotiating Work and Family

In a study using personal interviews, McGregor (2006) found that Zimbabwean nurses who had families worked in nursing homes because of child care obligations. Single mothers

found it especially difficult to balance work and child care. For those who had spouses, renegotiating domestic roles proved a challenge because of work imbalances, feminised employment and the lack of support from maids and extended family. Some nurses experienced divorce as a result of their husbands not being able to find employment in the UK due to their lack of transferable skills.

McGregor (2006) and Allan and Larsen (2003) found that some nurses initially travelled on their own to the UK to work. During this time nurses found it difficult and psychologically demanding for them to be separated from their families. Female nurses found it especially difficult to be separated from their children. Notwithstanding this separation from their children, nurses still make decisions to migrate.

McGregor (2006) found that the Zimbabwean nurses interviewed in her study had reconfigured their family lives to cope with conditions in the UK. Almost all the professionals interviewed in this study had to spend an initial period of separation from spouses and or children. After settling down, some nurses kept their children in Zimbabwe, or lived only with babies/toddlers while keeping older children in Zimbabwean schools. A few had children in other countries, particularly South Africa. These parents included working couples and lone fathers or mothers. Transitional arrangements, through which internationally mobile parents organised children to be brought up in Zimbabwe, included leaving children with grandmothers, aunts or others. This extension over different geographical spaces and a strategy of parenting through extended family is fine when distances involve only Southern Africa, but moving beyond Southern Africa introduces particular strains on family relations.

For many families, keeping the children in Zimbabwe was looked upon as a positive choice. Respondents cited the cost of bringing up children in the UK as a factor in this decision. Most parents also emphasised their negative assessment of the UK as a place to bring up children, particularly the lack of discipline in schools, the controls on parenting, lack of respect, the lack of space, the potential for children to lose their identity and an over-emphasis on sex in teenage youth culture and media. However, the majority agreed that British education was better as standards were deteriorating in Zimbabwe because of localisation of examinations.

McGregor's (2006) study is specific to Zimbabwean nurses and teachers who moved to the UK as a result of the political conflicts in that country. It deals specifically with the nurses' and teachers' negotiation of work and family in Britain. The study did not discuss the implications, if any, of this family reconfiguration on the teachers' or nurses' careers, nor the effect it had on their effectiveness as nurses or the effect on their stay in the UK.

McGregor's (2006) is the only study to have looked at African nurses' experiences of negotiating work and family in the UK, and the study only looked at nurses from Zimbabwe. Zimbabwe is going through a difficult time in its political history, and some of the nurses' experiences could be related to this. There is a need to study the experiences of other African nurses to determine if their experiences support this profile.

The UK government introduced the working parents' tax credits in 2003, which have been a great help to many nurses with children. However, this help is not available to non-EU nurses who do not have a settled status in the country. The WHO (2006) states that migrant workers should be recruited on terms and conditions equal to those of locally qualified staff. By denying tax credits to non-EU nurses, the UK government is denying the benefit of child care

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to which all EU nurses are entitled, the effect of this on the nurses working lives is not known.

There has been little research that explores social experiences and tied migration among skilled immigrants (Raghuram, 2004). Hardill and MacDonald (1998) found that women are usually losers in the labour force. A study by Wall (2004) found that immigrant families adopt different strategies in order to reconcile work and care for young children. Two prominent strategies were: for the mother to stay at home and look after the children, and delegation to other family members. Other strategies included were sharing responsibilities between partners by alternating the working of the two parents, and relying on help of older children. Some left children below 10 years old to fend for themselves. This suggests that migration to countries where domestic help is harder to obtain, and where the family is removed from social support, disadvantages women more than men and may result in women's withdrawal from the labour market. In the present study, women were the lead immigrants and therefore had no option of staying at home. The present study puts the situation of women immigrants as primary immigrants at the fore, since nurses are mostly women. This situation could affect stress levels that would affect nurses' performance at work.

3.2.2 Living in Two Places

Migrants often express a feeling of living in two cultures when they leave their country of origin to go and live in another country. On the one hand, migrants are expected to integrate with the host population; on the other, they are expected to be the guardians of their own culture and pass it on to the next generation. This creates a feeling of not belonging completely in any one culture. Currently there is little information in the UK regarding this

phenomenon in immigrant nurses. However, Dicicco-Bloom (2004), who studied the racial and gendered experiences of immigrant nurses from Kerala, India in the United States, reported that nurses experienced unsettling cultural negotiations. Nurses in that study felt subject to conflict in that their homes were so far away, in both geographical and social distance (developing world) and that members of the dominant culture did not acknowledge them as having familial relationships. At the same time, nurses perceived their own families as viewing them as too far away (developed world) to receive consideration for the similarities of their lives as well as their differences. One of the participants narrated the Experience surrounding her father's death in India 10 years previously, where her family did not inform her of the death for one month as the family felt they were protecting her from the need to go to the funeral. Her frustration was compounded by the fact that when she decided to go home to be with her family, her supervisor acted as if she did not believe her story. She felt as if, because she came from India, her supervisor thought that she could not have had a father who had died.

Bheenuck (2006) utilised a life history approach to explore the lives and experiences of ten individuals who arrived in Britain as student nurses during the 1960s and 1970s. He reported that nurses in this study felt they had multiple 'homes', and that most had continued to maintain contact with family members in their country of birth and made frequent visits to strengthen such bonds. The participants felt they belonged in two places, and at times this caused problems with their sense of self-identity.

Black African nurses in the current study expressed similar sentiments to those above. They described a detachment from their children in terms of culture and lamented the fact that they were not able to instil the African culture (as children readily adopted UK culture). Some

travelled frequently to their home countries in an effort to introduce children to nurses' own cultures. Some nurses had bought or were building houses in Africa, as they said that it was good to maintain roots in Africa. Almost all the nurses associated with others from their own countries in order to preserve their language and culture.

3.3 Professional Experiences

The professional experience of black African nurses in the UK can be explored by looking at the recruitment process, together with various means of support provided through adaptation and induction programmes, as well as mentor systems and support provided by colleagues, managers and professional bodies. Experiences can also be understood by exploring the history of migrant labour in the NHS. After the Second World War, there was a marked increase of overseas recruitment of nurses and student nurses to staff the newly established NHS (Doyal, Hunt and Mellor, 1981). The Ministry of Labour and the Ministry of Health in the UK collaborated with the Colonial Office in recruiting nurses from British colonies. By 1948 nurses were being recruited from 16 countries, including Nigeria, Sierra Leone, British Guiana, Mauritius, Trinidad and Jamaica. These migrants were being recruited mainly to fill difficult-to-fill posts in the NHS, posts which the white population was unwilling to fill (Doyal et al, 1981). The recent recruitment drive of overseas nurses has followed the same trend, with overseas nurses being concentrated in less desirable specialities like psychiatric and geriatric institutions. In addition, those that are in acute hospitals are concentrated in the lower grades (Allan and Larsen, 2003, Alexis, Vydelingum and Robins, 2006, Smith, Allan, Henry, Larsen and Mackintosh, 2006 and Larsen 2007). There are no studies dealing specifically with black African nurses and this review looks at the experiences of internationally recruited nurses in general.

3.3.1 Recruitment

Overseas nurses moved to the UK through different channels (Hardill and Macdonald 2000, Allan and Larsen, 2003, Withers and Snowball, 2003, Buchan 2002, Likupe, Kelly and Labonso-Abonyo, 2005 and McGregor, 2006). Some were recruited by agencies that are based either overseas or in the UK; others come as visitors, while others come as dependants of their spouses. McGregor explains that from the late 1990s to 2002, private agencies supplying the British market with nurses, teachers and social workers had offices in Zimbabwe, and held periodic recruitment drives in public venues. After this period, agencies and employers based in Britain were still accessible on the web, through information passed through networks of contacts between relatives and former colleagues, or after arrival in Britain. In some cases some agencies were set up or run by Zimbabweans themselves. In nursing, nurse training was used as a route for migration as free bursaries were still available to overseas applicants until 2002.

Findings from the above studies show that overseas nurses had to pay fees to recruitment agencies to come and work in the UK. Most nurses paid between £500 and £2,000. Nurses felt manipulated and cheated, because of this as they later found out that NHS agencies were not supposed to charge fees. The charges imposed on nurses by recruitment agencies put nurses at an immediate financial disadvantage.

3.3.2 Adaptation and Induction

The Nursing and Midwifery Council (NMC), (formerly UKCC), determines by using different criteria whether a nurse can be put directly on to the register or whether they need to undergo a period of supervised practice before they can register. The period of supervised practice is generally known as an adaptation period, and individuals are assessed individually

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as to how long this should be. The NMC regulations also depend on the country in which the nurse was educated as well as some recently imposed regulatory changes. For example, nurses trained in the EU do not need to undergo an adaptation period. From September 2006, all overseas nurses (from outside the European Economic Area) are required to undertake the Overseas Nurses Programme (ONP), which comprises of 20 days of protected learning time and where appropriate, nurses are also required to undergo a period of supervised practice prescribed by the NMC. In addition, from February 2007 nurses are also required to pass the International English Language Testing System.

According to the NMC, the adaptation period is required in part to orientate nurses to the NHS and the system of work in the UK. However, there have been complaints about adaptation courses, especially relating to those offered by the private sector in nursing homes (Allan and Larsen, 2003 and McGregor, 2006). Nurses described their experience as slavery, being paid as carers while doing registered nurses' jobs; they did not know their rights and were often threatened with deportation if they wanted to leave.

Although experiences of overseas nurses have been reported, only one study (Smith et al, 2006) has investigated whether the nursing home experience is adequate preparation for working in the UK hospitals where most overseas nurses aspire to work, and indeed end up working. Smith et al (2006) suggest that working in a nursing home with health care assistants is not an adequate adaptation for trained nurses who need to learn British nursing practices. Nurses in this study reported being used as a 'spare hands' in nursing homes. Smith et al (2006) also suggest that the lack of formal accreditation and assessment systems used in the UK has led to deskilling of overseas nurses.

3.3.3 Success of Adaptation Programmes

Using focus group interviews and individual in-depth interviews, Gerrish and Griffith (2004) found five ways in which the success of an adaptation programme was given meaning: gaining professional registration; fitness for practice; reducing nurse vacancy; equality of opportunity and promoting an organisational culture that values diversity. Gerrish and Griffith (2004) interviewed overseas nurses doing adaptation programmes in two NHS hospitals. They also interviewed managers, educators and mentors. All the above factors were rated as a success by stake holders, including overseas nurses. Nurses were anxious to register within the shortest possible time. However, the measurement of success was biased toward advantages of employing overseas nurses in the NHS, and focused little on the experiences of nurses themselves during the adaptation period or their social experiences in the UK. Matching overseas nurses' experience to their placement is regarded highly in facilitating the nurses' adaptation to the British system of working. The authors question if adaptation courses offered by nursing homes are suitable for preparing nurses to work in NHS hospitals.

Nurses' experiences centred on differences in medical equipment and management of patients, and how this matched with their previous experiences. Organisation of nursing care and the importance of working in a team were mentioned but not explored in great detail. This is important as it affects the effectiveness of nursing care to patients. This study was specifically designed to evaluate an adaptation programme in two NHS trusts, and as such its findings are restricted by this remit. This notwithstanding, the study has the strength of interviewing overseas nurses and other stake holders in the NHS trusts concerned.

In a systematic review of the literature, Konno (2006) found that the inclusion of cultural issues of difference in a transition programme for overseas nurses, and the provision of formal networks for overseas nurses, were necessary to ease problems of transition into Australian nursing. Konno (2006) concluded that this evidence should be taken into account when planning support programmes, but also stated that bridging programmes for overseas nurses should receive more attention from researchers and leaders, and should be regularly evaluated. It would therefore seem reasonable to expect that evaluation would include Seeking overseas nurses' views on the effectiveness of the courses in meeting their needs.

In a study of Filipino nurses adapting to a new culture, Withers and Snowball (2003) found that several nurses felt that mentors were not aware that Filipino nurses held nursing qualifications in the Philippines, and some of them had more experience than their mentors. These nurses felt that the word 'preceptor' instead of 'mentor' should have been used because they felt that students had mentors and trained nurses had preceptors to assist them.

Withers and Snowball (2003) reported that some respondents were frustrated that they were not allowed to carry out routine procedures, such as cannulation, vein puncture, and collecting arterial blood gasses, which were routinely undertaken by qualified nurses in the Philippines, and feared that they would lose their skills. This shows the mismatch and lack of information between expectations and actual experiences. The Filipino nurses were not aware that what was considered routine in the Philippines was not so in the UK. Withers and Snowball (2003) did not establish what information the Filipino nurses had about British nursing before coming to the UK. If given accurately this information would engender realistic expectations of British nursing.

3.3.4 Unmet Expectations

Overseas nurses coming to work in the UK have different expectations. Daniel et al (2001) and Withers and Snowball (2003) found that Filipino nurses expected to earn a lot of money, some of which they would be able to send home to the Philippines. Some expected to advance their professional knowledge, while some just wanted to experience a different culture and new ways of working, clean hospitals, fewer patients to nurse ratio and advanced technology. Nurses also expected that relatives and health care assistants would carry out the fundamentals of care and that nurses would be managers and planners of care, and undertake very complex tasks. Filipino nurses in Daniel et al's (2001) study expected to have equal opportunities in career progression and promotion.

Nurses' expectations were not all met. Nurses found the cost of living in the UK and taxation high, and they were not able to send as much money to the Philippines as they had expected. Others experienced hostility from their hosts. However, nurses' expectations of gaining experience and knowledge were met, although nurses expressed surprise at finding old-fashioned equipment on the wards. They also experienced heavy patient workloads and 'chaotic' working environments (Withers and Snowball, 2003).

Daniel et al (2001) recommended a long-term follow-up of Filipino nurses to determine if they would really achieve equality in terms of allocation of training opportunities and promotion. No such study has been done to date, but experiences of other minority nurses in the UK show that the outlook is bleak (Beishon, Virdee and Hagell, 1995).

Filipino nurses in the above studies were recruited in batches by recruitment agencies that had agreements with the NHS. They did their adaptation in NHS hospitals, and, although

some of them reported negative experiences, most reported positive experiences. Nurses felt that they were well supported. On the other hand, nurses who come to the UK from sub-Saharan Africa come as individuals who made their own application either through recruitment agencies or directly to hospitals and nursing homes, mostly because of codes of recruitment practice. Their experience requires investigation, as it may be different from nurses who were recruited in batches.

3.3.5 Differences in Nursing Practice

In a study of overseas nurses' experiences of working in the clinical settings in England, and the experiences of their hosts, Cooke (1998) found that nurses felt that their experience as overseas nurses was often not valued, and this was manifested by a failure on the part of managers and academics to invite them to make a presentation. Cooke (1998) also reported that managers and academics perceived these visits to be problematic or merely a method of raising funds. Cooke (1998) seems to imply in this study that the term ethnic means non-white people and their attributes such as culture and clothing; when clearly this is not the case. Her research concerned overseas nurses from the EU and Africa, who were on an educational visit, and managers of education and practice who were involved with these nurses. One would expect the results to conform to some rules of respect because of this relationship. The present study investigated these issues in relation to black African nurses who are employed by the NHS and practising in the UK.

Alexis and Vydelingum (2004) studied the lived experiences of overseas black and minority ethnic nurses in the NHS in the South of England using semi-structured interviews. Their sample comprised of 12 nurses, who came from the Philippines, South Africa, the Caribbean and sub-Saharan Africa. In this study the participants referred to nursing practice

in the NHS as being different from what they were used to, particularly with regard to the organisation of care. Many were familiar with task-orientated schedules rather than individualised and holistic nursing care. Nurses found that they had to do some tasks that were not considered part of nursing care in their home countries, such as giving patients baths and toileting patients (which were considered carer's jobs), whereas wound dressing and administration of medicine were considered nursing duties. To these nurses, nursing was about assessing patients and managing their care, and not particularly about attending to their needs. Allan and Larsen (2003) and Smith et al (2006) had similar findings. Overseas nurses in both studies were not asked why they considered such tasks as bathing and toileting patients as carer's jobs. They were not asked for their definition of a 'carer' and what they perceived to be the difference between a carer and a nurse.

Taylor (2005) reported that overseas nurses described one of their problems as being a need to adapt to different ways of working in the UK. Nurses cited examples of differing societal values in relation to the care of older people. Nurses from the Philippines, China and Nigeria in particular said the family played an important role in the care of the elderly in those countries, in contrast to the UK, where older people are cared for in nursing homes or residential homes. Nurses described differences in nursing responsibilities, decision-making, and accountability. Some described providing spiritual support as part of their role in their home countries, and said that they missed not providing this to patients. Taylor (2005) does not explain what effect this difference had on overseas nurses in her study.

Daniel et al (2001) found that differences between Filipino and British nursing practice included nursing routines, specialisation of nurses, use of verbal orders rather than written, jargon, abbreviations, different medication names, staff -patient ratios, role of qualified

staff, lifting and handling and status of the elders, which was not respected. Again, the effect of these differences was not explored.

In Taylor's 2005 study, nurses from the Philippines reported experiencing an increased level of autonomy which contributed to job satisfaction. This is in contrast to the experiences of nurses from Finland, South Africa and Nigeria, who felt that nurses are more dependent on doctors in the UK than in their own countries. According to the World Health Report (WHO, 2006), sub-Saharan Africa has the highest nurse and physician-to-patient ratio; as a result, nurses are required to perform some tasks which are traditionally performed by doctors. Research has so far not established how this affects the experiences of nurses from this region in the UK.

The RCN (2003) reported that one manager noted that nurses from Africa had different training in caring for long-term patients in institutions, and another noted that they had a different attitude to pain relief than UK-trained nurses. The researchers stated that this reflected the relative lack of pain drugs available in the nurses' home countries. While this may be true, the practice could also reflect different cultural practices in dealing and coping with pain.

In the RCN (2003) study, one manager noted that Filipinos tended to be more confident in the use of the internet than UK nurses; an observation which was not reported in the African nurses. However, another manager noted that nurses from the same country were less assertive, and went on to say that the biggest challenge was integrating the nurses while at the same time avoiding re-inventing imperialism.

Overseas nurses experienced a process of deskilling in the NHS, (O'Brien ,2007). O'Brien (2007) conducted her study in three North-West NHS trusts in England and interviewed overseas nurses from Spain, the Philippines and India. She also interviewed managers and British nurses, most of whom were mentors. O'Brien (2007) reported that overseas nurses in her study had technical skills built into their initial training; for example phlebotomy and giving of intravenous treatment. In the UK these skills are acquired by extra training, and are rarely available to newly qualified nurses. Moreover, training places are tightly controlled by line managers who act as gatekeepers, as funding for the training is usually part of the ward budget. Overseas nurses were prevented from performing this skill until they had undergone the prescribed training, for which they sometimes had to wait for over 18 months. This caused frustration, and on occasions loss of skill. Similar findings were also reported by Allan and Larsen (2003) and Smith et al (2006).

O'Brien (2007) found that managers were reluctant to allow overseas nurses to practise technical skills, as they feared that home nurses might feel undermined by overseas nurses performing to a perceived higher level than UK nurses. Some home nurses said they felt threatened or felt that some of the technical skills were not part of the nurse's basic role. (O'Brien, 2007) suggests that the evaluation of overseas nurses in their adaptation phase is wrong, that mentors expect overseas nurses to perform at the level of a UK-trained third year student. Overseas nurses could end up doing student nurses' and nursing assistants' jobs because of this assessment. In the long run the practice is responsible for constrained relationships that develop between nursing assistants, overseas nurses, UK nurses and managers.

O'Brien (2007) interviewed nurses from countries which are fairly well equipped in terms of both human resources and equipment. Nurses from sub-Saharan Africa usually work in difficult environments which are poorly staffed. Their technical abilities are therefore much more developed as they have to function without the supervision of doctors. It is therefore important to include this group of nurses in this type of research since African nurses form a substantial percentage of NHS staff, as described previously.

McNeil-Walsh (2008) interviewed South African nurses regarding the utilisation of their skills in the UK, and observed that, although South African nurses often had two registrations (such as adult nursing and mental nursing), they only tended to use one qualification in the UK. McNeil-Walsh (2008) concluded that this meant that technical skills needed for one setting could not be transferred to another setting, and therefore this allowed for the nurse's loss of skill. The author does not state whether nurses who were employed in the same speciality as that they had practised in their country of origin experienced a similar loss of skill or not. This would make a big difference, since nursing skills in mental nursing and adult nursing differ a great deal.

3.3.6 Differences in Culture and Caring Attitudes

Nursing is generally considered a caring profession. Although there is no consensus in the literature regarding the definition of 'caring', nurses agree that caring involves helping vulnerable people, meeting the needs of patients, providing an environment that promotes personal development and encouraging individuals to care for themselves (Kozier, Erb, Berman, Snyder, Lake and Harvey 2008).

However, overseas nurses need cultural adaptation in terms of the UK nursing culture (Matiti and Taylor, 2005). In this study nurses assumed initially that nursing is universally the same, and nothing was going to change. However, when they actually started working, overseas nurses found that they were faced with a new culture and a different reality.

Alexis (2009) reported that overseas nurses perceived UK nurses as lacking in empathy and team- work skills. Alexis (2009) interviewed 12 overseas nurses in one NHS trust who were from the Caribbean, Philippines, sub-Saharan Africa and South Africa. He states that, although understanding and sensitivity are necessary to having an empathic nature, overseas nurses in this study may have had a negative perception of UK colleagues in an attempt to counteract the hegemonic positions, which have long been the tradition of the nursing profession, between overseas nurses and their UK counterparts. While this may be true, Objectivity in nurses' observations cannot be ruled out without research.

Matiti and Taylor (2005) interviewed 12 nurses from various countries, and no UK nurses or Managers were interviewed. The results should therefore be interpreted with caution. Alexis' (2009) sample also comprised of a mix of overseas nurses. It goes without saying that the experiences of these nurses will be different because of differences in geographical and cultural origin. As no UK nurses or managers were interviewed for their perspectives, caution needs to be exercised in using these authors' interpretations. Research is needed to explore the experiences of UK nurses and managers in their work with overseas nurses.

In a study entitled, "The Rhetoric of Caring and the Recruitment of Overseas Nurses: the social production of a care gap", Allan (2007) challenged the notion that that caring is at the heart of British nursing. Overseas nurses interviewed in this research observed that caring is

often performed by care assistants. Overseas nurses were marginalised and their skills devalued. Allan (2007) argued that overseas nurses care differently, that they expected UK nurses to deliver basic care, but they found UK nursing practice to be less autonomous and of a lower standard than expected. Allan (2007) interviewed nurses from different geographical areas but the above comments tended to come from African nurses. Allan (2007) suggests that the lack of autonomy on the part of British nurses stems from several policy shifts, including the move of nurse education into higher education institutions.

Likupe (2009) observes that differences in curriculum between the UK and other countries may be the cause of this difference. She explains that, in many African countries, nurse education takes place in institutions of higher education, with many nurses having the option to qualify to degree level. These programmes tend to have more skills built into them than UK programmes. UK nurses have to attend courses after qualification to widen their scope of practice. Often the onus is on the nurses to acquire skills they deem necessary for their job. The attendance of courses is at the discretion of the ward manager and this restricts many nurses, not least overseas nurses, who have to do these courses to continue practising their skills, from widening the scope of their practice.

Okougha and Tilki (2010) found that Ghanaian and Filipino nurses in their study had negative perceptions of British culture in relation to death and care of the sick, as they perceived the British people as cold and uncaring. The authors suggested that overseas nurses need training in British culture, but added that British nurses also need an awareness of Overseas nurses' culture. Since there is no such a thing as overseas nurses' culture, this is difficult to achieve if overseas nurses are seen as one homogenous group.

3.3.7 Adjustment to a New Environment

Alexis and Vydelingum (2004) reported in their study that the unfamiliarity of the NHS environment in the South of England provoked a feeling of being displaced in their participants. Nurses spoke of the difficulties they faced while working in the NHS as 'frustrating'. The difficulties in adjusting to a new environment resulted from the lack of preparation about the healthcare system in the UK and what to expect from staff. It is not stated whether these nurses had support or not.

Matiti and Taylor (2005) reported that overseas nurses in their study experienced cultural shock while adjusting to new ways of life and the working environment. Matiti and Taylor (2005) state that there is a positive relationship between how well overseas nurses feel adjusted to the new environment and how well they adapt to the new environment. The authors suggest that induction programmes should be organised in the nurses' home countries to prepare them for life in the UK.

3.3.8 Differences in Communication

Communication is fundamental in healthcare. For many nurses who move from African countries to the UK, English is not their first language. Alexis and Vydelingum (2004) and Allan and Larsen (2003) reported that this caused difficulties for both participants and their British counterparts, and also for patients. Some nurses said that they were frustrated that they could not be understood because of their accents, and that undermined their confidence (Taylor, 2005). The nurses in Alexis and Vydelingum's (2004) study described a feeling of being thrown into a different world to communicate as best as they could with patients, relatives and members of the multidisciplinary team. As a result they experienced

embarrassment and humiliation. Using participant observation, Taylor (2005) observed that one UK-trained nurse tended to raise her voice each time she spoke to an overseas nurse.

Some overseas nurses felt that communication problems were used as vehicle for racism among British nurses and carers. Some reported UK colleagues giggling and laughing as overseas nurses gave the ward report. It is not clear from the authors whether overseas nurses interpreted this as plain misunderstanding or as racism. What is clear, however, is that there are many accents and dialects in the UK among the indigenous population and it would be interesting to see if this causes communication problems among these nurses.

Taylor (2005) observed that British nurses equated the term 'overseas' with non white and stated that nurses who were not fluent in English were treated as a distinct group that required different treatment from others. Most of the research on overseas nurses' experience in the UK has tended to treat all migrant nurses as a homogeneous group and has therefore failed to illuminate experiences of particular groups of nurses. If nurses are to be treated as individuals, some effort at understanding nurses from different regions and backgrounds needs to be made.

3.3.9 Exploitation

Several studies have reported that overseas nurses have experienced exploitation while working in the UK (Allan and Larsen, 2003, Buchan, Jobanputra and Gough, 2005, Buchan, Jobanputra, Gough and Hutt, 2006 and Larsen et al, 2005). Buchan et al (2005) found that some nurses, mainly from sub-Saharan Africa, had to pay for their adaptation course or that they received no pay during this period. Even when they started paid employment in the NHS, some nurses believed that they were underpaid, considering their experience and

contribution. Nurses from sub-Saharan Africa were more likely to report being on D grade (the lowest possible grade for a qualified nurse) than nurses from other countries. None of the studies attempted to explain why nurses from Africa were more likely to be on the lowest possible grade, either by seeking the views of the nurses themselves or those of their managers.

Henry (2007) found that Ghanaian nurses and midwives experienced difficulty in progressing into senior positions because of cultural differences and gaps in knowledge regarding promotion procedures. He found that these problems can become institutionalised and entrenched by practices on the wards and lack of support from managers. Henry's (2007) study consisted of Ghanaian nurses who were well established in the UK, had adapted and had more experience working in the NHS. All were in managerial positions and half of the respondents had been in the UK for more than 15 years, almost all had UK or dual nationalities. This study is, therefore, not representative of all Ghanaian nurses in the UK. Junior nurses were not represented. Moreover the author did not interview white managers for their experience of what they thought was the reason for this difficulty that Ghanaian nurses experienced gaining senior positions.

Henry (2007) explains that, in a system where the process of promotion is characterised by lack of transparency and unfairness, and a perception that few black (especially African) nurses and midwives are promoted, discrimination on the basis of race; ethnicity and national origin, or favouritism becomes the easiest way of explaining the problems which are perceived to affect all African nurses and midwives. However, the possibility that racism is a factor should not be simply dismissed without research. Henry (2007) states that data from nurses on lower grades indicate that suggestions of allegations of discrimination on the basis

of race and nationality are less common at lower levels than on entry to managerial grades: yet the evidence is not provided.

3.3.10 Racism and Harassment

Overseas nurses have frequently cited racism and harassment as distressing experiences in their working life in NHS hospitals, as well as in the private sector, in terms of career opportunities (Culley, 2000, Allan and Larsen, 2003, Alexis and Vydelingum, 2004 and Taylor, 2005). The most common form of harassment in these studies was denial of training and career development opportunities. Some overseas nurses were asked to pay for their own training. However, even after paying for their own training, nurses felt that they were being passed over for promotion. Lemos and Crane (2001), Shields and Wheatley Price (2002) and Beishon et al (1995) reported similar findings in studies regarding ethnic minority nurses in the NHS.

The second common form of harassment by managers was unfair work allocation. For example, nurses were quoted as saying:

> Any jobs that white colleagues don't want to do, she asks me.
> They always try to give you more work. If I am overloaded nobody helps me. I generally feel ignored.
> I will never advise my child to go into the NHS. All we do is menial work. NHS Needs to value black nurses. (Lemos and Crane, p. 23).

Shields and Wheatley Price (2002) investigated determinants of racial harassment and its impact on job satisfaction and quitting behaviour using a national survey of NHS nursing staff carried out in 1994. They reported that 20% of ethnic minority nurses faced discrimination with regard to promotion or access to training opportunities in their careers, and 40% of all ethnic minority nurses reported having experienced racial harassment from

work colleagues in their careers. The incidence of racial harassment from patients and their families was 65%. The authors found that black nurses reported a higher incidence of racial harassment compared with Asian nurses. They also reported that black African nurses were the most likely to have been racially harassed by work colleagues. This raises questions as to why the black African nurses should be more likely to be harassed by colleagues than black nurses of Caribbean origin or black British nurses. The Equality Act 2010 specifically addresses race issues which include colour nationality, ethnic or national origins and prohibits discrimination on these grounds and it is interesting to note that at the time writing (2011) these issues are still causing problems.

Shields and Wheatley Price (2002) found that male nurses, those who were married and those possessing higher qualifications reported frequent racial harassment from their work colleagues compared with other members of their respective groups. This raises questions as to whether the status of these nurses enabled them to report racial harassment more than their colleagues. Being married, for example, could mean that a nurse has more of a support structure at home and their spouse may encourage them to report incidents of racial abuse. Possessing higher qualifications could mean that these nurses were more aware of equal opportunities policies and therefore felt less threatened to report the incident. On the other hand, it could mean that these nurses posed the greatest threat to their white colleague, and this caused hostility to be directed to them (Likupe, 2006). Shields and Wheatley Price (2002) say that their study appears to confirm the expectation that those nurses who appear most different from the indigenous population will suffer abuse. However, this is in contrast to the study conducted by Lemos and Crane (2001),which found that Chinese people were the ethnic group most likely to experience racial harassment, followed by black African and black Caribbean, and that the black British was the least likely group to report racial

harassment. This could suggest that there are other factors at play rather than just a difference in colour of the skin.

Shields and Wheatley Price (2002) used a quantitative method in their study which could limit the study findings in terms of the depth of description of experiences. It could be argued that the fact that someone does not report discrimination on the grounds of race does not mean that they have not experienced racism. This is supported by the finding in the same study that, even amongst nurses who had reported no racial harassment, 50% were not satisfied with their jobs in the NHS. Of course there can be other explanations for this, but racial harassment could be one of them.

Shields and Wheatley Price (2002) concluded that perceived racial harassment at work has the largest detrimental effect on job satisfaction levels, and it increases nurses' intention to quit their jobs. They suggested that reducing the frequency of such attacks, particularly from work colleagues, may play an important part in the struggle to retain nurses in the British NHS. While this is true, it can also be said that, since this study deals with perceived racial harassment, education to change the perceptions of black and ethnic minority nurses and those of the British white nurses and patients, would also be effective, although it should be noted that change of attitudes is difficult and takes time.

Shields and Wheatley Price (2002) used a survey by the Policy Studies Institute, commissioned by the Department of Health, to explore the market consequences of harassment. Although the study contributes to the discussion of racial harassment in the work place, the information on which it is based was not designed for this type of study. In addition, the study does not adequately distinguish the ethnic groups of nurses. For example,

in the categories of black Caribbean one can distinguish from nurses who were born and had their education in the Caribbean and from nurses who were born in the Caribbean but had their nursing education in the UK and nurses who were born in the UK and had their nursing education in the UK. The same could apply for the other ethnic groups. These factors could affect nurses' experiences of harassment and whether or not it is reported. In addition, the study was concerned only with the determinants of racial harassment in the NHS; nurses are part of the British community, and the total experience of living in the UK impacts upon their experiences at work. Herbert, Datta, Evans, May, McIlwaine and Wills (2006) alluded to this in their study of the experiences of Ghanaians in London by including experiences of Ghanaians outside the work place and examining questions of identity and reconstructions of communities and transnational networks.

Herbert et al (2006) found Ghanaians felt that racism was endemic in the labour market that they were denied equal opportunities and stuck at the bottom of the employment ladder. The study established that the core aims of multiculturalism, to respect and value ethnic differences and protect groups from discrimination, were a distant rhetoric and had little bearing on Ghanaians' daily lives. This study concentrated on Ghanaians who were employed in low-paid sectors in London such as care work, hospitality, cleaning, food processing and construction. There are no similar studies on black African nurses.

Lemos and Crane (2001) used focus groups of black and minority ethnic staff in 52 Trusts including acute, community, mental health and combined trusts to analyse the attitudes of black and minority ethnic staff on racial harassment. At the end of the discussion in the focus group, participants completed a questionnaire on racial harassment and their perceptions of Their employers' responses. Four hundred and ninety people participated in the study.

Lemos and Crane (2001) reported that people with non-English accents were in many places targets for abuse and were more likely to have their competence and professionalism challenged. Lemos and Crane (2001) reported that nurses who were younger than 50 years old were more likely to report frequent episodes of racial harassment than those who were 50 or older. It can be assumed that these nurses were born in Britain and, if that is the case, they had developed ways of dealing with racial harassment and were therefore more assertive than their non-British counterparts. If this is not the case, peer influence could be in operation.

Taylor (2005) highlighted the fact that nurses who were not white were treated as overseas nurses and white overseas nurses in the same study were not regarded as overseas nurses. It May be that those nurses perceived to be 'foreign' will experience more harassment than those perceived to be British (Lemos and Crane, 2001). There is need to investigate this further in order to understand why African nurses are more vulnerable to racial harassment. It is interesting to note that in the Lemos and Crane (2001) study, as well as in other studies, participants reported being racially harassed by colleagues more than any other group. The second largest group of perpetrators of harassment reported by participants were patients, followed by other members of the public and managers.

Shields and Wheatley Price's (2002) study sample comprised of all ethnic minorities and, although there was an attempt to separate the experiences of the different groups, participants were drawn from different occupations in the NHS. Although these studies provide information on the experience of ethnic minority nurses, it is difficult to depict the experiences of the individual groups of nurses.

Allan, Larsen, Bryan and Smith's (2004) research on experiences of internationally recruited nurses defined racism as resentment to foreigners and internationally recruited nurses. Racism was described by nurses as an attitude that was expressed overtly and could make the overseas nurses feel that skin colour determined what their colleagues thought of them. The researchers admitted that there were challenges to interpreting some examples of discrimination as racism within the focus groups, and there were different views. In general, however, nurses agreed that discrimination existed and it could be based on colour and ethnicity but that it was as likely to be due to being a foreigner or having a different cultural background. Taylor's (2005) participants felt they were discriminated against by both patients and staff. Patients stated that they wanted to be cared for by British nurses, while colleagues called them 'students' in front of patients. Some were criticised because of their English. Sometimes racism was evident in the use of humour.

Larsen (2007) reported how racism is experienced at the individual level, and how it affects the individuals' career paths in particular, using two case studies of a female and a male nurse who had been in the UK for a number of years. Racism according to Garfinkle (1984) can be classed as anthropologically strange because it has become so familiar that people no longer recognise its impact at different levels. For example, if it is being dealt with at one level, i.e., the institutional level, then it is assumed that the measures taken to redress this will filter down to other levels, i.e., the cultural and individual levels; and Larsen's work demonstrates that this is, in fact, not the case.

The experience of racism is multidimensional and can be classified using a tripartite typology (Jones 1997). The first type is individual racism, where the individual is targeted by perpetrators. The second type is institutional racism, which results from exclusion from full

participation in the benefits offered to other members of the society. The third type is cultural racism, which occurs when the cultural practices of a 'dominant' group are generally regarded by society and its institutions, as superior to the culture of the 'subordinate' group. Victims of racism are marginalised, subordinated, disadvantaged, restricted, silenced and denied information for opportunities (Hagey, Choudry, Guruge, Turritin and Lee, 2001). However Larsen (2007) does not distinguish the different types of racism in this paper.

A study by the RCN (2008) into the work-life experiences of black nurses in the UK found discrimination of black nurses on all levels. Working hours emerged as an issue of greatest concern. Nurses described working long days and complex shift patterns, with particular pressure on nurses in senior posts. The study also found that stereotypical assumptions about the role of black nurses has categorised them as not having the potential to achieve supervisor or manager status, and that procedures for promotion were more rigorously applied to black nurses than to white nurses. The research also suggested lack of transparency in promotion Procedures.

The RCN (2008) reported that the majority of black nurses' lives in their study were structured by racism which was manifested in various forms, such as racist stereotyping by colleagues and institutional racism. This study concentrated on nurses who had been in the UK for over 20 years rather than recently recruited overseas nurses. Moreover, the study used the term 'black' to include nurses from Africa, Caribbean, South Asia, Chinese, South East Asia and South American. The RCN (2008) justified this inclusion by explaining that these groups have shared experiences of colonialism, migration and racism. While this is true, it cannot be denied that these groups are diverse groups and need to be separated to gain an insight of experiences of particular groups. The RCN (2008) recommended in this study that

research on black staff needs to be conducted by black researchers, because of the need for confidentiality and the possibility that some participants might be vulnerable to victimisation. Issues of empathy and trust were also highlighted.

Raghuram (2007) explains that it is almost always presumed that overseas nurses are victims of racism, and that either patients or the nursing management are the perpetrators. This ignores the possibility that migrants bring with them racial prejudice against other overseas nurses or against black patients and managers. The example offered by Mc-Neil Walsh (2004) cited earlier is a case in point. Raghuram (2007) contends that the "literature on integration on overseas nurses presumes that migrant nurses are introduced into a relatively homogeneous 'indigenous' nursing framework, without adequately training the lens on what that framework is" (p. 2,294). In this framework overseas nurses become bearers of difference, while the differences among UK nurses and their differentiated practice at both local and national level are foreshadowed. In this situation it is the overseas nurses' responsibility to integrate into the UK nursing system and questions are not asked as to what the British born nurses are doing to integrate overseas nurses.

Likupe (2006) reported in the findings of a literature review that overseas nurses faced racism and discrimination in the UK. The same study also revealed that there is little research done on specific groups of internationally recruited nurses, and in particular those from Africa. She recommended further research into different groups of overseas nurses in the UK to capture their different experiences, as this would help to devise adaptation programmes for a smooth transition tailored to particular groups. Similar results were reported by Nichols and Campbell (2010) in an integrative review.

3.3.11 Equal Opportunities

In a qualitative study Alexis, Vydelingum and Robins (2006) found that overseas black and ethnic minority nurses experienced inequality of opportunities in career development and inequality of opportunity for skill development within the NHS in the South East of England. Participants in this study reported being passed over for training and promotion. One of the participants put it like this:

> Opportunities are not given to us equally as I have been on this ward for three years. Promised by my manager that the next vacancy I should apply, went for the job and it was given to someone far junior to me. Another vacancy came up and I was unsuccessful. I just could not understand what I had done wrong on both occasions. I just can't help but think that I was denied this promotion because I am an overseas nurse and promotion is blighted because of the colour of my skin. (interview with person L, (p.133)

The majority of participants commented on equal opportunity policies as having little impact on their lives as overseas black and minority ethnic nurses. They described their experience of such policy implementation as a mere paper exercise in which managers had failed to follow through and act accordingly.

Regarding unequal opportunities in training and skills development, participants felt that training opportunities were not always available, either because of the financial constraints within the NHS or because it was perceived that, if they were offered training, the skills acquired would be used elsewhere. Another participant commented:

> It makes us feel that we are just filling the gaps. You go to work, do your job, go home, we will pay you and that is it. There is no development out there of skills. That is how I feel, and there is no career pathway, I just wonder in five years time where we are heading. Probably still the same, still doing the same jobs, and developing very little skills. (interview with person C (p.134)

Training and development of skill is important for advancement in nursing. If nurses are unable to develop their skills, their opportunities for development might be hampered. It is

also note-worthy that overseas nurses frequently cited personal development as one of their motivations for moving to the UK (Allan and Larsen, 2003, Withers and Snowball, 2003 and Allan et al, 2005). If personal development opportunities are perceived to be denied, nurses will get frustrated as expectations are not met.

Alexis et al (2006) carried out this research in one NHS trust in the South of England and as such the results cannot be generalised. Moreover, managers were not interviewed to explore their perceptions on equal opportunities, or indeed to investigate if they thought that they were providing opportunities equally. Although the research implies that overseas nurses were informed about equal opportunities policies, it is not clear what information nurses possessed. This is important if we are to ascertain overseas nurses' understanding of equal opportunities. Recognising the limitations of their study, Alexis et al (2006) recommend a larger-scale study to determine whether overseas nurses in other areas experience similar problems.

In a different study Alexis and Vydelingum (2009) reported statistical differences between different ethnic groups in their study entitled, experiences in the UK National Health Service: The overseas nurses' workforce. In this study nurses from Africa perceived equal opportunity and their prospect for skills development and training to be different to that of their overseas counterparts. In addition, the study found that African nurses were less likely to view their experiences positively, particularly if they were not working in any of the NHS Trust hospitals in London.

However, Alexis and Vydelingum (2007) reported that, although overseas nurses experienced mostly negative experiences such as lack of support, they appreciated the fact that they had

built ties with other overseas nurses. Some had even benefited in terms of personal and professional development.

Alexis and Vydelingum (2009) suggest that individuals who do not feel valued because of their backgrounds are likely to feel disenfranchised in their chosen careers. In addition, they point to a widely held view that Asians are generally regarded as model minorities who are successful, hard-working, loyal and do not complain and therefore, their career progression is unlikely to be affected. Alexis and Vydelingum (2009) also found that African nurses reported being passed over for promotion more than Asian nurses, and suggest that this could be because African nurses perhaps did not understand what was expected of them and Asian nurses perhaps did. This suggests that there is something wrong with the understanding of black African nurses and calls for further investigation. The present study will address this by interviewing managers about their experiences with black African nurses.

Alexis et al (2007) and Alexis and Vydelingum (2009) studied experiences of overseas and minority nurses in general, and it has already been established in this review that overseas and ethnic minority nurses are not a homogeneous group, and that an attempt to study various groups should therefore be made. Moreover, research is required into the experiences of managers who supervise black African nurses to explore whether African nurses are viewed differently from Asian nurses.

Using a structured questionnaire, Sheffield, Hussain and Coleshill (1999) found racism and inequality of opportunity as organisational barriers to ethnic minorities in the Scottish NHS. There were inconsistencies in the treatment of ethnic minorities in the Scottish NHS, and management policies were blamed for this. Sheffield et al (1999) suggest that barriers are a

result of a lack of awareness and a failure to recognise that differences can exist and allow for competence. This study adds to the debate surrounding progression of ethnic minorities in the NHS. However, it fails to distinguish problems faced by different ethnic minorities. It also suffers from methodological limitations, in that information was obtained by a questionnaire. Ethnic minorities were not involved, but rather managers were asked to respond to implementation of equal opportunities policies.

In a systematic review, Alexis and Vydelingum (2005) found that black and minority ethnic nurses have been denied opportunities to advance their careers because of racist attitudes. Hunt (2007) found that managing a diverse workforce is challenging for managers. She put forward several recommendations to help managers deal with a diverse workforce and reduce discrimination in the workplace, giving the NHS as an example. Hunt (2007) used a research workshop in which participants comprised researchers on equal opportunities for internationally recruited nurses, and other health professionals in the field of migration. Although the results are useful, information is needed from NHS ward managers who work with overseas nurses about their experiences. It is from this information, in conjunction with information obtained from overseas nurses themselves, which can form a basis for concrete recommendations.

Pike and Ball (2007) reported inequality of opportunity among black and ethnic minority nurses and internationally recruited nurses using royal college of nursing surveys conducted between 2002 and 2005. Black African nurses were at the most disadvantage, being employed mostly at D grade. Most of these nurses thought that they were employed below their abilities, and were denied development opportunities. This was robust quantitative research which suffers from lack of explanatory detail.

3.3.12 Discrimination

Taylor (2005) used a constructivist approach to study the experience of overseas nurses working in the NHS. Participant observation, focus groups and personal interviews were used to collect data. Eleven nurses from six different countries were recruited. Taylor (2005) reported that nurses recruited from overseas experienced loss of status and discrimination. The author further states that not all individuals who categorised themselves as overseas were seen as such by their UK colleagues. Their UK colleagues saw only those who were non-white, or whose first language was not English, as 'overseas' nurses. This could have an impact on treatment of overseas nurses by their colleagues. Despite the limitations cited here, this study makes a contribution to the wider study of overseas nurses in the NHS. The author recommends further research on views from other members of the multi-professional team, and an examination of the units of recognition that mark someone as an overseas nurse.

Allan, Cowie and Smith (2009) reported discrimination bullying of overseas nurses using three case studies. Overseas nurses were bullied by doctors, white nurses and their managers. The authors did not study relationships among overseas nurses. The current study suggests that, as well as experiencing racism from doctors, white nurses and managers, black African nurses experience racism and bullying from other overseas nurses. This could affect the dynamics of the working relationship among overseas nurses, and consequently patient care.

Archibong and Darr (2010) found that black and ethnic minority nurses were more likely to be disciplined in the NHS than their white counterparts. This was a robust research which was conducted in four phases including web audit, workshops, analysis of experiences and views of black and ethnic minority staff and a literature review. The involvement of managers in the workshops added to its strength.

Allan, Larsen, Bryan and Smith (2004) utilised focus groups to explore experiences of

Internationally Recruited Nurses (IRNs) in the British health services. They found that IRNs

experienced discrimination in both the NHS and the independent sector. The IRNs

experienced discrimination based on their being foreigners in the UK. However, different

types of discrimination appear to be in operation, as articulated by this white Zimbabwean

nurse in one of the focus groups:

> I also had a British passport, which I had got before I came, and that also helped such a
> lot. But I lived in a nursing home where all the immigrant nurses went and ...I was the
> only White and I listened to the stories of what these girls had to go through and, you
> know, I just thought I've lived in a continent where I've been privileged all my life just
> by being English-speaking and white, and now I come back to Britain, which is meant
> to be so emancipated and so progressive, and yet I saw exactly what was happening. I
> was put into the ward where I chose to be, they were put into the ward where they
> [employers] wanted them to be, so it was, it was very different, it was, and it was a
> strange thing because I wasn't accepted by the English people because of my accent
> and because they also didn't know whether I was what I said I was, you know?
> (Female, 55 years old, Zimbabwe, white, (p .121)

Allan et al (2004) found evidence that discriminatory and racist attitudes toward IRNs were

motivated by racist beliefs about skin colour, ethnicity and nationality. Taking this finding

into account it is important to study various groups of IRNs separately to explore their

various experiences. Allan et al (2004) recognised the limitation of their study as it did not

include white British nurses or managers. The present study aims to fill this gap by including

interviews with managers.

Larsen (2006) reported overt and covert discrimination of overseas nurses in nursing homes.

Discrimination was mainly carried out by care assistants, who were constantly reporting

overseas nurses to managers with the aim of discrediting their practice. In his discussion

Larsen (2006) seems to imply that this is a nursing home problem with no evidence that it

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does not exist in the NHS. However, the current study demonstrates that this problem is also present in the NHS.

Overseas nurses respond to discrimination in different ways. Some employ a strategy of accepting the discrimination and avoid labelling it as such to avoid the process of embodiment of discrimination, while others respond by giving up their hopes and aspirations (Larsen, 2007). Utilising a case study, Larsen (2007) explained that, among overseas nurses, discrimination works at interpersonal and personal level and is experienced as a form of symbolic violence that may be internalised. It can sometimes be resisted through meaning-making activity that explains, objectifies and embodies the experience. This can be in a way that either positively or negatively influences the individual's situation.

Larsen (2007) compared experiences of two nurses in his study, one male and one female. Both had been very successful in their home countries but experienced a drop in status and discrimination since coming to work in the UK. The experiences of the two nurses closely corresponded to gender differences and strategies adopted and demonstrated by the female nurse by her use of avoidance, and the male nurse's use of a problem-solving approach (Feagin,1991).

Larsen (2007) suggests that individuals may find ways to challenge and change the social conditions or structure in which they live by citing the way the two nurses in his study coped with their situation. However, this could be seen as blaming the victim, as happens in cases of domestic violence (Hart, 1992). In this situation victims are expected to change their behaviour to stop abuse, even though results are rare (Likupe, 2008). Equal opportunities

need to be more than an academic exercise if discrimination of overseas nurses is to be stemmed in the British health service (Likupe in Siva, 2009).

Alexis, Vydelingum and Robins (2007) used focus groups to explore experiences of overseas minority ethnic nurses in the NHS. Nurses in this study reported experiencing a devaluation process where they were not allowed to practise their managerial skills. Nurses said they were not trusted by their white counterparts, and they felt watched all the time. Alexis et al (2007) reported that nurses blamed themselves for their treatment because of the colour of their skin.

Nurses reported experiencing discrimination in terms of promotion even though they were more qualified than white British nurses. In the same study Alexis et al (2007) said that participants reported a feeling of invisibility, where they were ignored by consultants, managers and patients' relatives. Nurses also experienced fear as mistakes were blown out of proportion. However, participants reported some benefits of being in the UK. These included the ability to support their immediate and extended family members, gaining professional experience and the fact that patients appreciated the care given to them by overseas nurses.

Smith, Allan, Henry, Larsen and Mackintosh (2006) reported that overseas nurses experienced discrimination and racism in the workplace. The authors reported that the migration pathway of black Africans tended to be to the care homes rather than the NHS while Filipino and white overseas-trained nurses tended to be recruited directly to the NHS because of the recruitment restriction imposed by the Department of Health. Moreover, black African nurses were individually recruited and not recruited in batches. These factors have a

bearing on the experiences of black African nurses in the UK and therefore warrant a separate investigation.

Smith et al (2006) reported that black African nurses from Ghana blamed discrimination and racism for lack of promotion in the workplace, and disengaged from seeking promotion and self-development as a result. The authors state that these responses can become self-fulfilling and self-sustaining. They further state that perceptions of African nurses based on the premise that ethnic and racial discrimination are endemic in the NHS, and that Africans are at the bottom of the racial and ethnic hierarchy within the NHS, can lead to ignoring alternative non-discriminatory explanations, such as poor management or lack of skills or other deficiencies on the part of the nurses, and other factors such as favouritism. According to Smith et al (2006), a significant group of African nurses and midwives share this interpretation, and expect to be met with racism in the workplace. They become alienated and demoralised, and therefore do not apply for promotion.

While some of the explanations may be true, Smith et al (2006) show little evidence that this may indeed be the case. Any study should be careful in drawing conclusions without sufficient data and this is especially true as the authors appear to blame African nurses for their plight. The current study aims to interview managers to explore their experiences of working with black African nurses in the hope that explanations could be found for the experiences of both managers and the nurses working under them in the work place.

Smith and Mackintosh (2007) reported that overseas nurses are disadvantaged within UK nursing and that this disadvantage exists across gender, class and race. Furthermore, these are reinforced by international disadvantage which is articulated through migration. Smith and

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Mackintosh (2007) contend that nurse migrants fill skilled and unskilled jobs, sustaining market segmentation and professional hierarchies, as their numbers and diversity have been sufficient to exercise influence over the structure of the market and the profession as a whole. Smith and Mackintosh's (2007) results point to a pecking order in this hierarchy with black African nurses at the bottom.

Smith et al (2006) argue that 'overseas nurses are not recognised because they are not British and therefore not "safe" until credited against British standards' (p 48). Smith et al (2006) reported that some overseas nurses felt that discriminatory attitudes could be provoked when they took on more senior roles than British nurses. There is a link between British discriminatory attitudes and an apparent perception that overseas-trained nurses should work at lower grades (Smith et al, 2006). There is also evidence from this study that discriminatory practices are not only inflicted on black overseas nurses by white staff, but that various black minority ethnic overseas nurses discriminate against one another. Nurses and stake-holders described a pecking order in the NHS in order to get positions:

> So it's the white first; White British first, then White Australian, White South African. When you run out of all that you have only got Black left ; after all the Whites it's Asians. After the Asians you come down to Black and if you have to differentiate its Black its Caribbean then Black African…It's a pecking order. Local   NHS stakeholder –DL025 (p. 61)

 It is because of type of statements that the current study was carried out to investigate the effect of these perceptions on the experiences of black African nurses in the UK. Moreover the Equality Act (2010) specifically addresses race issues which include colour, nationality, ethnic or national origins and prohibits discrimination on these grounds. The findings of this study will demonstrate that the equality act is not being translated into action when it comes to black African nurses in the UK.

3.4 Discussion of Chapter

The literature has tended to treat overseas nurses as a homogeneous group in relation to their experience, with a few exceptions. However, there is an acknowledgment that, since overseas nurses differ in terms of culture, race, ethnicity and nationality, these factors should be taken into account when designing studies into the experiences of overseas nurses. Such experiences are shaped by the way overseas nurses are recruited and by their motivation to move to the UK. Nurses have experienced exploitation, unmet expectations, communication difficulties, differences in culture and professional practice, racism, discrimination and lack of equal opportunities.

Overseas nurses have experienced exploitation from recruitment agencies who often charge fees for processing papers and visas already paid by the NHS in some cases. Nurses are also exploited by managers in nursing homes who ask them to do jobs which they are not paid for. Nurses experience loss of skills and they are not allowed to perform certain procedures which they had performed in their countries without attending UK courses. Overseas nurses experience racism from colleagues, managers and patients, both overtly and covertly. Often overseas nurses are discriminated against in terms of training and promotion. In terms of social experiences, overseas nurses have reported having to reconfigure family life, and a feeling of living in two places at once. However, because overseas nurses are not homogeneous, their experiences of these factors have tended to be different.

Most studies have concentrated on the experiences of overseas nurses themselves, while a few have investigated the views of stake-holders. The literature search did not reveal any study on black African nurses as a group and their experiences in the UK, nor did it reveal any study which investigated the experiences of managers working with black African nurses. Studies have

consistently recommended that experiences of various groups of overseas nurses be investigated, and one study in particular (RCN, 2008) recommended that research on black minority ethnic groups should be conducted by black researchers. This investigation aims to fill this gap by exploring the experiences of black African nurses and the experiences of managers working with them.

CHAPTER 4

CONCEPTUAL FRAMEWORKS FOR MIGRATION AND EXPERIENCES OF BLACK NURSES FROM SUB-SAHARAN AFRICA TO THE UNITED KINGDOM

4.1 Introduction

In this chapter I review theories of migration. Based on this review I develop a framework on which nurse migration from sub-Saharan Africa and these nurses' experiences in the UK can be located. I also outline how current migration theories are positioned within the framework, taking into consideration the economic point of view that accounts for considerable part of the theoretical background of international migration. A framework of black African nurses' experiences in the UK is incorporated in relation to migration trajectories. These two frameworks are used to analyse black nurse' experiences in the UK.

In order to understand nurse migration to the UK, explanations need to take into account the phenomenon of human migration as a whole, since nurse migration takes place within this context. It should also be understood that ever since the dawn of mass migration scholars have striven to provide a general explanation of human migration. Disciplines such as economics, sociology, anthropology and geography have had some success at explaining the migration phenomenon. However, this explanation has mainly consisted of development of models, analytical frameworks, conceptual approaches and empirical generalisations, but formation of real theories has been scarce (Arango, 2000). Lee (1966), Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor, (1993), and Brettell (2000) echo similar sentiments when they state that there is not one theory that can explain why people migrate, and an interdisciplinary approach should be considered.

Migration theories can be classified as macro and micro according to their level of analysis. Macro theories focus on migration streams and identify conditions under which large-scale movement takes place; they describe demographic, economic and social characteristics of migrants. The macro level includes theories concerned with migrant adaptation process, economic and social integration or assimilation.

The micro level includes social psychological factors that differentiate migrants from non-migrants, theories of motivation, decision-making, satisfaction and identification (Richmond, 1994). Almost all theories address voluntary migration and, in most cases, economic factors are assumed to be predominant in determining the flow and interpreting the experience of the migrant.

4.2 Macro Theories

Ravenstein (1885 and 1889), generally considered to be the father of migration theories, developed laws of migration based on research he had conducted on internal migration in the UK. Some of his laws have stood the test of time, such as the fact that migrations are over short distances, that they generate counter streams, and that they are related to technological development. Others have been refuted, including the suggestion that urban populations are less migratory than rural populations, that females are more migratory than males, and that migration proceeds in stages from rural areas to small town and then to cities.

Neo-Classical Economics Theory

Neo-Classical Theory is considered to be the oldest and best-known theory of international migration (Massey et al, 1993). The theory stems from the systematic theory of migration put forward by Ravenstein above. It was developed originally to explain labour migration in the

process of economic development. During the 1960s and 1970s, when this theory was

developed, there was rapid and sustained international economic growth. The decolonisation

process was just beginning, and the development economic activity in the Third World

resulted in an increased study of both internal and international migration (Todaro, 1976 and

Arango, 2000).

According to Neo-Classical Theory, international migration, like internal migration, is caused

by geographic differences in the supply and demand of labour and capital. The difference in

wages which result influences workers from low-wage countries to move to high-wage

countries. As a result of this movement, the supply of labour decreases and wages rise in the

poor country, while the supply of labour increases and wages fall in the rich country. This is

supposed to lead to an equilibrium in international wages that reflects the costs of

international movement (Massey et al, 1993). However, in the case of nurse migration from

sub-Saharan Africa, nurses do not necessarily move from surplus labour countries to

countries where labour is scarce. Sub-Saharan countries themselves have nurse shortages.

Moreover, there is no evidence that wages rise in these countries as a result of migration. In

addition, there has been no report of an equilibrium ever being reached between developed

and developing countries.

Neo-Classical Theory contends that the movement of capital mirrors the movement of the

workers, in that investment of capital flows from capital-rich to capital-poor countries. The

movement of capital includes human capital, with highly skilled workers moving from

capital-rich to capital-poor countries in order to reap returns on their skills in a human

capital-scarce environment, leading to a parallel movement of managers, technicians, and

other skilled workers. However, this is not true of modern migration as highly skilled workers

including nurses move from capital-poor developing countries to capital-rich developed countries.

Neo-Classical Theory also asserts that, at the microeconomic level, individuals have a choice and decide to migrate to maximise their financial benefit (Todaro, 1969). People undertake certain investments, which include the material costs of travelling, the costs of maintenance while moving and looking for work, the effort involved in learning a new language and culture, the difficulty experienced in adapting to a new labour market, and the psychological costs of cutting old ties and forging new ones (Massey et al, 1993).

The 'push-pull' theories have their foundation in this theory; these theories emphasise the tendency of people to move from low-income to high-income areas, and link migrations to fluctuating economic conditions. The push-pull model has been used as a dominant framework for explaining international nurse migration (Aiken, Buchan, Sochalski, and Powell, 2004, Buchan, Parkin and Sochalski, 2003 and Vujic, Zurn, Diallo, Adams, and Dal Poz, 2004).

Portes and Rumbaut (1990) suggest that major labour flows come from countries at intermediate levels of development rather than the poorest countries, and that migrants are not drawn from the poorest groups in society as implied by the push-pull framework. Piore (1979) suggests that migrant behaviour is rooted in particular social contexts, but that these attributes are suppressed when only economic factors are considered. Migrant nurses from sub-Saharan Africa come from some of the poorest countries in the world. This literature review has not revealed any research concentrating on which section of the society immigrant nurses come from. It may be that those nurses who can obtain information on the internet and

in the media, those who can afford air fares and those who can afford the initial cost of migration are the ones that move to the UK. Moreover, nurses are skilled immigrants and professionals, therefore do not necessarily come from the poorest groups in their countries.

While the Neo-Classical Theory goes some way toward explaining international migration flows within the European Union (Jennissen, 2004) it is inadequate to explain other forms of international migration, such as that of nurses from sub-Saharan Africa into the UK. In such countries, political forces and government policies have a big influence. The theory does not explain why so few people move given the huge differences in income, wages and levels of welfare that exists among countries. It also fails to explain why some countries have relatively high out migration rates and others, structurally similar, do not. Restrictions on entry imposed by governments are not taken into account, and it ignores the fact that in contemporary international systems free circulation of workers is the exception rather than the rule, and hardly conforms to the ideal environment in which individuals move freely to pursue their own interest and maximise utility. Moreover, in the case of recent migration from sub-Saharan Africa, human capital in the form of highly skilled workers has tended to flow from capital-poor to capital-rich countries, which has provoked the debate on the so - called 'brain drain' of developing countries.

Dual Labour Market Theory

Dual Labour Market Theory argues that international migration is mainly caused by pull factors in the developed, migrant-receiving countries. It attributes migration to a permanent demand for foreign labour that stems from certain intrinsic characteristics of advanced economies, which in turn result in the segmentation of their labour markets (Castles and Miller, 1998). According to dual labour market theory, segments in the labour market in

developed countries may be distinguished as primary or secondary in nature. The primary segment is characterised by capital-intensive production methods and predominantly high-skilled labour, while the secondary segment is characterised by labour-intensive methods of production and predominantly low-skilled labour. In the primary segment, there is more autonomy and less direct supervision, and unemployment is low. Most professional and managerial work is part of the primary independent segment.

Local workers shun low-paid jobs because they are of low status and prestige, and promise limited upward mobility (Arango, 2000). Foreign workers, on the other hand, are willing to accept such jobs because low wages are usually high compared with standards back home and because the status and prestige that count for them are those they have at home.
In addition, Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor (1994), emphasise that such structural labour demand for low-paid jobs can no longer be filled by women and teenagers as before, because now women prefer autonomous, career-oriented work. Moreover, lower fertility and longer periods of education have diminished the availability of youngsters for such jobs.

In Dual Labour Market Theory, race plays a role in determining in which labour market one is employed (Bohmer, 1998). The high concentration of black men and women in the secondary labour market is explained by this theory. The higher rate of unemployment among black people is explained by under-representation of black people in the primary labour segment and the high concentration of black women and men in the secondary labour market.

Proponents of this theory argue that Dual Labour Market Theory explains racism on the ground that employers are racially biased when employing black people, tending to employation

black people mainly in secondary labour markets. However, Rumberger and Carnoy (1980) observe that black workers in primary sector jobs face labour conditions characteristic of the secondary labour market. Dual Labour Market Theory can complement a theory of racism, but it does not explain how and why black people are concentrated in the lower segments of labour. For that a theory of racism is required.

As a general explanation of the causes of international migration, Dual Labour Market Theory is not without problems. In the first place the theory posits that all international migration is demand-driven, and excludes push factors which are a reality in many sending countries such as those in sub-Saharan Africa. Secondly, not all migration results from recruitment practices; some migrants leave on their own initiative and do not necessarily fill pre-existing jobs. Finally, the theory does not explain why different advanced industrial economies, which have similar economic structures, exhibit different rates of immigration.

New Economics of Labour Migration

In the New Economics of Labour Migration Theory, migration decisions are not made by isolated individuals but by families or households. People act collectively to maximise expected income, and also to minimise risks and losses (Stark and Taylor 1989). In this model, a wage differential is not a necessary condition for international migration to occur. Although the theory has gained much attention, very few proponents of the theory have conducted field work to interview people about their own decision-making to test their hypothesis (Oishi 2000). In addition, the theory concerns itself only with migration from the sending countries. Clearly there are factors in the receiving country which influence people to migrate. In the case of nurses, migrating to the UK from sub-Saharan Africa, the shortage of

nurses, in the UK and relaxed immigration rules for nurses have contributed to their migration.

World Systems Theory

The World Systems Theory considers international migration from a global perspective. The development of this theory was influenced by the work of Wallerstein (1974), who explained the European hegemony that took shape from the sixteenth century and which consists of three concentric spheres; core states, semi-peripheral and peripheral areas which constitute a modern world'. Core countries are developed countries with capitalist systems. These countries have the accumulation of capital as their objective. World Systems Theory argues that the drive to accumulate capital led core countries to colonise peripheral (developing) countries for new resources, low-cost labour and new outlets. Colonisation led to cultural exchanges between the coloniser and the colonised. Transport connections were also created to stimulate economic exchange. However, the changes were not equal, especially with respect to economic exchange, and resulted in a large net flow of capital from the colonies into the coloniser. Semi-peripheral areas are in-between the core states and the peripheral areas, depending on a series of dimensions; such as the complexity of economic activities, the strength of state machinery and cultural integrity. Semi-peripheral areas may have been core states once, and some may have been promoted from the peripheral as a result of the changing geopolitics of an expanding world economy (Wallerstein, 1974). The semi-peripheral areas, according to Wallerstein (1974), act to deflect the political pressures which groups primarily located in the peripheral areas might otherwise direct against the core states and groups which operate within and through their state machinery.

World Systems Theory may shed light on the importance of past and present linkages between countries at different stages of development. It also lends understanding to the observation that migration often connects countries that were linked in the past by colonial bonds, on account of many vestiges left by such bonds. Wallerstein (1979) discusses the importance of politics, particularly the state, in securing European hegemony over the rest of the world. He shows that, by virtue of industrialising first, the capitalist states of northern Europe were able to secure favourable market relations for them, thereby consolidating their economic and political supremacy. Further, Wallerstein (1979) demonstrates how historical domination of colonised states both contributed, and continues to contribute to the uneven development of the world, with the core states located in Europe and the peripheral states located in Asia, Africa and Latin America.

The World Systems Theory links the concepts of nationalism and race to the evolution of capitalism. It specifically argues that the international economy has developed into a world system in which developed countries exploit developing countries. Race is regarded as part of the pseudo-justification of this division of the world. Nationalism is part of the ideology that justifies the position of developed nations in the hierarchy. Finally, ethnicity is regarded as a device to segment the labour market. It is used to justify the lower position of some groups in the labour market. Additionally, ethnicity is related to the different ways in which individuals are socialised within their families and in the community, and hence perpetuates differential labour opportunities.

Although the World Systems Theory explains the causes of inequalities in rates of economic development between developed and developing countries, it does not explain fully the causes of international migration. In addition, world systems theory does not explain

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migration flows between unconnected or weakly connected countries. However, it may be well placed to explain the experiences of exploitation and racism by some African nurses.

4.3 Micro Theories

<u>Migration Network Theory</u>

Migration networks can be defined as sets of interpersonal relations that link migrants or returned migrants with relatives, friends or fellow countrymen at home. They convey information, provide financial assistance, facilitate employment and accommodation, and give support in various other forms. These reduce the costs and uncertainty of migration and therefore facilitate it. Network connections can be regarded as social capital that people can draw upon to gain access to foreign employment (Massy et al, 1993).

The Migration Networks Theory accepts the view of international migration as an individual or household decision process, but argues that acts of migration at one point in time systematically alter the context within which future decisions are made, greatly increasing the likelihood that later decision-makers will choose to migrate (Massey et al, 1993).

Massey et al (1993) explain that the cost for the first migrants may be high, as they have no social ties on which to draw, but for subsequent migrants the process is less costly because each migrant creates a set of people with social ties to the destination area. Migrants are inevitably linked to non-migrants, and the latter draw upon obligations implicit in relationships such as kinship and friendship to gain access to employment and assistance at the point of destination. Networks also make migration extremely attractive as a strategy for risk diversification. When migrant networks are well developed, they put a destination job

within easy reach of most community members and make migration a reliable and secure source of income (Massy et al, 1993).

The Network Migration Theory is applicable to nurses from sub-Saharan Africa. Women tend to rely on their personal networks more than men (Oishi, 2000). However, social networks cannot explain why such networks developed between one country and another in the first place. For example, the theory does not explain how migration of the first immigrants occurs for those without networks. Governments often develop economic, social and political policies which may promote or discourage migration; for example, the UK allows only a spouse and children under 18 to join family members. In many respects the theory assumes that men are the primary migrants and women follow their husbands. Since nursing is a predominantly female profession, the theory does not adequately explain the importance of networks to this type of migration. The role of recruitment agencies is also ignored.

Institutional Theory

This theory argues that, once international migration has begun, private institutions and voluntary organisations arise to satisfy the demand created by an imbalance between the large number who seek entry into capital-rich countries, and the limited number of immigrant visas these countries typically offer. This imbalance creates a black market in migration which creates conditions conducive to exploitation and victimisation. Voluntary humanitarian organisations, which can be legal or illegal arise to enforce rights and improve treatment of both legal and undocumented migrants. These organisations can sometimes provide support in terms of (clandestine) transport, labour contracts, (counterfeit) documents, dwellings and

legal advice for immigrants (Jennissen, 2004). This theory tries to explain why migration continues once started, but does not explain why it starts in the first place.

As far as migration of African nurses into the UK is concerned, the Institutional Theory falls short, as this type of migration is partly government-initiated. However, nurses are permitted to join trade unions such as the Royal College of Nursing and others and do derive benefits from them in the form of better working conditions and better pay. For example, in cases where nurses are being discriminated against, unions can fight for their rights.

Cumulative Causation Theory

In this theory the cause of migration is cumulative. Each act of migration alters the social context within which subsequent migration takes place, typically in ways that make additional movement more likely (Massey et al,1993). So far, six social economic factors that are potentially affected by migration in this fashion have been discussed by sociologists: the distribution of income, the distribution of land, the organisation of agriculture, culture, the regional distribution of human capital, and the social meaning of work. The first five provide advantages for migrants and their families in their home countries, while the last factor leads to labelling of some jobs in destination countries as 'immigrant jobs' and makes it difficult for the host country to recruit workers to these jobs, leading to continued demand for immigrants. This has been the case with nursing in the UK. However, the theory does not explain factors which lead countries to limit immigration.

Social Exchange Theory

Social Exchange Theory is closely related to Neo-Classical Economic Theory. It argues that the control of power over marital resources determines power in the decision-making process

to migrate. Thus, if the husband has a greater earning ability than the wife, he has the primary say in the migration decision. If the husband subscribes to traditional gender role beliefs, then he is more likely to ignore migrating on the basis of his wife's employment and her well-being than when he subscribes to progressive gender role beliefs. On the other hand, if the wife has greater earning ability and occupies a traditional gender role she will ignore the benefit of migrating for the benefit of her own career and well being. If the wife has progressive gender role beliefs, she will consider the effect of migrating on her husband's employment and well-being (Cooke, 2005).

Black nurses from sub-Saharan Africa are the primary immigrants, and therefore the main earners in their families. However, Cooke (2005) found that being the main wage earner does not ameliorate the negative effect suffered by women in cases of family migration. For example, with respect to distribution of housework, Brines (1994) argues that the more the husband is dependent on his wife economically, the less housework he does, most likely as a way to reassert his masculinity. This has an implication for the experiences of nurses from sub-Saharan Africa, especially since nursing is a female-dominated profession.

4.4 Evaluation of Theories

Old and recent theoretical contributions have contributed a better understanding of the causes of migration, and the mechanisms that contribute to its self-perpetuation. The various explanations may seem contradictory if one adopts the rigid position that causes must operate at only one level, but on another level the theories can be seen to complement one another. For example, it is possible that individuals engage in cost-benefit calculations; that households act to diversify labour allocations; and that the social economic context within which these decisions are made are influenced by structural forces operating at the national

and international levels (Papademetriou and Martin, 1991). Migration networks connect the migration process with personal, cultural and other social bonds. In sending countries, information on foreign jobs and living standards is mostly transmitted through personal networks such as friends, neighbours and relatives who have emigrated. Modern communication systems such as the telephone and the internet also play a part.

The World Systems Theory explains migration as a natural consequence of economic globalisation. Factors that connect sub-Saharan Africa to the UK, such as historical bonds formed by colonialism and the Commonwealth, use of the English language in education, and similar educational systems, may explain immigration of large numbers of nurses to the UK from former British colonies. Structural requirements of modern industrial economies may act as "pull" factors for immigration in the dual labour market theory, but "push" factors are also prevalent in many sub-Saharan countries and these can also influence nurses to migrate.

4.5 A Multi-model Framework

An approach that takes a broader position that causal processes relevant to international migration might operate on multiple levels simultaneously would be preferable to individual theories that concentrate on either causalities or perpetuation of migration (Massey et al 1993). However, it is apparent that migration theories have tended to concentrate on economic factors. Although these are important, attention needs to be paid to social and cultural factors. The relevance of political factors needs to be taken into account, as Arango (2000) has stated; "nothing shapes migration flows and types more than admission policies" (P. 293). Political considerations and state interventions are so prominent that theories that are built primarily on economic concepts are bound to be inadequate.

Attention needs to be paid to other aspects of migration which are equally important; these include processes and consequences, including modes of migrant incorporation and social transformations associated with international migration; social structures, including kinship ties, emerging processes of transnationalisation and their implications; the state; and the political context in which they take place (Papademetriuo and Martin, 1991, Arango 2000, and Massey et al 1993). In addition, the role of gender and migration needs to be included (Oishi, 2000).

Problems of theory-building in the study of migration are related to the general difficulties that the social sciences experience when trying to explain human behaviour affected by a large number of interrelated variables. In addition, migration is hard to define and difficult to measure (Davis, 1988 and Arango, 2000). In regard to this complexity, Fielding (1983) commented 'perhaps migration is another "chaotic concept", one that needs to be "unpacked" so that each part can be seen in its historical and social context so that its significance in each context can be separately understood' (p.3). Arango (2000) states that this 'unpacking' calls for a better integration of theory and empirical research, but adds that unfortunately there are no simple and easy prescriptions for such a reconciliation.

Formulation of a theory of migration that reconciles all the complex facets of migration is not the aim of this research. A multi-model framework is therefore suggested where multiple factors that motivate sub-Saharan nurses to move to the UK are suggested. Given that not one model or theory of migration is adequate in explaining the migration of sub-Saharan nurses to the UK, an examination of several factors may be of help. The multi-model approach draws from several theories and models of immigration, as has been discussed above. Oishi (2000) suggests three levels of analysis: (1) macro-level (the state), (2) micro-level (individuals), and

meso-level (society) are drawn upon to propose a complementary aspect to the one proposed above.

4.5.1 Macro-Level: Emigration and Immigration Policies

At the macro-level the state plays a major role in determining international nurse migration. Both emigration and immigration policies have a big influence on whether migration takes place. The classification of nursing in the UK during late the 1990s as an occupation of shortage played a major role in facilitating the entry of sub-Saharan nurses into the UK, as the Government made it easier for employers to obtain work permits for registered nurses from overseas. At the same time, political change in many countries in sub-Saharan Africa made it easier for women in their own right to seek work abroad, as governments facilitated change in the male dominated cultures to give women some independence. Education of girls also played a part, since women were now able to enter careers outside the home. However, immigration and emigration policies do not explain the entire phenomenon of international nurse migration. For example, given the same policies, why do some nurses choose not to migrate? Micro-level factors may answer this question.

4.5.2 Micro-Level: Individual Autonomy and Decision-Making Power.

At the individual level there must be willingness and motivation on the part of nurses to migrate. In sub-Saharan Africa, extended families are prevalent and young nurses, especially women, are willing to move to support their parents, younger siblings, nephews, nieces and grandparents. However, nurses also emigrate to earn money for themselves and to seek some adventure and advance their careers (Buchan, 2002 and Allan and Larsen, 2003).

On the other hand, married women may be motivated by the desire to work for their children's future, and others to enhance the family income. Older nurses may emigrate to enhance their pensions. The key to their migration lies in whether they are able to make the decision independently or whether they have the support of their family. In sub-Saharan Africa most decisions are taken by men (in the case of married women), and the extended family plays a part in the decision-making of those who are not married. Hence the support of the family is important in making the decision to migrate, as it has repercussions for all should one want to emigrate. However, other nurses make decisions independent of their families and still migrate, despite objections from their husbands or parents.

4.5.3 Meso-level: society

At the meso-level the micro and macro factors merge to give migration a social legitimacy (Oishi, 2000). Social legitimacy of nurses' international migration is rooted in factors such as the country's integration into the global economy which results in the feminisation of the labour force, women's rural to urban mobility, and gender equality (particularly in education). Women's education affects the level of international migration in several ways. First it attracts the investment of multinational corporations. Foreign investors normally prefer to hire skilled female workers who are cheap and docile (Oishi, 2000). Having Education also increases the women's expectations for better life, and family tends to expect returns from daughters as well as sons. Education also causes emigration for women to be viewed positively, since it is believed that they should be able to make wise decisions and protect themselves in unfamiliar environments.

4.6 A Framework for Migration of Black Nurses from Sub-Saharan Africa

Nurses from sub-Saharan countries can be regarded as skilled migrants, since they have professional skills in a specialised profession and they are normally educated to degree standard (Iredale, 2001). Developed countries like the UK deem skilled migration as a means of filling labour shortages in order to ensure that economic growth is not impeded in the short term. Usually migrants are taken on a temporary basis, supposedly to meet skills shortages until those countries can train their own stock of workers. This policy was stipulated by the UK government regarding the NHS plan (DoH, 2000).

According to neoclassical theory, people move from a low-wage to a high-wage country; there is no room in this theory for informal training, or for the role of institutional factors, discrimination and other factors that lead to imperfections in the labour market. The world systems theory allows for the impact of gender, race and class, as well as the impact of the difference between rich, core countries and poor, periphery countries. Goss and Lindquist (1995) argued that both private businesses and the state are engaged in active recruitment to fill labour needs, that there are important individual and organisational agents who both provide employment opportunities that motivate migration, and directly recruit workers, while exerting indirect control over recruitment, by setting qualifications for employment.

Salt and Findlay (1989) argued that a theoretical framework for skilled migration needed to incorporate a mixture of macro and micro elements, including the new international spatial division of labour , the nature of careers, the role of intra-company labour markets, and the lubrication provided by recruitment and relocation agencies. The current framework aims to reflect these factors.

The present framework proposes that at the heart of the migration motives for black African nurses moving to the UK are economic reasons. These economic reasons include, among other things, the following: higher salaries, lack of employment, personal education and development, limited health care resources, poorly staffed hospitals and better education for their children. However, these alone are not strong enough as sole motivating factors for black African nurses to choose to move to the UK. Other factors need to be present at the same time to facilitate nurse migration to the UK. These lubricating factors are globalisation factors in education and labour, as well as the effect of information technology, emigration policies of sub-Saharan countries, IMF and World Bank policies, nurse shortages in the UK, UK government immigration policies and practices, language compatibility, family and friends' networks, and NMC registration rules.

Figure 4.1 is a framework which illustrates the interplay of these factors on the migration of black nurses from sub-Saharan Africa to the UK. The framework incorporates causalities from the systems approach. The causalities are derived from the following theories: Neo-Classical Economic Theory, Dual Labour Market Theory, New Economics of Labour Migration Theory, The World Systems Theory and Network Theory. However, there are factors in the framework, such as globalisation, sub-Saharan countries' emigration policies, IMF and World Bank conditionalities and NMC registration rules, which are not addressed by these theories.

Figure 4.1 Conceptual framework for migration of black African nurses from sub-Saharan Africa

Globalisation
Commerce
Knowledge
Culture

Economic

Black African nurses

factors

IMF and World Bank conditionalities

Sub-Saharan countries' emigration policies

MIGRATION

Society
Cultural
Social
Demographic
Education

United Kingdom

Nurse Shortage

UK immigration Policies and practices

NMC

Recruitment agencies
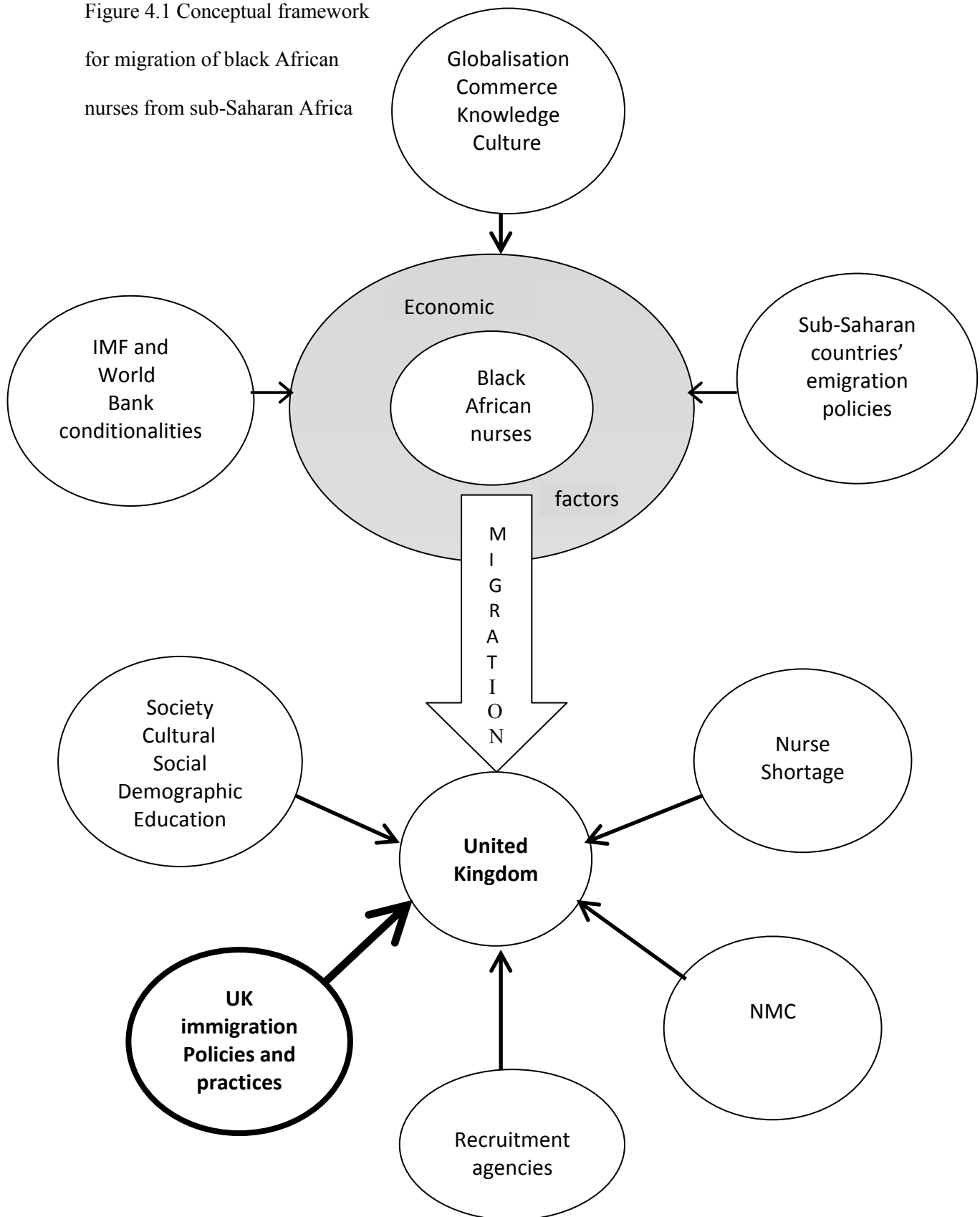
The above framework proposes that sub-Saharan African nurses are primarily impacted by economic factors which include low salaries, unemployment and poor employment conditions. These factors are made worse by globalisation and policies of the International Monetary Fund and the World Bank, which affect the ability of sub-Saharan countries to maintain economic stability.

Hahnel (1999) explains that when the world faced a global financial meltdown in 1997, the IMF "came to the rescue" of those countries that were affected. Sub-Saharan countries were of course among the worst affected. The IMF offered loans but in exchange imposed ruinous conditionalities under which countries had to raise interest rates, privatise public investments, open their economies to unlimited foreign ownership, cut social welfare and rewrite their laws to eliminate workers' rights. Hahnel (1999) contends that in effect the goal of the IMF was to turn each stricken country into a "debt–repayment machine" (p ix). The imposition of structural adjustment conditionalities by the World Bank and the IMF on developing countries in sub-Saharan Africa further weakened these economies. Further, the IMF and World Bank imposed a ceiling on the training and employment of health care workers in developing countries. In countries like Kenya and Cameroon, this resulted in nurses being trained but having no employment at the end of their training. The alternative for health workers, including nurses embroiled in these situations, is international migration.

The number of sub-Saharan Africans living in extreme poverty has risen. Whereas the global supply chains of the western supermarket culture deliver exotic, year-round, affordable foods, it is estimated that over a billion people in the developing world are too poor to feed themselves adequately (WHO, 2006).

Hahnel (1999) states that a comparison of fifty-six countries showed the spread in Gross Domestic Product (GDP) per capita between the richest and poorest increased from 40:1 to 72:1 between 1973 and 1992. By 1996 the world's 200 richest people had doubled their worth, while the number of people in absolute poverty had increased to 200 million. Hahnel (1999) says this illustrates the case that, under free–trade conditions, poor countries suffer even if there are efficiency gains, from trade; as each country specialises in what it does best, the wealthy countries get the best share of the gains and global inequality is aggravated.

It should also be noted, however, that factors such as crop failure and famine contribute to economic instabilities experienced by sub-Saharan countries. The AIDS pandemic has also contributed to the economic instability of some sub-Saharan countries by depleting human capital due to an increased death rate among professionals (Buchan and Calman 2004, Bueno De Mesquita and Gordon, 2005) other factors include oppressive political climate, lack of funding, limited career structures, and poor intellectual stimulation (Hardill and MacDonald, 2000).

The advent of the internet and cheap transportation (which have been exploited by both businesses and individuals) has brought about opposing results. On the one hand, developed countries have benefited from conditions which have created space for personal fulfilment, stimulating wealth through efficiency and encouraging cross-cultural experience. On the other hand, developing countries have been left behind, with sub-Saharan countries being affected the most.

Over the same period that globalisation has gathered pace, a number of sub-Saharan countries have emerged from dictatorships and liberalised their emigration policies. A good example is

Malawi; before 1994 all Malawian civil servants required a government clearance certificate to travel outside the country. This was discontinued with a change of government in 1994, giving an opportunity for many health workers to emigrate. In addition, before 2003 Malawian nationals did not require visas to enter the UK. Nurses could enter as visitors and were permitted to change to work visas whilst in the country. This practice encouraged many nurses to migrate.

However, as mentioned above, these conditions in themselves are not responsible for the migration of nurses from sub-Saharan countries to the UK in the number seen from the late 1990s to 2007. The main factors influencing sub-Saharan nurse migration to the UK have been immigration policies and practices of the British government. Immigration of nurses was encouraged by the UK Labour government in an effort to boost numbers of nurses in the British NHS and fulfil its promise of the NHS plan (DoH, 2000). This increased the number of nurses migrating to the UK as the UK government relaxed its immigration rules to allow overseas nurses to enter and work in the UK. At the same time, it can be expected that the NMC relaxed its entry rules to enable more overseas nurses to register with the council. However, it is worth noting that, as the UK immigration policies softened towards nurses and other skilled professionals, the UK government did not encourage mass migration; on the contrary, immigration rules were tightened.

Black nurses from sub-Saharan Africa are also influenced by social and political linkages to move to the UK. These include colonial ties, common language, compatible educational systems and family networks. However, there is a contradiction between globalisation, nation- states and multiculturalism (which is particularly being encouraged in the UK as a result of a large number of immigrants that have settled in the country). There is an

increasing realization that globalisation has not heightened the sense of integration, but rather it has shaped the lines of fragmentation (Papastergiadis, 2000).

4.7 Synthesis

The conceptual framework above demonstrates potential influences on the migration of black African nurses from sub-Saharan Africa to the UK. This section explains how the theories of international migration discussed in this chapter can be fitted into the framework. According to Neo Classical Theory, real wage differences between two countries cause workers to move from a low-wage to a high-wage country, as a result the supply of labour decreases in the high-wage country. This is supposed to lead to equilibrium in international wages. However it is well-established that this is not the case between the UK and sub-Saharan Africa.

Within this framework one of the main influences on nurse migration from sub-Saharan Africa is the wage difference between countries, with society exerting a greater influence than all other factors. According to Neo -Classical Theory, migrants are relatively younger. It is therefore most likely that nurse migration will have an ageing effect on sending countries and a rejuvenating effect on the UK. In the long run this will change the demographic composition of the nursing workforce in the UK.

Dual Labour Market Theory argues that international migration is mainly caused by pull factors in developed countries. Piore (1979) explains that the demand for foreign workers in developed countries is caused by general labour shortages and the need to fill the bottom positions in the hierarchy, together with labour shortages in the secondary segment of a dual market. In the case of nurse migration from sub-Saharan Africa, nurses were recruited to fill

the lower ranks of the nursing hierarchy in grades D and E, which are now band 5, regardless of their qualifications or experience. Massey et al (1993) contend that bottom jobs are difficult to fill because of motivational problems and demographic and social changes in developed countries. Motivational problems come about because jobs at the bottom of the hierarchy have a low status and limited upward mobility. These factors were discussed in the literature review in chapters 2 and 3. In this framework, nurse shortages in the UK prompted the Government and recruitment agencies to recruit foreign nurses. These nurses help to eliminate shortages and contribute to growth and quality of care in UK health care. Here, the main influencing factors for migration are shortages of nurses in the UK, economic factors affecting nurses in their country of origin, demographic factors and UK immigration policies, and practices.

The World Systems Theory posits that capitalism drives international migration. The theory explains that international migration is found primarily in the extension of capitalist modes of production, from core nations to peripheral ones. Colonisation of peripheral nations by core nations is explained by capital accumulation, which forced capitalist countries to search for new natural resources, new low-cost labour and new outlets. After decolonisation, political dependencies disappeared but the economic dependencies of the former colonies, which are regarded as peripheral countries in the world system, remained and are strengthened. World trade is dominated by core countries, which determine producer prices. This leaves the developing nations unstable in terms of world producer prices, resulting in slow economic expansion and a growing dependence on core countries (Amankwaa, 1995).

The World Systems Theory explains the existence of differences in economic development between the UK and sub-Saharan countries, and the existence of linkages such as language

and educational systems. Linkages in terms of technology, such as television programmes and the internet that provide information about culture and employment opportunities also exist.

According to the New Economics of Labour Migration, migration decisions are made within households. Households act collectively to maximise income. Within this theory, migrants abroad may send remittances back home, which may increase the household income. Previous research has found that black nurses from sub-Saharan Africa regularly sent money home to their families (Allan and Larsen 2003, Mensah, Mackintosh and Henry, 2005). The literature indicates that remittances have a positive impact on the sending economy (Lowell and Findlay, 2001). However, remittances do not negate the negative effect of migration of health professionals on health outcomes for the population as a whole. In addition, remittances are sent to individuals, and not to governments and individuals can choose how to spend the remitted money in ways they see fit, which may not be necessarily to the benefit of the country.

The Relative Deprivation Theory states that the relative income position of a household or an individual is an important determinant of international migration. Nurses are skilled professionals and as such, have marketable skills to developed countries such as the UK. Having specialised skills is an incentive to migrate. A large number of successful emigrants may serve as an example for potential migrants who are still contemplating emigration. Previous research has shown that nurses used their qualifications as a passport to the UK, as the NHS in the UK needs their skills. Nurses spoke of wanting to further their education in the UK (Allan and Larsen, 2003, Larsen, Allan, Bryan, and Smith, 2005). Presumably this

would make them more marketable and create more opportunities for them, which would enhance their income and status (Van Eijck, 1996).

Migrant networks help potential migrants in a number of ways, such as providing finance for the journey, providing an initial place to stay, and providing information for jobs. This reduces the cost of migration and increase the probability of employment in the country of destination. In the case of sub-Saharan African nurses, networks could be in the form of relatives and friends. Friends and relatives who migrated first may want to help others by providing accommodation while their friends find jobs and get settled. Friends and relatives may also provide information on the cost of living in the UK and how to adapt to the UK culture generally. The network theory partly explains the continuation of migration once it has started (Massey et al, 1993), and it is well suited to explain why the number of nurses from African countries increased year-on-year from 1998 to 2001 (Fig 2.1, chapter 2) before the British government changed immigration rules for nurses.

Cumulative Causation Theory explains that each act of migration alters the social context in ways that make additional movements likely. Of the six social factors potentially affected by migration (the distribution of income, the distribution of land, the organisation of agriculture, culture, the regional distribution of human capital and the social meaning of work), the last factor leads to labelling of some jobs in the destination country as 'immigrant jobs'. This is reflected in the employment of black African nurses in the lower grades of nursing (D and E) regardless of their qualifications and experience. Several studies have shown that black African nurses occupy the lowest grades in nursing with little prospect for upward movement in their careers (Sheffield, Hussain and Coleshill, 1999, Smith et al, 2006, Alexis and Vydelingum, 2005, Alexis, Vydelingum and Robins, 2006).

4.8 Relationship between Migration Routes and Experiences of Black African Nurses in the UK

From the foregoing discussion, a framework was developed through which experiences of black African nurses in the UK can be analysed. This framework includes the historical factors influencing migration, such as colonialism and neo-colonialism, discussed by Wallerstein (1974), elements of Neo-Classical Theory as explained by Todaro (1969) and Portes and Rumbaut (1990), the pull and push factors explained in the New Economics of Labour Migration Theory, elements of Dual Labour Market theory as far as employment of immigrants is concerned in either the primary or secondary labour segment, and other motivational factors (such as migration networks and social family decisional factors). Motivational factors as expressed at the macro-level and micro-level also influence experiences of black African nurses in the UK. However, it is emphasised that, superseding these factors, the most important drivers of migration of nurses from sub-Saharan Africa to the UK are the immigration policies and practices of the UK government. Experiences of black African nurses in the UK are largely related to this factor.

Phizacklea and Miles (1980) argue that black people's experiences in Britain are best understood first as migrant labourers in a capitalist society. Their framework is embedded in concepts of capitalism and class; and migrant labour is analysed within this framework. They argue that the individual's economic place in a capitalist society plays a principal role in determining social class. The authors introduced the concept of class fraction as a means of identifying the base stratification within classes.

The concept of fraction in Phizacklea and Miles' (1980) view refers to an objective position within a class boundary, which is in turn determined by both economic and politico-

ideological relations. In this framework women constitute a class fraction as they perform a dual role in production, first as a wage labourer and also as a means for the maintenance and reproduction of labour power. Various British governments have recognised the second role by providing various incentives such as maternity benefit and child allowance. Phizacklea and Miles (1980) contend that women's work is considered secondary and temporary because women are viewed as actual or potential domestic labourers: therefore women are concentrated in low-pay industries. Moreover, most women are forced to find work which enables them to meet child care responsibilities in the absence of day-care provisions for all under fives.

In the case of black migrant labour, Phizacklea and Miles (1980) argue that it constitutes a distinct fraction of the working class. Black migrants constitute a class fraction not only because of their position in political and economic relations, but also because of ideological relations. Phizacklea and Miles (1980) consider two levels of this position which are connected in reality. First, the arrival of black migrant labour to Britain is said to have produced a 'race relation' situation – that is, migrants are perceived to belong to 'races' which, by implication, are distinct from the 'race' of the perceivers (p.21). The second is racism, which they define as "those beliefs and arguments which give rise to the identification of a negatively evaluated racial category. Negative beliefs held by one group identify and set apart another by attributing significance to some biological or other 'inherent' characteristic(s) which it is said to possess, and which deterministically associate that characteristic(s) with other (negatively evaluated) feature(s) or action(s). The possession of these characteristics is then used as justification for denying that group access to material and other resources and/or political right." (p.22)

Phizacklea and Miles (1980) note that this definition indicates that racist beliefs can be held about groups which are not distinguished by colour for example, Irish migrant workers and Jewish refugees. However, they concede that skin colour is an obvious feature to which significance can be attached, and goes some way towards explaining the prevalence and apparent potency of racism articulated from within all classes in Britain since the 1950s. Phizacklea and Miles (1980) contend that there is evidence to demonstrate that 'governments, individual politicians, neo-fascist political organisations, the mass media, employers, institutions of the labour movement and sections of the working class in Britain have all acted and articulated racist beliefs which have identified migrant black workers as an Excluded racial category'(p.23). The authors posit that the political belief and practice of black immigrant workers is explicable in terms of both their class position and as a racialised and/or sexually categorised fraction of that class.

Racial and ethnic markers play a part in race relations. Rex (1999) links race relations to other sets of social relations, such as class. In Rex's (1999) model, race relations are encouraged by the existence of structural conditions such as conflict over scarce resources. He identifies the existence of a number of unwanted and low-status industrial jobs that are associated with immigrants, and shunned by locals, as a source of greater relative deprivation for immigrants. The situation with nursing is of course different, as nursing is classed as a skilled profession and qualified nurses have an entry level to the profession regardless of immigration status. However, it is progression in the profession that may relate to Rex's (1999) theory, since it can be argued that immigrant nurses will be found in the lower grades as these are the grades that are less appealing to British nurses.

Rex (1999) argues that stratification and other structural aspects characterise race relations situations. Colonial societies emerged from such situations. Another alternative of course is that the colonialists introduced an alien labour force of varying degrees of freedom and unfreedom as part of their economic enterprise. He is careful to note that slavery (which has existed from time immemorial) did not produce racism, and that racism is a modern invention. Rex (1999) believes that some race relations are based on a class system in which there is an exploitative relationship between the upper class and the lower classes. However, he concedes that a system of this kind is less perfect in modern times, and that it breaks down into a status system. "Everyone is therefore allocated a certain standing in society along a quantitative scale. This position accorded to a man may be high or low according to the lightness or darkness of his skin" (p.339).

A race relation situation arises when: (a) one group of people behaves to another group of people in a way which denies them equal access to social services; (b) the groups involved are recognised by signs which are regarded as unalterable; (c) the unequal relation between the groups is justified by various deterministic beliefs (Rex, 1970). The first of these conditions stresses the significance of inequality, the second emphasises the importance of physical differences and the third emphasises the subordinate group possessing the negative characteristics which justify racial inequality (Pilkington 1984, 2003). These ideas, which have their origin in the nineteenth century, have their foundation in the belief that biologically black people are inferior to white people: however, other ideas can perform the same role (Pilkington, 1984).

The three conditions above which give rise to race relations are distinguished by Pilkington (1984) as racialism and racism. Racialism comprises of practices which disadvantage people

on the basis of their supposed membership of a particular race, while racism comprises those beliefs which consider that the disadvantaged group invariably has those characteristics attributed to it. The best example of a race situation is imperialism, involving the domination of White West European countries over countries in which most people were of different skin colour (Pilkington, 1984 and Rex, 1999). In the case of Britain, this was manifested by colonisation of most of sub-Saharan Africa. Since the decline of the British Empire, that domination has been in the form of multinational organisations such as the IMF and the World Bank.

Rex (1999) argues it is important to appreciate that the above problems have been encountered at some point by British people in their colonial dealings. He further asserts that colonial immigrants in British society are not only distinguished on the basis of their skin colour, language, religion and domestic culture but are also known through indicators to have come from fulfilling colonial roles to adopting the role of the worker in the metropolitan society.

His model describes relations between immigrants and locals within the metropolitan society, which are most problematic because of housing conflicts. He contends that the problem is a racial, colonial and class problem. The emergence of deprived industrial roles and deprived neighbourhoods exposes immigrants to categorisation into a pariah group, and in times of crisis, they may be made scapegoats.

Pilkington (1984) states that in Britain black people are discriminated against on the basis of skin colour, and not just because they are immigrants as Phizacklea and Miles (1980) insist. Pilkington (1984) is supported by two studies of political planning: (Daniel, 1968 and Smith,

1977), which concluded that black immigrants are discriminated against on the basis of their colour. Later studies (Brown 1985, Brown and Gay, 1984) came up with similar results. Furthermore, the Smith (1977) study was carried out after the Race Relations Act of 1968, which outlawed discrimination in housing and other commercial services, indicating that the Race Relations Act had had little effect. Since then successive acts, such as the Race Relations Act 1976, amended in 2000 and 2004 have had limited success.

Richmond (1994) asserts that an understanding of sociological dimensions of international migration and related questions of race and ethnic relations requires an understanding of concepts of power, conflict, agency, structuration, security, identity, and communication. In the current framework power is the most important, as it influences the experience of black African nurses both professionally and socially. Any perception of power imbalance can be destabilising to a relationship between UK nurses, UK nurse managers and black African nurses. Communication is important as it is a medium of expression. Identity will be discussed here in conjunction with stereotyping and the concept of the 'other', as these concepts are closely related and form the basis on which people view others whom they perceive as strangers.

4.9 Power

Power is defined by Richmond (1994) as 'the capacity to achieve individual or collective goals through co-operation and, if necessary, by overcoming opposition' (p.4). Traditional Marxists such as Cox (1948) explain power in terms of ownership of private property and capital accumulation, and the struggle between the ruling class and the working class. Miles (1987) emphasises the importance of 'unfree labour', such as slavery and various forms of migrant labour in capitalist societies, which are subject to controls on their movement and have limited rights. In this system the state is an agent of the elite ruling class. The social

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condition created by this struggle induces subordination by the working class and can only be overcome by a demonstration of false consciousness that diverts the working class from their real interests. The ruling class exploit the division in terms of race, ethnicity and religion that exist among the working class to maintain power and reduce their propensity to revolt. Neo-Marxists, however, recognise the relative autonomy of the state and identify structures of dominance in situations of racial conflict as socially constructed definitions of race that are at the root of the power struggle (Hall, 1980).

Weber (1947) defines power as 'the probability that one actor in a social relationship will be in a position to carry out his will despite resistance, regardless of the basis on which this probability rests'(p.152). According to Weber (1947) power is exercised legitimately when it is based on tradition, bureaucratic rule of law or through the charismatic influence of a leader who might challenge established systems by appealing to higher moral authority. He said nothing about the illegitimate use of power, including exploitation, domination and coercion. Often power is exerted over immigrants by those in authority in these forms.

Richmond (1994) states that power is implicated in all forms of action, whether co-operative or conflicting, and that it requires mobilisation of resources as a means of achieving goals. Resources are divided into material and symbolic resources. Material resources are allocative and include energy, raw materials, and property as a means of production, while symbolic resources include language and the capacity to communicate (Giddens, 1984). Resources are not distributed equally between individuals and groups, and this gives rise to structures of domination. Exploitation can result where there is a difference in power. This exploitation can be both physical and psychological, implying manipulation of others through ideological indoctrination as well as material deprivation (Giddens, 1981).

These structures influence how people interact and perceive others. For example, by classifying nurses into EU and Non-EU, and by using different recruitment strategies as well as ascribing an ethnic group to nurses in the form of the NHS equal opportunities monitoring forms, the NHS could be implicitly practising a divisive practice. This could have an influence on the experiences of black nurses. Classification of people as immigrants, refugees, visible minorities and, in the case of the NHS, overseas or foreign nurses, is a technique of domination that tends to be reinforced in the individual through the process of internalisation. Others' perceptions of the person's identity and place in society are actively Incorporated into the subject's self-image (Richmond 1994).

Richmond (1994) states that it is a mark of a racist society that skin colour or any other physical attributes are used as a basis of social classification. Terms such as 'white' and 'black' or other minority labels which are used in census forms in the UK and are adopted by the NHS for use on forms monitoring equal opportunities, are social constructs, the use of which reflects patterns of power relations. This is well supported by Foucault (1973, 1978) who states that treating human beings in categorical ways which divide them from others is a dividing practice. According to Foucault (1973, 1978) dividing practices separate people using criteria such as age, sex, gender, race, class, religion or other descriptive criteria. These categories then influence how people interact and how they are perceived by others.

4.10 Communication

Related to the idea of power is communication. Communication can be in different forms, verbal or non-verbal (such as gestures, the written word, pictures and art). Communication barriers are present for people who speak different languages. These cannot be completely

overcome, even with the use of interpreters. Even where people speak the same language, there are other impediments to mutual understanding, such as hostility from individuals and groups and fixed frames of reference from the subjects' own group. Barriers which influence perception and relationship of status and power can be based on stereotypes (Richmond 1994). Communication usually improves when barriers are removed and there are support mechanisms in place.

Previous research on overseas nurses in the UK has indicated that communication is a concern jointly for overseas nurses and UK nurses, both in terms of power relations and everyday practices (Withers and Snowball, 2003, Taylor, 2005).

4.11 Stereotyping

Hall (1999) contends that "difference is ambivalent as it can be both positive and negative. It is necessary for production of meaning as it is for formation of language and culture for social identities and subjective sense of the self. At the same time difference is threatening, a site of danger, of negative feelings, of splitting hostility and aggression towards the character Of difference, its divided legacy." (p. 238)

Hall (1999) describes the periods when the West encountered black people first, during the sixteenth century, when there was contact between European traders and West African kingdoms which provided a source of black slaves for centuries; second, was the European colonisation of Africa and the scramble between European powers for control of colonial territory; and third was the post-world-war-II immigration from the third world into Europe and North America. Early images of black people during these periods were, according to Hall (1999), ambiguous. On the one hand Africans, were viewed positively because some had

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converted to Christianity and black saints appeared in medieval Christian iconography. However, this image changed as Africans were declared to be descendants of Ham cursed in the Bible to be forever a servant to his brothers. Africans were identified with nature and Symbolised "the primitive" in contrast with the "civilised" world. (McClintock, 1995).

During centuries of slavery, two main themes were used to describe Africans in terms racial representation. First, black people were described as innately lazy, naturally born fit to be slaves of their masters, but at the same time stubborn. Secondly, black people were described as primitive, simple and lacking in culture, which made them genetically incapable of civilised refinements (Hall, 1999).

Hall (1999) explains that this racialised regime of representation was the practice of reducing black people's cultures to nature or naturalising difference. Naturalisation would ensure that the differences between black and white were fixed and not open to modification: hence black primitivism (culture) and blackness (nature) became interchangeable and black people could not escape from this. After the abolition of British slavery in 1834, an alternative imagery of black and white relations took place which emphasised common humanity and not difference. However, the stereotype of black people as savages was substituted by one of simplicity and docility. After the American civil war, American film makers represented different stereotypes of black people which ranged between submissive to violent renegades. The 1980s and 1990s saw the growth of confidence in black cultural identity as well as black separatism.

From the above discussion, it is evident that black people were reduced to few and simple characteristics which are fixed by nature. This process is referred to as stereotyping (Dyer

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1977, Hall 1999). Hall (1999) identifies four aspects associated with stereotyping: otherness and exclusion, power fantasy and fetishism. The first two are relevant in describing experiences of black African nurses in the UK and will be discussed here.

The process of stereotyping reduces everything about a person into a few simple vivid, memorable, easily grasped and widely-recognised characteristics; exaggerate and simplify them and fix them without change or development forever (Dyer, 1977). Dyer (1977) further asserts that stereotyping deploys a strategy of splitting. It divides normal and acceptable from the abnormal and unacceptable. In this way stereotyping practises exclusion by fixing boundaries and excluding everything which does not belong.

Hall (1999) adds that stereotyping maintains a social symbolic order by differentiating between "normal" and "abnormal", "acceptable" and "unacceptable", "insiders" and "outsiders", "Us" and "them" and facilitates the "binding" or bonding together of all of us who are "normal" into one imagined community, and it sends into symbolic exile all of them – "the others" – who are in some way different "beyond the pale" (p. 258). He further explains that stereotyping tends to occur where there are gross inequalities of power, which is usually directed against the subordinate or excluded group. An aspect of this power according to Dyer (1977) is ethnocentrism, denoting the application of the norms of one's own culture to that of others.

According to Hall (1999), power needs to be understood not only in terms of economic exploitation and physical coercion but also in terms of cultural and symbolic terms, including the power to present someone in a certain way. Stereotyping is a key element in the exercise

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of symbolic power. Stereotyping could be used by UK nurses and managers to exercise power over black African nurses in situations where their authority is threatened.

The ideas discussed above are incorporated into the present framework to explain experiences of black African nurses in the UK.

From this framework, several factors, such as historical, economic, cultural and religious beliefs between UK and black African nurses will combine to cause conflicts which may result in power imbalances. Other factors such as social institutions may also influence the relationship between UK nurses, UK nurse managers and black African nurses. It has already been acknowledged in the above discussion that black African nurses migrate to the UK for different reasons and that the routes taken during this migration are also different among African nurses themselves, as well as between African nurses and nurses from other countries. These migration trajectories have an influence on how black African nurses are viewed by their hosts in the UK. A previous study of overseas nurses by Larsen et al (2005) found that UK nurses perceived overseas nurses as economic immigrants who were in the UK for money, and as a result overseas nurses felt devalued and not respected.

However, Larsen et al (2005) illustrated how this was a mistaken idea by discussing the complex motivational factors that induce nurses to migrate. Previous research (Beishon, Virdee and Hagell, 1995, Culley, 2000, Alexis and Vydelingum, 2005, Alexis et al, 2006, and Alexis et al, 2007) has indicated that black and ethnic minority nurses suffer racism, discrimination and lack of opportunity in the NHS. These experiences have often been discussed in a vacuum, without taking into account the historical and modern factors which contribute to their perpetuation.

The present framework proposes that black African nurses are perceived as the "other" and are viewed with suspicion as to their nursing skills, and are therefore treated without respect. This is compounded by the UK government's statements that overseas nurses are here to help the NHS until British nurses can be trained. This may imply that overseas nurses are not as good as British nurses, and that is why they can only be employed as a temporary measure. Differences in culture, religious beliefs and communication serve only to emphasise this idea.

4.12 Summary

There are many theories and frameworks that try to explain the causes of international migration. Taken on their own, these theories do not give adequate explanations as to why international migration occurs. Available theories and frameworks are also inadequate at explaining the experiences of immigrants in receiving countries. Most theories are generalist and inclusive of all immigrants. Understanding why nurses from sub-Saharan Africa immigrate to the UK requires a multi-model framework as there are many factors involved. Motivations for black African nurses migrating to the UK are multifaceted and complex. Lubricating factors for this migration are as complex as the motivational factors, and these factors are reflected in the present framework.

Exploration of experiences of black African nurses in the UK needs to take migration trajectories, historical and political factors into account. Only when these are understood can an adequate explanation of black African nurses' experiences in the UK be put forward. The frameworks developed in this chapter are a start toward this process. Results of this study will be analysed using these frameworks in order to explain migration and experiences of black African nurses in the UK.

The current frameworks demonstrate that at the heart of sub-Saharan nurses' decisions to immigrate to the UK are economic factors. These economic factors are brought about by effects of globalisation on sub-Saharan countries, policies of the World Bank and the IMF and unequal development brought about by neo-colonial regimes, as outlined by Wallerstein (1974), and influence nurse migration from sub-Saharan Africa to the UK.

However, the main factors which encourage nurse migration from sub-Saharan Africa to the UK are nurse shortages in the UK which prompt the UK government to change its immigration policies to facilitate employment of foreign nurses. The NMC is also influenced by the UK government to facilitate registration of international nurses. Without these factors nurse migration from sub-Saharan Africa to the UK would not take place at the unprecedented scale seen between the late 1990s and early 2000s. Other factors which facilitate nurse migration in this framework include networks in the UK, common language, education, distances, and availability of information about jobs from the internet. Aggressive advertising and recruitment by recruitment agencies also lubricate this process.

The current frameworks aim to take all of these factors into consideration in explaining nurse migration from sub-Saharan Africa into the UK. The frameworks also propose that experiences of black African nurses in the UK will emanate from their migration trajectories which will shape the relationship between UK nurses and their managers. Additionally, migration trajectories will shape the relationship, between black African nurses and other overseas nurses.

CHAPTER 5

METHOD

5.1 Introduction

In this chapter, I discuss theoretical issues concerning the design of the study, and describe the methodology of the study. Previous research into overseas nurse recruitment in the UK has used both quantitative and qualitative methods to study recruitment and experiences of overseas nurses in the UK. This study builds on this work by exploring motivational factors for black African nurses moving to the UK and their experiences once they arrive in the UK using a qualitative approach. The study also set out to explore experiences of nurse managers Who were working with black African nurses to obtain the managers' perspectives on their assessment and their interaction with the nurses.

Qualitative research has its foundation on an interpretative orientation that focuses on a complex process of making sense and preserving the meaning of data (Liamputtong and Ezzy, 2005). Qualitative research aims 'to capture lived experiences of the social world and the meanings people give to these experiences from their own perspectives' (Corti and Thompson 2004, p. 326). Therefore the attempt to understand motivational factors for black African nurses coming to the UK, their experiences once in the UK and experiences of their managers in the UK was at the heart of this research.

Liamputtong and Ezzy (2005) state that 'qualitative research cannot be described in terms of a set of theories and techniques that always apply. Rather, qualitative research draws on a variety of theoretical perspectives and practical techniques, including theories such as phenomenology, symbolic interactionism, cultural studies, psychology, feminism and techniques such as interviewing, narrative analysis, ethnography, and focus groups' (p. 2).

Bryman (1988) supports the idea that qualitative research is a naturalistic, interpretive approach concerned with understanding the meanings which people attach to phenomena (actions, beliefs, decisions and values) in their social worlds by stating that 'the way in which people being studied understand and interpret their social reality is one of the central motifs of qualitative research' (p.8). However, Mason (1996) acknowledges that there is no consensus on what constitutes qualitative research and it is no surprise that qualitative research does not represent a unified set of techniques or philosophies and that it has grown out of a variety of intellectual and disciplinary traditions.

5.2 Choosing the Approach and Method

Holliday (2007) argues that it is possible to devise a qualitative research approach from almost every conceivable scenario, and also states that 'it is therefore very clear that one does not begin by choosing a method…methods can be sufficiently flexible to grow naturally from the research question and in turn, from the nature of the social setting in which the research is carried out' (p.20). In addition Denzin and Lincoln (2005) state that there are no clear cut categories in approaches and that one can be flexible. Holliday (2007) demonstrates that there is a significant overlapping of approaches and strategies of inquiry. This overlapping is mirrored in the present study. Moreover, Silverman (2001) states that 'methodologies may be defined very broadly (e.g. qualitative or quantitative) or more narrowly (e.g. grounded theory or conversation analysis)' (p.4). The methodology in this research is therefore broadly defined and draws from a range of theoretical approaches such as Grounded theory by Glaser and Strauss (1967), phenomenology (van Manen, 1990) and feminist approach (Kiztinger 2004, Olesen, 2005).

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Grounded theory was utilised during data collection by using data saturation (the point where I felt that no new information was being obtained) as a termination point. Phenomenology was used during data analysis when making sense of nurses' and managers statements from interview and focus group data so that meaning could be explained in the findings. The feminist approach was used as I identified with the nurses background and as such I was able to handle sensitive issues that needed further probing.

I used source and method triangulation (Lincoln and Guba, 2000, Flick, 2006, Bryman, 2008 and Denzin, 2009). Source triangulation consisted of black African nurses and their managers, whilst method triangulation combined individual semi-structured interviews and focus group discussions. This approach is distinguished from mixed methods which combine qualitative and quantitative methods because I used within method triangulation using different data collection methods (Denzin, 2009). (See section 5.4 for further explanation and illustration).

Dunbar, Rodriguez and Parker (2002) argue that using interviews is one of the major ways of documenting lived experiences and cite their respective studies in the field of race to illustrate this. Dunbar et al (2002) further add that interviewing as a qualitative research method is especially suitable for exploring issues involving racialised populations and women. It is reasonable to draw parallels between research on minorities such as black people and women since both groups may be described as silenced groups for various reasons. Black peoples' silence may be self imposed because history has portrayed them as 'stupid and no good' (Hall, 1999 and Dunbar et al, 2002) or it may be imposed by society as a tool of subordination (Rex, 1992, Pilkington, 2003). Similarly, women's silence may be self imposed or societal imposed as a tool of subordination (Reinharz and Chase, 2002). Dunbar et al (2002) argue that race should be treated in a similar way as gender in research.

The choice of focus group discussions and semi-structured interviews for this research was guided by the fact that I am a black African nurse, interviewing mostly black African nurses. I say mostly because white British ward managers were also interviewed. As outlined in the introduction the aim of this research was to explore reasons why black African nurses move to the UK and their experiences once in the UK. Therefore the adoption of a qualitative approach using in-depth interviews was preferred as Miller and Glassner (1997) argue that 'information about the social world is achievable through in-depth interviewing' (p. 99). Qualitative interviews would provide a means for exploring participants' experiences and their points of view.

Focus group discussions were chosen as a method to provide a forum for black African nurses to discuss their motives for coming to the UK and their experiences in the UK. Focus group discussions have the advantage which allows a lot of data to be collected in a short period of time (Morgan, 1997). They allow the researcher to develop an understanding about why people feel the way they do, participants are able to bring up issues they feel are Important to them, and are able to challenge each others' views and the researcher may benefit by having a more realistic account of what people think.

As a researcher I recognised that I would have an influence on what participants would say because of the type of questions and the way questions were framed. In addition I recognised participants would respond to me based on who I am i.e. a black African nurse. This factor was important because as well as being practical it is an epistemological factor (Miller and Glassner, 1997). Miller and Glassner (1997) explain that sharing participants' membership group may engender trust in the researcher because participants are able to understand the researcher's questions and this may lead to more accurate answers. In addition as a black

African nurse I had some knowledge about the phenomenon under study to ask the right questions. Interviewing is therefore in this perspective interaction research where both interviewer and interviewee are 'seen as actively and unavoidably engaged in the interactional co-construction of the interviews content' (Gubrium and Holstein, 2002 p. 15). Other methods such as observation and personal diaries have also received much attention. However these methods are not discussed as I did not employ them in the study.

5.3 My Epistemological Position

A researcher's epistemology is her/his theory of knowledge, which determines how social phenomena are studied Creswell (1994). In this study, my epistemological position was that black African nurses living and working in the UK and their managers had the experiences I wanted to study, because of this I engaged with these groups in collecting data. I am an academic researcher and a professional nurse, which means I am well placed to interview both black African nurses and their managers.

Focus group discussions and semi-structured interviews were used as they provide a means to explore the points of view of research subjects, while at the same time 'granting these points of view the culturally honoured status of reality'(Miller and Glassner, 1997 p. 100). However Miller and Glassner (1997) also state that interviewees respond to the researcher based on who the researcher is in terms age, gender, class and race. This is important as social distance may mean that respondents do not trust the researcher, may not understand questions or may purposely give misleading information. By the same token lack of membership of identification with participants may result in the researcher not knowing enough about the phenomenon under study to ask the right questions. During interviews I made sure that participants were aware that I was a black African nurse who had immigrated

to the UK and the circumstances surrounding that immigration. This helped in building rapport and trust as participants (in this case black African nurses) could be confident that I would not be judgemental during interviews but probably also that I empathised with their Experiences.

This stance is supported by Lewis (2003) who asserts that a common cultural background between researcher and participants may enrich the researcher's understanding of participants' accounts and the language they use. He adds that there may be instances where the researcher's experiences mirror those of the participants in terms of oppression or imbalances of power, especially if issues of oppression and discrimination are relevant to the study. Douglas (1985) refers to this type of interviewing as creative interviewing and states that to achieve thick descriptions of data and depth the interviewer must establish a climate for mutual disclosure. Dunbar et al (2002) concurs by saying that in most interview situations, emphasis in research is disproportionately placed on researchers obtaining information from respondents. This is problematic as it includes little or no exchange or disclosure about the background of the researcher. More importantly black people may regard outsiders with suspicion because of their marginalised position.

However my position as a university lecturer could have put me in a privileged position and create a barrier between respondents and myself. I could be viewed as someone who was just interested in extracting data from black African nurses without having their interests at heart. These problems seemed to be outweighed by the shared attributes of culture, race, and experiences and it would work to my advantage. In addition I was cautious of how much information I could reveal about my experiences as Miller and Glassner (1997) explain that the amount of information the researcher reveals to respondents about her/himself can

influence what participants are willing to tell. Therefore my self-disclosure was limited to

the common aspects of being a black African nurses who immigrated to the UK.

5.4 Data Collection Methods

Research data were collected using audio -taped focus group interviews and individual semi-

structured interviews. This section describes these approaches and the rationale for their use.

I used triangulation to address issues of validation (Flick, 2006 and Denzin, 2009). Source

triangulation consisted of black African nurses' and managers' perspectives while method

triangulation combined focus group discussions with individual semi-structured interviews.

The method triangulation used here is described as 'within method' meaning that two

different data collection approaches were used within the qualitative paradigm. Method

triangulation was used for validation and also for inclusion as I wanted to include participants

who were not able to attend focus groups thereby contributing new information to the

research. Individual interviews were used to collect data from those participants who were

not able to participate in focus groups because of personal and time issues. This was also the

best method to collect sensitive information. The types of triangulation used here are derived

from Denzin (2009), see table 5.1 below.

Table 5.1 Denzin's (2009) description of four types of triangulation

Type of triangulation	Meaning
Data	Multiple sources of data used to obtain differing views about a situation in order to validate findings.
Investigator	Two or more skilled researchers are involved in the study
Theoretical	Use of all possible theoretical interpretations as the framework for study, competing hypotheses are included.
Methodological	Use of two or more research methods. Across- method: different data collection approaches used in the same study. Within-method: two or more data collection approaches in the same study.

5.5 The Study Population

The study aimed to explore experiences of black nurses from sub-Saharan Africa from their perspective and from the perspective of their managers. Characteristics of the nurse population are described in tables 5.2 and 5.3 below. Nurses' had experiences ranging from 5-20 years from their countries and had been in the UK between 3 and 5 years .

Table 5.2 Characteristics of the black African nurses in the study

Characteristics	No of nurses (n= 30) 28 female and 2 male
Married	28
Married with children	26
Age range and Mean age	25-48 years (mean = 35 years)
Diploma qualified	24
Degree qualified	6
Nursing grade at the time of interview	D (lowest possible grade at the time for a qualified nurse

Table 5.3 Distribution of nurses by country

Ghana	Kenya	Malawi	Nigeria	South Africa	Zambia	Zimbabwe	Cameroon
2	6	4	3	1	8	5	1

5.6 Sampling

Non -Probability or purposive sampling was chosen for this research. Purposive sampling is different from random sampling or probability sampling in which the nature of the population is defined and all members have an equal chance of being selected (Marshall, 1996). Random

sampling is used in quantitative research to draw a representative sample from the population from which the results can be generalised to the whole population. Purposive sampling is directed by the question being asked. It involves application of specific criteria to ensure that the selected sample will answer the research question. In the case of nurses, black African nurses were chosen because they had the experience relating to the phenomenon to be researched. Managers were selected on the basis that they supervised and worked with black nurses and therefore had the experiences I wanted to study. Krueger (1988), Patton (1990), Pollit and Beck and Hungler (2001) and Groenewald (2004) have discussed this sampling method in qualitative research.

In looking for black African nurses from sub-Saharan Africa, it was hoped that participants would share some common attributes. This region shares some common factors, which would influence nurses to immigrate to the UK: most sub-Saharan countries are former colonies of the British Empire and have a similar educational system to the UK. The countries use English as the main language in schools and nurse education. Most sub-Saharan countries have suffered the effects of structural adjustments imposed on them by the International Monetary Fund and the World Bank in the late 1980s and 1990s, which have resulted in the weakening of health systems in those countries (discussed in chapter 2 and 4).

Four big NHS trusts with known concentration of ethnic minority nurses were chosen for this study (Lupton and Power, 2004). Sampling was done at two levels. First was the hospital level while the second involved choosing black African nurses from the pool of ethnic minority nurses.

Adverts (Appendix 1) were placed in various wards in the selected NHS trusts asking black African nurses to come forward and talk about their experiences of working and living in the UK. Additionally nurses who came forward following the initial advertisement were asked to inform their friends of the research and ask them if they would like to participate in the research. This is known as the 'Snow Balling Approach' (Browne, 2005). A separate advert (appendix 2) was placed in wards in the same NHS trusts inviting managers who were working with black African nurses to come forward to discuss their experiences. This method did not attract sufficient numbers so I decided to go in wards personally to advertise the research. In total, 10 managers came forward. One of these managers was male, one black Caribbean (female) and the rest were white females (a full profile is given in chapter 8).

5.7 Access

I was aware that this investigation was sensitive owing to reports in the literature and the media that African nurses are subject to discrimination in the private sector and in the NHS. Access might be denied because of the sensitivity of the issues, fear of criticism, and anxiety that as a researcher, I might disturb the setting and potential participants might be embarrassed or fearful (Holloway and Wheeler, 1996).

The study area involved four large NHS hospital trusts in the north of England. Holloway and Wheeler (1996) state that researchers need to negotiate with gatekeepers for access to the research site. In this study permission was sought from various gatekeepers (see figure 5.1).

Figure 5.1: Gatekeepers to the study:

Central Office Research Ethics Committee

↓

Multi-Centre Research Ethics Committee for Scotland

↓

Research and Development Committee NHS Trust

↓

Ward managers

The study proposal was first presented to the Central Office Research Ethics Committee (COREC), which was responsible for allocating the responsibility to Multi-Centre Research Ethics Committee (MREC) for Scotland. It received approval as a justifiable investigation under reference number 05/MRE00/29. Approval also had to be sought from various local research development committees before the research could begin. Issues that proved problematic with regards to access were discussed with the ethics committee and the necessary individuals as they occurred.

Exclusion Criteria

The study was concerned with experiences of black African nurses in the UK. Therefore all nurses who came from Africa to work in the UK but were not black, were excluded from the investigation. Managers who were not working with black African nurses were also excluded.

5.8 The Pilot Study

A pilot study was carried out to test individual semi-structured interview questions using three black African nurses who were known to me. The aim of the test was to see how easy it was to ask the questions. It was discovered that some of the questions were vague and a few were leading questions so that they did not yield much interview data. The interview questions were modified to eliminate vagueness and to encourage respondents to talk (Krueger and Casey, 2000). The managers' interview guide was piloted on one manager and the phrasing of a few questions was altered. The results were incorporated into the main study. Focus group questions were not piloted to the focus groups, as it is time and labour intensive to set up a focus group. I felt that the results from the first discussion should be used rather than considered a pilot (Krueger and Casey, 2000). However, at the end of each focus group interview participants were asked if questions were clear and if any of the questions could be made clearer and the schedule was altered accordingly.

5.9 Ethical Considerations

Before commencement of the study, a protocol detailing the aims and objectives of the study as well as the method of investigation and dissemination of the results was sent to COREC and MREC and, it received approval as a justified investigation. After this approval the protocol was sent to research and development committees of the four selected trusts and also received approval in all four cases.

Nurses and managers who participated in the study were assured that they would not be identified in any way in any report or publication emanating from the study. Nurses and managers were also informed that the study was being undertaken for fulfilment of my PhD study and that information may be used for conferences and publication of articles in

journals. Nurses and managers were also informed that they could terminate the interview at any time if they had concerns. Participants were informed that their identity would be protected by changing identifying features in any reports or publications that may result from the research. This practice is consistent with informed consent by Beauchamp and Childress (1994) and May (2004).

I recognised that participants may reveal some negative experiences in their interviews that may affect their work (Kvale, 1996). With this in mind, I took the view that if any sensitive issues came up during the interviews or focus group discussions, participants would be advised to follow established procedures of the relevant Trust for resolution. This would apply to both nurses and managers. This is consistent with Patton (1990) who emphasises that the purpose of the interview is first and far most to gather data and not to change people and that the interviewer is not a judge or a therapist.

5.9.1 Informed Consent -Black African Nurses

Before commencement of the study I produced an information sheet, which contained information about the research (appendix 6). This information was given to every nurse that showed willingness to participate in the study. Nurses were given at least a week after reading the information to decide whether they wanted to participate in the study. This meant that they could discuss this with friends and family but it also gave them time to ask me questions if they wanted any clarification.

On the day of the focus group or individual interview nurses were given consent forms to sign as an indication that they had agreed to participate in the study. Before the interview nurses were reminded that interviews would be audio-recorded and that their consent

included this. Nurses were also reminded that they could terminate the interview any time. They were assured that the tapes would be destroyed after transcription.

5.9.2 Informed Consent for Managers

Managers were provided with information about the research, which was similar to that of nurses (appendix 7). The procedure for obtaining consent was similar to that used for nurses discussed above.

5.10 My Role as the Researcher

My background influenced my choice of the research topic and the perspective judged most adequate for this purpose, (Malterud, 2001, Finlay, 2003, Mauthner and Doucet, 2003, and Denzin and Lincoln, 2005). I wanted to understand the experiences of this particular group of nurses in the UK and perhaps this would help me to understand my own experience. I therefore approached this topic from the insider perspective. Anthropologists and linguists call this the 'emic perspective (Patton, 2002). However, Holloway and Wheeler (2002) note that this involvement can be dangerous as the researcher can lose awareness of their role and rely on assumptions, which do not necessarily have a basis of reality. To counterbalance this involvement, I also took the 'etic perspective' or outsiders view (Patton, 2002). As a researcher, the etic perspective is important in order to make sense of my observations and Minimise bias. This necessitates placing participants' ideas within a framework. It means that as a researcher I needed to interpret or identify the phenomenon described by the participants. This would empower participants as they would not just be reacting to my questions but they would have a voice and guide the study (Holloway and Wheeler, 2002).

I kept my own research diary in order to reflect on my feelings and reactions during data collection. The diary enabled me to modify or add questions to my interview schedule in areas that were initially neglected or areas that required clarification. This required me to immerse myself in the data, to move in and out of the data continuously in an interactive Dialogue seeking the meaning of the participants' experience (Finlay, 2003 and Spencer, Ritchie and O'Connor, 2003). This reflexive process is said to reduce subjectivity and make data analysis more reliable (Bednall, 2006).

I needed to reflect on my own experience of being a black African nurse from sub -Saharan Africa studying other black nurses from sub-Saharan Africa. On the one hand I am an insider and feel comfortable with my role. I feel as one of them as we all come from Africa and share certain common aspects of culture. We have all immigrated to the UK and can share common experiences. Through understanding of my experience as a black African nurse, I would be able to understand theirs. However, making assumptions like these could have put me in danger of missing points that might be different. For this reason I needed to stand back and look at the data as an outsider. At the same time I needed to acknowledge that my position as a black African nurse will influence the data that I would get from participants (Finlay, 2003). For example nurses might be able to discuss issues, which they would not be comfortable discussing with a white researcher and participants could also ask me questions regarding my experience, to which I would need to respond. Kvale (1996) explains that the research interview is an inter-view, an interaction between two people and that the researcher and the participant influence each other. I needed to be aware that the interview situation may be characterised by positive feelings as well as anxiety and it may evoke defence mechanisms in both the participants and me. As a researcher I needed to plan ahead as to what would be done when situations of tension or concerns arose during the interview regarding experiences

of nurses. This response to this situation has already been discussed under ethical considerations above.

5.11 The semi-structured interview

The semi-structured interview was used to encourage participants to talk about their experiences and obtain 'thick' descriptions (Legard, Keegan and Ward, 2003). Flexibility allowed for responses to be fully probed and explored, it also allowed me to be responsive to issues raised by respondents (Arksey and Knight, 1999).

Interview guides were developed to help focus on the issues to be covered and to guide lines of inquiry (appendix 3 and 4). As these were only guides, it follows that the sequencing of questions was not the same for all the participants. Questions depended on the process of the interview and the response of each participant. In addition the interview guides were not followed strictly as participants raised issues that needed to be followed. Holloway and Wheeler (2002) state that the guide can be revised after several interviews because of ideas that arise. However, they also state that researchers need some control over the interview so that the purpose of research is not lost. This was particularly important in this research as many emotional issues were involved.

I asked questions that encouraged participants to talk about their experiences and I listened carefully so that subsequent questions could be related to these answers. Legard, et al (2003), state that when probes and other interview techniques are used this way, the researcher can achieve depth of answers in terms of penetration, exploration and explanation. In addition this form of interview allowed me to explore fully the factors that underpinned participants'

answers in terms of reasons, opinions and beliefs (Kvale, 1996 and Holstein and Gubrium, 1997).

Since qualitative research interview is concerned with the life world of the subjects and their relation to it, its purpose is to describe and understand the central themes the participants experience and live toward (Kvale, 1996). In the interviews I talked to participants about topics that were of interest to both me as a researcher and to them as black African nurses. The aim of the research interview was to describe and understand the meanings of the central themes in the life world of black African nurses from sub-Saharan Africa, and to explore reasons why black African nurses move to the UK. As a researcher this involved interpreting what was said and how it was said and, for this reason the interviews were tape recorded so that they could be transcribed verbatim and also listened to again during data analysis.

5.12 Focus Group Discussions

Questions to be discussed in the focus groups were developed from introductory questions, transition questions, and key questions to ending questions (Krueger and Casey, 2000). Introductory questions were designed to encourage conversation among groups by letting everybody introduce themselves, while transition questions introduced the participants to the broader view of the topic. Key questions were the driving questions for the study and asked participants to discuss specific topics. Ending questions enabled participants to reflect on previous comments and identify most important aspects of the discussion (see appendices 3 and 4 and 5 for a list of questions).

Focus groups comprised between three and five participants. Four focus groups comprising a total of fifteen nurses were conducted in this study (see Table 5.4).This enabled each participant to have an opportunity to share his or her experiences. I was flexible as to the number of participants needed for a focus group, as I recognised that some participants can be highly involved and others cannot, and that ultimately it is the purpose of the research and the constraints of the field situation that must be taken into account (Stewart and Shamdasani 1990, Krueger 1994, Morgan, 1997, Sim 1998 and Krueger and Casey, 2000).

Table 5.4 Distribution of focus groups and individual interviews

Trust	No of focus groups conducted	No of nurses	Individual interviews	Total
1	2	4 5	3	12
2	1	3	0	3
3	1	3	6	9
4	0	–	6	6
Total	**4**	**15**	**15**	**30**

Focus group discussions lasted between 90 to 130 minutes. For both focus group and individual interview participants, interviews took place at the time and place selected by the participants. This meant that the participants were comfortable with the environment and their work schedules were not disturbed. Some interviews were carried out in participants' homes, others in hospital common rooms, while others took place in restaurants. For interviews that took place in restaurants, a quite place and time was always selected to minimise noise during the recording of the interview.

The literature review had revealed that information on what motivates black African nurses to move to the UK and their experiences once in the UK is lacking. Focus group interviews therefore provided an ideal method for exploration of these issues. In addition focus groups were used as one of the methods for collecting data and it was given equal importance with individual interviews. The goal was to use each method so that it contributed something unique to the understanding of experiences of black African nurses in the UK. However this was also influenced by the setting of the research and availability of participants. Because nurses were interviewed in their own time, it proved difficult to organise regular focus groups, and some nurses were interviewed individually depending on their availability.

During individual interviews I had a close relationship with the participants and was able to use subtle cues to control the direction of the conversation than that which is required to guide a group (Kvale, 1996 and Morgan, 1997). However the dynamics of the focus group interview put the burden on the participant to elaborate statements with little input from the moderator in that members could be challenged by others to explain their viewpoints (Agar and MacDonald, 1995). Control tended to be easier with focus groups as I was able to give control to the group on the direction of the interview.

In this research I was looking for a range of motivations and feelings that black African nurses had of living and working in the UK. I wanted to understand different perspectives between black African nurses and their managers, to uncover factors that might influence their opinions, motivation and behaviour. As I wanted ideas to emerge from the groups, focus groups were the ideal method to achieve these objectives. Krueger and Casey (2000) explain that a group possesses the capacity to become more than the sum of its part and to exhibit a

synergy that individuals alone do not pose. This was influential in the choice of focus groups as a data collection tool in this research.

The two main factors considered in forming focus groups were that nurses were black and from sub-Saharan Africa. These factors were considered to offer greater commonality than other factors such as sex, income, occupation, education and religion. However one focus group comprised of two men and three women which may have influenced the group dynamics and hence the data collected. Men and women behave differently in group situation in that men may be more aggressive than women Stewart and Shamdasani (1990). However I did not observe this dynamic in the focus group concerned. This may have been because there were only two men in the focus group concerned.

Before beginning the research I was aware that I needed to acquire moderating skills (Stewart and Shamdasani, 1990 and Kruger, 1994). I therefore enrolled in a module which dealt with qualitative interviewing at the University. In the module I learnt some practical lessons on how to conduct both semi-structured interviews and focus group discussions. However the training undertaken during the qualitative interview module did not make me an expert moderator, therefore it is possible that the quality of data obtained was affected by this lack of experience.

Before the start of each focus group discussion I made sure the sitting arrangements were such that discussion among the group was encouraged. This was usually around a table or a circular sitting arrangement. I introduced the topic in order to open up the discussion (Krueger and Casey, 2000). Although I was well acquainted with the subject under discussion I avoided offering a lot of personal anecdotes during the discussions for fear of becoming a

participating member of the group and thereby biasing the discussion (Stewart and Shamdasani, 1990). Members of focus groups were notified that discussions were being tape recorded, and all members were assured that their presence and opinions were valued and necessary for the success of the discussions.

To obtain the depth of information required in the exploration of motivations of black African nurses coming to the UK and their experiences, I used various probes during the discussion. These included follow up questions facial expressions and gestures such as can you explain more about..? and head nodding to signal that a participant should continue. I encouraged all members to participate by letting people finish their sentences if they were interrupted by other members of the group. Members were encouraged to talk about sensitive issues by relating their stories and this created an atmosphere which was less threatening (Stewart and Shamdasani, 1990).

The focus groups discussions were conducted in series until saturation point was reached. This was the point where it was felt that no more new information or insight was being gained on the topic (Morgan, 1997 and Krueger and Casey, 2000). Fifteen nurses were interviewed using individual in-depth interviews. A total of 10 ward managers were also interviewed, eight individually and two together.

5.13 Reliability and Validity of Data Collection Methods

Data collection took place between 2005 and 2008, which means that there was a prolonged engagement with the study participants. Data analysis was carried out concurrently and I was able to validate statements with participants. This enabled me to clarify questions, which, may have been vague. When conducting focus groups, dependability of the results is assured

by the fact that the procedure used is trustworthy (Krueger and Casey, 2000). In this study, I was concerned about the quality and accuracy of the information from participants. I wanted to be sure that the information would reflect how the participants felt and thought about their work and life in the UK. Several steps, as discussed below were taken to ensure this.

I piloted the questions to a group of nurses from sub-Saharan Africa to ensure that they were understood. Some modifications were made to the guide questions following this pilot study. I was the sole moderator for the focus groups, and because of my background, I was able to identify with participants and make them more comfortable. I listened carefully and observed how the participants answered questions and I sought clarification on areas, which were ambiguous. At the end of each focus group discussion, I asked participants to verify my summary comments (Krueger and Casey, 2000). This is referred to as respondent validation (Bryman, 2008). However this approach can have problems in that participants can be either defensive or compliant if they have developed a fondness for the researcher (Bryman, 2008).

5.14 Data Analysis

Data analysis aimed to answer the following questions identified using the research objectives and interview guides:

- What motivates black African nurses to move to the UK? (Chapter 6)

- What are black African nurses' experiences once they arrive and start working in the UK? (Chapter 7)

- What are managers' experiences of working with black African nurses? (Chapter 8)

Although I was aware of computer –assisted qualitative data analysis soft ware (CAQDAS) packages such as NVIVO, I decided to use manual methods in order to help the process of

data analysis (Webb, 1999). With specific reference to PhD students (Webb, 1999) suggests that manual analysis is preferable as it facilitates the process of learning. Webb (1999) argues that manual analysis adds an 'intimacy with the data which give a close feeling and familiarity with what participants have said that leads to a process of analysis that could appear almost automatic and even have a physical elements' (P.369). Joffe and Yadley (2004) and Corbin and Strauss (2008), concur by saying that computers can do the coding but thinking is the engine that drives the process and brings the researcher into the analytical process. I therefore reasoned that coding and analysing the data manually would make me more engaged with the data, as at the same time I would be reflecting on the data and its interpretation. In addition lack of experience in handling qualitative data dictated that the use of an approach that focused on gaining experience with the analytic approach rather than the technology was wise. Analysis was a continuous process from data collection so that codes and themes from the first interviews were subsequently used to reflect and reframe probing questions for the whole period of data collection.

5.14.1 Thematic Analysis

'The term theme refers to an element which occurs frequently in the text (van Manen, 1990) "Theme analysis" refers then to the process of recovering the theme or themes that are embodied and dramatised in the evolving meanings and imagery of the work' (P. 78). Therefore data analysis involved the process of making sense of texts of lived experiences, which black African nurses and their managers described. The making sense involved interpreting the meaning of text and determining what motivated black African nurses to move to the UK, their experiences once in the UK and what the experiences of their managers were.

I transcribed two of the interview tapes so that I could get a good grasp of the data. Services of a professional transcriber were used for the rest to save time. However during the process of theme formation I listened to the tapes several times before comparing them with the transcriptions to ascertain accuracy. I used van Manen's (1990) selective or highlighting approach to isolate themes. Statements (or phrases) that seemed particularly essential or revealing about the phenomenon were highlighted. This approach involves immersing oneself in the data to understand its meaning and to retain participants' view point while allowing an understanding of the subject under scrutiny (Moustakas 1990). Different themes emerged under different topics (defined by the opening question).

The analytic hierarchy described by Spencer, Ritchie and O'Connor (2003) was used as a platform for initial ordering of the data (table 5.5). Since the process is not linear, it enabled my thoughts to move forward and backwards in the initial process of data analysis which involved assigning data to refined concepts, refining and distilling abstract conceptions, assigning meaning and generating themes and concepts. This process helped refine the analysis.

Table 5.5 Spencer, Ritchie and O'Connor's (2003 p. 212)

ANALYTIC HIERACHY

A depiction of the stages and processes involved in qualitative analysis

Seeking applications to wider theory / policy strategies

Developing explanations
(answering how and why questions)

Detecting patterns
(associative analysis and identification of clustering)

Establishing typologies

Identifying elements and dimensions , refining categories, classifying data

Summarising or synthesising data

Sorting data by theme or concept
(in cross-sectional analysis)

Labelling or tagging data by concept or theme

Identifying initial themes or concepts

RAW DATA

EXPLANTORY ACCOUNTS

DESCRIPTIVE ACCOUNTS

DATA MANAGEMENT

Iterative process Throughout analysis

Assigning data to refined concepts to portray meaning

Refining and distilling more abstract concepts

Assigning data to themes / concepts to portray meaning

Assigning meaning

Generating themes and concepts

The first stage in the analytic framework or index (Spencer et al, 2003) was to identify themes form the interview transcripts. In order to do this I familiarised myself with the data by listening to the tapes and comparing with the transcriptions. This was important to form a foundation on which to perform the analysis. This process continued until I felt that I had understood the characteristics of the data. While reviewing the data I was simultaneously identifying recurring themes and ideas, such as motivations, attitudes and behaviours. These themes were then sorted and grouped under main themes and sub-themes (table 5.6).

Table 5.6 Examples of main theme and sub –theme formation

Motivational Themes and Sub - Themes for black African Nurses	Black African Nurses' Experience Themes and Sub- Themes	Managers' Experiences Themes and Sub- Themes
Economic reasons • Lack of employment • Higher salaries • Investing back home • Limited health care resources	**The process of recruitment** • Exploitation by recruitment agencies • Inadequate information from recruitment agencies • Different adaptation processes	**Communication** • Communication with patients • Communication with colleagues • Importance of support • English tests
Professional development • Fear of change on the part of managers • Poor management structures	**Professional experiences** • Similarities and differences between British and African nursing • Staffing of hospitals • Poor infection control practices • Discharge planning • Different practices in nursing documentation • Different diseases • Cultural differences in nursing • Loss of skill	**Differences in nursing culture** • Holistic and task oriented nursing • Different priorities • Use of resources • Work ethic • Relationship with care assistants • Differences in adaptation courses
Personal development and education		**Documentation**
Altruism • Acquire new knowledge • Improve skills	**Communication difficulties** • Different accents	**Racism and stereotyping** • Racism from patients • Racism from colleagues • Racism from managers

Adventure • Experience a different life • Distance • Easy access to visas and jobs • Following Colleagues and spouse • Change of environment	**Racism and discrimination** • Racism from white British nurses • Racism from patients and relatives • Racism from managers • Lack of equal opportunities	**Discrimination and equal opportunities** • Information availability • Availability of funds • Allocation of funds • Lack of support
Other • Nursing as a route to preferred career • Language • Distance	**Social experiences** • Racism in the neighbourhood and from police. • Employment problems for partners	

After themes were identified, the next step was to order the data so that similar statements were grouped together. This allowed me to sort the data into categories and assign it to themes (table 5.7).

Table 5.7 Examples of themes and category of statements supporting themes

Motivational theme	Category of statements
Economic reasons	Statements about money, remuneration, economic situation in country of origin, and statements about helping relatives back home.
Professional development	Statements about managers' lack of understanding on professional development issues. Statements about attempts to block improvements in nursing practice. Statements about bad nursing practice in countries of origin.
Altruism	Statements about gaining knowledge in the UK with the intention of returning home and improving nursing care.
Adventure	Statements about wanting to travel and explore the outside world.
Nurses' experiences theme	**Category of statements**
The process of recruitment	Statements about the application process. Statements about adaptation period and statements about activities of recruitment agencies.
Professional experiences	Statements about differences in nursing practice. Statements about difference in nursing resources and equipment and statements about patients' rights. Statements about the behaviour of patients'relatives.
Communication difficulties	Statements about different accents, telephone conversations and gossiping.
Racism and discrimination	Statements about personal barriers to career progress and statement about being looked down upon because nurses were black and came from Africa. Statements about discrimination in work allocation, professional development and promotion allocation along colour lines.
Social experiences	Statements about not getting along with neighbours and the police. Statements about children facing racism in schools. Statements about partners facing employment difficulties.
Managers experiences' theme	**Category of statements**
Communication	Statements about black African nurses' difficulties in understanding slang. Statements about communication with patients
Differences in nursing culture	Statements about differences in approach to care. statements about the use of resources
Racism and stereotyping	Statements comparing between nursing staff of different racial and geographical origin.

The third stage in the data management process involved synthesising the original data. This

involved scrutinising every word in the original data and considering its meaning and

relevance to the motivation and experiences of black African nurses in the UK. In this

process key terms, phrases and expressions from the participants, language were retained. Interpretations were kept to a minimum so that I could always revisit the original expression if required in the later parts of the analysis. I worked through data systematically to ensure that all the data were included at this stage. Data that did not immediately fit into a category theme were noted so that I could group it and allocate a category or categories later. Next I created thematic charts by refining the process of indexing illustrated in table (5.8). When constructing the thematic charts each main theme and associated topics were plotted on a separate chart. The content of the tapes was carefully summarised so as to retain the participants' language. In the thematic chart I included a separate column for my summary observations.

The fourth stage in the analytical hierarchy would have been to develop typologies. This was not carried out as the study did not lend itself to creation of typologies (Richie et al, 2003).

Table 5.8 Example of a thematic chart

Respondent characteristics	Motivation for coming to the UK	Recruitment experience	Professional experience	Researchers notes
Female nurse 29 Zambian	Wanted to seek adventure and explore a different country. Wanted to earn more money	Given some contact addresses by the UKCC for adaptation experience. Did not know that she needed to do adaptation course before applying for registration.	Found different equipment being used onwards. Different management of diseases on wards. Different accents difficult to understand. Found gossiping on wards a problem. Africans are looked down upon. African nurses are denied development opportunities.	Motivated by adventure and economic reasons. Arranged for self adaptation placement but faced difficulties because of lack of information. Experienced communication difficulties. Found differences in nursing practice involving equipment used management of diseases. Experienced racism and lack of opportunity.

Respondent characteristics	Motivation for coming to the UK	Recruitment experience	Professional experience	Researchers notes
Female nurse 30 Zambian	UK is nearer than the USA Wanted to send money home to relatives	The recruitment agency charged £1400 for a placement. Placement was not available on arrival and had to wait a long time. Worked as a carer while waiting to make a living.	Was given undesirable shifts and heavier workload. Worked without adequate supervision. Was not promoted despite having qualifications and experience. Mistakes were made a big issue Was seen as stupid because she was African. Was ignored by patients' relatives Experienced different management systems, differences in documentation of nursing care	Motivated by economic factors and distance Exploited by recruitment agency Perceived racism and discrimination Racism form patients' relatives Different nursing practices.

The table above shows the process of thematic charting on only two nurses because of word limitations the process was carried out for each interview transcripts and focus group discussion transcripts. Throughout the process in the analytic hierarchy I was seeking for meaning and attributing it to the original data. Each interview was examined for content and its meaning labels were assigned to the data and similar ideas were grouped together as I began to interpret the meaning of data. This process was adapted for focus group data and each participants contribution was charted separately (Ritchie et al, 2003)

The final step in the analytical framework was to develop explanations from the data. This step involved going backwards and forwards between the data and the emerging explanations until I was satisfied that that data and the explanations fitted. During this process I also searched for rival explanations to the data in order to understand what was influencing the phenomenon (Ritchie et al, 2003). Explanations were constructed first by using participants' own accounts obtained during individual interviews and focus group interviews. During the interviews, participants were asked why they felt or believed as they did, and answers to these questions were valuable in understanding motivations and experiences. Secondly for explanations that were not immediately available from participants, meanings were inferred. As a researcher I identified factors which were not evident in the data for example the policies of IMF and the World Bank responsible for crippling third world economies and in turn causing migration. In this process I was seeking for explanations by weaving connections between unconnected themes (Ritchie et al, 2003).

Thirdly my explanations were drawn from previous studies in the area. Here I compared my own findings with those of others, borrowed some of the concepts from these studies to

explain my own findings (Ritchie et al 2003). Finally theoretical frameworks devised in chapter 4 were used to develop explanations in a broader sense for the motivations for black African nurses coming to the UK, experiences of black African nurses in the UK and experiences of their managers. The process of developing explanations is incorporated in chapters 6, 7 and 8 with findings of the study which are discussed next in the study.

CHAPTER 6

MIGRATING TO THE UK: MOTIVES AND EXPECTATIONS

6.1 Introduction

In this chapter I describe qualitative findings from focus groups and individual interviews Regarding black African nurses' motivation for immigrating to the UK an their expectations. The chapter is divided into two sections which cover different aspects of the findings:

- Motivations for immigrating to the UK

- Expectations of nurses before and after coming to the UK

6.2. Motivations for Immigrating to the UK

Black African nurses' motivations for moving to the UK can be classified into economic reasons which encompass personal development and education, poor health care and systems, social political reasons and personal reasons. Expectations of nurses before they left their countries for the UK mirrored these themes.

6.2.1. Economic Reasons

Nurses were asked about their motivations and expectations before leaving their home countries. Most nurses responded that they expected better pay, working conditions and standards of nursing, better quality of life, professional development opportunities and educational opportunities for their children. They described the need for improved salaries as a motivation for moving to the UK:

> My priority was money. The PI (Personal Information Pack) was quite big, it explained a lot of things, they even asked how much you want to be getting, and so we compared salaries . (F Malawian 28)

> The salaries here are higher than in South Africa. (F South African 30)

A Malawian nurse explained that salaries in the UK could be up to 10 times the salary she got paid in Malawi. This differential in salaries would enable her to send money home to help her family and relatives. Help ranged from sending relatives to school to just sustaining them from day to day. Others concurred:

> ...because there is the economic bit of it. Because here you get a bit more and you've got to help your people. I think that is the main thing. Having been a single mother it's Been a bit tough for me so financially here it's been a bit better here than it was back home. I have also benefited by being able to help my family who are back home, my Mum and dad. It's tough but financially I have benefited because when I was back Home I wouldn't be able to do most of the things I have done. (F Kenyan 34)

> I couldn't do anything for my mum when I was back home; I couldn't buy anything, that's why we moved. I help my sisters who are still in school. She stopped but she wants to go to school now. (F Zambian 29)

Although the cost of living in the UK is higher than in sub-Saharan countries, data indicate that this is not as important as the perception of higher earnings. Discussions in focus groups as well as individual interviews revealed nurses expected a better quality of life in the UK for themselves and their families. A Malawian Nurse explained how salaries in Malawi could not even cover basic requirements such as accommodation. Some nurses were quite distressed when they spoke about not being able to feed their own children from salaries that they got in their countries. Nurses said this left them with no choice but to emigrate:

> The time I was leaving they were giving K10,000 as housing allowance and the K3,000 As salary but you can't rent a house for that, you can rent a miserable house but you won't be happy there. (F Malawian 28)

> I would want to be in my own country because I know there is no any other better place than home. But because of the way things are, you can't, you always run to where There is food, where you can manage to eat. Its hunger that is chasing us, It's just like when you got children and you can't provide for them, they are starving, one day they Will run away from you, they will go where there is food isn't it? This is what we are doing; it's not that we want to. You would want to stay with your parents but if they are not providing for you, you start going to other houses where there is food. (F Zambian 34)

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Exchange rate was £1 to K250 at the time of interviews.

Nurses stated that their financial problems were caused by poor economies in their countries

but that countries were constrained by some factors beyond those countries' control:

> It's the economy that is not as good as it should be or as good as the first world so
> definitely there will be people going to work in the first world where there is more
> development and more earning power. I think our own governments are a bit
> handicapped in that area because how are they going to improve the economy so they
> can pay me as much as they pay me here? It's almost impossible. They are not well off,
> we are not rich, even without the corruption they talk about they are still not going to be
> able to pay me as much as they pay people here or in America. I believe it's really
> beyond some of the governments. I think it's what these people poverty history was
> talking about that we want justice; we are tired of getting aid and charity. So if things
> were done the right way round the balance would tip. Personally that's what I believe in
> because I did a bit of politics. (F Kenyan 34)

Nurses explained that the world economic situation needs to be equitable in terms of fair

trade which, influence distribution of worth, as African countries are simply unable to get the

money needed to pay nurses high salaries. Nurses also explained that unfair loan terms from

developed countries are crippling developing countries with the effect that developing

countries cannot grow their economies. This point is well articulated by the Kenyan nurse

Below:

> They have to tip the balance. They then can have good economy. I don't think it's as
> simple as saying; pay the nurses a little more and they go back. Where do they get the
> money to pay the nurses a little more and the doctors? They only pay as much as they
> can afford. If they don't have enough money in the central bank to allocate to the
> hospitals, where will they get the money to pay the nurses? Borrow more from the
> western world? And then they end up paying more taxes to the western world. So I
> don't think it's as simple as pay the nurses a little more and they go back. And that's
> what these people are talking about injustice in world trade and world economics. And
> the debt situation, the economists at home tell me most of our taxes go into paying back
> the debts than helping the local people. Our infrastructure will not improve because all
> our taxes come back here and their infrastructure improves. It's like using a credit card;
> you are always paying over and above what you owe and that makes somebody else
> richer other than you. (F Kenyan 34)

Nurses agreed that they would prefer to stay and work at home if their financial situation was improved but they also expressed a wish to travel around the world for the sake of travelling. However, the salaries that they earned in their countries were not enough to enable them to achieve this objective without migrating. For nurses who came from Zimbabwe economic problems were compounded by political problems which made it difficult for nurses to stay in that country:

> I mean, it's like we were last in Zimbabwe in 1993 and if life was the way it was then, we could happily go back to it because we know we could look after ourselves and be able to lead a comfortable life as the way we were but now with children and schools and everything it's a bit difficult, so it's a matter of weighing and seeing because it has to be better for the children as well. If there was another way, if things were different maybe it would be different. I would want to go if things were to change and Zimbabwe would be like any other country I'd be happy to go back home.
> (F Zimbabwean 37)

It is clear from the above statements that the better quality of life that nurses are seeking is not a life of luxury but simply to survive in terms of food and shelter. The Kenyan nurse above articulated this very well, by saying that this is not an individual problem but a government problem, since their governments' "hands are tied." There has been much publicity by the G8 and the media about some sub-Saharan governments' debt being written off. What is not publicised is that there are conditions attached to these agreements such as raising taxes, cutting public spending and privatising public services (as discussed in chapter 4). Nurses acknowledged that even if their governments wanted to raise salaries, this could not be done because governments had no money. This was due to governments paying debts to Western countries. This problem resonates with Wallerstein's (1974) world systems theory and Hahnel's (1999) statement in that developing countries seem to be forever indebted to core countries in the West and as the Kenyan nurse rightly says improving infrastructure in

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sub-Saharan countries in this situation is difficult, and it is expected nurse migration will continue.

On the financial and economic theme the data indicate a complex relationship between nurses' ambitions and the availability of finance in their countries to achieve these. Political and global factors are intertwined and bring about inequality in world economies which motivate nurses to migrate in search of a better quality of life not just for themselves but also their families and relatives.

Nurses' accounts indicate that their financial status is so dire that they are few alternatives to migration. Political problems such as those in Zimbabwe make the situation worse. It appears the nurses' situation was so bad that they did not mind, at least initially accepting lower grade positions in the UK which did not recognise their qualifications and experience. Dual Market Theory states that this is indeed what happens to migrants in the destination country (Castles and Miller, 1998). However the NHS policy in the UK was to employ overseas nurses at the lower grades of D and E. All nurses interviewed in this study started their employment at grade D which is the lowest grade for a qualified nurse. The explanation given by employers for this practice was that it gave nurses time to get used to new ways of working and to adapt to UK practice. It could be that the motivation for NHS employing overseas nurses at the lowest possible grade was saving money and thereby exploiting these nurses.

Nurses' accounts are also consistent with Neo-Classical Theory Massey (1993) which posits that wage differentials between countries cause workers to move from low wage to high wage countries. Although nurses were employed in lower grades, the money earned in the UK was still substantially more compared to their salaries at home. Sending money home is consistent

with the Relative Deprivation Theory which states that families try to maximise their family income relative to others by sending their profitable members as migrants so that they can Improve the families' position. Here the household's improvement is discussed in terms of providing material goods and future investment in terms of sending relatives to school.

In the case of Zimbabwe the situation is exacerbated by domestic conflict which has further Destabilised the country's economy, apart from this some nurses may face danger because of their political ideologies. Consistently nurses said that if the situation were to change they would go back to Zimbabwe, indicating that although it may appear on the surface that nurses migrated voluntarily, for some, there may be an aspect of forced migration as refugees as a result of the political turmoil in that country which ultimately affected the economic situation.

6.2.2 Lack of Employment

It seems paradoxical that there is a lot of talk in the literature about shortage of health care staff especially nurses and doctors in sub-Saharan Africa. This shortage prompted Nelson Mandela in 1997 (BBC news, 2002) to ask the UK to 'stop poaching, nurses from South Africa which was suffering from severe shortage of nurses, yet in some African countries nurses are trained and are unable to find employment. Nurses from Kenya said that country had trained so many nurses that all those nurses could not be employed and that migration represented part of a solution to the problem.

A deeper examination of causes of unemployment in countries such as Kenya and Cameroon reveal that unemployment of nurses may not be due to oversupply but rather it may be due to cuts in health services budgets and early retirement age. Nurses who are employable but have no jobs have few options and migration is attractive to them. Unemployment may also be due to poor planning which can create inequalities in the health sector.

In the case of Cameroon, for example, government reform began in the early 1980s as part of the Structural Adjustment Program (SAP) administered by the World Bank and the IMF measures affecting the health sector resulted in suspending recruitment, strict implementation of retirement at 50 or 55, limiting employment to 30 years and suspension of any financial promotion or additional benefits. There were two salary reductions totalling 50% and currency devaluation which resulted in an income loss of 70% over 5 years (Liese and Dussault, 2004). The result was a truly demoralised workforce which encouraged nurses to see migration as an escape route:

> I know our governments are not helping, and then the other thing is you train so many and there are no jobs what do you want to tell a twenty year old? We trained you and there is no job? Me who is twenty plus years and have worked and I am able to move Away why can't I just move away and let this young lady begin her career (F Kenya 48)

> I think in Kenya it (nurse migration) is not a problem because like I said even the doctors who trained here, because the universities are training people, the training colleges are training people and there is a problem with unemployment. They cannot employ all the people they are training so in a real sense for Kenya it is not a brain drain. It is a profit that people can go out to other countries and as we go out the young ones coming out of university or training schools can get a job. So I think for Kenya it's an advantage. (F Kenya 29)

This echoes sentiments of some researchers such as Padrath et al (2003) that health work migration could be beneficial to countries as remittances help immigrant's families.

A nurse from Cameroon said that unemployment in that country was caused by policies of the International Monetary Fund and the government, indicating that health workers are aware of the ruinous effects of the IMF and World Bank policies. However the nurse also blamed corrupt government officials who abuse funds:

> The international monetary fund demand that a certain number of nurses be trained but these funds end up in the hands of highly placed individuals in the government and so when we get trained there is no cash. (F Cameroon 27)

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Unemployment in Kenya, especially at the higher end of the nursing career was also said to be caused by foreigners who demand high salaries and drain the economy of its resources:

> We had a problem of fat cats. We are in a private hospital and most of our administrators were foreigners who came and got the big jobs and got a lot of money and of benefits and they are not passing that on to juniors. So it's the fat cat mentality which is bad and that drained resources and the local people are not helped. So I think the government needs to be really strict with foreigners who are coming to invest at home and take up the big jobs as executives. I think the government needs to put tighter restrictions on how much they can earn because they are draining the company. Well, basically if the fat cats don't take everything it means that the money will trickle down to the bottom people. (F Kenya 28)

In the case of Kenya the situation is complex where organisations employ expatriates who demand higher salaries instead of employing locals. Data from interviews and focus groups indicate that donors and funders demand that their own staff be the ones to administer hospitals. This leads nurses to immigrate in search of employment.

Soon after obtaining independence from Britain, many sub-Saharan countries relied on expatriates to provide expertise in various fields including health, until the local population could be trained to take over. However, many countries have continued to rely on Volunteer Services Overseas (VSOs) and other groups of expatriates because of shortages in specialist areas. Some organisations also like to manage their own finances if providing financial aid. In most cases these arrangements are not transparent and it may appear to the local population to be unfair. In some cases expatriate workers may be part of the general trade agreements between countries.

Another factor is that sub-Saharan countries are often heavily dependent on imported technology, machinery and equipment developed by and for use in developed countries. Sub-Saharan countries therefore have no choice but to use this equipment which may not be suitable for their needs. This dependence is made worse by the practice of some donor

agencies and private foreign investors who either tie their aid, and /or recommend their equipment which is costly but irrelevant to the stage of development, skills and employment strategies of African countries. Paradoxically migration of nurses and doctors to developed countries can create vacancies which have to be filled by expatriates at high costs perpetuating further the unemployment problem.

However some nurses migrated for reasons other than unemployment. It is reasonable to say economic reasons cited by most nurses have a link to globalisation of the world economy in which sub-Saharan countries continue to suffer unfavourable conditions. The unfavourable trade tariffs leave most sub-Saharan countries without sufficient funds for health care, education, housing and other basic needs. When nurses and other skilled professionals emigrate, these problems are exacerbated because of limited human resources, creating more migration.

6.2.3 Lack of Professional Development

Younger nurses felt they were not listened to and that managers felt threatened by nurses' knowledge and were afraid of change:

> Many of the 'senior' nurses in the hospitals have archaic ideas of nursing and definitely refuse to understand that health sciences evolve. When we, the new breed go in the field and try to bring some new ideas, they feel their places are threatened, and adopt a biased attitude toward us. They often feel challenged, forgetting to know that this world is in constant motion, and things change. They just don't read books; remain blank since refresher courses are rare. (F Malawi 31)

Nurses felt that managers clung to old practices partly due to lack of equipment but sometimes it was just plain malpractice. This creates a feeling of not being supported by managers which affects the care nurses that give to their patients, as a result nurses may

become demoralised and leave. A Nigerian nurse who had gone back to Nigeria after working overseas for a time expressed frustration with management, who blocked his attempts to develop nursing practice in his area of practice. He had to leave the country for the second time. A nurse from Cameroon concurred:

> In wound dressing it is not abnormal to find an initially clean wound suppurating within 2-3 days post-op. The aseptic techniques are far from ideal. We still sterilise equipment by boiling. It is quite common to dress 2 or more patient's wounds with the same pair of forceps. In some places alcohol is still considered as a disinfectant. Honestly, the malpractices are so many that if one has to focus on them, the next step would be to bow out of the profession. (F Cameroon 27)

However some nurses were appreciative of the difficult circumstances in which they worked and acknowledged that managers were doing their best. As one of the motivational factors for nurses migrating was professional development, it is not difficult to appreciate that managers themselves may have lacked professional development due to limited resources and hence lacked appreciation for change in practice. On the other hand resistance to change could be due to power struggle and the threat which comes with change.

Change usually requires commitment of resources from the organisation and not just knowledge. Lack of resources is implicitly acknowledged in an account by the nurse from Cameroon who cited outdated practices in sterilisation and wound dressing practices. Changes in these practices would require a large amount of financial resources.

The World Systems Theory is well suited to explain this disparity between developed and developing countries as core states benefit from globalisation policies and peripheral states are disadvantaged. Poor management structures and misuse of resources should not be ignored however, as these have been reported in some countries (Liese and Dussault, 2004).

6.2.4 Altruism

Some nurses said that they moved to the UK to learn new ways of nursing which would help

Them to improve nursing and people's lives when they return to their own countries:

> I wanted to discover why their people don't die as much because looking at the statistics on a daily basis more people die in our hospitals than they do here, I wanted to find out how they manage their systems here and how they nurse, just how they do Things here and how it's different from back home. I just wanted to see how the whole set up is organised here. Just to see what I can learn here so that when I go back home I can do that. (F, Zambia 30)

> …my long term plan is actually to go back home and major in women and children's health. And then when I go back home I have to go and work with women and children those that are in the rural areas. Because the most disadvantaged women back home are those that are in the rural areas who have never been in the classroom. So I would actually want to take some development back home to my country. (F Zambian 29)

> On the other hand I think at some point, once we have got all this knowledge and we go back may be we may be able to improve some of the things I don't know. (F Malawian 28)

Nurses said that experience gained in the UK would help them have a better relationship with

Doctors who had trained in the UK when they went back to Africa:

> And many times we had doctors that trained here and came home and they wanted us to use things like I see here like PCA (Patient Controlled Analgesia) on the ward which We couldn't use. So I think it's interesting to come and get the knowledge and see what goes on and how they do their things so that perhaps if more people come then more doctors train and go back to Africa. (F Kenya 29)

Nurses who had been lecturers in their own countries hoped to improve their skills of

teaching by using resources in the UK. Nursing is a caring profession and, some nurses refer

to it as a calling. There is an intrinsic motivation among such nurses which can be so strong

as to motivate them to migrate to learn new ways of nursing in order to improve lives for

their patients. It could be argued that the British NHS is not the best health care system in the

world, especially when one takes into account reports in the media about waiting lists and

rationing of treatment, but facts about differences in health and longevity of the British have

not escaped the attention of African nurses. Some nurses said they were aware that some diseases are different due to geographical positioning of the two regions, but still this is not sufficient to explain the huge differences. These nurses expressed the desire to improve and develop themselves first so that they could be better equipped to deal with health problems in Africa.

For some nurses better relations with doctors were important so that both nurses and doctors could work towards the common good. In the end they hoped this would improve retention of nurses and doctors in African hospitals. Whether these sentiments and expectations can be met is debatable. In the UK black African nurses in this study were employed in unpopular specialties such as care of the elderly and intensive care units while few nurses were employed in cancer nursing. Nurses said that they would not normally be employed in this type of nursing in their own countries as most elderly people were looked after by relatives at home, intensive care units are not as high-tech as those in the UK and cancer units were nonexistent with the exception of South Africa. It is therefore doubtful whether experiences gained in the UK would prove transferable to sub-Saharan Africa. Nevertheless individual nurses might gain from the challenge of learning new skills depending on circumstances and opportunities.

6.2 .5 Personal Development and Education

Some nurses expressed a strong ambition to develop their skills and knowledge. In this theme nurses said that they were not able to achieve their full potential in their own countries because of lack of equipment, lack of facilities for education and the high cost of courses. Some nurses expressed frustration that though they possessed a lot of theoretical knowledge with which to teach student nurses, they also needed to put this theory into practice but they

had not been able to do this. As a result they felt that they were not teaching 'real' nursing.

Nurses explained that this did not mean that student nurses were not doing their practical, but

only that there was a mismatch between what they were taught and what they actually did in

the clinical area or rather the equipment that was used to perform their duties on the wards:

> I came to advance myself in my nursing skills and knowledge we do not do proper teaching because of lack of resources. We just do theory but practical was very difficult. (F Malawian 31)

Nurses explained that personal development was difficult because of a shortage of university

places and sponsorship. One nurse from Kenya explained that she had a constant mental

battle, dilemma and debate as to whether she should educate herself or her children. This

constant dilemma had motivated her to immigrate to the UK to give herself a chance to

develop professionally:

> And I think the other thing is back home like how many universities do you have in your country right? And how many are you to go in as nurses? And how many are you? I mean how many hospitals will be able to sponsor 20 for example? For a degree in nursing or a degree in community health? You know so you get frustrated but if you had somewhere, where you could do that we pay for them don't we, yeah, some of us can afford to pay for them even back home any way but, there is no chance for you. At the end of the day there is no chance. So it's congested and only the very few can afford to do that. Only the big names can afford to do (study for degree programs) that but here it's different because I can afford to do that community or whatever and somebody else can afford to do that. Politically you also have to look at different areas and different aspects where you feel this is what you support, the ideal standard as far as practice is concerned but you feel like politicians are trying to jeopardise the whole system so it's quite frustrating like that, when you go there are so many factors like these. (F Kenyan 48)

The above statement illustrates how even nurses who can afford to pay for their own

development are unable to do courses because of limited places. Presumably there are not

enough lecturers to run courses or other resources may not be available. Nurses said that the

problem was exacerbated by big differences between the rich and the poor and also by

politics and by the fact that there are very few places for the number of people wanting

education. Politicians may have politically motivated agendas when choosing areas for development which may be different to needs perceived by nurses. These factors may be responsible for discrimination in the allocation of scholarships for university places. The situation is made complex by political considerations which means nurses have few choices. However governments are sometimes constrained by limited finance which needs to be balanced against the needs of the larger population. Nurses recognised that migration was not a good thing for their countries but they were caught between developing themselves and staying at home without developing:

> I know it's hard on our country because we have got a brain drain, but at the end of the day it's me and my family , you don't remain as a just nurse there going to work , work and go home , we would like to stay and help our people but it's about moving on. (F Zambian 34)

Another participant agreed and added:

> Somebody else will look at you and say okay, back home you have to look at your pocket you probably have some children going to university, you would like to go to University but you can't, why? Because you need to identify among the five of you who needs to go? You see because you need to support them as well. You know it's a whole lot of issues. And if you have to grow because knowledge is strength any way, yeah your family then is comfortable. (F Kenyan 48)

These nurses had a real dilemma when it came to their own development or the education of their children. However it was not a matter of choosing one over the other. It was the fact that one choice influenced the other. Nurses were aware that their own education and development was necessary if they were to develop their careers and provide for their families. Nurses described their desire to stay home and change the practice of nursing there, if they had the necessary experience and knowledge:

> Personally I would like to stay at home and change my country but for that I need to have good practice in nursing, good experience and great knowledge. (F 27 Cameroon)

In many sub-Saharan countries education is expensive and many people have to make do with only the very basic education they can get. Tertiary education is especially expensive as many universities rely on overseas universities to provide this and students have to be funded by way of scholarships which are competitive. In addition, most countries in sub-Saharan Africa have few training institutions which may lack the required number of trainers and training resources and have limited student facilities. This negatively influences institutions' ability to increase supply of newly trained nurses or provide development opportunities for existing staff. As a result nurses find that they are unable to achieve their ambitions. Careers stagnate for many nurses and eventually nurses may be demoralised. Nurses had plans of studying for degrees and masters degrees before they went back to their own countries as they found courses more readily available in the UK than in their own countries:

> At the moment I am aspiring to go back to university, because what we did was a higher diploma, so I would like to go and do a top up degree. This course is starting in January, and you study part time and work full time so that will be a challenge because knowing school it doesn't matter that you are only going once a week and then having to work as well you find yourself very tired and its going to be a challenge as well because I have to balance school and work because I don't think they would let me go on the course full time because that would mean that they would be short staffed. That's why they offer us this course so that you do your hours of work and then you do some study as well. In the end it's worth it. Because I am thinking here they have got all the facilities they have got everything. At home we don't have this. I might as well take advantage now in the position where I have all this I am not paying. Take advantage learn as much as I can. Whatever degrees I can take whatever education I can reach to. (F Zambian 30)

This nurse was willing to do anything to get a degree qualification. The difficulties of balancing work and family were overlooked because her motivation to develop herself was so great. Other nurses said that education and self development was very much valued in their countries and that this would help them gain promotion of progress in different areas of nursing when they returned. Most nurses hoped to go into education, management or become independent practitioners:

It's just up to your mind and what you want to be. If you have a focus that you want to move up, you learn about these opportunities by asking your colleagues, phoning around, asking questions and more so I am in a teaching hospital, (name of hospital) , I am at the tip of the University there, like I am starting my Masters in September, MSc in Advanced Nursing. So it's a matter of asking questions, researching, you have to research. First of all have a focus. Are you here to remain as a stagnant nurse? Are you here to develop yourself increasing your knowledge, skills and attitude towards your practice, and then you ask yourself how do I want to develop myself, which way can I go through to develop myself. (F Nigerian 42)

The desire for self development was so strong that nurses were constantly searching for opportunities. When these were found nurses made sacrifices to ensure they achieved their goals of furthering their education. Nurses said that children's education was particularly important as the children could not get a good education in their own countries:

And this is for my children; I want better education for them. That is why I came here. I thank God because back home if I have to send my children to university I would have to pay through my nose. These children who come from Africa or other countries they pay a lot of money to go to University and that is one thing that I thought I would cut out on university expenses. I will have to pay something but it will not be as expensive as it is back home. So I got here, got the children into schools. It wasn't difficult to get them into school at all. (F Zambia 40)

The benefits are just as (name of nurse) has said. The children are happy for the kind of education they have here. They are able to express themselves better and communicate better and I think if they get to university they will be better depending on how they pass their GCSE. (F Kenya 31)

For some nurses it was more than just academic education for their children:

What is happening is that we have a little daughter who we would like to educate the British way of life. (M Ghanaian 25)

I wanted to bring up my children, bring them up over here. Because my father brought up two people out of saving here and they are doing very well. I have two sisters in America and I've seen what their children are like. I said what I experienced in Nigeria I'm not going to let my children experience. So that's basically why I've come. (F Nigerian 38)

It is evident from the nurses' statements that pull factors such as education and push factors such as limited resources are responsible for their motivation to migrate as explained by Dual

Labour Market Theory. However other factors such as family decisions, and wage differentials are also evident supporting New Economics of Labour Migration Theory and Neo-classical Theory. It will be seen later that expectations of nurses are frustrated because immigrants are treated as cheap labour which often result in inequality of opportunities when compared to the local population (Stark, 1991). The perception that British culture is better than African culture was not a shared one. However, it illustrates the influence of colonialism on many sub-Saharan countries. The West according to Pilkington (2003) separated itself from the rest of the world in terms of culture and development and has managed to convince the world that western culture is better than the rest.

6.2 .6 Adventure

Nurses expressed a desire to discover what other parts of the world were like before they got too old. Some related to stories told by previous migrants, which created excitement and a desire to experience life in the developed world:

> Basically I just wanted to explore what is on the side of the world (F Zambian 40)
> Also to experience   adventure see how other people work also for a bit of life in that line, other than the professional side. (F Kenya 48)

Nurses felt that travelling was good for them as they could learn about different cultures. They compared themselves to their British colleagues who had not travelled and had very little or no knowledge of other cultures and other ways of life. A Zambian nurse put it like this:

> I have leant much as well because a lot of them (the white nurses) are very friendly, they want to know what you are interested in, you are talking about life style, and they are also interested in life style. Some people have never even heard of Zambia, they don't know where it is, they would say, is it in the Middle East? So you tell them and they are enlightened. You learn about them and they learn about you. (F Zambian 30)

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From my field notes I noted that another participant concurred with this nurse by describing an experience she had with a white British nurse. She said she had mentioned to this nurse that she was sending a car to Malawi and the nurse had responded by asking if there were any roads in Malawi. The Malawian nurse could not believe that people were really that ignorant about other countries.

Nurses said that if they earned enough money to be able to afford holidays abroad then they would probably not need to migrate. The desire of adventure was so strong for some that they were planning to look for job in places like Australia, New Zealand, Canada and the United States. Some Nurses said that friends had already left and they planned to follow. It is evident that motivation to migrate also came as a result of hearing from friends and family that working conditions were better in these countries than in the UK. This move is consistent with Network Migration Theory (Massey et al, 1993). These nurses were influencing and helping each other.

6.2 .7 Limited Health Care and Resources

Some nurses described lack of basic health care as one of the reasons they left their countries to move to the UK. In some cases there was no medication even for people that could afford to buy:

> Because back home if you become ill you have to pay for treatment. Even if you have the money the medicines that you want if you go the pharmacy, it's not there. So those are some of the things that make people say, what is the point of me being there? But here you know that when you become ill and you go to hospital you will be well looked after as well. And you have other things like social services in place. Back home you don't get that. (F Zimbabwean 25)

Some nurses said that the standard of care in their countries was so bad that this was a motivation to migrate. They cited lack of medication and people dying needlessly as some of

the reasons that motivated them to seek employment in the UK. Those that had managed to

migrate felt sorry for their colleagues who were not so lucky. The majority of nurses said that

most African hospitals lacked basic equipment to enable them to care for patients. They

expressed frustration that they knew what they should be doing to provide quality care for

their patients but they did not have the necessary equipment to do this. Some nurses had

experienced poor nursing standards themselves as a result of lack of equipment and this had

strengthened their resolve to leave:

> I had an asthma attack at home and they took me to one of the hospitals. It's classed as
> an average class hospital. They took me there and there was oxygen there and they
> wanted to give me an oxygen mask which was there and I totally refused and I said I
> need you to change that oxygen mask because I don't know how many people have
> been using it. And one of the doctors there was not happy because they said oh, who is
> she, who does she think she is and I was like I'm not having it. But they didn't like it
> because I think they thought maybe she thinks she knows it all, but it was for my health
> as well, hygiene wise I wouldn't like an oxygen mask that has been left there you know
> and everyone using the same mask. (F Zimbabwean 25)

These statements demonstrate the difference in financial might between core countries and

peripheral countries as explained by Wallerstein (1974) in the World Systems Theory. In this

post-colonial era , the hegemony of core countries is also exercised by global corporations

which, according to Hahnel (1999 p ix) are 'gobbling up the economic resources of countries

that have spent the past century struggling to escape from colonialism', leaving them

incapable of developing their health systems. But as explained before, some of these

problems are also caused by failure in structures of governments.

Ironically nurses in sub-Saharan Africa are often educated to high academic standards.

Naturally they would like to put this knowledge into practice. When hospitals lack equipment

and resources, it puts nurses in direct conflict with what they know to be the best care

standards for patients. This creates a feeling of powerlessness as nurses perceive that having

academic qualifications is not necessarily sufficient to provide adequate care for patients. The desire to put academic knowledge into practice motivates nurses to emigrate. When nurses experience poor care, they appreciate the risk to patients even more and it strengthens their resolve to emigrate.

6.2 .8 Excessive Workloads

Some nurses cited shortage of staff which left them exhausted as one of the reasons why they were motivated to move to the UK:

> Staffing was also difficult, most of the time we would be very short staffed, and it was a teaching hospital as well. (F Malawian 28)

Another nurse agreed giving an example of the labour ward where she had been a midwife:

> The situation on the TB ward was even worse. In the labour ward two of us would deliver more than 30 babies in one night. (F Malawian 31)
>
> I worked on the TB ward at … hospital. In terms of staffing, I think it was not bad because on a normal day shift, we were at least 4 staff nurses and at least 2 auxiliary nurses, I was the only registered nurse in that ward , the rest were enrolled nurses, so it was me and three enrolled nurses and two auxiliary nurses. On a night shift there would be an enrolled nurse as well. Because most of the nurses have left, most of the nurses that are there are enrolled nurses which is very difficult for the hospitals because most of the things that are supposed to be done by registered nurses are now done by enrolled nurses which is not good. We have depleted our hospitals. They are short staffed, there is a lot of work load for the nurses there, and enrolled nurses are in charge. (F Malawian 28)

According to the Malawian nurse this ward had 200 patients making the ratio one nurse to fifty patients but, the nurse was used to this situation so she thought it was not too bad. This situation is made worse by migration of nurses. When a lot nurses migrate, those who are left behind have to cope with heavy workloads. In addition many sub-Saharan countries have lost staff to AIDS making the situation unbearable to staff who are left (Tawfik and Kanoti 2003). Migration may present an attractive alternative for them. The situation is not all bleak

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however. A nurse who had worked in the private sector stated that the situation was different

there as wards were well staffed:

> My situation is different from (name of nurse) because it was a private hospital, and it
> was just opening so it was attracting many nurses because the salaries were slightly
> higher. So we were well staffed and the equipment was there. (F Malawian 35)

This situation illustrates migration at a local level, where nurses move from poorly staffed

government hospitals to private hospitals and from rural to urban areas (where private

hospitals are located) leaving large populations without adequate care. In many countries

there is underdevelopment of rural areas which are mostly served by government hospitals.

The underdevelopment is not only in health care, but also education and housing. Nurses who

aspire for better education, housing and health for their families are deterred from working

and living in the rural areas. Underdevelopment of rural areas in sub-Saharan countries is a

colonial legacy which has continued after independence (Adepoju, 1977).

6.2 .9 Investing Back Home

Some nurses saw working in the UK as a temporary measure that would allow them to get

capital to invest in their own countries. Some talked of friends who had already opened

surgeries and other businesses. For those who planned to stay in the UK for some time,

investing back home involved continued financial support for their families and relatives.

They spoke of returning home eventually and they wanted to make sure they had established

themselves when they returned. Again this involved building houses and business:

> She invested at home. If you go back in hospitals they don't have equipment
> things like that drugs. But the thing that I know is that some of her friends
> have opened surgeries. So I might end up opening a clinic. (F Zimbabwean

A Zambian nurse from another hospital also said that she did not intend staying long in the UK as she had projects to do back home:

> When I went into the nursing home I gave myself a period of four years. I said after four years I must leave, because I have projects to meet in those four years.
> (F Zambian 40)

A Zimbabwean nurse in a different trust echoed a similar sentiment. Nurses saw working in the UK as a way of getting money to invest at home not just for them but also to improve the quality of life for their relatives:

> We are investing back home and helping other families. I think it's good in a way because some of the people will go home with the education that they gain from here with probably material that they gain from here it will still enrich our countries and it might open some economic for foreign currencies somehow cause you have been to the UK and you have a house. I have just bought two houses I have got one in the low density and one in the high density I let one out but the other one my relative is occupying it, am planning to help out to buy more for my family, because I am not the type of person who wants to be rich or to develop while the rest of my family are suffering. You invest back home where your family is suffering I think even coming here you are also developing the country because you are supporting your family back home. We are investing back home and helping other families. (F Zimbabwean 42)

The investing was not just limited to working and sending money home to buy houses and establish businesses, nurses said that educating themselves and their children was a kind of investment that they could always fall back on in case businesses failed. Migration is viewed as a kind of investment both in the short term in terms of money and in the long term in terms of education. Nurses act to strengthen their own economic standing as well as that of their families. Families become dependent on remittances and have improved living standards. However remittances can also exacerbate social inequality where families with no migrant members are disadvantaged (Castles and Miller, 1998). Although most nurses spoke of going back home, none of them had actually made any plans to return, suggesting that they planned to stay in the UK for a long time.

6.2 .10 Easy Availability of Jobs and Visas

With the advent of information technology nurses were able to apply for jobs on line as

advertised by recruitment agencies. Some nurses cited the ease with which they were able to

get jobs and visas as a motivation to come the UK:

> Then this agent came, then there was a kind of policy that said they are short of nurses,
> they need to recruit nurses into the country. And the agent wanted people who were
> highly experienced, who had worked at the University College. So I went there and
> paid some agent fee. And the man said to me you have to go again because I have
> submitted your name along with the list that I have submitted. When I got to the
> embassy the man at the cashier's desk just said come for your visa tomorrow.
> (F Nigerian 44)

A Malawian nurse concurred:

> I actually had to apply for this job that was advertised on the internet by this agency
> (name of agency). They were looking for a staff nurse to work in a nursing home in
> (name of city), so I applied for it. They never interviewed me or anything and I had to
> be interviewed when I got here, so my first day of work that's when I had my interview.
> The nursing agency, what they did was they got in touch with this nursing home and
> told them that there is someone who is willing to take up this position. So they just sent
> me a work permit and my visa was because of that work permit. So I came straight into
> that job. (F Malawian 28)

Another nurse explained:

> This company (name of agency) they have offices in London and all over, they have
> got homes what they do is they say you pay us half of that money and when you have
> paid they get a work permit for you send the papers so that you can come over here
> because you have to have all the papers to apply for a visa at the embassy and you use
> the work permit and their letter of invitation so you can come and do adaptation.
> (M Zambian 35)

A Kenyan nurse in a different hospital also cited the ease of getting jobs as an incentive to

come to the UK:

> I think when I started looking for a job, the hospitals themselves were looking for
> people to work because I got 4 jobs at a go. Yeah and I had to choose which one I
> wanted. (F Kenyan 47)

In some cases the availability of jobs was also linked to a fast registration by the NMC.

And the process just went smoothly for me to be honest. NMC responded in a very short time, I got a supervised program. (F Zambian 29)

These statements illustrate the role of the UK Government in facilitating immigration. Immigration policies and practices of the UK government appear to change depending on labour demands in the country. In the case of nurses the UK government made it easier for nurses to get work permits so they could help relieve nurse shortage in the NHS to reflect the policy of the then labour government soon after it came into power in 1997. Although sub-Saharan countries were on the list of countries where there were nurse shortages, the Code of recruitment practice formulated by the UK government in 2001 and revised in 2004 (DoH, 2001 and 2004) excluded recruitment agencies and individual application. The NHS was therefore still able to employ nurses from sub-Saharan Africa once they had fulfilled their contracts with recruitment agencies. Nurses attributed the ease with which they were registered by the NMC and with which they got jobs to staff shortages in UK hospitals:

> The hospitals were short staffed and even before my PIN (Personal Identification number) came they wanted me to come and work but I refused. I told them no I wanted to have a pin number. It's always nice to go somewhere and work as who you are. Because what was happening was that they employed you as health care until you get your number, and until your Pin number came through, they paid you less and I didn't want that, so when I came I left that job and came directly to this job so the transition was alright then yeah. (F Kenyan 47)

However some nurses found registration with the NMC and finding jobs difficult, but their determination to come to the UK was still strong:

> I was sent a form by the UKCC which had areas of nursing homes that offered placements for adaptation. So I went through that blindly and applied to so many places and one lady responded to me and said that she was going to Zimbabwe to do an interview Zimbabwean nurses and she asked me if I could go to Zimbabwe for an interview. I paid the fare and everything but she never communicated. I wrote to her but she never responded so I just took it that I was not successful. So I pursued different ways and I went through somebody who knew the nursing director of the hospital

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where I did my adaptation and she spoke and she agreed that I could be offered an adaptation place I the hospital so I came over. And by the time I came over I had spent almost everything I had with me and on reaching here I was supposed to do the adaptation. (F Kenyan 48)

Another nurse from a different hospital had a similar experience:

For me it was different from other people because I did not come through the agency. I applied directly to the hospital. I had applied to the agency but I opted to come into a hospital directly. It was a long process because when I applied it was UKCC. You get all your transcripts in, and they send you more paperwork and then all the payments. It would be starting over one year of communicating with UKCC and then they approve and start looking for a hospital that will take you. So (name of hospital) told me to come and I came. (F Kenyan 31)

According to Dual Market Theory, advanced economies can fix their capital as a factor of production that can be laid off when demand for labour is low, but can be released when demand for labour is high. Foreign workers are hired in times of higher labour demand to take up jobs which are shunned by locals. Governments flex their immigration policies in times of high labour demand to hire cheap foreign labour. Globalisation factors are influential in these decisions to migrate as information is easily available. According to Wallerstein (1974) this demonstrates the spread of the new world system to the rest of the world with an increase in exploitations of foreign workers.

Statements made by nurses above regarding easy availability of jobs and visas reflect this flexibility in immigration policies by the British government. However some nurses experienced a tortuous process which reflects problems that immigrants will encounter when not using designated agents and channels. It also illustrates the situation in sub-Saharan Africa which drives nurses to migrate in the face of so many obstacles.

6.2.11 Following Colleagues and Friends or Partner

Some nurses said that they were encouraged to move to the UK by their colleagues and their friends. A Malawian nurse boasted that an entire class of 45 nurses had managed to move to the UK by helping one another. This indicates a form of peer pressure as it seems that once colleagues had emigrated others did not want to be left behind. It also illustrates the importance of networks which make it easier for nurses to migrate by reducing the cost economically, socially and psychologically. The cost of migration is reduced economically as nurses help each other to find jobs and accommodation. Socially there is already an existing circle of friends where nurses can draw on to learn the culture of the country, to find shopping areas and schools for their children. Psychologically networks help to maintain a feeling of solidarity among nurses when they are abused or exploited:

> I think once one nurse starts, then, you follow like a chain. Like me I followed my sister. (F Malawian 35)

> While I was in Malawi I got a phone call from my friend who was working here in a nursing home saying, where I am now they are looking for someone who can come so if you are ready can you come, so I came and all the visas and work permit were processed by the nursing home I just came as a visitor. For our group we have managed to get all of us here and there were 45 of us in our class. (F Malawian 31)

A nurse from a different hospital said:

> We had colleagues over here that were very encouraging as well. I did and I got my information through colleagues. (F Kenya 47).

These nurses confirmed in their own words that networks are important in maintaining migration Massey et al (1993). Some nurses may not have wanted to migrate but the influence of friends and relatives acted as a pull factor. Some nurses said that they had moved to the UK because of their partner's education or career:

> For me it was my husband, he came here to study then he asked for me to come. (F Malawian 42)

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However, some nurses who had migrated because of their husbands, had similar reasons as the nurses who were the initiators of migration which included education and self development:

> It was because of my husband that we are here. He wanted to do part 2 of his medical training and, you need to do some two years in an NHS hospital. He came in 1999 cos that's when he could afford to come. When he came initially, because he was just going to come and do his studies, write his exams and come back home because I did not want to come and be far away from home. So anyway, four to six months down the line it was too much for him, he could not do a thing, and we had to come and live here. (F Zimbabwean 35)

This type of migration is consistent with family migration where the husband is the primary immigrant and the wife and children follow. Although nurses who followed partners expressed initial reluctance to come to the UK, they cited similar reasons as their colleagues such as better development opportunities and education for themselves and their children for preferring to work in the UK. Some of these nurses were actively pursuing education in the Form of first degree or masters' degree to develop their careers.

Nurses who had migrated because of peer pressure tended to stay in the same city, for example nurses said there were more than 40 nurses from Malawi in one NHS Trust. This helped them to continue their social circles from their countries. These nurses also tended to have similar aspirations on what they wanted to achieve in the UK. This finding is consistent with those of Archives and Heritage Service (no date) in their study of Birmingham's Post war immigrants. The findings also support the Network Migration Theory which posits that networks facilitate migration by providing accommodation and information about jobs to potential immigrants among other things. Social Exchange Theory is evident as some nurses spoke about following their husbands in order to advance their husbands' careers. However some nurses took advantage of this to advance their own careers.

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6.2.12 Change of Environment

Nurse who had family problems said that migration helped them to get away from the

situation they were in and that migration acted as a form of divorce:

> It's just change. The change of environment, because for you to leave your country it's
> just because you want the change. I have an Aunt who is leaving for the United States.
> She used to work at (name of institution), she left for Dublin, she left Dublin and
> crossed into UK, she works at (name of hospital), now, she is going to an Oncology
> ward in US, and it's just change. She has marital problems that's why she decided to
> migrate. She said she migrated as a form of divorce. (F Nigerian 42)

Nurses in this situation discussed how immigrating to the UK had given them independence

and freedom from their husbands and given them a chance to start afresh. This type of

migration does not seem to fit neatly into the migration framework at first. A closer

examination suggests it is a form of economic migration since jobs obtained in the UK would

provide the independence that the divorcees needed. On the other hand, moving to the UK

could provide separation by creating a physical distance which provides safety from an

abusive spouse. Hence this is a deviation from the economic framework used here.

6.2.13 Nursing as a Route to Preferred Careers

Some nurses used nursing as a stepping stone to other careers. Nurses said that it was easier

to move to the UK as a nurse, but that they would use this opportunity to pursue their dreams

in other careers. These nurses had found it difficult to pursue their careers of choice in Africa

where opportunities are limited:

> Originally I wanted to do Pharmacy and then she told me about the nursing course. I
> researched into it and I knew if you do the nursing course, you could then go further
> and do the pharmacy course. It would take you one and a half years because you do
> your nursing first and then do your pharmacy that way. (M Ghanaian 25)

One nurse spoke of a colleague who had just completed accounting and got a job in the city.

Other nurses were also contemplating of changing their careers as they weighed opportunities

found in the UK. Nurses stressed that the money earned from their nursing jobs enabled them to pay for the education they needed to pursue other professions.

Although this type of migration seems to be outside the framework, it can be argued that it is a form of economic migration since preferred careers once attained would give nurses the freedom to pursue their goals. In addition it can be argued that limited resources in countries of origin led to limited choices of careers for the nurses. Moving to the UK gave these nurses an opportunity to pursue their original career choices. This finding is unique to this study and it presents black African nurses as resourceful and forward planning immigrants capable of exploiting opportunities to change their careers by using their nurse qualification.

6.2.14 Language:

Nurses said it was easier to move to the UK because their countries were former British colonies and as such they had been taught in English. Some even said that they followed the British curriculum:

> We went to Germany initially but you know the language is difficult, I mean English because I am originally from Ghana and the language is English not German.
> (M Ghanaian 25)

Another nurse agreed:

> Yeah, and even the curriculum that we follow back home is British because they (the British) left all these things and you learn English from primary school it is almost your first language . (F Nigeria 38)

Nurses explained that it was easier to move to a country where they understood the language than going to a country where the language was different. They did not want the problem of having to get used to a different way of working as well as learning a new language. Nurses were able to communicate in English because of colonial ties between their countries and the

UK, and also the educational system which closely follows that in the UK, again because of

colonial ties. However, as will be explained in the next chapter black African nurses found

that the fact they could speak and understand English in their countries did not mean that they

could be easily understood in the UK and vice versa.

6.2.15 Distance

For some nurses it was easier to move to the UK because it was nearer to their countries than

either the United States (US) or Canada for example:

> I initially wanted to go to the US but then, the US is miles and miles away from home, So I decided to come to the UK as it is only 8 hours away if you are needed you will be able to go home. (F Kenya 47)

> You look at you situation and think well at least here if I am needed back home I can go quickly and the air fare is cheaper than if I were in Australia or Canada. (F Malawian 28).

However, once in the UK some nurses decided that they would immigrate to the same

countries, which were once considered further away from their home countries i.e., the USA,

Canada and Australia. They explained that they were not able to get opportunities they had

hoped for in the UK. This factor will be explained in the next chapter. This finding is

Consistent with Ravenstein's Laws of Migration (1885) where he noted that migrants proceed

for a short distance. By today's standard the journey from Africa to the UK is indeed short

since it can be done in 6 to 8 hours which is comparable to some bus and train journeys

within the UK. However, for some nurses the perception of distance as a barrier to other

countries seems to have faded once they were in the UK, probably having raised money,

travelled and experienced living in a foreign country, distance was no longer a barrier.

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6.3 Expectations

All migrants expect certain things from their country of immigration to make migration worthwhile. Black African nurses were asked what they expected to find in the UK and in particular UK hospitals. In general nurses expected to find better hospitals with modern state of the art equipment which would result in better nursing care than they had experienced in African countries. They expected to develop professionally, and study for higher qualifications. They also expected higher salaries. For the greater part these expectations mirror the reasons why black African nurses chose to move to the UK. These are explained further below.

6.3 .1 Better Resources

Nurses expected UK hospitals to be better resourced than those in their own countries:

> In terms of resources, I expected that they would have everything because you are coming to a developed country and at home, there is no paper to write patients notes, treatment charts they didn't even have that when I was in the wards. (F Malawian 28)

Another nurse concurred:

> It is very difficult to do dressings even to administer the basic care, you know what should be done but you simply don't have the resources or the equipment to carry it out. (F Malawian 42)

6.3.2 Better Salaries

Nurses expected better salaries for their jobs and this was encouraged by employment agencies that lured them with big salaries in the UK. They also expected to lead a better quality of life:

> The other thing is salary, I expected a big salary, even the agencies they like tell you how much you are going to be getting I thought this is more than what we are used to back home.(F Malawian 28)

6.3.3 Professional Development

Nurses expected to be supported in their professional development. This included initial

support as they started their work in the UK. There was a general agreement that they

expected to be orientated to their work environment and have somebody to support them

before they assumed independence. Nurses said that they also expected development

opportunities in terms of education and continuing professional development:

> I expected to be more supported here, because I can't remember one single time when
> my career was followed by a practice development or anybody in that area. (F Malawian
> 28)

Others wanted to study at degree or higher degree level while others just wanted short

courses:

> I have been a nurse for ten years and the reason why I came here is to for progression in
> my career, to get a bit more than I would have back home. (F Kenyan 42)

A colleague agreed:

> For me I want to be self sufficient, I want to gain knowledge or rather skills, in as much
> as I want to be here I just think I need , in a few years time I want to see myself in
> another speciality. Something a bit more dynamic. (F Kenyan 31)

6.3.4 Better Nursing Standards

Nurses said that they expected nursing standards in the UK to be better than those in African

countries. They also expected working conditions to be better and expected to be treated well:

> I must say professionally I was expecting when I came here to find better nursing
> standards, something better than what we have back home. (F Kenyan 31)

Another added:

> I also expected there would be better conditions like the way you are treated, the way
> you get to work, I thought it would be different from what I had back home.
> (F Kenyan 47)

Black African nurses in this study came from former British colonies in sub-Saharan Africa which have a great British influence ranging from curriculum in schools and universities to working practices. A few countries still employ expatriates from the UK in their health services. Naturally the UK is held in high esteem by many black African nurses:

> I think for many of us we have, you know before you held these people at a very high pedestal, they are so skilful, they know so much, but then you realise that's not the truth. Your training is basically the same. I think we are all the same so I think if I worked with especially people from the first world. I don't know whether it comes out right but what we say is I think even at home we have hospitals and they all tend to treat you all the same, and you didn't know and they didn't know that you don't know. Basically what we've learned is that we are well trained and we need to be proud of what we have learned and how we were trained. So if you work with other doctors it's not that they are well trained than our doctors it's just that their exposures are different.
> (F Kenyan 35)

However, once in the UK nurses realised that such expectations were too high as explained by the Kenyan nurse above. This nurse recognised that British nursing is not all that African nurses esteem it to be. There are some gaps in knowledge in British nursing just as there are in African nursing. The difference is resources and the environment in which nursing is practiced.

6.4 Summary

Data from individual interviews and focus group discussions provided a good understanding of black nurses' motives from sub-Saharan Africa for moving to the UK. The interviews and discussions confirm that migration motives for nurses are complex and inherent in historical links and in global values. This is consistent with most migration theories such as Neo-Classical Theory, Dual Labour Market Theory, New Economics of Labour, Migration Network Theory and World Systems Theories. These theories (see chapter 4) explain migration in terms of inequalities in world economics which result in differences in labour availability and differences in salaries. However the integration of macro and micro-

processes is essential in seeking to understand the complexities involved in international migration of nurses from sub-Saharan countries.

The root cause of nurse migration from sub-Saharan Africa is embedded in history between sub-Saharan countries and Britain and has colonialism as a major factor. The World Systems Theory (Wallerstein, 1974) explains that the hegemony of European countries has been maintained after decolonisation by multinational institutions such as the World Bank and the IMF and trade agreements which favour developed nations. Economic instability in sub-Saharan Africa has been maintained mainly by these institutions. However, natural disasters such as famine and manmade conflicts have exacerbated the situation as has the effect of HIV/AIDS. Economic conditions created by these factors have resulted in poor infrastructure, difficult working conditions and low salaries for the workforce.

To improve their lives and those of their families, nurses have migrated to the UK in search of better salaries and better working conditions. Related to these reasons are the need for Professional development and education for nurses' own children. During the individual interviews and focus group discussions, nurses spoke of the huge difference in salaries between the UK and their own countries and how money earned from the UK enabled them to help parents and relatives back home. It is important to note that the difference in salaries is magnified by the strength of the British pound to African currencies. As a result of IMF and World Bank policies, and structural adjustment programs, most Sub-Saharan countries were forced to devalue their currencies. In some cases this resulted in 70% salary reduction (Liese and Dussault, 2004). In addition, countries were forced to put up taxes in order to cut deficits. At the same time governments cut training places for nurses and other professionals

which resulted in shortages in health care workers. Countries such as Cameroon set retirement age at 50 to 55 years and limited service to 30 years which created unemployment. Nurses mentioned and discussed various factors which led them to move to the UK to seek employment. When examined, these factors are embroiled in the so-called New World Order, the shifts in production patterns due to globalisation and the restructuring of gender in global development project which have stimulated international migration for professionals such as nurses but have created obstacles for others. This is not to say that individuals have no choice but that choices are limited.

This was well articulated by the Zambian nurse (section 6.2.1) who described being forced to move because she could not provide food for herself and her family. The Kenyan nurse (section 6.2.1) illustrates the constraints faced by sub-Saharan countries because of imbalances in the world economy. Nurses recognise that poor infrastructures are not only due to economic mismanagement by their countries but that it is a complex problem involving relations with other countries and institutions. As such, it is difficult to find a solution to benefit nurses which would encourage them to go back to their countries or better still stop them migrating. There is an implicit recognition that a solution to these problems will not be found in the short term, implying that nurse migration could continue depending on the UK government's immigration policies and practices.

Nurses in this study consistently expressed the wish to return to their countries if only conditions in their countries would allow. Factors such as poor salaries, poor working conditions, poorly staffed hospitals and limited resources as well as poor career prospects, compel them to emigrate. Other factors such as altruism need for adventure and change of environment are related to economic factors to a greater or lesser extent.

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Although migration trajectories of nurses from sub-Saharan Africa seem to conform to some theories discussed in the chapter 3 which have economics as their lynch pin, the data demonstrate that economic factors in themselves are not strong enough to cause nurses to migrate to the UK in numbers observed without other lubricating factors. These factors are globalisation, policies of the World Bank and the IMF which, favour developed nations and impose ruinous conditions on developing countries leading to breakdown of infrastructures in those countries.

Immigration policies of the UK are usually changed by the UK government depending on the nursing labour situation in the UK. The NMC also relax its registration criteria for overseas nurses, to allow more nurses to register. Alongside all other factors, these are major causes of sub-Saharan nurse migration to the UK.

Recruitment agencies make the migration process easier by handling all the paper work and sometimes finding initial accommodation for nurses. However some recruitment agencies are unscrupulous and exploit nurses. Some nurses who do not follow established recruitment routes experience great difficulties but these difficulties are not strong enough to stop them from emigrating.

This chapter has discussed factors which encourage black African nurses to relocate to the UK. Social and professional experiences of these nurses once they arrive and start working in the UK are discussed in the next chapter.

CHAPTER 7

NURSES ACCOUNTS OF EXPERIENCES OF THE RECRUITMENT PROCESS, WORKING AND LIVING IN THE UNITED KINGDOM

7.1 Introduction

In the previous chapter I presented motivations and expectations for black African nurses choosing to migrate and work in the UK. In this chapter I present nurses' accounts of their experiences of recruitment, working in the UK and living in the UK. The lived experiences of black African nurses in the UK are shaped by their motives, expectations and migration trajectories. It is acknowledged that professional experiences are influenced by personal and Social experiences and vice versa, therefore this study's focus is broad encompassing all these factors.

The main findings relate to perceptions of exploitation and poor treatment by nursing agencies; discrimination and racism from managers; colleagues and patients; loss of skills; differences in adaptation programmes; cultural differences and problems balancing work and family. The theoretical framework presented in chapter 4 will be used to analyse various experiences of black African nurses in this chapter. As outlined in chapter 4, migration trajectories which are embedded in historical, political and economic factors have a great influence on how black African nurses are perceived by their colleagues in the UK, other overseas nurses and nurse managers. In addition, theories of racism by Phizacklea and Miles (1980) Miles (1982) Miles (1989), Rex (1999) Pilkington (1984, 2003) and Hall (1980) and ideas by Richmond (1994) will be used to explain nurses' perceptions of racism and discrimination.

Five main themes were extracted from the data using the thematic approach by Van Manen (1990), Spencer et al (2003) and Ritchie et al (2003) as outlined in chapter 5:

1. The Process of recruitment

2. Professional experiences

3. Communication difficulties

4. Racism and discrimination

5. Social experiences

7.2 The Process of Recruitment

During individual interviews and focus groups nurses mentioned various means by which they were recruited which included recruitment agencies, self application and help from friends as outlined in the previous chapter. Nurses who were recruited by agencies reported mostly negative experiences but there were a few exceptions. Nurses reported being charged exorbitant fees by recruitment agencies, inadequate orientation procedures and adaptation processes. Some were provided with inadequate or inaccurate information on where they would be working. Some nurses were told that they would be employed in hospitals but instead they were placed in nursing homes which did not match their training and experience.

7.2.1 Exploitation and Inadequate Information from Recruitment Agencies

There was a strong feeling that recruitment agencies were charging exorbitant amounts of money and there was little or no explanation to nurses as to why nurses were required to pay this amount of money. Agencies were so keen to get nurses to the UK that sometimes they Even offered to pay nurses' air fares which they were later asked to repay. Nurses explained how they were forced to work for long hours in nursing homes to pay agency fees. In some

cases agencies provided expensive accommodation for nurses and recovered rent from

nurses' wages. One nurse explained:

> What happened was the agency was asking for this amount of money as soon as I met them at the airport which they had not told me about. And I never expected that they would be asking for money from me , because before I came they wanted to pay for my ticket, which I said no I will do that myself so they still had to find means of demanding money, I think may be because they processed the work permit. I was told to pay them (the agency) £500 so I told them I was going to pay it in two months, £250 a month.
> (F Malawian 28)

Another nurse was told to work for the agency at a lower pay:

> When I came here they said that I had to work with them for some time before I move but the rate they were offering me was a bit low because they said they offered me the job while I was still in Malawi so I did not know the rates. So after working for two months I said I can't continue. Some nurses were getting £9.50. Some were getting £10.00 but because I didn't know the rate they took advantage of that and they said because we gave you the job whilst you were still in Malawi and we processed your work permit which came quickly we will be giving you £7.00 per hour.
> (F Malawian 31)

A Zambian nurse described how he was required to pay lots of money to the recruitment

agency that recruited him and how he had to work shifts that were not paid and a lot of extra

shifts just to survive:

> And when you do the adaptation course for three months you do like 8 hours in a day. You don't get any allowance. When you work for them (agencies) you don't get paid because when you work for them you are like a student. They say okay you have 5 shifts in a week of about 5 hours; they don't pay you because you are a student. When you finish your 5 hours they will give you like extra hour may be 4, 5 shifts, a week. Those are the paid ones you get paid for that, yeah so it was very hard for us to go through the system you had to work and get the other money for your rent and survive and the find then money and pay the other £500 for three months. (M Zambian 30)

These statements support the perception of black people being perceived through their

colonial roles which, Rex (1992, 1999), Phazicklea and Miles (1980) note that migrants have

been called upon at certain times to the UK, to meet labour needs not met by the indigenous

British population. They continue to say that on their arrival migrants find an ideological

climate still structured by white dominance. Data indicate that dominance is articulated through exploitation of black African nurses. This might be legitimated by recruitment agencies through perception of extreme poverty and the need for nurses to migrate. Agencies therefore charge exorbitant fees knowing that nurses have no choice but to pay. Since this exploitation was practiced during the recruitment process, nurses might not have had membership of a labour union which would fight for their rights.

When the labour government came into office in 1997, it committed itself to reforming public services and the NHS was its priority. Improvement required among other things an increase in the nursing workforce. International recruitment was viewed as a way to bridge the gap until British nurses finished their training. By doing this, the government encouraged the view that overseas nurses were in the UK temporarily, and this shaped their subsequent treatment by agencies, UK nurses and managers.

Agencies sometimes had hidden costs and nurses were told to pay sums of money once they had already arrived in the UK. Some were even told that they would be enrolled in a school. This put some nurses into debt and others were helped by relatives:

> And there was one woman that I went to who does agency, and she said I should bring £2,500. So my brother said don't worry, if I give you £1,000, beg that manager, you can give her £1,000 then you pay her the rest. So I was sitting in that woman's office when the agent told me that I should go to (name of city), that I should go to one agent there and they are starting me in a school. So I went to buy notebooks, pen, and ruler because I thought it was a school. (F Nigerian 42)

Nurses discussed how they managed living in the UK soon after their arrival. Nurses had different visa conditions when they came which, meant that some were paid during adaptation period and others were not as they had student visas. Those who had student visas had to work extra hours to make a living. For some this lengthened their adaptation period as

they were not able to be recommended for registration at the end of the stipulated period.

This practice was divisive and it created confusion among nurses. Some agencies allowed

nurses to be employed as care assistants in nursing homes while they were doing adaptation

courses. However it seems that these nurses were working for free because they had already

been charged illegal fees by agencies as explained by this Zambian nurse:

> The letter they wrote said immediate you finish your class we allocate you and you start
> your practical placement and you will be earning something toward your day to day up
> keep. So that money finished because I was paying to this Nigerian landlord they
> organised for us. So after those three weeks we run out of money and they could not find
> a placement for us and we said now what happens and they said no we haven't got a
> placement for you. So they forced us now to register with an agency and it was really
> hectic. You can just imagine you are just four weeks in a foreign country, in Europe for
> that matter and then you join this agency where they send you to different places where
> you don't even know. It was really hard for me and very stressful for me. (F Zambian
> 34)

Some nurses found it difficult to find placements for adaptation courses and this added to

their financial hardship. Recruitment agencies were over recruiting that they were not able

find placements for nurses to do their adaptation in the specified time. In most cases

recruitment agencies did not provide information on where nurses would work or what their

working conditions would be after arriving in the UK and this added to their sense of being

exploited.

Nurses felt that the information provided by agencies was not adequate and this resulted in

confusion, in some cases nobody was there to welcome nurses at the airport and in extreme

situations nurses were directed to empty offices where they were not expected. Nurses said

the lack of communication contributed to their hardship. Recruitment agencies are of

different types: international, single country focusing on assisting outflow; single country

assisting inflow; and also function differently. In some cases the agency is the instigator of

nurses' movement; in others it fulfils a facilitating and supporting role (Buchan, 2003). The data indicate that agencies were actively recruiting nurses from sub-Saharan countries on their own behalf since sub-Saharan countries had been put on the list of nurse shortage from which the NHS was prevented from recruiting (DoH, 2001 and 2004).

Although the intention of the code of practice was good for developing countries, it violated human rights in terms of freedom of nurses to move and seek employment. Private agencies that did not adhere to the code were still allowed to recruit nurses, mainly to nursing homes, but eventually these nurses were employed by the NHS. This recruitment process exposed black African nurses to exploitation by the agencies. Some nurses were employed as nurses but were paid as care assistants. Some of these nurses were practicing without being registered first by the NMC. In this case nurses were put at risk of losing eventual registration by the NMC.

It is evident that experiences of nurses were like other immigrant workers in that they were recruited to fill jobs which could not be filled by British nurses. Nursing as a profession is not shunned to the same extent as other low status jobs by British workers. As has been discussed before, the international recruitment nurse drive was due to nurses shortages in the UK caused by various factors. Nevertheless black African nurses were often employed in the less prestigious specialities shunned by British nurses:

> You know, so when we come to this country nothing is explained that we are going to work in nursing homes and we need PIN numbers, work as auxiliary nurses, nothing is ever explained. I never thought I would work in a nursing home because we don't have many nursing homes in South Africa any way. I thought that I was going to work in a Hospital. (F South African 30)

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The above statement shows the need for information and how this would have prepared

nurses to cope with the situation they found themselves in. It is not known why recruitment

agencies did not provide adequate information to nurses. One can only speculate that they

probably feared that they would not have been able to recruit nurses if they had given the full

information:

> When I got there I found out that it was not a school but an office. I said I am here to start school from such and such a nursing Agency blah, blah. And the woman said this place is not a school so she said, well we don't have your name. So I had to sit in that place until nine o'clock and he said she is very sorry, they changed the manager of the nursing home and the new manager does not want any adaptation nurses at the minute. So I rang my agency immediately, by then I was boiling, and said you told me I was going to start school here today. (F Nigerian 35)

Some nurses were not told that they were required to register with the NMC before they

could work as registered nurses in the UK. These nurses felt inconvenienced, as they had to

find extra money to pay the NMC and also find their own place to do an adaptation course. It

also appears some nurses were being told that they were registered with the NMC when they

were not and, this lead nurses to believe that they were being conned by the NMC. Some

nurses were given jobs but were not told what kind of jobs they were. In some cases this

caused a lot of problems as nurses were given responsibilities which they later found out they

were not supposed to have, as it put them at risk of litigation. This lack of clarity was viewed

as a form of exploitation by nurses:

> You know they (the agency) will send you papers, all the documentation and then they say can you pay so much. What I didn't know was that I needed to do adaptation before I could register. I told the employers that I am registered and I have got all these papers and everything and they said no you must do adaptation first. So that's how we started again looking for this adaptation college for us to do the adaptation. But we needed to make a payment and make your own travel arrangements and then you had to register with UKCC. I thought I had just registered with UKCC before I went to live in (name of city) to do my adaptation and that money had just gone to waste. But it looks like

they were also just conniving and just getting people's money. So that money just went to waste. (F Zambian 45)

Another nurse added:

> And when I came I didn't have my PIN and I didn't know anything about PIN. I thought because I sent everything from the South African nursing council I am automatically registered here. So I came, I worked as a Nurse without a PIN, I did everything, I was paid a salary as a registered Nurse. At the end of June they had cut my salary , so I phoned them, I said to her what's happening with my money? No you don't have a PIN and because you don't have a pin we can't pay you as a staff nurse, I said you should have told me. She said no we told your agency at the end of May and the end of June we gave you the salary of a staff nurse which means you owe us. I said I don't owe you anything. I said number one my agency never told me that I would be paid this salary. And secondly I am working here as a Staff Nurse and you won't pay me as a staff nurse?   (F South African 30)

This nurse was especially angry because she thought she had been lied to and perceived the agency and the home to be taking advantage of her experience. Nurses explained that they had no choice of going back home as they had spent so much money, but also returning to their countries would cost them dearly psychologically as nurses who had not emigrated and their own families would perceive them as failures.

Phizacklea and Miles (1980) explain that in the UK, migrants' position in the labour market exposes them to exploitation by employers because their status as inferior is legitimated by government policies, which class them as wage labourers. Although black African nurses are professional immigrants, they were recruited to fill the lowest positions in the nursing hierarchy, (all nurses in this study were initially employed at grade D, irrespective of their qualifications of experience) a position which is similar to that described by Phizacklea and Miles (1980) of other migrant workers.

The recruitment agency's conduct could be described as exploitation because they did not seem to have any concern that the nurse could lose the right to register in the UK as this was

illegal. The agency also neglected the rights of the patients who were legally entitled to be

looked after by a nurse registered with the NMC. However in some cases action was taken to

investigate agencies with bad practices and in other instances the police were involved and

nurses reimbursed, these were only isolated cases, but as this Malawian nurse explains one

agency was still recruiting nurses while it was under investigation:

> Unfortunately the agency was under some kind of investigation which we did not
> know. I don't know whether it was demanding money from us nurses was illegal, but
> something was not supposed to be the way they were doing it. The police followed us
> up and they came at the nursing home in (name of city) to tell us not to pay any money
> and the nurses who had already paid, they were given back their money. (F Malawian
> 28)

7.2.2 Different Adaptation Processes

Nurses were concerned that the adaptation process or courses were different throughout the

country. In the case of Malawian and South African nurses they did not have to attend

adaptation courses. Nurses were assessed and registered by the NMC using either experience,

in the case of South African nurses or qualification in the case of Malawian nurses.

Apparently South African nurses did not require adaptation as their practice was deemed to

be similar to that in the UK, while Malawian nurses were exempted on account of holding

degree qualifications. Either way, this practice is unsafe and could have been detrimental to

patients as this Nigerian nurses explained:

> It is better to have an adaptation. Because you can't just come here and find yourself in
> a pool otherwise you will make mistakes. When I am saying mistakes I am not talking
> in terms of drug errors. I am not talking about that, I am just here with nobody to
> orientate me. If you are not orientated, I saw a friend who came from Jamaica and just
> started working here. She had problems on the ward because she was not well
> orientated. No orientation, nothing and she had to ring me to share her problem with
> me and I had to advise her, do this, do that, this is the way you handle it. It's the
> knowledge that I acquired from my own orientation. And I think that's what adaptation
> is. You've not come to be taught as a nurse but to adapt to the society here. So I think
> it's good. It's like when I change from one ward to another and I say oh don't bother

orientating me, I am a nurse. How do I know where they keep their things, where is their clinical room. (F Nigerian 47)

Although the practice of nursing may be similar worldwide, it cannot be denied that the culture in which it is practiced differs from place to place. Even within the UK newly employed nurses have to be orientated to policies and practices of a particular Trust. Some black African nurses recognised that each society has its own set of values and ways of doing things and they needed to know this in order to be effective nurses. This demonstrates the importance of experiential learning in that one has to experience the situation in order to appreciate the difference. Nursing is constantly changing and developing. This development proceeds at different rates in different countries according to the stage of development of each country.

Nurses who went through an adaptation course felt that it could have been better structured to meet their needs. They felt that they had not benefited from these courses as they had been carried out mostly in nursing homes and the content was at the discretion of the provider. The NMC (2005) probably had the same concern when it announced that from 1st September 2005 nurses trained outside the European Economic Area (EEA) who wish to register in the UK would have to successfully complete the Overseas Nurses Programme (ONP). The ONP is a compulsory 20 day period of protected learning and, where appropriate, a period of supervised practice. This will hopefully eliminate discrepancies in adaptation courses throughout the country:

> I went through the different procedures, the different aspects of nursing; it was all in the procedure book. It was different for different people, I did three months, but when I Came my colleagues were doing six. And also it's in their hands. I think again for those who do about six months and they think their English is not good enough. (F Zambian 29)

A nurse from a different hospital said:

It depends on whichever home you are doing it. It could be in an NHS Trust, it could be in a nursing home. But the agency that I worked with, their whole programme is like a study session. You do things like infection control, manual handling, and the policy of each home or hospital. Each home or hospital has their own procedures. (F Nigerian 44)

Most nurses who did their adaptation courses in nursing homes complained of lack of structure. This lack of structure, combined with the fact that nurses paid so much money in some cases for these courses left nurses feeling that they were being exploited. Furthermore, nurses felt that there was little benefit in doing adaptation courses in a nursing home as it did not prepare them for nursing in UK hospitals:

Normally they will send you to the nursing home for your practical, eight weeks placement, paperwork and they tell you whether you have passed that written assessment or not. They are supposed to give you their expectations, you give them your expectations but for them it was just a recruitment exercise. It was just a quick way of making money. Otherwise that adaptation does not prepare you for what is actually on the ground. The nursing home is a wrong place for you to go to, you are wasting your skills there as a nurse. (F Zambian 42)

Nurses felt that hospitals were an ideal environment in which to do adaptation courses as hospitals had various specialties and equipment. Some felt that the involvement of university tutors would have enhanced their experience especially on cultural issues:

It was nothing because I did it (the adaptation) in a nursing home and what we were really doing is the tablet were already in a dosage boxes and to me I really feel that it was not really necessary because after that I went to work in an acute hospital so to me I don't feel it was really relevant. (F Zambian 29)

These statements indicate that adaptation courses were not fit for purpose as nurses wanted to work in hospitals but were instead placed in nursing homes. It is not clear whether nurses were placed in nursing homes to relieve nurse shortages or if there were simply no suitable placements in hospitals. If nurses were deliberately placed in nursing homes, it could be assumed that agencies expected them to work in nursing homes on completion of adaptation

course. Therefore nurses were expected to be employed in a subordinate position in the lowest class of nursing jobs which is consistent with the position of other migrant labour (Phazicklea and Miles, 1980). Phazicklea and Miles (1980) contend that black workers are legally disadvantaged in order to achieve the goals of a capitalist state. In the UK, nursing homes suffer from recruitment problems because this type of work is not attractive to nurses. Nursing homes are usually shunned by British nurses because of their low status, and black African nurses presented a reserve army of labour at a time of shortage.

Nurses were not given a choice on where they could do their adaptation courses and some were threatened that they would not complete their adaptation if they applied to do it in hospital. Some nurses said that they were threatened with deportation if they tried to leave the nursing homes. Others had their passports taken away from them. Some nurses talked about lack of supervision and some nurses were even being supervised by their colleagues who were also on adaptation:

> But when you come here, nobody gives you any information about anything, all they want is ok, adaptation, you just do that theory then you do your practical then you go into the nursing home. There was actually little choice for me to go into a hospital and it was actually they were not even recommending or even talking about hospital. Because I know during our time there was a hospital that was taking nurses but then they were telling you if you go there, you won't get this, you won't get that. So you can imagine you are here, you have your family back home, you have to register, and then they tell you if you go into a hospital this is what will happen and there is no guarantee that you will finish your adaptation within such a time. (F Zambian 42)

However some nurses were satisfied with their orientation programmes. It appears that the quality of orientation programmes was different in different hospitals depending on the availability of staff as explained by this Malawian nurse who had worked in two hospitals:

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I was very satisfied because when I came in they gave me like a booklet with divisions in all areas that I needed to cover and I was supposed to work with somebody which I did and every time I achieved something I had to discuss it with my mentor, but in the second one when I started at the second hospital I was given a booklet and was told that I have mentor but I did not have chance to work with mentors at all. I mentioned that to the ward manager when I was doing my evaluation and he took note of that and said sorry because they were short staffed at that moment but I wasn't satisfied with the excuse at all. (F Malawian 35)

The process of adaptation proved difficult for nurses as there were so many courses and there was lack of coordination between various institutions. Nurses did different things from writing essays, manual handling procedures, infection control to visiting pharmacies. There was a general agreement among nurses that adaptation ought to be done in hospitals as they felt that they had learnt nothing from nursing homes.

7.3 Professional Experiences

Black African nurses described their professional experiences in a mixed fashion. On the one hand there were many similarities between British and African nursing. On the other hand there were a lot of differences which they found difficult to cope with. Differences included infection control practices, discharge planning, nursing documentation, cultural differences and loss of skills due to bureaucratic practices.

7.3.1 Similarities and Differences between British Nursing and African Nursing

When nurses were asked to describe their experiences of nursing in UK hospitals, there was a consensus that British nursing was basically the same as that in Africa with a few differences in technology and culture. Nurses attributed similarities to the fact that countries were former British colonies and tended to follow the same curriculum as the British in most cases. Nurses said there are differences in the way patients and relatives behave in Africa and in the UK. Differences in culture related to etiquette among nursing staff and between doctors and

nurses. There was a general feeling that addressing superiors by their first names undermined respect and authority.

Nurses described differences in the care of the elderly. They felt that UK nurses were not respectful to the elderly. Black African nurses did not like the practice of putting elderly people in homes. However some appreciated the practice as they mentioned that they would like to open nursing homes in Africa for Patients suffering from AIDS who were not looked after properly in their communities:

> We were British colonised, the same teaching as the one in England here. So it's all the same. The only difference is when you read those things back home in a text book like you read about the hoist, in my hospital at home there is a water bed but it's not working, because those things were shipped in. Technology keeps improving every day, development all the time, renovations, and probably they are using something that was invented five years ago when there is another one existing here on trial. So it's all the same. The only thing is you are here to adapt to their culture. That's the only difference that I think have changed. I have to know their culture because I am from a different cultural background. I was able to do that through the adaptation. (F Nigerian 44)

This statement demonstrates the inappropriateness of imported equipment and technology in African hospitals when there is no technical support as explained earlier (Adepoju, 1977).

7.3.2 Staffing of Hospitals

Another similarity between British and African nursing was that hospitals are short staffed. Nurses explained that wards rely on agency nurses who are not familiar with the wards and patients. Since the 1990s, it has been recognised that the nursing shortage is global. Black African nurses however expected to find well staffed hospitals in the UK. They soon found that the UK is suffering from nurses shortages of its own. The WHO (2006) expected this global shortage to continue due to various factors including an ageing population in

developed countries. In the UK this situation will probably get worse because of a declining

economy. The statement from the Zambian nurse below illustrates that a similar situation to

that in sub-Saharan Africa is occurring in the UK where nurses have started leaving their jobs

because of stress caused by nurse shortages:

> There are a lot of vacancies but they are not yet filled in because they are saying that they
> don't have money for all them. And then you hire the agencies they are always
> cancelling in the last minute like what they did this morning and also the agencies they
> book them up to twelve instead of covering a full shift up to three but they book them up
> to two like right now I don't have anyone on my side. And a lot of people are leaving
> like someone left a month ago and two more are leaving and some are looking for jobs.
> (F Zambian 44)

Another difference that was noted was the availability of different equipment and different

specialities in terms of allocation of wards to patients. However, African nurses found that

the division of nursing and staff into different specialities is beneficial.

7.3.3 Poor Infection Control Practices

 Some nurses were of the view that infection control is better in African countries than in UK

hospitals despite the fact that in the UK nurses have the best resources at their disposal to

control infection. Nurses discussed how hand washing was not taken seriously and how some

British nurses displayed bad practices when making beds by sometimes putting linen on the

floor. This was particularly bad in nursing homes:

> Infection control is very good at home honestly; washing hands for us was no problem.
> Cross infection from patient to patient was strict and it was no problem. It was drilled in
> everybody from our nursing days and I think we took more care like cleaning patients.
> Here they use one glove to do everything and yet they have all the gloves here but they
> don't change the gloves as they should. So there are all those things you know with the
> dirty gloves, touching door handles, curtains, equipment and then if the equipment is
> not clean it goes on between patients. So it can take the infection to the next patient. So
> it surprised us when we first came but now we just carry on. (F Kenyan 42).

> And that's one thing I used to tell people at home, if there is one thing I learned about
> infection control I don't drop my standards because I would like to go and work in a

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developed country. And then when I came here I realised that the standard is not even here. And not only me, many of us are shocked. You don't believe what you see. Like the wound infections some of the wound infections are caused by medical staff. Doctors open one wound, they don't wash their hands, then they go and open another wound. It's a bit sad. (F Kenyan 35)

Related to this point was a feeling that there is a lot of wastage of resources in the UK:

And coming from back home we tend to look after things very carefully because we know the meaning of expensive because here you find that there is a lot of wastage, carelessness especially in the NHS. People just use things carelessly and just throw them in the bin. (F Kenyan 30)

These statements may reflect different training for African nurses as mentioned in the previous chapter. It also demonstrates that poverty should not be equated with ignorance as clearly black African nurses observed that some UK nurses who have necessary resources at their disposal fail to practice infection control practice. It also illustrates that theory needs to be translated into practice for it to be beneficial.

On the other hand the training received by UK nurses may not have equipped them with the skills necessary in practice. Whatever the case, the representation of African education as inferior (Hall, 1999) does not hold true in this respect as it appears that some in this group of black African nurses were more perceptive with regard to infection control practices. It appears that black African nurses did not voice their concerns regarding unsafe practice to management because they feared for their jobs.

7.3.4 Discharge Planning

Differences were also found in the areas of discharge planning and different services provided to patients before or after they went home. Nurses explained that in Africa they do not have to deal with physiotherapists or occupational therapist as these services are only available in hospitals and not in the community. Nurses were also surprised with the amount

of drugs that most patients have to take. This can be probably be explained by unequal

distribution of resources between core countries and peripheral areas (Wallenstein, 1974).

Most African countries are not able to provide adequate numbers of nurses and doctors. The

services mentioned above are rare. Most patient care is hospital-based and community care is

patchy as it requires nurses to have suitable transport. The situation is similar with regard to

the availability of drugs, which were described as scarce or not available to patients by nurses

in the previous chapter:

> The main difference here is really like discharge planning. Here it's so complicated
> because back home we do not have social workers and OT (Occupational Therapists)
> and the like. If someone for discharge you just discharge them and relatives will look
> after them but here you have to do the physio, OT, social worker referral then you have
> to inform the relatives while back home most of them do not have phones so the
> discharge part of it is very complex. Then TTOs, (To Take home Orders) I find that
> most patients here are on a lot of tablets so it takes longer to discharge and I think that's
> where the different is. (F Zambian 44)

7.3.5 Different Practices in Nursing Documentation

Some nurses cited the amount of paper work that British nurses are required to do as

detracting from patient care:

> There is more documentation, you know you always have to balance up, so you have to
> divide your time, and there is more documentation than actual laying hands on the
> patient. I think maybe that's why here they have the health carers to assist but then you
> have to interact with the patient, it's not only about the medication but you have to
> interact with the patient, get to know the patient because giving psychological support its
> part of nursing. Some people there is nothing wrong with them but it's because of their
> social life, so interaction also helps because they will see that you've got ample time for
> them, that you care. Some people they just need time like we are sitting here but there is
> never time, you have to document. (F Zambian 35)

There appears to be a difference in values on what is good nursing care, as what black

African nurses described appears to be holistic care which, encompasses the physical,

psychological and social aspects. It seems that documentation was perceived as an

impediment to the provision of effective care to patients. However it must also be noted that

black African nurses mentioned limited resources as one aspect of their dissatisfaction.

Resources included stationery for documentation. This may have contributed to their perception of documentation as unnecessary. On the other hand some managers also complained that patient care is sometimes compromised because of excessive documentation. Writing about the history of nursing in South Africa, Marks (1994) comments that, the introduction of the nursing process (imported from the USA) imposed unnecessary additional paperwork on nurses. Marks (1994), observes that the nursing process has had a similar effect on UK nursing that some members in the profession doubt its benefit for patients.

However, some black African nurses felt that documentation was good because it ensured continuity of care and it is also a form of legal protection and described lack of patient records in their own countries as an impediment to continuity of patient care. It needs to be acknowledged that both aspects of nursing care are complementary and one need not dominate at the expense of the other.

7.3.6 Different Diseases

Some nurses noted that the conditions of patients that they came across in the UK were different from those in Africa, and that British nurses lacked the knowledge to nurse patients with tropical diseases:

> The conditions that you have, drugs are also a bit different from home because the disease pattern is different from home. (F Zambian 44)

A Malawian nurse said:

> …you know they have no idea. One day a patient came in my ward and this patient had malaria. They put him in an isolation ward and when I came on duty this nurse is telling me, do not go in there without you mask and your isolation gear, and I am laughing and saying but do you know how malaria is transmitted? And they are saying oh you could catch it in there and you could die. It really showed me how they don't know anything about malaria. (F Malawian 31)

This statement shows the influence of globalisation in that diseases are not restricted to geographical areas anymore. As people travel, they come into contact with various diseases which need specific nursing and medical knowledge. Sharing this knowledge is beneficial to patient care. Of course this applies equally to African nurses who acknowledged that knowledge gained in the UK could help them improve care in their own countries. However black African nurses often found themselves working in new specialities which caused them a dilemma as they considered this experience and their actual needs of development incompatible when they returned home to Africa:

> I am trying to think twice about specialising in this oncology because I have always wanted to go back home at some point, probably once I have my master's degree, but that means I will be a specialist cancer nurse. But this comes to mind, when I go back home, of course we have got cancer at home but in terms of treatment, they are not actively treating cancer at home mainly because I think the treatment is very expensive which leaves me with not a lot of options because I know there are no hospitals that have got cancer departments. I am ending up thinking of changing the whole direction of my career, and may be doing something as well which I am not really happy about because I like this because it's quite challenging. (F Malawian 28)

Different stages of development between sub-Saharan countries and the UK may explain this situation. There are differences in resource availability and hence disease treatment. As discussed in the previous chapter, equipment and technology developed for use in developed countries often prove to be of little use in developing countries. This is encapsulated in the Malawian nurse's statement above. If the UK government is right that overseas nurses benefit their countries when they return with UK experience, this situation needs to be addressed by employing nurses in areas where skills gained would eventually benefit their countries. However it can also be argued that as we are increasingly living in a global world, African nurses would be able to use their knowledge from the UK to nurse people suffering from diseases common in the west. This will only be possible if world economic inequality Between countries is addressed and developing countries' hospitals are well resourced.

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7.3.7 Cultural Differences in Nursing

Nurses found nursing homes a strange environment and, some were shocked to find mixed wards and had difficulties coping with these differences:

> There is no nursing there (in the nursing home) that you are learning apart that it's a new environment and a new place. Because back home we don't have nursing homes so everything was so strange. I was so shocked to find males, females in one place. But after a time you get used. (F Zambian 35)

Cultural differences in looking after the elderly and parents were also disturbing for nurses:

> Its only here it pains me when people do not want to look after their mum they don't want to visit them, mostly they end up in nursing homes I know that they cannot help it but it was very difficult for me to accept it at first. I was like oh I should look after my mum I can't let my mum go to the nursing home. And the other cultural difference respect between like son or daughter with their mums. Like am not allowed to see my mum naked but here they do, they even take them to bed. (F Zambian 29)

This point was mentioned by several nurses as a reason why they would not want to grow old in the UK. They feared being put in nursing home and not being treated with respect. It is interesting to note that media reports indicate that residents in nursing homes and elderly patients in hospitals are treated without due respect. The UK government, having recognised this problem promised to abolish mixed wards (DoH, 2005).There is a problem when overseas nurses are asked to adapt to UK nursing Practices and UK culture when some UK nursing practices are called into question as this case demonstrates.

Nurses also said that they thought patients in the UK were more autonomous than patients in Africa. Largely this was perceived as a good thing but in some cases patients could suffer as Nurses had to respect patients' wishes even if this was to their detriment:

I think they have more autonomy here. I guess for the patient is good. They have more right to have this and have that and be told and informed, which at home, patients were informed of what was going on but they trusted the medical staff. It is good what you see here that the patient has a right in so many aspects but I think it makes it a bit difficult for the medical staff. Before they make a decision on the treatment of a patient they have to wait for the patient to agree. Even for the nurses like if I want to turn a patient because of pressure area care and if they say they don't want to be turned they say it's their right. They don't want to be turned, you don't turn them. And then they get pressure sores. While as at home the patients were made to understand, all patients will be turned every three to four hours and when we come round we would like to help all patients to change their position because we don't want pressure sores. So I've seen more pressure sores in this country than I saw at home. (F Kenyan 34)

While appreciating the autonomy that patients have in UK hospitals, it appears that patients' rights are misinterpreted to justify negligence and poor nursing practice by some UK nurses. Clearly there is a problem if black African nurses are being asked to adapt to this type of nursing. It appears that some black African nurses are aware of what constitutes good nursing practice in this situation but they seem to resign themselves to the idea that UK nursing practices are better even when they can see the adverse results. Nurses did not explain why they were unable to challenge this practice. It may be that black African nurses lacked confidence since their nursing skills and experience gained in Africa are not valued.

Patients' relatives were perceived to be more demanding than in Africa and expecting too much from nurses. Nurses compared this to Africa where relatives are more understanding and help to look after their loved ones. Nurses working with terminally ill patients found this particularly difficult and stressful to deal with:

Some of them are very outspoken, especially the relatives, they are so outspoken about irrelevant things; they expect you to perform miracles when there are no miracles to be performed. Sometimes they might be having their own emotional problems, they try to push it against the staff, and they want to blame it on you. There is that kind of shift of their problem on the hospital and the staff. (F Zambian 44)

I am finding it difficult to cope in my place of work because it's a very stressful environment to work to the point that even though most of the time I am at work, but

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even the few moments that I am at home , my mind is occupied with things that are happening at work which is not healthy. It is difficult to work with the patients that we've got because most of them are terminally ill and that brings in difficult relatives as well as denial, they don't accept that their relative is dying so the relatives are becoming more demanding than the patient which is very difficult to cope with. (F Malawian 28)

These statements demonstrate lack of support for nurses working in stressful environments. They also demonstrate unrealistic expectations by some relatives, probably as a result of media reports on advanced technology and modern treatment regimes which are supposed to improve longevity.

Nurses explained that they had noticed that some British nurses work hard and give their best in their work. They noted how nurses try everything in their power to save patients lives. They attributed this to good pay that British nurses get and in particular said that they had learnt a lot and really appreciated this experience. They attributed the lack of motivation on the part of nurses in their own countries to poor pay. However, it is evident from prior discussion in chapter 5, that other factors such as poor work environments and lack of resources are also to blame:

They really value life in this country, they really work tirelessly, and they put in all the best. They are not laid back like back home. I am not trying to condemn people back home because I know there are facts that make people perform the way they do. It's because of the economy, poor conditions of service, that's why you are not motivated, but in this country, you work for your money. They are paid well, the money is ok and you don't see any reason why people should not perform the way they are performing. So you learn to work hard and value life. You see somebody dying you come to accept that no I think we have done all that we can and we have failed, we have worked really hard, which is another thing that I have really appreciated. (F Zambian 31)

This nurse's statement demonstrates the relationship between motivation and reward although it is acknowledged that in her own country there are reasons why salaries are low. Hard work on the part of British nurses is attributed to better pay. However, British nurses might feel

that they are poorly paid. In this instance, availability of resources has more influence as does the setting of treatment targets by the government. The expectation of the public from health services is also high as explained above, and the threat of litigation could influence British nurses to be more conscientious.

7.3.8 Loss of Skill

Due to staff shortages usually in rural areas in most sub-Saharan countries, nurses are trained in more complex skills which are performed by doctors in the UK. Procedures such as vein puncture, suturing and even some minor surgical procedures are performed by nurses. Nurses expected they would be allowed to perform these procedures in the UK as routinely as they performed them in Africa. They discussed how they felt that they were losing their skills first by working in nursing home but also working in hospitals and not being able to perform procedures they were competent in doing. They were surprised that British nurses have to get extra training to perform what they considered basic procedures:

> …I am not allowed to practice some skills that I know I can do because like catheterisation whether male or female, as long as you are qualified, we were allowed to do that back home. You have to do a course and you have to be deemed competent. You have to do a study day for that particular skill. (F Zambian 29)

> It's actually amazing that you are required to do this training when you already have the knowledge. I started work last year. I have not been on this medical equipment training. When you are on the ward they expect you to put IVs up, everything up as a staff nurse, but they will tell you oh we are too busy today you can't go. And then because in my directorate we are too busy, so they will tell you that you can't do IVs. (M Ghanaian 28)

This finding is consistent with previous research (Gerrish and Griffith, 2004, Obrien 2007 and McNeil Walsh 2008) that overseas nurses experience loss of skills, especially technical skills. To understand this, one needs to appreciate that black African nurses like most immigrants are recruited to perform a particular task. As noted earlier, the government

recruited overseas nurses to bridge the gap created by nurse shortages while British nurses were being trained. This meant that overseas nurses were recruited to fill the position of newly qualified nurses regardless of their skills and experience. Overseas nurses were therefore expected to occupy a subordinate position in the nursing hierarchy.

In the case of black African nurses this position is also legitimated by stereotyped ideas of inferiority of African education compared to the British. Hall (1992) and Pilkington (2003) explain that the relationship between the British and people from previous colonies has always been unequal one. There has been economic, political and cultural domination by the British. The process of deskilling black African nurses can be viewed as an attempt by white British nurses to maintain dominance. It can be said that by not acknowledging black African nurses' skills, UK nurses and managers will be able to maintain their dominance since upward mobility of black African nurses will be curtailed. On the other hand, it needs to be noted that bureaucratic practices of the NHS demand that even British nurses who have acquired their technical skills from a different NHS trust be assessed when they start work in a different Trust. Here the difference would be the speed at which this assessment is performed.

7.3.9 Communication Difficulties

Although African nurses in this study came from former British colonies and had their nurse education in English, they found it difficult to get used to different accents in the UK and experienced communication difficulties. Nurses said that they found it difficult to understand the local accents and that it was also difficult for them to be understood. Telephone conversations especially proved to be a challenge:

> The accent was difficult initially, you answer the phone and you can't understand what they are saying. (F Malawian 31)

It was very difficult at first like when you are doing hand over they can't understand you. (F Malawian 28)

However some nurses coped well with these differences by developing patience:

The language, I think it's a case of when you are in Rome you do as the Romans do, because at the end of the day they have their accent and most of them or almost three quarters of the people you work with will use that language and the client will understand that language. So then it's an issue of how do I then communicate to them? If someone doesn't understand you initially they will ask you what did you say and without getting upset go over it and you just get on with it. It doesn't bother you, no and if you ask them repeat that, they are alright with that yeah. (F Zambian 37)

Some nurses tried moving to a different part of the country within the UK but found similar problems:

When I was in the south of Wales I was the only person that looked like myself in the nursing home where I was working and the matron would call me and ask me questions about what I am feeling about the place the main problem was that I could not understand what they were saying. And I thought I would come here and face the same problem they speak in their language. So I said to myself how long are you gonna be running? That's how I consoled myself. And I began to feel confident. (F Kenyan 35)

Within the theme of communication, nurses felt that there was gossiping among nurses. They Observed that British Nurses tend to talk behind African nurses' backs instead of discussing issues with them if there was a problem. African nurses were frustrated by this as they felt it hampered their effort to learn and provide good patient care. They expected British Nurses to discuss issues directly with them as this would iron out any misunderstanding that might be present. A Kenyan Nurse put it like this:

I don't know if it's a culture but there is a lot of gossiping in this place and it really takes you backwards and it also frustrates your effort and at times it is also time wasting. Because if I don't do something that was not right, and you find that instead of somebody showing you this is not supposed to be like this, you find that people group together and talk about it which is no good for you or the patient. It's actually a hazard because if I am here and I am struggling with something, but if it was a colleague of their own they would be very supportive and they will want to show them everything but you will be left to struggle with it. And it's not good for the patient, it's not good for

your and it's not good for the equipment because most of these equipments
are very expensive. (F Kenyan 47)

Familiarity between senior and junior staff was sometimes blamed for the gossiping on wards

but there was a general agreement that this detracts nurses from their work:

> You find there is over familiarity between juniors and seniors and that kind of thing,
> because of that over familiarity that they have established within themselves and that
> hampers the work. For me I am just patient focused. I don't interest myself with the
> gossiping that goes on. (F Zambian 44)

These problems demonstrate how culture can affect communication and how people from

different cultures communicate differently. According to Mcllwain, Mitler-Idriss and Collins

(2005) culture consist of norms, values and beliefs across time and space. People from

different cultures have different speech codes and therefore the way we interpret words and

the way words are said can be different at different times and in different places.

Communication processes are acquired during socialisation of the individual in childhood, in

school or at work. It is possible that communication problems in the case of gossiping are

rooted in different socialisation processes. British nurses may regard it as confrontational to

approach African nurses directly where as African nurses regard this as gossip and

unproductive in conflict resolution. The value of adequate adaptation courses which include

cultural aspect cannot be overemphasised in this respect.

7.4 Racism and Discrimination

Under this theme, nurses described various experiences related to racism and discrimination.

Racism was perceived as emanating from white colleagues and other overseas nurses,

managers and patients and their relatives, as well as from members of the community in

which African nurses lived. Discrimination was mainly concerned with equal opportunities

and the daily work of nursing on the hospital wards or in some cases nursing homes. The racism perceived by nurses was in most cases covert but in some cases it was quite obvious and it caused them considerable distress and confusion.

7.4.1 Perceived Racism from White British Nurses and Other Overseas Nurses

Racism from colleagues did not just emanate from white British nurses but from other overseas nurses as well. Black African nurses felt that their experience and knowledge in nursing was not respected. Nurses blamed this partly on ignorance and also on inaccurate portrayal of Africa by the media:

> On the other hand what I have experienced with my colleagues from Ghana is that if you come to the UK, there is lack of respect. (M Ghanaian 25)

> It could be anybody from Hungary, the Philippines it could be someone   but because you are coming from Africa and there's lack of respect. We are all professionals trained and if someone comes to a ward and doesn't know the ward, they way it works, obviously the person will ask some questions. Africans are treated not nicely at all. (M Zambian 40)

> We had one Hungarian lady who was working with us but you won't believe this lady was treated differently. At the end we say the work she was doing wasn't the right thing. but she was treated like… you know because of the colour as if she knows what she is doing, We were telling her that the things she was doing were wrong but she had the full backing of her British colleagues, and I believe that's where I got to know   that's the problem here also discrimination. (M Ghanaian 25)

The view that there are differences in overseas nurses with Africans having the most undesirable attributes is not a new one. Goodland (1965) described experiences of overseas nurses recruited to the NHS to relieve nurse shortages. He observed that managers tended to classify overseas nurses and attribute their characteristics according their place of origin. In Goodland's (1965) report managers described nurses from the East as having an advantage Because "they have a natural grace which is appealing and which engenders a good deal more latitude toward them when, through ignorance, they made their mistakes. Nurses of Chinese origin, very rarely made mistakes. These have a feminine daintiness with which practically

no other race can compete they are quick and intelligent, with extraordinary capacity for detail and generally speaking more reliable. Nurses from India are lethargic because of the climate from which they generally come; they also master facts without much difficulty. West Indian nurses show evidence of having long been conditioned by western ideas and approach, and they also represent variation in application to their work, not much different from nurses who come from the British Isles; but it is often nurses who come from Africa who find themselves very much up against it" (p. 241). These descriptions mirror managers' descriptions of African nurses (discussed in chapter 8). However the language is tempered perhaps as a result of social acceptability in language which tends to emphasise political correctness. Black African nurses here describe how this behaviour was manifested:

> Even if there are things to improve or to teach this nurse from Africa to improve on the information will be hidden, given to a white person, a Filipino, or any other person and these are things which are going on and in a nutshell what I want to say is every nurse is trained purposely to do something and to know whatever the other person is doing. If you give the person the option to explain first or to come to you and ask I don't know how to use this infusion pump it doesn't mean the person is not a nurse or stupid. (M Zambian 40)

> ..With my colleagues most of us are foreign nurses in fact out of ten of us eight of us are from different countries. Most of them are from India. It's unfortunate because sometimes it feels that they feel that we are inferior to them. And then the other thing is about the way people are recruited here. When the Indian nurses were recruited there was this thing about recruitment and retention so you find that the kind of treatment that they were given is that kind of treatment that would want to keep people where they are and then after a while it all worn off and that's why they came up with this attitude that they are better than you because they were given the impression that they were needed more than you are. But now they have recruited so many Indians that there is now an issue of promotions, it's like at the beginning the Indians should be promoted faster than we are promoted. (F Kenyan 47)

On examination, it appears that there are different types of racism in operation. First black African nurses felt they were the object of racism from their white colleagues and managers. This racism was expressed as lack of respect or black nurses' skills and experience. Here it is perhaps helpful to introduce Gilroy (2004) who contends that 'when Kant compromised Himself by associating the figure of the 'negro' with stupidity and connecting differences in

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colour to differences in mental capacity, a symbolic marker was provided and from that point race has been a cipher for the debasement of humanism and democracy' (p. 9). Gilroy is referring to Observations on the Feeling of the Beautiful and the Sublime published in 1799 and 1960. The current data explicate this statement in the nurses' own words.

Secondly black African nurses felt that they were the object of racism from other overseas nurses as a result of recruitment practices which favoured nurses from the Philippines and India for example. It should be remembered that the Code of Recruitment Practice (DoH, 2001, 2004) advised against recruitment of nurses from countries with nurse shortages of their own. Most of these countries were sub-Saharan countries although the Caribbean was also included. The code was advisory and not prohibitive, therefore recruitment agencies continued to recruit from Africa and some African nurses were recruited from individual applications. Through the code, government policies created a division among overseas nurses which, seems to have left African nurses feeling inferior to other overseas nurses. On the other hand it could be that racial perception influenced the behaviour of other overseas nurses toward black African nurses in keeping with the racialised idea that black Africans are at the bottom of the racial hierarchy (Rex, 1999). Simple competition among overseas nurses may also have been in operation.

Thirdly managers seemed to be operating a divide and rule approach by treating other overseas nurses more favourably than black African nurses as stated by the Ghanaian and Zambian nurses above. This could confirm black African nurses' suspicion that they are regarded as inferior to others. This could also legitimate racism perpetrated by other overseas nurses. Marks (1994) commented about a similar practice among white South African nurse managers in apartheid South Africa where the nursing hierarchy was organised along colour

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lines with black Africans at the bottom of the hierarchy. Some nurses appeared to have lost

confidence in their abilities because they were told that they were not good enough, and some

even internalised this and accepted that there must be something wrong with them, but some

doubt still remained as articulated by this Kenyan nurse:

> It's really bad you feel pain that a colleague of yours from home is being told that they
> need to look for a job elsewhere because they are not catching up! When you know
> back home you and me what do we do? You have no doctor around but you have to go
> through a hundred patients, IVs and everything then how come the same person cannot
> function? There has to be something wrong, and then it will affect the quality of work
> that they give out. Somewhere so I think they need to know that and they need to know
> that we are smart just like anybody else. We went through the same training and we can
> adapt to do anything. Mm same training, communication need to be there. (F Kenyan
> 44)

Some nurses thought that the negative experience they got from their colleagues was a result

of jealousy as British nurses were academically less qualified compared to their African

counterparts which, directly challenged the stereotype that black Africans are inferior:

> And if they get to know that you know, that's when the problems start. Wait a minute.
> I did not have all this problem at first until she knew that I have a masters, that's when
> my problems started on this ward. I never told anyone, I don't know how they knew
> maybe they saw my CV I don't know. (F Nigerian 40).

Black African nurses were perceived as arrogant if they voiced any dislike of their treatment

by their colleagues, confirming the stereotype that an assertive attitude is not expected from

Africans (Hall 1999). Marks (1994) described black South African nurses being disciplined

and even dismissed if they voiced their concern at their treatment by white administrators.

One of the nurses put it like this:

> It's like that because we as Africans, we are not like Filipinos and Indians who are very
> gullible because we fight back, they don't like that. And they term that as arrogant. You
> can see that most things that are going on its lack of respect. That's what I mean

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because as a trained nurse, I worked on this ward, the sister sat down with me at my appraisal and I said this is what I can do, I know how to do it, but because of the policies, if you need documents I can try to get them for you. She never believed. (M Ghana 25)

 This point was corroborated by data from managers discussed in the next chapter. Managers described watching black African nurses especially as they could be lying to them regarding their experiences.

African nurses said that they found Nursing Auxiliaries having management responsibilities and nurse managers relied on these auxiliaries to carry out their agendas. Black African nurses perceived that as a result of the power auxiliary nurses were given by managers; auxiliary nurses were not willing to take instructions from black African nurses. The context of this power struggle relations can perhaps be understood on two levels. First, as a result of nurses shortages the NHS implemented various types of skill mix in the 1990s which were designed to provide effective care on hospital wards. As a result unqualified carers found themselves doing similar tasks to qualified nurses and thus felt some form of empowerment.

Overseas nurses were recruited to fill a subordinate position, that of the newly qualified nurse. This created power struggle for nursing assistants who may have wanted to show that they were more experienced than overseas nurses. Nursing assistants may also have felt that their position was threatened by overseas nurses. Secondly, black African nurses may have presented a particular problem, not just as migrant workers, but as inferior migrant workers because of stereotyped ideas discussed above. Managers legitimated nursing assistants feeling of superiority by assigning them to supervise black African nurses:

When I got here I found Auxiliaries running wards, because here it's the auxiliaries who run the wards not managers I tell you. If the auxiliaries don't like you, you are finished. Cos they say things to your manager and the manager's take them seriously. That's my own experience. And whatever somebody who was not on duty hears about you,

when they are on duty they use that to judge you. Auxiliary nurses will tell you don't do this do that. If I'm on night duty and my colleague goes on break I should not get instructions from an Auxiliary. The Auxiliary is telling me oh that this person is on break now and I think you should do this. So I asked them do you know what to do and they say no I was asked to tell you, so I am not happy about it. (F Nigerian 42)

Even this nurse that I was telling you about who has worked there for 15 years and the carer who has also been there for the same length of time, they always work together, I found them working together, they make their off duty together all the time. I worked with them on nights, every time you try to say something to this carer, she will not take notice of you, she will say oh I have been here a long time, I know everything. Even if it's something that is right, you are trying to tell her this is the way I want things to be done, she won't, she would do it her own way. And if her friend the qualified nurse hears that I was telling her what to do, she will always get back to me. Where I did my adaptation where even carers, people who have never even gone to school, they look at you like you are nothing. (F Zambian 31)

Here the situation is not dissimilar to that of apartheid South Africa described by Marks (1994) of white nurses refusing to work because they objected taking instructions from African doctors. The possibility of white nurses taking instructions from black doctors and senior black nurses was unpalatable to most white nurses. To them it represented an "Inversion and subversion of the 'natural' racial hierarchies, in which all whites, regardless of class or gender, were superior to blacks" (p.140). It appears that even in the UK, in the 21st century this power relation and organisation of domination is central, so much that white nurses may have been threatened by the possibility of black Africans being in a position of authority.

However, some nurses thought that conflicts came as a result of not understanding the role care assistants as most African countries do not use care assistants for nursing duties. Ward assistants used in African countries are mainly assigned to cleaning duties on the ward:

Some things you read in the textbook, you could read about carers back home, you cannot really explain what carers are; you may not be using the word carer back home. We use the word ward assistant. And then in shift planning you have to come across that carer. But how do you explain who a carer is, but if you are here, where the textbook is written, you know who a carer is and you can really apply what you are reading to your environment. (F Nigerian 44)

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Some nurses spoke of how they were made to look stupid if they asked for help with new procedures and believed that this was a result of racism:

> I once gave an example to one of the nurses, I said you have been a nurse here for some time, if I take you home and just dump you in my ward, would you be able to perform the way you have been performing? She said no, you must be very courageous to come here. But you see, instead of giving us support even to show us, but people look at us if you fail to operate a hoist, we've never seen a hoist in our own country because we look after our old people at home anyway and we don't use such machines, so if you fail to operate they say oh you are dull, as if you are not a nurse. They always say oh look at that, just because you are from Africa but they forget that some of the things they have here we don't have them there. (F Zambian 35)

By withholding information some British nurses were probably preserving their authority and a sense of superiority since it is acknowledged that knowledge is power. However, this can sometimes backfire when patient care is compromised as a result and the whole nursing team is held to account. Some nurses were able to assert their authority and were able to perform their duties as illustrated by this male Zambian nurse:

> It's mostly the Auxiliaries who think that you being black means that they are white and they are on top. I had some problems with them but I just tell them I am the registered nurse, you are the auxiliary therefore you are under my instruction. I don't care if I am black or what but I am the registered nurse. (M Zambian 40)

It is interesting to note that this is a male nurse, which means he may have used his gender as an advantage to assert his authority over the auxiliary nurses. Some nurses put the lack of respect from their colleagues down to lack of exposure to other cultures:

> Again most of them don't know where we are coming from and what we have learned. For those who have worked outside they have a lot of respect. When you work with them you can tell the difference from those who have always worked here. I think it depends on their exposure and their culture. Those who are exposed to other cultures are different. Those who are not exposed I guess you can't blame them. (F Kenyan 34)

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Lack of respect from doctors was also cited as a problem and it was attributed to either culture or lack of trust in African nurses. Nurses felt that they had to fight to gain respect and understanding among their colleagues:

> I think among themselves it's just like we had an understanding at home, the nurses respected the doctors and vice versa. I think it's the same here. But I think the doctors have no respect for the foreigners. Among themselves they are ok, but the understanding we had with the doctors and the rapport, we don't feel it as foreigners. Because at home we were able to discuss patient care with the doctors but here when you try to discuss with them they won't. "Where is the ward sister, where is so and so". So we don't know maybe they don't trust you or something. I think that you have to fight for you to gain respect and the kind of understanding you had with your colleagues at home. (F Kenyan 35)

On the surface it may seem that a simple difference in culture is in operation but a deeper examination reveals that ideas of superiority may be at the root of this lack of respect. Pilkington (2003) contends that 'the relationship between the British and people from former colonies has entailed simple representations such as White /Black... in which one pole of the binary was clearly dominant' (p.179). The consequence of this representation was the emergence of a discourse which represented the world as divided according to a simple dichotomy- the West versus the rest (Hall, 1992).

Black culture and African culture has been designated inferior in this dichotomy in a similar case to race (Hall, 2000). Therefore for blacks 'primitivism' culture and 'blackness' nature are interchangeable. Hall (2000) states that ' blackness has functioned as a sign that people from Africa are closer to nature and therefore more likely to be lazy and indolent, lacking in higher intellectual faculties, driven by emotion and feeling rather than reason…. Correspondingly those who are stigmatised ...as 'culturally different' and therefore inferior, are also characterised as physically different in significant ways (though not as visibly as

blacks)' (p. 223). Marks (1994) alluded to the same concept when she stated that 'blatant racism asserted the inferiority of blacks, albeit now in a coded language of culture and psychology, and fear of black competition' (p. 150).

Using Hall's (2000) and Marks' (1994) analysis it is possible that cultural racism is in operation in the treatment of black African nurses by white UK nurses, their managers and doctors.   Racism as an ideology is not constant but changes in relation to time and space and this is one such manifestation. Here racism is being expressed by marginalising black African nurses in various nursing activities.

7.4.2 Perceived Racism from Patients and Relatives

Black African nurses described racist attitudes towards them from patients and their relatives. Elderly patients were especially singled out as having the most racist attitudes:

> Like we are talking, the most difficult age group I would say are the elderly because those are the people who have never even seen the blacks. Because their time there were only whites, it's only now that there are a lot of blacks around. So the older people are even more difficult. I have had difficult encounters with them. Sometimes you are giving them medication, medication that they have been taking every day. If it is coming from a black person, they will look at you suspiciously, like you are not giving the right tablets. One patient really insulted me; it was really nasty I had to write an incident form about that. I've had such bad incidents with patients, when you are advising them or you are saying something they won't listen to you. (F Zambian 31)

Another nurse concurred by saying:

> Some of the residents accepted me but some were not happy to be looked after by a black person and I was told by the manager that room 40, room 43 and room 18 you should not go there because they don't like to be looked after by a black person. (F Malawian 31)

It is probably true that the elderly have had the least contact with black people but have had the longest exposure to stereotyped images of black Africans and are more likely to display

racist attitudes. Marks (1994) described similar situations in South Africa where white

patients refused to be nursed by black nurses and attributes this attitude to racist socialisation.

Nurses recounted how racism from patients led to role confusion on their part as they did not

know how to respond when patients were in need of their skills:

> It was very strange because I didn't know what to do. One of the residents became poorly and the care assistant told me so and so is poorly in room 18. When I went she refused for me to get into the room so I had to call the ward manager to come and sort her out and take her to hospital, so it was very difficult. (F Malawian 31)

> Even relatives, a relative will come and visit, they see that you are the nurse; they have seen your badge, because we have similar uniform with the health carers but you can still see the difference. If they are enquiring something about their relative, they will bypass you, even if you are the first person they see , they will go to the health carer and then the carer will say no you go to that one, that's when they will come. So it's really difficult, sometimes you just have to put your foot down but like I've said, if you do at the end of the day sometimes they will say you are stubborn and they will just make your life difficult and you just end up quitting. (F Zambian 29)

Nurses perceived this behaviour as racism as they thought that it implied that black nurses

were incompetent: resonating with race theories and representations of the late nineteenth

century (Hall, 1999).

7.4.3 Perceived Racism from Managers

Apart from racism from their colleagues and patients, black African nurses also perceived

racism coming from managers. They described how other nurses from overseas were allowed

to perform certain procedures even when they were not competent but black African nurses

were prevented from performing the same procedures even when they were competent. A

Zambian nurse told of how this happened on a ward he was working:

The whole thing is this lady was the one when we had an emergency, someone had chest pain and we had to do an ECG and I did it because I know how to do it although there is a pack that you should have which I don't have. She said what you did was wrong and you don't have the pack so don't do it again. I said ok. She called an Indian lady to do it and she said sister but I don't have a pack as well and she said go and do it. I said what you are doing is discrimination. (M Zambian 40)

In some cases it was felt that their experience was not recognised and, if they voiced this to

their managers, they were labelled confrontational:

Nobody recognises any black no matter how intelligent you are. If you are intelligent and they would rather prove you to be too confrontational. So I tell you I cannot hide , I told my manager last week I said I'm not happy. (M Ghanaian 25)

…because I would say the best word I can use is racism or discrimination, as long as you come from Africa you are not one of them, you are not a white person, you are looked down upon in every way, there is racism, even when you are in a meeting, like a suggestion, they won't take it into account because to them you are black and you don't know anything, you know, that's the thing. (F Zambian 31)

These statements mirror that from Searle who said; the non-European nurse in South Africa is

being drawn from a social milieu and has a psychological attitude which is completely

Different to the generally accepted concept in the Western world… I am not prepared to

Describe her as a real nurse… (Select committee Section 6 -155 quoted in Marks, 1994 p.

146). These statements demonstrate that stereotypes of black Africans described above are

not a thing of the past but are very much alive today. Nurses said that allocation of

Responsibilities reflected managers' lack of confidence in black African nurses. Nurses were

perceived as lazy when they were sick and some were not paid:

I injured myself when I was in the Nursing Home making a bed, I was never told any lifting and handling course and they expected me to do everything. I was never given induction in how to operate the bed yet they expected me to do everything. (F South African 30)

Mine happened just like you. I was supposed to report for late shift but I was sick but the Sister wouldn't change the shift. The next time 3 staff nurses friends working on the same shift, the others wouldn't help me so I went to lift this patient and I injured my

back so the following day I called in sick and they said she's too lazy, because she moved two beds she called in sick she couldn't come to work. But I have seen people on the same ward who have been sick for one week, two weeks and they are now giving me grief. I said I have been here for almost a year and I have only phone in sick two days. Is it an offence not to come to work when you are not well? The same week three E grade nurses phoned in sick simultaneously, they are friends, two days each nothing happened. (F Nigerian 44)

Here, it seems nurses were not trusted and therefore they were denied their employment rights. Nurses were given labels of indolence and laziness consistent with those explained by Hall (2000). Black African nurses noted that managers were partial in the way they allocated leave for family reasons. They were thought to be insensitive to the culture of black African nurses, and this behaviour was perceived as racist:

All these frustrations she started from the rota, she knew I had a kid; my wife is also a nurse here. She knew we had to work opposite shifts, so that we can look after our girl, although she was going to a preschool which we are paying so much money for. After having all this and saying ok you can plan your rota and I will work according to that at the end she writes the rota and if my wife is working early and she would put me on early and I said no I cannot work that shift and she told me categorically, she said you know some have children and some have dogs so some of us who have dogs we also have time off to take care of our dogs. (M Ghanaian 25)

One experience I had at the hospital I was working in, I lost my mum, so I couldn't go to work for a few days. Although there is compassionate leave, I was given unpaid leave. Another lady lost her father and she was given compassionate leave. So I asked my friend and said who is given compassionate leave? And she said it's at the discretion of the director. (F South African 30)

Here managers displayed discriminatory attitudes and hid behind cultural difference. The NHS introduced several initiatives designed to encourage nurse recruitment and nurse retention. These included family friendly policies such as maternity leave and child care (DoH, 2005). NHS staff have always been entitled to compassionate leave and clearly the manager above was being discriminatory. At times racism from managers was blatant as the Nigerian nurse below explains. This nurse had particularly asked for this incident to be reported as she thought it was absurd that at previous hospital nobody had complained that

she smelled. In addition several black African nurses had left this ward because they had been told they smelled:

> Another thing is that they tell us that we smell. In all my life I have never used perfume, since I was born. Because I wash two times a day so why do I have to smell. I shave, so where does the smell come from in my body. And I worked in another hospital before I came to (name of hospital), I didn't smell to the whites, but when I came to my ward, and then I smell… I said why people would smell, they should have a shower, if they are having a shower everyday why should they smell. All these people were black. Now we are two left, we were four or five but they have all gone. It happened to my friend on another ward a week after mine and she has been working on that ward for three years. (F Nigerian 44)

This experience echoes stereotypes of the late nineteenth century described by Hall (1999) when advertising became the vehicle of racialising black Africans. In one instance soap was said to have the capacity to cleanse and purify, it apparently had the power to wash the black skin white (Mclintock, 1995). Black African nurses in this study felt that racism was worst outside London, where black African nurses and other ethnic minorities were few in number:

> In London it was really very good because people from the outside, most of them were from Sierra Leone, Portugal, and the Irish, only two of them were from here, one from Pakistan. So it was really nice and I used to enjoy so when I came here for the past four years I have been the only black. And I feel they do have it really but its hidden you cannot say it out. Here they can say it but you cannot pin point it because you do not have enough evidence but you can tell especially with individuals. Some you can clearly say for some you can't but there is a difference yea. I just get on with my work. (F Zimbabwean 42)

In the north east, where this research was carried out, black nurses are probably more visible and therefore more threatening to the local nurses. On the other hand it could be that it is easier for white British nurses to take advantage of black nurses because there are more white nurses than black African nurses. This is perhaps well articulated by the Zimbabwean nurse below who did not have a sense of belonging. Nurses said they were reluctant to tell anyone

when they experienced racism because no one would listen to them and besides it was difficult to prove or feared that their lives would be made difficult:

> I don't bother telling anyone because I do not think that people can listen to me. You don't have a sense of belonging. (F Zimbabwean 42)

Some nurses claimed that they were so frustrated by racism that they suffered stress as a result:

> My experience when I came from (name of hospital) to (name of hospital) in October. Between October and December I was sick for ten times because of the frustration that were here. I wanted to speak to anyone in a higher position but no one was willing to tell me anything so through this mechanism, they got me through to the board, that is where I was able to express myself. So being sick the code said why you are being sick. I said I was sick for ten times for good reason. There is always someone there who will frustrate you and pretend, I mean they are most of the time sisters. What is really happening is they either see you to be foolish or if they see you can do something, they don't like to see that at all, because of the colour, so you can't win. (M Ghanaian 25)

The stress of racism is known to affect not only social opportunities, but also physical and psychological health (Hagey et al, 2001). Physical and psychological effects include cardiovascular diseases and emotional problems such as depression which can then lead to marriage breakdown, professional difficulties, seeking out new job opportunities and financial insecurity all of which can have an impact on the care that nurses give to their patients. This nurse did not elaborate on what his particular health problems were, but the effect seems to have been quite adverse as to result in a significant amount of time off for sickness.

7.4.4 Discrimination and Lack of Equal Opportunities

Black African nurses saw racism and discrimination as going hand in hand and described how they were discriminated against in terms of promotion, professional development, supervision of duty rotas and even the way mistakes were dealt with, echoing Archibong and

Darr (2010) who reported that mistakes made by ethnic minority nurses were treated disproportionately and that these nurses were likely to be disciplined. Some nurses said their knowledge and contribution was not taken into account. Often they were ignored and marginalised. When it came to off duty their requests were often ignored. A nurse recounted how the off duty book was hidden away so African nurses could not make off duty requests:

> They have taken away the request book because we used to tell them what we want this so we can have enough time to rest but they don't want that. If they put you on the off duty you just work what you have been given. When I started I never used to request I was just given shifts, but the way I was given the shifts, you wouldn't like it. I would be given four nights and then you are given one day off and then you are back again on a long day, just like that, just one day off to rest. Then I saw that I was always run down, stressed all the time and not getting enough rest. It was like when they are doing the off duty they will give them better shifts but we were never given normal shifts like them. We would work crap shifts all the time so we started requesting until they took away the request book and said it was only for special occasion. (F Zambian 31)

Black African nurses are often given undesirable shifts without sufficient rest in between (Shield and Wheatley price, 2002 and Allan and Larsen, 2003). A nurse in the present study commented on how a lecturer from university was telling students that black Africans do not suffer from stress and thought that this is probably why black African nurses were expected to cope with discrimination and the undesirable shifts they were given.

Black African nurses described being passed over for promotion. They said that their experiences were not taken into account even when they had been on a ward for some time promotion was given to junior British nurses instead:

> I can give you another example, whilst I have been there more than a year now, but there was a white nurse who came to work there after finishing her training, she just worked for six months and now she has been promoted to E grade. And you can imagine what impact it has on us. (F Zambian 31)

Discrimination was also evident in the way that managers dealt with mistakes. Nurses felt that when black African nurses made a mistake, they were blown out of proportion. Nurses described feeling under scrutiny, as if managers were just waiting for them to make mistakes:

> …because if you make a mistake it will be a big issue. I will give an example, there was a patient who was on this antibiotic, there was no antibiotic on the ward, I handed over to the night staff and the night staff was white, she didn't give it also and the patient after two days died. But we were so busy I did not have a chance to start phoning the pharmacy and then the thing came back to me and they started asking me why did you not phone the pharmacy, why did you not do this, when I had handed over and I had given responsibility to somebody else. But recently there was a white nurse who gave a tablet that this patient was allergic to and after a week or so later the patient died. But nothing has been said. (F Zambian 31)

> With my senior colleagues there was of course that feeling that I was under scrutiny all the time and it took time for them to understand that I can do the same things they do just as well as they do. A good example is like if a phone rang and you come to pick it up and someone stands next to you to try and prompt you what to say like you would not know what to say. (F Kenyan 47)

These statements were echoed by managers in their interviews in the next chapter which gives a fuller discussion. Black African nurses explained that often they were not given information of equal opportunity policies. They were only told that it means everyone should be treated equally. Sometimes nurses were given booklets to read. Nurses said that managers were especially not forthcoming with information on graduate or post graduate courses if they were not graduates themselves. This suggests that managers may have been discriminating black African nurses by withholding information on equal opportunities in addition to not putting the policy in practice.   If this is the case, it is direct contravention of the Equality Act 2010. There was a general agreement among nurses that equal opportunity policy was only on paper and in very few cases was it practiced:

> I think the main training that we've had so far are mainly to do with like the ward development, they want to give you knowledge in terms of where you are but then in terms of Master's, I don't know I haven't found an opening. (F Malawian 35)

> The other thing is because she hasn't even got a first degree herself so I thought it was a bit intimidating for her for me being a junior nurse to go and ask her that I want go for this now. That other thing that I faced was that this lecturer who looks after the nurses that are doing degree programmes, when I asked her she wasn't flexible to talk about the course, I think she also only have a first degree herself so it looked as if she did not have much information about it as well. (F Malawian 28).

Managers may have been withholding information because of limited funds for development but, in the case of one Trust a nurse explained that this was not the case. This nurse had been warned by personnel officers that her manager would tell her that overseas nurses were not entitled to tuition for degree programmes, but she was to apply for the course anyway because the programme was free to all NHS employees. It seems plausible therefore, that in some cases the primary motivation for denying black African nurses educational Development was discrimination on the managers' part. The relationship between discrimination of this type and power has been already examined. However the Nigerian nurse's point below makes the point clear and supports the view that African nurses are placed at the bottom of the nursing hierarchy. When this stereotype is challenged, managers react by denying nurses opportunities shown to preserve their power. Black African nurses said British colleagues may have resented the fact that at times they (black African nurses) seemed to know more than they did:

> And if they get to know that you know, that's when the problems start. I did not have all this problem at first until she knew that I have a masters, that's when my problems started on this ward. I think they don't like black people who are at the same level as they are, some are Enrolled nurses and they have gone to posts like E grade, some got certificates and they treat us like nothing maybe because of the experience they have on the ward. (F Nigerian 42)

Some nurses were denied courses, and not given support if they chose to pay for courses themselves:

> There are times when I have asked to go for a course, like me and another person want to go for the same course, they will choose their own people. She just said there are people who have been waiting and they have been here longer than you so it's not fair. I wanted to apply but my manager couldn't sign the reference for me that's why I had t o go to (name of university) We should feel that we've got the same qualifications and we contribute the same skills like white nurses and I think they should put equal opportunities in practice otherwise its of no use. (F Zambian 29)

Some Nurses felt their qualifications and experience was not taken into account when they were employed. This experience may have been the result of lack of information during recruitment. Nurses were not told that they were required to fill the lowest posts in the NHS so naturally they must have assumed that their qualifications and experience would be taken into account in their employment. Withholding this information is exploitative and it reduces nurses' choices:

> I think with the experience that I have I think I am at a lower grade here than at home. Because at home I did my BSc and I was teaching students and I was supervising in the clinical area. When I came here I started at the bottom, lower Grade D, which was not encouraging. When I asked the manager she said everybody had to start from the lower grade because you need experience from here, you haven't worked in the UK so you can't just start from the higher grade. (F Malawian 31)

> What I don't like is that no matter what certificate you have at home, it's not relevant here. It is very sad that when you come here you have to start all over again. I have spent 25 years or 30 years in nursing and somebody says it's not relevant. (F Nigerian 42)

However some nurses said that some qualifications were accredited, especially in cases where nurses wanted to study at a higher level:

> I had a colleague who has a degree from home then he had to do a Masters here. I think he has completed now. So if you want to do another qualification they will look at your qualification from home and give you points on what you have. (M Zambian 40)

In some cases nurses explained that British colleagues respected them for their knowledge indicating that some Trusts have policies which recognise overseas qualifications:

> …they always ask me for advice. It's not that I have told them that I am this, but from the way they saw me do my things, they know the stuff is there. And times when I explain some part of anatomy and pathophysiology, they look at themselves. We know

you are well learned, come and tell us. I am not trying to show off or anything but you cannot hide what you know because it's there and you unconsciously say it out. There are people that I had to teach about blood groups, rhesus positive, rhesus negative, they don't even know it, five years in practice, they don't know it, and I had to teach them. (F Nigerian 44)

It is paradoxical that black African nurses cited advancement of their nursing skills and education as motivating factors for coming to the UK, yet they were resentful of their Employment at the lowest grade of the qualified nurses' hierarchy and were not satisfied with the explanation for this grading. It could be that after working in the UK for a while, nurses recognised and indeed some verbalised, that their experience and skills from Africa were better than those of nurses in the UK. Nurses said most of their skills were transferable to the UK nursing situation and that they were not assessed adequately on employment.

7.5 Social Experiences

When nurses were asked to describe their experiences of living in the UK, they explained that they found a lot of cultural differences. These differences related to the role of the state in bringing up children, the way they were treated by their neighbours, the way children were treated in schools and the way partners adapted to them being bread winners in the family.

7.5.1 Racism in the Neighbourhood and from Police

On this theme nurses explained that they had experienced racism from neighbours and that the police were not very helpful:

In (name of place) my family and I were assaulted by someone threatening to kill us.. The person just came, smashed the door. So we called the police while he was trying to get into the house. And he was saying black men get away from here we don't want to see you. I phoned the police so when they weren't coming, my daughter started screaming because she saw this and they said we should stop screaming otherwise they were not coming. How can you stop a small child from screaming? I said look we can't stop someone is trying to kill us. It's in the court now but I don't want to attend because I told the police that look you are all over. What is really happening is as a

black person in England or in Europe, where ever you are discriminated against. (M Ghanaian 25)

I had problems with paedophiles. My daughter received a phone call from a paedophile. So the police came and took a statement and somebody was arrested but we never heard anything back from the police and I believe they don't care because I am black. If I was a white person they would have taken it seriously and informed me of what's happening but they never did. (F South African 30)

These statements indicate that black African nurses and their families suffer similar episodes of discrimination and racism as other black people in Britain. Pilkington (2003) contends that the consequences of such harassment which is often an ongoing process of victimisation are extremely damaging because they can create a climate of continual insecurity for victims and their families. This type of harassment can provide a background for racist violence, an example being the murder of the black teenager Stephen Lawrence by five white youths in 1995. Nurses explained that these experiences discouraged them from socialising with people in their communities. Nurses preferred to live in areas where there were other African nurses and ethnic minorities:

Working culture and lifestyle is different so basically you are on your own with a few friends that you have so you feel lonely. Not only for me but even for young families who come here and find themselves on their own, the kids are on their own. Even in the neighbourhood where you live people are not very accepting, so the kids will not mix. So you have to find things to do on your own. (F Zambian 31)

I do socialise with people from my background after work when I go home. We have got a lot of friends and I can't manage to entertain all of them really. There is a lot. With them (the white people) I can't go for a drink. (F Zimbabwean 42)

I don't even mingle with my neighbour, it's just when I meet her in the corridor I just say hi but is just home, work or maybe I go and visit a few Zambian friends. We don't really mingle with these local people. There is nothing wrong in mingling with neighbours if they are ok and if they can accept you. It's just that maybe they are not interested, who are you and it's just very demoralising because sometimes you just feel like maybe I cannot make a move, I don't know how she is going to answer you, so you just keep to yourself unless they start, because they are the majority here. You just don't make a move because you have had enough at work and you say oh maybe I will get the same attitude and you just keep to yourself. (F Zambian 29)

Richmond (1994) explains that when given a choice, minorities prefer to live near to each other to promote family reunion, provide support services or generate a voting base. He adds that such concentrations must be voluntary and not a result of discrimination, the housing market or the community at large.

The data indicate that some black African nurses chose to live in proximity to each other because of racism and prejudice. This is contrary to network migration theory which posits that immigrants form enclaves to preserve their culture.

Another problem for black African nurses was racism experienced by their children in schools. Nurses explained that children found it particularly difficult to deal with racism as they did not realise they were black in the first place but in addition that there was something wrong with being black:

> When my son got into school he got into serious problems. When he first started the teachers were very good, oh these children are very well behaved and blah blah blah. But he got into a situation whereby he was being segregated upon because he didn't even know that he is black. He came and asked me one day, mom am I black? He couldn't understand why he is called black because he is not black. So that's when the behaviour problems started because he started fighting back and from there he got a bad name. He has got into this habit of racist and racism and that's all at school, he doesn't do that at home. The school where he goes to now they started a system whereby parents of black children were called to discuss how this can be resolved and the parents were all saying the same thing because when teachers come across these boys of ours and they grow so tall and the teachers feel threatened one way or the other. So I am not happy about that because now I have a problem in my hands which have come because of the differences. (F Kenyan 47)

> Well, my girl she is young but still sometimes she comes to me crying, sometimes she will say somebody was telling me my food, my pack up was yucky, somebody was telling me they can't play with me because my skin is dark, you know, there are just few comments that I just tell her that no you just play, if they insult her one day she was telling me a friend of hers insulted her but I said you tell the teacher every time. (F Zambian 31)

Pilkington (2003) has demonstrated that there is stereotyping and racism against Afro Caribbean students, especially boys in the British educational system. He explains that two thirds of teachers agree that Afro Caribbean boys are less able and give rise to disciplinary problems. No specific research has so far looked at black African pupils or boys, but the Afro Caribbean results are not encouraging.

The response of Afro Caribbean boys to this stereotyping and racism from teachers often takes the form of resistance, confirming their teachers expectations and entering into a self-fulfilling prophesy which in some cases results in suspension or expulsion (Pilkington, 2003). The racism from white children in schools seems to emanate from media stereotypes of Africa or from socialisation. Either way nurses said that there did not seem to be any discouragement of this behaviour from teachers, indicating a form of socialisation. Nurses also found it difficult to adjust to the British way of bringing up their children. There was a feeling that the government has got too much say in the way children are disciplined. Nurses found that a clash of culture was developing between them and their children. This is in fact common between immigrant parents and their children who grow up with the values of the host country (Pilkington 2003):

> In this country at 16 you are an adult, in Kenya at 16 you are still a child. The child will come and tell you I am 16 and I am an adult. And discipline, we are not allowed here, we have disciplined our children back home and a little smacking is not too bad, but here we are not allowed to smack them. My daughter came home one day and said you have no right to beat me, because that's what she has been told at school. I think we should be allowed to discipline them in a way that we think is best as long as we are not harming them. I was listening to the radio this morning about discipline in school, and they were saying that if only teachers were allowed to smack a little bit. (F Kenyan 47)

From my field notes I noted that another nurse described how she had shocked the police by asking them if they did not have enough criminals in the UK after they had reprimanded her of smacking her son.

7.5.2 Employment Problems for Partners

Initially female nurses came to the UK by themselves but after a period of what they called settling down a lot of them were joined by their partners and family. The family acted as a strong support system and some nurses said that they would have gone back if it was not possible for their family to join them in the UK. However it was difficult for partners to find jobs. Partners found that they had to help out in the home because there were no maids or relatives to help and found it very difficult to adjust. For some nurses, whose partners could not adjust, it meant a lot of stress as they had to be doing house work by themselves as well as doing their jobs in hospitals. It was also difficult to deal with their partner's frustrations:

> When he came here, he couldn't get a job. He was at home for one year and I had to work extra hard to be able to put food on the table and to do other things. Eventually he got into odd jobs, working at (name of company). He didn't want to work in nursing home because as you know with African men, looking after women, they don't even look after babies at home. So with that restriction, he just had to go for these odd jobs. He was a draughtsman at home. (F Kenyan 47)

> You know when you have your husband back there they have got their job and you got your work permit and you find a job and you say come with the kids. They wouldn't because otherwise they would end up doing care work or working in industrial whereas back home he is a manager or something. At first he was working as a care assistant and in the industry. (F Zambian 44)

Nurses also found that it was difficult to work fulltime and look after their children as they did not have help either in the form of hired help or in the form of relatives as they had in Africa. This was a constant cause of worry as they felt that the children were missing on

essential discipline and were watching too much television. This resonates with Cooke (2005) who says that a woman being the main wage earner does not ameliorate the negative effect they suffer in cases of family migration:

> ...and I need to move out now to something else out of hospital life. The reason being that I have a little one and, as much as we like to give my all in hospital, we tend to miss out on the kids. The big ones are okay but the little one, you are not home for home work and everything, then you are compromising. You see here it's like sharing between me and my husband but back home you have grand ma you've got have aunties so you have got people who are still instilling what we would like to instil in our children, discipline and everything. But when you are away and your husband is away and the children are at home they watch telly and watch telly and home work is not done. So I would like to be there to give them that little boost. (F Kenyan 44)

> It's very hard because you have to change a shift with the husband and it's really difficult and strenuous because you don't get to see each other one is working day and the other is doing nights. (F Zambian 31)

This finding is consistent with McGregor (2006) who reported that Zimbabwean nurses in the UK had problems balancing work and family. The UK government's policy of denying child benefit and tax credits to overseas nurses until they become permanent residents of the UK Put overseas nurses at a disadvantage. It is discriminatory and goes against the government's own recommendations that overseas nurses should have the same employment rights as UK nurses. Black African nurses appear to have experienced child care problems and financial hardship as a result.

Nurses related the lack of discipline and high crime rates among teenagers to government policies. They also lamented the fact that children had nothing to do except watch TV, and said that they did not want their children to grow up like British children:

> Every day I have to speak to my kids about imitating this bad behaviour here because it is unAfrican, it's not our culture, it's not our practice. People kissing on the bus stop, kissing in the bus, all sorts of things. Even on the TV they are bombarded with it. They

will say that pornography is on the computer but it's on the TV staring in your eyes. The next thing you know you hear that this one was raped because they are advertising themselves walking naked on the streets. So they are contradicting themselves with whatever policies they put up. They have no morals, I detest that. People have no respect, kids have no respect for anybody. People just spit anywhere, smoke anywhere, the dressing, the language, they like swearing. Everything about moral decay, you find it here, so I am not impressed at all. (F Zimbabwean 42)

However it seems that the behaviour outlined above is not the norm as some nurses explained that some British People detest it as well and put it down to loss of moral values and breakdown of the family. Moreover black African nurses said that educational standards in the UK were better than in their own countries and it was better for their children to get a British Education.

7.6 Summary

Data presented in this chapter indicate that black African nurses experiences are embedded in their status as immigrants. It indicates the experiences of black African nurses can be articulated as a function of history due to the fact that sub-Saharan countries were former colonies of Britain, and from a political and economic perspective. An examination of the various experiences of nurses in this chapter reveals that many of these experiences are rooted in racism. The racism experienced by black African nurses results from their position in the nursing hierarchy as immigrants and also from stereotypes of Africans presented by different sources of the media of African as inferior (Hall 1999).

Overseas nurses have always been essential to the running of the NHS since 1948 and have always endured discrimination (Beishon et al 1995, Daniel et al 2001, and Alexis and Vydelingum 2005). Studies on the experience of overseas nurses in the UK NHS have mostly tended to be descriptive. Therefore our understanding of why racism and discrimination occurs in the NHS is patchy. The data in this study indicates that history,

politics and the economy are articulated together. Articulated here means a kind of joining together even if it is loosely, to shape experiences of racism and discrimination of black African nurses in the UK NHS.

Racism was experienced by black African nurses as exploitation during the recruitment process as nurses were charged exorbitant fees by recruitment agencies. There were inadequate orientation processes. In addition nurses were placed in nursing homes which did not match their experience. These practices were legitimated by the nurses' position as migrants (Miles 1993), which was reinforced by government recruitment practices.

It has been noted earlier that the UK government instituted the code of recruitment practice (DoH, 2001 and 2004) which discouraged recruitment of nurses from countries with nurse shortages. In effect the code excluded all sub-Saharan countries. The effect of the code was to deny human rights to black African nurses so that when African nurses were recruited by private recruitment agencies into UK hospitals and nursing homes they were open to exploitation. It can be argued that by excluding sub-Saharan countries the code of recruitment practice put black African nurses in the position of illegal immigrants and illegal workers and this further encouraged their exploitation by employers. In addition, stereotypes of black people as illegal immigrants in various sectors of the media helped to confirm this position. The fact that some employers hid nurses' passports and threatened them with deportation Further validates employers' perceptions of black African nurses as illegal immigrants. The data indicates that in common with other migrant workers black African nurses were recruited to fill jobs which could not be filled by British people. This was as a result of nurse shortages in the nursing profession, black African nurses were therefore used as a reserve

army of labour, (Castles and Kosack, 1985). In addition, black African nurses were employed mostly in less desirable specialities such as elderly and nursing homes.

Phizacklea and Miles (1980) contend that black people in Britain constituted a class fraction because of their position in political, economic and ideological relations. Rex (1992, 1999) and Pilkington (2003) concur and add that, ideas of black people as an inferior race persist today and underlie a status division between the white majority and minority groups. Pilkington (2003) adds that discrimination results in minority ethnic groups being restricted to those occupations that are characterised by low pay, poor job security and few promotion prospects, he contends that status disadvantages here are translated into class disadvantages and there is therefore a formation of an underclass comprising ethnic minorities. Giddens (1981) has argued that ... "In many European societies immigration has led to a "transient underclass" being imported from the outside' (p. 220). The current data indicates that through divisive recruitment processes, black African nurses have come to occupy this underclass status.

Phizacklea and Miles (1980) argue that British perception of colonised people have been structured by pre-existing racist ideologies. Miles (1982) claims that the existence of an ideology of black inferiority and white superiority aided the exploitation of developing countries to further the economic development in Britain. International nurse recruitment can be regarded as one such example in the 21st century.

For those nurses who were assessed as needing adaptation courses, placements were often in nursing homes which did not match their expectation or experience. This is a form of exploitation as often nurses were not paid but also used as a "pair of hands" to fill nursing

shortages. Nurses described being used as care assistants which did nothing to enhance their nursing skills. Nursing, to these nurses was described as taking care of all the patients needs not just bathing and dressing them. Nurses said that they were not given information on structure of adaptation courses. This denying of information by recruitment agencies and employers might be regarded as a form of exerting power and authority since the nurses would have limited or no choices. This can be regarded as repressive practice on the part of the employers exerted by disempowerment of nurses (Foucault 1980). In a few cases adaptations done in NHS hospitals were of good quality and nurses were satisfied with their experience, demonstrating that with good planning and awareness training, success can be achieved.

When describing their professional experiences, nurses said that mostly the practices of nursing in the UK were similar to those in Africa. A deeper examination of nurses statements reveal that these similarities were in the technical aspects of nursing such as drug administration, wound dressing, prevention or pressure sores and so on. Differences mainly involved the social and cultural aspects of nursing such as treatment of the elderly, etiquette among nursing staff, discharge planning and communication.

Although black African nurses had cited language as one of the motivational factors for coming to the UK, they found that communicating with colleagues and patients was problematic. Communication is different in different cultures (McIlwain et al, 2005). It is a function of primary socialisation in childhood and anticipatory socialisation i.e. when we face a new situation. Values norms and beliefs change across time and space and within and across cultures. Therefore it is not surprising that black African nurses found communication challenging. Communication also involves knowing how one relates to people in positions of

power and it is evident that black African nurses found this different. This is well articulated by the Zambian nurse in section 7.3.8 who said that over familiarity with juniors hampers nursing work.

African nurses described other differences such as poor infection control in hospital wards and excess documentation which were an impediment to good nursing care. Nurses said they were shocked at how poor infection control practices were in nursing homes and hospitals. It is not clear whether they voiced these concerns to their managers. However the Kenyan nurse in section 7.3.3 seems to imply that they didn't when she says "we just carry on."

It is important to note that black African nurses said that their skills and experience were not valued by UK colleagues. This may have prevented black African nurses voicing their concerns when they came across unsafe practices. Differences in other nursing practices such as discharge planning, availability of drugs and equipment can be attributed to unequal global development and unequal distributing of resources explained by globalisation (Richmond, 1994) World Systems Theory of migration (Wallerstein, 1974).

Black African nurses in this study felt that they were objects of racist discrimination from managers, white UK nurses and other overseas nurses. Racism was both overt and covert but nurses were reluctant to report incidents as they felt reporting would threaten their positions. Racism from managers was articulated by the way managers allocated tasks and shifts to black African nurses. Nurses said that they were often given unpopular tasks and duty rotas compared to other nurses. In addition other overseas nurses were given favourable treatment by managers. Managers operated a similar approach between nursing auxiliaries and black African nurses. However in this case nursing auxiliaries were asked to supervise and 'police'

African nurses. This behaviour is embedded in racism brought about by the perception that African education is inferior. Kyriakides and Virdee (2003) reported that a climate exists in The NHS whereby low standards are synonymous with 'overseas' doctors from the new Commonwealth and overseas doctor is a euphemism for 'black doctor' whose medical standards are inferior. Nursing studies on overseas nurses have so far not investigated this phenomenon. Results from this study indicate that perceptions of black African nurses in the UK, is not different from that of overseas doctors. Racism from patients and relatives was expressed along similar lines, where they refused to be nursed by black African nurses.

Managers labelled black African nurses as lazy when they were sick but also expected them to carry out heavy duties without help. This point is illustrated by the Nigerian nurse in section 7.4.3. This is consistent with representations of black people which are grounded in colour and culture (Hall, 2000). By the same token black African nurses were not trusted to tell the truth about their skills and experiences. Nurses described feeling under scrutiny and mistakes made were blown out of proportion which, seem to be a direct result of lack of trust from managers. Furthermore, managers displayed a reluctance to take reported instances of Racism which resulted in black nurses' reluctance to report incidences of racism. In some cases, nurses feared reprisals.

Racism faced by black African nurses mirrors that faced by other migrant workers. It is important to appreciate that black African nurses did not expect to be met with racism and hostility when they relocated to the UK because advertisements in the press promised them a better life and opportunity. Racism encountered on arrival perpetrated by white colleagues and white neighbours caused black African to turn to each other and create spaces for themselves where they could feel accepted.

Hall (1992) and Pilkington (2003) argue that in Britain, a period of economic and political decline has coincided with increasing European integration and formation of minority enclaves within the nation state. This is felt by the some members of the dominant group to be a threat to the British way of life. One response to this has been the creation of a closed And exclusive definition of "Englishness" as a way of refusing to live with difference. These sentiments have created hostility both in the workplace and in the neighbourhood. The experience of racism and discrimination was felt by African nurses as a group and extended to nurses' children in schools.

CHAPTER 8

MANAGERS' PERSPECTIVES OF THEIR EXPERIENCES WITH BLACK AFRICAN NURSES IN THE UK

8.1 Introduction

Chapter 7 discussed experiences of black African nurses in the UK health care system. This chapter discusses managers' perspectives of their experiences with black African nurses. Eight managers were interviewed individually and two managers were interviewed together (see table 8.1 for managers' profiles). Interviews started with the statement "tell me your experiences of working with black African nurses." Probing questions were used where appropriate to clarify answers and to elicit new information. In general accounts of managers echoed experiences recounted by black African nurses in the previous chapter. Managers' experiences with black African nurses centred on four main themes:

- Communication

- Differences in nursing culture

- Racism and stereotyping

Table 8.1 Managers' profiles

Ward Manager	Trust	Years in post
Colorectal ward	1	5
Medical ward	1	7
Surgical ward	1	3
Renal ward 1	1	1
Renal ward 2	2	4
Critical care ward (mixed race white and Caribbean)	2	3
Medical elderly	3	6
Medical elderly (two managers)	4	3 and 6
Assessment ward	1	5

8.2 Communication: Managers' Perspective

Data from managers indicate mixed reactions to communication issues. Some managers indicated that they did not have any communication problems with black African nurses while others said that they had experienced some problems. Those who said there was a problem said that problems were a result of culture and slang that is often used in different parts of the UK. Communication issues were divided into two categories: communication with patients and communication with colleagues and doctors. Related to this theme was the importance of English tests to all nurses from non EEU countries instituted by the Nurses and Midwifery Council in 2006.

There was some corroboration of nurses' accounts discussed in chapter 7 in terms of difficulties of communication among nurses and between African nurses and patients.

However some managers said black African nurses came across as harsh and rough, and this caused aggravation with colleagues and patients (see section 8.2.3).

8.2.1 Communication with Patients

Managers felt black African nurses had problems understanding patients and vice versa. Some problems were attributed to different accents while others were attributed to the fact that some posts were rotational and nurses had little time to get used to patients. It seems rotation was particularly a problem with black African nurses as it meant that they encountered different ways of working and communicating in various wards which made their situations worse. The managers did not refer to any other group in connection with this problem. Therefore it is not known whether other nurses had problems. Some managers reported that telephone communication was difficult for the nurses as they could not see someone face to face. This problem was also mentioned by nurses in their interviews with some describing white colleagues standing over them whenever the telephone rang. This is a form of paternalism which indicates an attitude of mistrust on the part of white nurses of black African nurse's ability to handle telephone conversations. It appears this was a problem when it was assumed that every African nurse had problems communicating on the telephone. Most agreed that slang was the main problem:

> The main problem really is communication with black African nurses mainly because of culture and sometimes we use slang you know sometimes, in England, and certain ways of saying things and they don't understand that part sometimes you know, and you might say that (I can't think of something of the top of my head) sometimes they might not understand what the patient is saying. (Charge nurse surgical ward)

> That's quite difficult really we have one black African nurse a rotational nurse who did have quite a lot of communication problems which did not help by the fact that she was rotational   because after six months they moved on to the outpatients and it was very difficult and it did not help and she works now with patients and that's when the communication problems sort of came quite high in outpatients before she moved on to here because in outpatients there is a lot of face to face communication there is a lot of over the phone communication and that's where we had problems. (Charge nurse renal ward)

A lot of communication in hospital wards takes place on the telephone especially when speaking to relatives and other members of the Health Care Team. In these instances trying to understand different dialects and accents presented a particular challenge for nurses. This finding corresponds with the experiences of black African nurses themselves in the previous chapter.

According to the managers, some nurses found it difficult to explain procedures to patients. One charge nurse related an incident where a patient woke up to find a thermometer in her ear with no warning and it made the patient very frightened. The issue was not communicating with the patient before a procedure. In chapter 7 black African nurses did not discuss such experiences. The nurses may have been embarrassed or it could be that none of the nurses interviewed had experienced this problem. However, this is a serious problem as patients could be vulnerable if communication problems were not resolved. While most problems with communication were attributed to slang, other problems were attributed to differences in sense of humour on the part of nurses:

> It's just her sense of humour and it's just the way she comes over but she is doing a lot better I think than when she was previously. She knew we were speaking English the way we might say something and she takes in on face value. (Charge nurse renal ward)

This statement is subjective as the type of humour is not explained. It may be that the humour referred to was not considered humour by the nurse concerned. It is also true that what is humorous to one person may not be humorous to another (see section 8.2.3).

Sometimes nurses were judged by their facial appearances to have communication difficulties, but it is not clear how managers dealt with this problem. It is difficult to tell using facial appearances whether someone is serious or not as some people appear serious even

when they are not, but even if they are it is difficult to tell why they are serious without talking to them:

> She still has difficulties with the slang and things and she appears quite serious some times which she is not. I mean it's difficult with slang because she is not staring much than what she used to do when you said slang to her. (Charge nurse renal ward)

Again this is subjective as facial expression seems to be what is being referred to here and there is little one can do about one's natural features. However, some managers said that communication was not a problem, in any case there are many accents in the UK that even UK nurses find problems communicating with one another:

> …issues may be around accents because even here we have a lot of accents. But the ones (black African nurses) that I have worked with they all seem to have a good command of English. Sometimes, if patients have issues, I haven't had anybody raise issues about having difficulties in understanding. (Charge nurse renal ward 2)

> Conversation in English is different because it's difficult when you get more colloquial expression, so it also depends on what part of the UK you come from. I have an experience of going somewhere in the UK and saying something which meant totally a different thing there and they did not understand because of colloquialism. I guess you would have to have an understanding of grammatical English. (Charge nurse medical ward)

This reasoning mirrors black African nurses' own accounts in which they explained that different accents in the UK made it difficult for them to understand patients and vice versa.

8.2.2 Communication with Colleagues

Managers thought that black African nurses had difficulties expressing their opinions and that they needed a lot of support to gain confidence and start expressing themselves. However it was not clear why they thought that black African nurses lacked confidence. Some believed it to be due to lack of experience with the British nursing system. It appears there is an association between the way black African nurses felt they were treated and listened to and

their confidence in communication. In their interviews and discussions (Chapter 7), black African nurses said that they were often ignored by their white counterparts. They felt that their opinions often did not count even if they were valid and often they were thought of as being confrontational when they challenged certain decisions. It could be that because of these experiences nurses found it difficult to express themselves and withdrew from active participation:

> ..She is not very good on communication, not good at coming forward or expressing her opinions and saying I don't think that. (Charge nurse renal ward)

> ..She needs to have confidence because she can speak out more on her rounds. when she starts feeling more confident, that's when she can start speaking up on her rounds and nurses will know what she is talking about which is the problem really. (Charge nurse colorectal surgical ward)

When nurses are constantly ignored, they can easily withdraw from active engagement and Get into the mode of "I do what I am told" where they just do their work without exercising their full potential. This is a loss to the NHS and to patients.

Some managers said that communication is a cultural issue and involves the way people speak as well as tone of voice. They explained that, sometimes patients are not happy with the way they are spoken to. Managers also recognised the part played by familiarity with culture and with individuals when it came to communication:

> We've had a few issues mainly with the way she came across to people not pleasant, jolly, respectful in her tone and manner and somebody said to the junior sister, there are patients that were not too happy with her tone of voice and the manner and they were saying to some of the staff the she had said something that made my hair curl. It was very inappropriate. But speaking to her about it, it wasn't that there were things that she was saying it was just the way it came across. It just didn't sound right. And we had a lot of issues, so it knocked her confidence because I said to her other people are saying you are this and that and she would say I'm not. And when she explains it I'd say that's fine but this is how you are coming across. It was frustrating for her and I am

somebody who can appreciate those accents, the way people talk even if they are from Yorkshire or Liverpool is hardly the same. (Charge nurse colorectal surgical ward)

There are quite a lot of cultural differences to them I felt that that there were no soft side to her, she was quite a harsh lady that talked to people quite harshly, even in her nursing practice, there were no pleasantries to her but I just put that down to our cultural differences. I don't know whether that's right or wrong but all the time I knew her, she did not have any soft side to her. Now I work with a lot of African nurses and I still feel that there is a harsh side to them whether it's just talking to people. I don't know but that's my views. (Charge nurse 1 medical elderly)

The above statements are quite derogatory and convey the meaning that black African nurses are harsh and unpleasant and apparently patients felt the same. This could be a simple difference in expression as black African nurses had said they preferred to be direct in their conversations where as the British tend to be indirect and meaning is often inferred from the tone of voice and action.

Culture defines acceptable ways of behaving for members of a particular society and such definitions vary from society to society. This can lead to misunderstanding between members of different societies (Haralambos and Holborn 2004). As discussed in the previous chapter, individuals learn the culture of their society through socialisation. Primary socialisation takes place during infancy. The peer group, educational and occupational systems contribute to socialisation in secondary socialisation. In addition every culture contains guidelines that direct conduct in particular situations. These guidelines are known as norms and define acceptable and appropriate behaviour in a particular situation. It appears that these norms were different between black African nurses and UK nurses, patients and managers. However, the above statements appear to be consistent with stereotyped attitudes described by Fredrickson (1999), who contend that the stereotyped image of Africans as primitive is related to aspects of colonisation and the relationship is that of the coloniser and the colonised. However, it would be simplistic to say that this type of stereotype is a result of colonisation and images emanating from that period. Pilkington (2003) states that such

stereotyping continues to this day in various forms in the media. It echoes what Hall (1999) calls a strategy of 'splitting' which divides the normal and acceptable from the abnormal and unacceptable. Black African nurses' culture seems to be ruled abnormal and unacceptable by their managers.

In some cases managers said that black African nurses were very respectful:

> I am relating to the nurses that we've got here at the moment. I think there is a cultural difference. Not particularly with the nurses we've got here I don't think it's her harsh side but I think they don't tend to converse as much, don't tend to talk about social things as much and are very respectful and for us as sisters they are very respectful to what we say. I have one nurse who when I go to speak to her she always wears a cheeky smile and I feel like a school teacher but she just does that automatically and I think she just does it without even thinking about it and I think that maybe she feels that she doesn't have the same relationship with me like the other nurses because she doesn't approach me the same as they do but I think it's that respect. (Charge nurse 2 Medical elderly)

The two managers who provided the above perspectives worked on the same ward with the Same nurses. The different perspectives may mean a difference in each manager's Interpretation of the nurses' behaviour. This is of concern as it affects the managers' relationship with the nurses and in turn patient care. Managers did not say how they handled this situation, or if they intended to approach the nurses concerned to discuss this problem, which is again of concern since nurses were already concerned with gossiping, which was affecting their practice. One of the managers said that cultural awareness should be included as part of the induction procedure. This is vital since it would provide a forum where nurses and managers could express their concerns and have their questions relating to cultural

> I think people need to understand our culture. I know they do this in the citizenship but I think that should be included I think they should be aware of the particular area where they are going to work. And I know it probably sounds daft but areas have different cultural things and background. So it's important that people know about the culture in the area that they are going to practice in. (Charge nurse 2 medical elderly)

The need for British nurses to be aware of African culture was not mentioned. This lack of insight shows that appreciation was not given to understanding what would make the work environment a better place for both parties. In this era of valuing diversity in the NHS, it is surprising that this understanding of culture should only be one sided. This point was discussed in the previous chapter as the idea that British culture is better and superior to other cultures, therefore it is necessary for others to adapt to British culture. This idea is backward looking in this era of globalisation since people from different parts of the world can be found in the UK for different reasons at different times. It may therefore in the interest of UK Nurses to be aware of other cultures if the government's ambition of embracing diversity is going to be realised.

Charge nurses felt that communication problems were sometimes made worse because of the gossiping on wards. White nurses preferred to report issues to charge nurses instead of speaking with the individual nurses concerned:

> I think she might have felt that way because on some occasions people were coming to me rather than saying … you know; you could have said it softly or said it in a different way. It was to me so it kind of took everything to look more official and things like that. So she might have felt that way but I'd say the way I try to handle it , I go back and speak to the rest of the staff and say instead of tottering to me you could have sorted in straight away you know, going back to them and explaining to them that this is what happens. (Charge nurse colorectal ward)

This statement echoes the experiences of black African nurses themselves which, they described as unhelpful because in the end nursing care is affected if nurses are not told directly that they need to change something, or if they are not shown the correct way to do something. This charge nurse is unique in tackling the problem head on, as in many instances black African nurses said that even managers were joining in on the gossip. As a result many black African nurses lost their confidence and became suspicious of their white colleagues as

they thought that white colleagues talk about them behind their backs. One charge nurse

Explained that even some doctors are not approachable and are "quite quick to knock you

down". African nurses said that this type of behaviour and attitude   upset them as they

interpreted it to mean that they did not know anything. Loss of confidence was mentioned by

the colorectal charge nurse previously; however the charge nurse did not explain whether the

right climate was created on the ward where black African nurses were able to express

themselves.

8.2.3 English Tests

Since 2004 all nurses from non European Union (EU) countries are required to pass an

International English Language Test (IELTS) before they can apply for registration with the

NMC. This could be interpreted as discriminatory and Eurocentric, as many EU countries do

not have English as their first language. Many non EU countries on the other hand use

English as the first language in their educational institutions. It is therefore not surprising that

nurses from Sub-Saharan Africa and especially those from countries which were former

British colonies have better written and spoken English skills than those from the EU, as

mentioned by some managers.

Managers generally agreed that English tests should apply to anybody whose first language is

not English. However managers also emphasised that general English testing is not very

helpful as there are different accents in the UK and even English nurses find it difficult to

communicate when they move to a different area. They therefore advocated local support for

nurses to understand accents and the slang of the areas in which they are working:

> I think that if English is not your first language then I think that it's important that you
> tell them that it's sufficient for them to perform their job properly and it's essential that

people speak a common language that you can communicate with doctors, nurses, the whole of the multidisciplinary team and patients. I think that anybody that comes into a profession where communication is a most important aspect, I think yes they should have the same expectations of those people as they do of anybody outside the EU. They should have the ability to communicate in an effective way. (Charge nurse critical care)

It's just that little bit of support at the beginning really because it's very hard It's not just grasping the English, its grasping the slang and the different ways we express things as well and an English test wont test them on that would it? I don't think so. I think that supervisory practise is better because it is a matter of supervision for a period of time and support from somebody will be excellent. I don't think that an English test solves anything really, personally. (Charge nurse surgical ward)

Managers added that English tests deterred some nurses from doing courses and developing themselves as they had to take an English test first. They noted that they had some bright nurses who could easily do the courses but these nurses did not want to take the English test. Black African nurses probably did not want to take the test as they perceived them to be unfair because EU nurses whose first language is not English and who have difficulties communicating in English are not required to take it. Some managers even felt that communication was not a problem with African nurses as they always understood what they were asked to do and did it. On the other hand some EU nurses' English was described as appalling:

I interviewed an EU girl who had a Masters degree in nursing but I interviewed her for a healthcare assistant and her English was appalling. She didn't even get the job as a healthcare assistant because she couldn't understand what I was saying she couldn't follow the interview. (Charge nurse 1 medical elderly)

Sometimes you have to check out their (black African nurses) understanding if you are asking something, you have to check how they understand but I wouldn't say that communication is a problem because they understand whatever they are asked to do. (Charge nurse Medical ward)

This study indicates that the practice of selective English testing on overseas nurses is Eurocentric and it is also a dangerous policy since it puts patients' lives at risk by allowing nurses who are not competent in English to work in the UK without language training.

8.3 Differences in Nursing Culture

Although managers acknowledged that black African nurses had a lot of experience in their own countries before relocating to the UK, they said that there was a difference in approach to care. Managers noted that Black African nurses had different priorities in their approach to nursing. The differences centred on holistic versus task orientation in style of care as well as the use of resources and the work ethic. These issues are described below.

8.3.1 Holistic versus Task Oriented Care

Managers said they had observed that African nurses tended to be task orientated in their nursing practice and that they probably did not understand the care plan. The nursing care plan is a document which outlines what and how nursing care should be carried out for a particular patient and how it is to be evaluated:

> And I suppose she had plenty of experience, twenty years in Africa and the way we approach our nursing care is quite different and she didn't really understand the care plan and how that works. She is very task oriented I don't know how it is in Africa but when the doctor tells us to do something she will do it on the ward round. (Charge nurse Medical ward)

However there seems to be confusion as to what priorities should be in the care of patients. Managers acknowledged that African nurses value individual patient care but at the same time said that nurses do not have the right priorities, they did not say what they thought the priorities should be apart from the fact that African nurses did not take breaks, and carried out doctors' orders during the round.

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From my field note I noted that some African nurses explained that they did not find the care plan being used in UK hospitals. They instead found pre written care plans and care pathways being used. They explained that to them this did not seem individualised and lamented that they will have forgotten how to write a care plan when they returned home. Again this represents a difference that occurs because of lack of explanation, as the prewritten care plans and care path ways have provisions for individualised care. On the other hand, individualised care plans do not take much time to write and, given the prominence that documentation is given in British nursing, one would assume the care plan to be an obvious tool for carrying out nursing care. Some managers felt that black African nurses priorities for patients' care was at the expense of their own professional development. This is paradoxical as nurses felt that they were being denied professional development:

> ...and the way she works she is very much for the patient she is fantastic but she has to prioritise different things so everything has to be done this minute and everything is for patient you know but you've got to learn how to prioritise during the day otherwise she would work all the time and won't have a break because It's for the patient which is lovely but she has a lot of support and she is a lot better. (Charge nurse renal ward)

> The black African nurses I find to tend to be for the patient which is fine, its excellent nursing care. They (black African nurses) will attend to those patients every need to the detriment of other patients they look after very well but they are not able to prioritise very well and they don't like taking breaks. They (black African nurses) just work through the day. White nurses are much more proactive in their approach, black Africans aren't proactive so it's adapting yourself to different ways of doing things and different staff . (Charge nurse medical elderly ward)

> I find that they (black African nurses) do not push themselves to do courses. You have to actively find something that is simple for them and send them for it. Again it's all about patients, it's almost like a sacrifice thing you know, like I am here for the patients never mind the courses, so you've got to make sure that they are developing but you have to push them for it. (Charge nurse renal ward)

This observation was not echoed by nurses' interviewed as nurses said that they had to fight to get on courses and some of them had even been denied both money and time for going on courses. Moreover it is logical to think that professional development should not be an end in

itself but should lead to better patient care and patient satisfaction which African nurses seem to be doing. The above statements seem to suggest that nurses should put their own development above the care of patients. If this is the case the managers' priorities should be questioned as well since the purpose of professional development is to improve patient care. It is proposed that managers need to balance the needs of patients with needs of nurses.

With regard to the failure of black African nurses to take breaks when on duty, managers did not explain why nurses were unable to take working breaks. It would seem good management practice to ensure that nurses relieve each other by rotating breaks to make sure patients are not left unattended. It appears that black African nurses took their own initiative to ensure this situation at the expense of their breaks. If this is the case, nurses should be applauded and not criticised.

It also appears that some managers regarded black African nurses to be of low motivation. The statement from the charge nurses on renal ward above is a case in point. The charge nurse is emphatic that black African nurses will not go on courses unless they are simple, and even then, they have to be made to go. In fact this is a paradox since black African nurses expressed frustration at not being able to carry out procedures for patients without doing courses in the same procedures for which they were already qualified (see Chapter 7).

Managers did not state clearly what they thought nurses' priorities should be. It seems that they wanted nurses to provide good patient care and at the same time develop themselves. This is good but it appears the sentiment was not matched by provision of time and suitable opportunities for nurses. One manager had this observation to make about black African nurses and suggested that the practice of exploiting nurses is wrong echoing black nurses' observations that black African nurses were not valued. Note that the charge nurse who

expressed this idea below was from a medical elderly ward, which as explained previously is not a popular speciality with UK nurses:

> You can't bring people and then after you have used them say off you go now because that is wrong. It's actually benefited us for not having many jobs around because we are one of the last places to recruit as older people services because people go to cardiology. (Charge nurse medical elderly)

8.3.2 Use of Resources

Some managers said that African nurses use resources wisely:

> ...has got a lot of experience behind her and she is aware of the use of proper resources I think she does use resources wisely. I would not say that she wastes things because she has a lot of experience on that and she is aware of proper use of material. She uses things wisely. (Charge nurse critical care)

Charge nurses showed their appreciation of this trait in black African nurses as they said even though nurses may not have understood the budget they were careful with resources than some white nurses who were aware of the cost of resources. From my field notes I noted that managers associated the fact Africans are poor with the ability to appreciate the cost of resources. This may not in fact be the case. It is not always the case that those who are poorest are careful with resources and vice versa. The key in resource management is the effective use of resources. This is good management and it is beneficial to the NHS. Some black African nurses also indentified the waste of resources as a negative factor in nursing care in British hospitals (see Chapter 7).

8.3.3 Work Ethic

Some managers observed that some black African nurses are hard working and they have a different working culture. They explained that black African nurses working in their wards were very concerned with the well being of their patients that, they were willing to do what they could to make patients comfortable. Managers also said the fact that there are differences in diseases encountered in the UK and Africa probably accounted for this difference, as different diseases required different practice. The NHS was also mentioned as a factor accounting for differences in work ethic. These differences could probably be accounted for by differences in the way African hospitals are resourced both in terms of finance and human resources. However, this is in contrast to the observation made by some nurses who said that some managers thought that black African nurses were lazy.

The value placed on education and development may explain the willingness of black African nurses to share knowledge with others. Black African nurses recounted experiences of severe staff shortage in their own countries which would account for their hard working practices. The WHO (2006) states that sub-Saharan countries face severe shortages of doctors, nurses and other health workers, hence the work load per individual nurse is usually high:

> … their experience and some aspect of it, I think that everybody has something to offer. For example with treatment of TB patients I would think that they have got more to offer than someone like me. Your experience no matter whether you are coming from overseas nurses will be able to identify certain specific needs like cultural things that I might not be aware of and can be able to communicate with people that do not know how to speak English. Also their willingness to share and to teach other people. The nurses that I have worked with have played an integral part in teaching other people. (Charge nurse medical ward)

Some managers acknowledged diversity and valued this. However it is not clear how managers encouraged their staff to value the experience of African nurses and how and if

African nurses were rewarded in order to make them feel valued. Related to this theme was the idea that nurses should be allowed to practice their skills as lack of practice leads to the loss of skill. Black African nurses also emphasised this by saying that they were not allowed to practice their skills without courses being offered by their employing Trusts:

> There was a point where they were saying that if you haven't done cannulation in this trust then you would have to do it again. But I think that would be something that whatever skills that person come with then they would feel that they were ok and they knew what the protocols and procedures our Trust relate to and that would be something to be followed through in adaptation rather than saying no you can't do that. I think I can understand that they are deskilled. (Charge nurse surgical ward)

As the assessment criteria used for skills is the same for a particular procedure, it would make sense to assess nurses as soon as they are employed and allow them to practice accordingly. This would save time and resources and would boost confidence of the nurses concerned. However as discussed in the previous chapter power relations and stereotyped ideas about African education could probably be responsible for this practice.

8.3.4 Relationship with Care Assistants

Managers agreed that generally the relationship between black African nurses and care assistants was difficult. Managers said that health care assistants were resentful of being told to do something rather than being asked:

> There might be occasions where healthcare assistants feel that they always have been told what to do but I think it's down to the perception the healthcare assistants. And sometimes nurses tell them to wash the patient that is a big element of their role. I think that sometimes the healthcare assistants feel that they get told what to do instead of being asked. (Charge nurse critical care)

This mirrors black African nurses statements in chapter 7 in which nurses said that care assistants refused to take instructions from them. Some managers put this down to

personalities and the way individual nurses speak to care assistants. However this does not seem to be the case as all the nurses interviewed complained of the same problem. Black African nurses said that they were not used to working with health care assistants in their own countries and it may be that there is a misunderstanding of the role of the health care assistants as the charge nurse above has commented. However in their interviews black African nurses said that nursing care assistants would carry out the same instruction if it was given by a white nurse. This suggests care assistants felt black African nurses were inferior to them and as such they were not qualified to give them instructions.

Marks (1994) writes that in Apartheid South Africa, there were complaints that white student nurses found themselves juniors of blacks who had longer service than they. The chief secretary of the national party at the time had to write to the secretary of the nursing association and express his strongest disapproval because the practice was in conflict with the philosophy of white people. One officer boasted that that practice lasted only half an hour when she arrived on the scene. The situation in apartheid South African was of course legal and overt. Black African nurses in this study seem to have experiences covert discrimination. Their situation is consistent with Rex (1999) who states that black Africans occupy the lowest Position in term of structuration of 'races'. The experience of black African nurses with nursing assistants illustrates this relationship. As discussed before, overseas nurses were recruited to a subordinate role to fill the lowest position in the nursing hierarchy. This position is traditionally filled by students and nursing assistants.

Black African nurses, it appears were seen by nursing assistants as occupying a lower position than themselves. In addition this was legitimated by managers as nursing assistants were given responsibility to supervise black African nurses and observe them (see previous

chapter).This legitimated authority and superiority over black African nurses would explain

why nursing assistants were reluctant to take instructions from them. The quotation from the

renal charge nurses below illustrates this point. It seems nursing assistants tried to justify

their behaviour by saying that they wanted to be asked and not told to do things. In a health

care setting the rules of delegation are well established and it is expected that nursing

assistants will take instructions from qualified nurses. The question of communication

probably has great importance here as this is where appreciation of culture is required and is

helpful on both sides. One manager (an ethnic minority) commented thus:

> The care assistants have very strong personalities so it's easy to clash with them. But
> sometimes it's not worth arguing with them because if you argue with one they all gang
> up so it's not worth it. Sometimes you say something and you can be sure that there will
> be repercussions there is someone who can be quite aggressive and she can cause
> conflict. It's come on from some of my staff that she can undermine some of my staff.
> (Charge nurse renal critical care)

It appears from this statement that health care assistants resent black African nurses giving

them instructions. In chapter 7 nurses explained that health care assistants felt superior to

black African nurses and this was a constant cause of conflict in their working relationship.

It also appeared that managers relied a lot on health care assistants and gave them the same

status as registered nurses:

> Its healthcare assistants you are relying on to do and it's supposed to be done under
> supervision that care and it's not because they are just left to get on with it and its not
> done We've actually got a different grade now, a band 3 in post, a senior healthcare
> assistant with NVQ 3 just to give more care to the patients because we know that that
> the qualified nurses are taken away, especially on an assessment ward. The admission
> paperwork alone is quite massive. (Charge nurse assessment ward)

> We had a lot of senior nurses taken away at one point. I'm actually replacing them
> with health carers. So when the senior lot left, I couldn't get more senior posts in so
> there was a period before Agenda for Change where there were no actual place for
> them (black African nurses) to move into. We lost an F grade and four E grades
> replaced with 4 health carers. (Charge nurse colorectal ward)

It is clear from the above statements that health care assistants were given a lot of authority and responsibility. It is therefore not surprising that they felt resentful at having to relinquish this position to black African nurses. At the same time the practice is of concern as nursing assistants without nursing qualification are trusted to replace senior nurses. One can only imagine what this practice can do to nursing care and patient safety.

Some black African nurses said that they found health care assistants running wards in the UK (see previous chapter section 7.4.1). The above statement illustrates this point. It is especially more worrying if qualified black African nurses are not allowed to take posts in preference for care assistants. This was demoralising for African nurses who felt that nursing care should be led and provided by qualified nurses. It also poses questions as to the type of care provided for patients if those providing it do not possess the necessary qualifications.

8.4 Documentation

Mangers felt African nurses misunderstood the importance of documentation and that is why they complained about there being too much documentation in British hospitals. However managers corroborated the concern raised by African nurses that a lot of documentation takes time that could be spent on nursing care:

> I think that documentation is really a big caption (sic) and I don't think that it is carried out perhaps the way it is meant to be and I think there is a lot of duplication. I know there is also a thing about litigation because if there was a litigation in court they look at what has been documented. And I think that perhaps a lot of people get caught up in that kind of thinking. And sometimes we lose the communication so I can understand how people would look at it and feel that it is a lot and that perhaps it is not worth doing. (Charge nurse surgical ward)

> I think we are having more and more paperwork each day. There are things like the acute dependency score which is more paperwork for nurses and it takes nurses away from the bedside and makes them concentrate on paperwork and that's what we find

with newly qualified nurses is that they are concentrating so much on the paperwork that they forget that they have got patients to look after and they are writing about something that someone else is supposed to have done and it's not being done. (Charge nurse medical ward)

However, charge nurses recognized that each speciality had different paper work, and these demand different levels of attention:

Paper work is different in different specialities but, because of the speciality you are very tied, because we work with over 80's predominantly, because if you want to refer an over 80 home, the social factor, you have to have a whole lot of paperwork otherwise they won't take the referral. So we have no choice but to do that because otherwise we can't refer to other agencies, and if we can't refer we can't get people home. (Charge nurse medical elderly)

Different regulatory systems may be responsible for this difference in appreciation in documentation. This is perhaps one aspect that needs to be emphasised during the adaptation period so that nurses understand why so much documentation is important in the UK. Charge nurses did not say whether they explained to African nurses why a lot of documentation is necessary or the response of black African nurses when the rationale for documentation was explained. It seems that the only reason given to nurses was litigation as nurses themselves emphasised this point. They described having to document care "to cover Their backs" all the time as mistakes were blown out of proportion. This would make nurses weary but also it would make them regard documentation as if it is not part of nursing care. It has been explained in chapter 7 that the adoption of the nursing process by the NHS brought with it excessive documentation which has detracted attention from patient care. However extensive documentation now seems to be an integral part of nursing in the UK. According to the statement by the charge nurse below, it is clear that documentation is essential to nursing care:

It's something that I feel that its understanding that is there for all the nurses that we know we want to spend more time with patients but we are also legally bound to do this paperwork. Because that's why we came into the job to look after people and not just

lie about, but because of the litigation people are so careful. I know with one African nurse who is very focused on being careful. (Charge nurse assessment ward)

8.5 Differences in Adaptation Courses

Related to the theme of differences in professional practice was differences in adaptation courses or period of supervised practice. Managers explained that there were differences in adaptation courses provided by nursing homes and NHS hospitals. Generally managers agreed that nursing homes were not the ideal environment for adaptation courses as they did not provide the necessary skills to prepare nurses to work in NHS hospitals:

> I think issues happen if the nurse has come from a nursing home and they come to a hospital setting, in a nursing home the way people work is different because in the nursing home the trained nurse just does medicines and nothing else. And to come into a hospital setting where they are expected to give nursing care and all the rest of it, they find it difficult to adapt to that. (Charge nurse surgical ward)

Charge nurses explained that adaptation courses need to be tailored to individual needs of nurses and take into account the individual nurse's previous experience and the speciality. This would enable individual nurses to enhance skills that they already possess:

> If you have somebody coming into respiratory medicine who wants to come and get some experience and support of working within respiratory medicine then we would try and get those individuals to go and observe some specific tests that may be carried out relating to these areas. There are nurse specialists for that area. Because I think it's more about getting a feel and the adaptation is about getting confidence of working within a specific areas. It's like an orientation where they would be supervised so that they can identify what areas they need to gain more experience. They would need to familiarise themselves with medications. (Charge nurse medical ward)

Black African nurses were often employed in areas in which they had little or no experience after a nursing home adaptation practice. Often these were unpopular areas such as medical elderly and Intensive Care Units where recruitment of nurses is difficult. It is paradoxical that

these are also areas where most vulnerable patients are found. In the ideal situation nurses

working in these areas should be those who are interested and have experience in the area.

Some charge nurses had specific aspects that they would like to see in ideal adaptation

programmes for African nurses. These aspects mirrored those that black African nurses said

they would have liked in their adaptation or orientation period:

> There is lots and lots we do about social needs a lot of it is quite complicated a lot of the
> referrals we make, and the role of the occupational therapists the role of physiotherapist
> in discharge, about setting up home care. That's something that we have to teach nurses
> on here because that's an experience that they never had. You need to cover legislation
> you need to know about you need to have an awareness of the National Service
> Framework, health and safety legislation, moving and handling there is a lot that you
> have to cover but you also need that experience of working in the NHS. Some of it is
> transferable but I think it depends on your previous experience and what speciality you
> are interested in so if people are interested in surgery or high dependency or older people
> and because we are older people services I think people think it's not acute experience
> and they think oh I work in a nursing home I can do that. (Charge nurse medical elderly)

Tailoring adaptation courses to individual nurses' needs would be an effective way of using

nurses' skills and would increase job satisfaction. The feeling of being used as a pair of hands

that African nurses expressed, would also be addressed as nurses would be working in areas of

their interest.

8.6 Racism and Stereotyping

Managers indicated that black African nurses suffer racism from patients as well as from

colleagues. Managers also displayed stereotyping between different groups of overseas

nurses. This is consistent with the black African nurses' experience which was outlined in

chapter 7. These issues are explained next.

8.6.1 Racism from Patients

Racism from patients was manifested in various ways but mainly it was through racist

comments and attitudes:

> I think part of it is also the way patients approach the African nurses as well because a
> lot of our patients do have racist tendencies. (Charge nurse1 medical elderly)

> From a cultural point of view I think the issues are when nurses come towards the
> patients who are prejudiced but I haven't really come across a lot of that, they tend to be
> more isolated incidents. (Charge nurse medical ward)

Some managers put patients' racist attitudes down to age. Others said that it was due to

personality as other nurses also had a similar experience:

> When we are working we hear them say things but we just carry on because we know
> that's what old people can be like. (Charge nurse 1 medical elderly)

> Some issues could be attributed to personality, I have had issues but maybe somebody
> being abrupt but they haven't been necessarily just for African nurses but all the nurses,
> white nurses, Filipino nurses. So it could be down to personality rather than anything
> unless there is a cultural thing, I don't know. (Charge nurse 2 medical elderly)

The influence of age on racist attitudes has been discussed in the previous chapter.

There was a tendency among managers to defend patients. This was particularly evident

when two managers above with different views were discussing the issue. The manager who

wanted to discuss the issue of racism with patients was always being contradicted by the one

who thought patients were just making generalised comment about the nursing staff. This

made it very difficult to get specific examples from these two managers. The effect of a racist

remark or attitude to nurses was not appreciated. This is understandable as it is difficult to

appreciate the effect of such behaviour unless one has been a victim. Some managers put

racism down to the condition of the patients:

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> There is only one patient who has got psychological problems and he would say like I don't want a black nurse but you do make allowances for that but generally they are alright. (Charge nurse colorectal ward)

However, accounts from black African nurses indicate that even patients who had no

psychological problems refused care from them because of the nurses' colour.

8.6.2 Racism from Colleagues

Racism from colleagues could be quite overt. Managers described incidences where nurses

were bullied and some were called names:

> I don't like saying these things either because I feel disloyal to them (white nurses) by saying that. But some of the staff are harsh, they have got this harsh side to them but I really feel sorry saying that. (Charge nurse surgical ward)

> I think she felt bullied as well because people's expectations were a lot higher all the time she was aware that people were looking at her practice all the time. (Charge nurse colorectal ward)

> They all have a bit. But she needed that little bit of guidance and a bit of understanding because you know some people have given her "she's crap" and as a manager I've said this is not on. (Charge nurse medical ward)

Managers appeared to contribute to racism by their mistrust of Black African nurses by applying

inappropriate scrutiny to African nurses and instructing others to do so as well:

> …but it's good that they can come into our area and say I've seen this before, I know this kind of operation and I know what kind of things to look out for, because that is good for me as a manager because the confidence is already there. I still observe because they could fib to me. They might say yes I can do this but they but I still got to be aware that they could be telling me a few mistruths. So, I still watch. Other people might say be there because I'd be mentored, I'd be looked after and supported and make sure that it is done right as well so it's not only my eyes but somebody's eyes as well, and they are monitoring as well. (Charge nurse colorectal ward)

This type of management could account for some of the bullying discussed above which,

black African nurses' experienced in the work place. It could also be responsible for some of

the racism that black African nurses experienced from patients and colleagues. The charge nurse above showed a lot of mistrust in the African nurses to the point where she is specially observed by the charge nurse. The charge nurse instructed other nurses to observe her as well. This is almost as though black African nurses have a greater propensity to lie than other nurses. This manager confirms the observation made by black African nurses that they felt under scrutiny. These sentiments demonstrate that the situation has not changed much since 1965 when Goodland noted that 'there is a tendency among westerners to feel that these nurses come from comparatively primitive backgrounds and that their intelligence may be Less than their British colleagues'. (p. 241). Goodland (1965) notes that "this is of course totally untrue, the African nurses may not come from primitive backgrounds and even if they did their intelligence is not less than anybody else's. …the African nurses excited curiosity from the moment they entered the ward. Everyone knows that they come from a continent, which is emerging from a background perhaps comparable to that of Britain centuries ago, emerging fast and determined to place itself upon an equal footing with the western world, not over the course of centuries, but within the space of a lifetime. These nurses face prejudice and disbelief or at the very least an intense interest to see if they "shape up" (p.241). He further adds that, they excite curiosity and attention, because their colour is even more apparent in the white world of the English hospital. This attitude resonates with racial stereotyping of black people described by Hall (1999) which existed during the 18th and 19th Century which reduced them to "their essence, laziness, simple fidelity, mindless, '*cooning*', trickery, and childishness,.. (p.245) (emphasis original)

Goodland (1965) notes that African nurses were aware of the intense interest and observation and adds that when a person is the subject of that kind of interest and attention it requires a

tremendous act of bravery to carry out his/her normal duties without letting it worry her. The

language in this study is coded reflecting political correctness of the 21st century but the

Sentiments expressed here are similar to those expressed in Goodland's (1965) report. Cox

writing earlier in 1948 also recognised this state of affairs when he wrote:

> The colour prejudice of whites has other potentialities; it functions as a regulator of
> minor racial prejudices. Whenever there are two or more races in the same racial
> situation with whites, the whites will implicitly or explicitly influence the relationship
> between these subordinate races. In other words, the whole racial atmosphere tends to
> be determined by the superior race. …The race against whom the whites are least
> prejudiced tends to become second in rank, while the race that they despise the most
> will ordinarily be at the bottom. (p. 349)

This behaviour can hardly be expected to create an atmosphere that enhances nursing care.

8.7 Stereotyping

Although managers recognised that black African nurses were facing racism they failed to

recognize that they were perpetrators themselves. Racism from managers came in the form of

stereotyping as they indicated that other overseas nurses were better than black African

nurses. For example a ward manager made the following statements about a Filipino nurses:

> She is Filipino and she is an excellent staff nurse and I think she would be excellent as
> a junior sister but she is not interested she doesn't want the aggravation, doesn't want
> the responsibility. So what I have done is we have two kits for our band 6, I have dug
> then out and I have started to work through them with her to develop her further but at
> the end of the day if they don't want develop you can't make them, can you?... I would
> probably say that (name of black African nurse) knowledge of hospital policies it is
> probably very limited, because again they focus on patients. Now in our KSF and
> competencies there is stuff in there about hospital policies, for example pressure area
> care policies and wound care policies for them to do but I suggest that she does not
> have a clue on what is going on the ward to be honest because her focus is just the
> patient.

These statements seem to favour the Filipino nurse although both nurses seem to be focused on patient care. This manager thinks the Filipino nurse is excellent and the African nurse has not got a clue regarding hospital policies. Also notice how the manager is providing information to the Filipino nurse and not to the Black African nurse, probably thinking that this would be wasted on the African nurse as she is not able to articulate and use the information. It is evident here that this stereotyping leads to discrimination. Black African nurses were concerned about this practice as discussed in the previous chapter. They explained that it amounted to discrimination and it was manifest in the allocation of nursing duties and personal development.

A charge nurse from a different area also said:

> Like Filipino nurses they were there, there was one that was there for three years and was extremely good and I had jobs on ward 19A and she was really good, an E grade post came up and I said why you don't go for it. You are doing the role, you just need to get a little bit of confidence in yourself and go through a few interview techniques, you know, and go through things that you need to be saying and how you need to be saying it. But it took a good two years of bullying in a nice way, saying there is an E grade coming up; I want to see you go for it. And those that ended up doing it were promoted. But like I said for (black African nurse) there hasn't been an opportunity on this ward, but there have been on other wards. I know she likes it here, she likes the people, she likes the work, and it works out well within her home life. (Charge nurse colorectal ward)

Notice how the charge nurse went out of his way to encourage the Filipino nurse to apply for promotion because   she was "extremely good", but he preferred the black African nurse to stay on the ward as she supposedly liked it there, the charge nurse had not apparently informed the black African nurse of promotion opportunities elsewhere. He just assumed that the black African nurse was happy with her grade on the ward. Different managers made similar remarks about overseas nurses from different areas:

I mean if you look at Filipino nurses are pretty quick and they are quite good. African nurses are not bothered about developing themselves honestly, they just want to go back to Africa. One is just concerned about child care. They are just concerned with their work but they are not bothered about some of them just came here to work. (Charge nurse renal ward)

… (black African nurse) has been here five years now so she is well used to taking charge of the ward herself so I don't know how she found it earlier on. I also have an Indian nurse who did her adaptation in a nursing home but she was a cut above the rest and she has been in charge and she has got her independence but she did not have a pin number when she started. But it is a new speciality and it is different but I have not come across any conflicts with her because I think she has been learning and she has a lot of experience which I think for her maybe made her transition more settled. (Charge nurse medical elderly)

These statements show the same theme that somehow black African nurses have low motivation and less capable than other overseas nurses and it is not worth encouraging them to develop professionally. Interviews with black African nurses in chapter 7 reveal that nurses felt that they were treated as if they did not know anything and, if managers and colleagues found their stereotype challenged, they blamed black African nurses and called them arrogant. This leads to discrimination as can be seen from the preceding statements that black African nurses were not being informed of development opportunities as it was perceived that they were not interested. They were also not being provided with training for interviews.

This stereotype is contradictory to black African nurses' motivation for coming to the UK discussed in chapter 6. In their interviews nurses explained that their motivation for coming to the UK was to develop themselves and improve their knowledge. This was apparent as many were seeking higher education and some professional courses. Admittedly there were some who had put their development plans on hold because of family reasons but these nurses explained that it was their intention to get as much education as possible to develop themselves as they did not have this opportunity in their own countries.

8.8 Equal Opportunities and Discrimination

There was a general agreement among managers that equal opportunities were implemented through the Knowledge and Skills Framework (KSF). However there was a lot of variation on how managers interpreted the KFS document. It was clear from interviews that some managers were good at informing nurses of the equal opportunities policy while some relied on documents in ward files and the internet. Most managers thought that black African nurses were not motivated due to cultural reasons and had to be dragged to do courses but when asked about promoting nurses to higher grades managers said that either nurses were not

ready or there were no posts available. It appears that managers interpreted equal opportunities and anti discrimination legislation through the KSF document. Although important the KSF document is only part of the equality legislation but managers seemed to be unwilling to discuss how they implemented the 2010 Equality Act in practice.

8.8.1 Information Availability of Development Opportunities

Managers said that they provided information through yearly appraisals and six monthly updates on KSF. On one ward the KSF document was given to every nurse. However this is an exception and generally managers appeared to pay lip service to the provision of information as discussed above:

> Promotion doesn't exist anymore for staff nurses in a way that you move from junior band 5 to senior band 6. You sort of move through the KSF into senior band 5 post unless you get stopped. Before you used to apply for an E grade, it doesn't happen anymore. We have yearly appraisals. We have six months update. We have the   clinical educator, we have competencies. I work on the wards all the time so I know my staff. I would pick that up. I would have been moving them up the KSF; I would use competencies for a more senior post. I would develop them, getting them on courses that they need for a junior manager if they wanted that. (Charge nurse renal ward)

Some managers saw it as their responsibility to inform nurses of development opportunities

on the ward through various means and blamed nurses for not being motivated enough to take

up opportunities. These opportunities were mainly in the form of courses and study days:

> It's my duty to make sure that I disseminate all the information that I get to my staff. So
> I will put out all the information out but it's up to them to read it, if you go to the notice
> board they are all sorts of information there, newsletters, information, minutes. I will
> pop out information for them to read. And it's not just for (name of black African
> nurses) but you will find junior staff, because they are junior, they can't see past the
> ward. I find that they do not push themselves to do courses. Again it's all about patients.
> (Charge nurse surgical ward)

Some managers admitted not discussing any development plans with Black African nurses:

> I don't know what they think because I have not had any discussion with them about
> their career path. Personally I haven't done any personal development or appraisals with
> African nurses. (Charge nurse renal ward)

Others said that it was difficult to send African nurses for development because of funding

problems:

> I know colleagues who have African nurses in their wards and when they are doing their
> personal development plans on lots of courses and they ask for help with funding but at
> the moment the trust is quite stringent with how many study days one can do because
> they have to pay for them. So a lot of people don't get an awful lot but as far as I am
> aware it is fair between all the nurses on the ward and that the ward manager would
> ensure that everybody would have equal access to study leave. (Charge nurse surgical
> ward)

However managers admitted that it was difficult if not impossible to apply equal opportunities

as applicants could be identified from application forms:

> The Trust does operate equal opportunities in terms of career progression and in terms of
> recruiting for any individual post, someone on the panel that shortlist, does not have
> access to the geographic background of the individuals. Having said that, we know that
> on the application form you have to write down where you had your education or
> professional qualifications so you can identify individuals who were not educated in this
> country according to that. So whether that is up to the individuals people I think at the
> end of the day as to whether equal opportunities is carried out in the way that it is

intended to go, I don't know of any individual who doesn't work to that but I also know that at the interview they have got some kind of a point scoring system. I am not suggesting that people don't work within equal opportunities but I am saying if somebody knows that person whether they can be truly objective I don't know. (Charge nurse renal ward)

Richmond (1994) has stated that it is a mark of a racist society that classifies people according to certain attributes. The statement above shows how data which was meant for good could be used to discriminate minority candidates. The only ethnic minority (black) manager interviewed in this study offered some insight on how difficult it is or it may be for Black African nurses to develop and advance their careers. She related her own experience and how it had been difficult for her to develop and advance in her career:

To get the sisters post I have applied about three times before I got the sisters position and before and I was convinced am going to leave the unit because I had to go off and do a masters degree, I had to do a lot of courses, did everything and then when I applied for the job I realised that am just banging myself against a brick wall then I thought I am going to leave and see if I can work with the consultants to do some sort of research. (Charge nurses critical care)

This charge nurse explained that black nurses have to prove themselves if they wanted to move up the career ladder. They have to get extra qualifications. She added:

It's just a fact of life that if you come from abroad you have to prove yourself. Then you've got to prove yourself a bit more because of your colour.

This statement echoes black African nurses' experiences in the previous chapter. Nurses felt that they had to work twice as hard and have better qualification to get a similar post to a white British nurse. However even with extra experience and qualification black African nurses still found it difficult to move up the career ladder and have the same opportunities as their white counterparts. In some cases they felt their qualifications made a negative impact as their white colleagues resented them and called them arrogant. Pilkington (2003) notes that minority groups are under-represented among employers and managers of large

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establishments. He argues that this suggests there is a glass ceiling inhibiting upward mobility

beyond a certain point. In addition he argues that a comparison of educational qualifications

between Whites and minority groups at comparable job levels reveal that possession of

qualifications does not always allow minority groups to have access to the more desirable

jobs on the same terms as Whites. Pilkington (2003) points out that this may result from

racial discrimination which prevents minority groups receiving the same return from

investment in education. This statement from a charge nurse explicates the point:

> I think that is where the problem lies. They do the courses and then afterwards they
> don't always get the responsibility. I think because of the nature of them they are
> bothered. Some of them have applied for the courses the ones we got here are quite
> good so they have been applying for the courses but soon after they finish the courses
> but they are not bothered some of them just do the courses and not use them. (Charge
> nurse Renal ward)

This lack of recognition can result in withdrawal from engagement in practice and lack of

commitment. The charge nurse above describes this as not bothering, nurses just want to

come do their work and go home as they see no real rewards for their efforts in terms of

career development. One charge nurse commented:

> The African nurses they just get on with their work and they don't want to do any more
> than they have to do. They just don't want the responsibility and also the main reason
> these nurses don't' want the responsibility is they are not paid for it so they feel why
> should I? That is the main one. I mean they have the experience to deal with it, but
> then there are not that many posts available. (Charge nurse critical care)

This is a generalised statement which suggest that all African nurses lack motivation.

However the manager contradicts herself in the same sentence by saying that if nurses are not

given responsibility and rewarded for their jobs, they will not be motivated. The lack of

reward is explained by the unavailability of suitable posts, yet in their interviews black

African nurses stated that junior white British nurses without experiences were being

promoted to senior grades.

8.8.2 Lack of Support

A related theme on equal opportunities was the lack of support for black African nurses.

Mangers explained that often there was no support on wards for nurses due to staff

shortages.

Newly qualified nurses were able to cope better because they were educated in British

institutions but were also required to have a preceptor and a period of supervised practice. On

the other hand African nurses were allocated mentors but working with a designated mentor

was not always possible:

> when she came we were very busy, the staffing levels were very low and we were cutting costs at the same period so in fairness she didn't get as much support as what she should have done really and she kind of came in and just got on with things and we tried to do it as best as we can so it just took that bit longer and slowly as months went by she just got more and more confident. (Charge nurse colorectal ward)

> I know that they weren't supported. And none of them are young girls and automatically if you see a mature lady nursing, you assume they have been nursing for a long time. I know because we went to find an induction package. (Charge nurse medical elderly)

Charge nurses agreed that although Black African nurses were well qualified and

practitioners in their own right, they still needed support to adapt to the British system of

nursing. Documentation and policies were special areas that were singled out for needing

supervision:

> ..we already know that as qualified nurses they have got qualifications from their own countries and coming from adaptation courses of course to get their PIN numbers. So they are practitioners in their own right already, it's just a matter of readapting them to this work environment and the way that this hospital do things, what sort of traditions are in the hospital as far as following national and local policies.(Charge Nurse colorectal ward)

It is therefore not surprising that in their interviews Black African nurses singled out

documentation as well as different policies as areas which were especially of concern.

8.9 Summary

This chapter presented manager's perspectives on experiences of black African nurses in the UK. The data indicates that accounts of managers' experiences largely echo experiences of black African nurses. Interviews with managers revealed subjective, stereotyped and discriminatory attitudes.

Managers indicated that some black African nurses had problems speaking on the phone and some had problems with different accents used in the UK. Slang was perceived as a particular problem. It was noted that during adaptation period, black African nurses did not have communication as one of the areas where orientation was directed and that this may be the root of the problem.

Some managers were subjective and patronising towards black African nurses but at the same time said that nurses lacked confidence in their communication. Although they recognised that communication was a cultural issue, there was agreement among managers that it is necessary for black African nurses to adapt to the British culture.

It was discussed in the last chapter that European contact with other people involved a process of representation and with European expansion, a construction of the West's sense of self through its sense of difference from others. This resulted in a discourse which divided the world between West/the rest (Hall 1992). In this dichotomy European and Western culture is viewed as superior to other cultures and the adoption of Western culture is termed civilisation (Miles 1989). Pilkington (2003) states that " While it is important to recognise representations which ground differences in colour and culture do not operate in a similar manner, it is

equally important not to overstate the opposition between a discourse which privileges biological markers like skin colour and a discourse which privileges cultural markers like religion." (P.180). However, Hall (2000) contends that a discourse which privileges cultural markers often indirectly contains a biological reference. In Hall's (2000) view "biological racism and cultural differentialism therefore, constitute not two different systems, but racism's two registers" (p. 223).

It is therefore not surprising that managers said nothing about British nurses need to understand black African nurses' culture. For an institution that has committed itself to multiculturalism this finding is alarming. The lack of commitment was exemplified by the Home Secretary in 2002 when he announced that, people applying for British citizenship would be required to learn about aspects of British culture (The guardian 2002).

Managers said that black African nurses had different priorities when providing nursing care. Black African nurses were said to concentrate on the patient to the detriment of their personal safety (in terms of taking work breaks) and personal development, according to managers, black African nurses lacked motivation for self development and therefore, had to be pushed to do even the simplest courses. This is contradictory to nurses' own accounts who said that self development and professional development was one motivation factor for coming to the UK.

It has been established that a number of nurses interviewed had graduate qualifications and had ambitions of studying at Masters Degree level. Those who were not graduates aspired to study for a degree. The data also indicates that black African nurses were often denied these opportunities. It could be argued that nurses did not consider that the simple courses they

were asked to attend were necessary for them. It is also important to note in this regard that black African nurses were asked to attend courses for skills in which they were already competent. Nurses could hardly be expected to be motivated to learn something which they already knew.

Managers observed that black African nurses were careful with resources which, corresponds to the nurses observation that British nurses waste resources. This is one aspect of care which British nurses can emulate since it can result in the efficiency of the NHS. Some managers acknowledged that black African nurses were hard working and attributed this to differences in diseases encountered in the UK and Africa and different nursing practices between the UK and Africa. It was acknowledged that diversity is important to the NHS. Managers said that it was important for nurses to be assessed objectively so that they can utilise their skills in the NHS. However this is difficult to implement in a bureaucratic system such as the NHS. The situation is compounded by the struggle for power and authority of which these nursing skills are integral in the nursing hierarchy.

Managers noted that the practice of exploiting nurses was wrong. This was discussed by black African nurses themselves and it is consistent with employment of migrant labour in undesirable occupations shunned by locals. In the case of nursing, this situation was created by nurse shortages. According to Richmond (1994), 'asymmetrical distribution of resources (including information and knowledge) gives rise to structures of domination embedded in political, economic and social institutions that can be oppressive' (p. 7). Giddens (1981) adds that exploitation is more than purely economic in form. It can occur whenever power is used for sectional interests at the expense of other individuals or groups. People can be manipulated through ideological indoctrination as well as material deprivation. Managers in

this study appeared to have used their power in this way. Black African nurses were denied development on the premises that they were less motivated. This could be termed asymmetrical distribution and material deprivation.

Relations between black African nurses and nursing assistants were viewed as problematic by managers. Managers corroborated statements made by black African nurses in the previous chapter that on occasions, health care assistants refused to take instructions from black African nurses. Although managers said that this was due to the way instructions were given, a deeper examination of the relationship reveals that the behaviour of healthcare assistants toward black African nurses was legitimated by managers.

This legitimacy was probably promoted by government policy which stipulated that overseas nurses were recruited to fill nursing gaps pending qualification of British trained nurses (DoH, 2000). Consequently, this was demoralising for black African nurses. The problem of employing black migrants to fill the lowest jobs is not just a problem within the nursing hierarchy but it has also been identified with other migrant workers. Rex (1999) is right when he says that the problem is not only a class problem as Phizacklea and Miles (1980) contend but also a racial problem.

Differences in documentation were explained by different regulatory systems. However, it is not clear whether adaptation courses included explanations of this important element of nursing care. Managers agreed that nurses need to be employed in specialities which match their skills and experience but it is apparent that this was not the case because black African nurses like other overseas nurses were recruited to relieve nurse shortages in the UK which often involved undesirable specialities.

Managers often displayed prejudice and stereotyped attitudes toward black African nurses. Nurses were often said to be abrupt and less motivated than other overseas nurses. Managers said that black African nurses were bullied and white nurse expectations of them were high. Black African nurses were not trusted regarding their skills and were closely watched by both managers and white nurses. Managers often utilised a divide and rule approach by favouring other overseas nurses over Africans.

The management approach described here is embedded in institutional racism and consistent with treatment of migrant labour described by Phizacklea and Miles (1980) and Rex (1999). Managers recognised that black African nurses faced prejudice and racism from colleagues and patients but failed to recognise that they were the perpetrators themselves. In the current study prejudice as practiced by managers ensured a divisive tool among overseas nurses and among the nursing staff as a group.

Managers said that equal opportunities were implemented through the knowledge and skills framework. But very few actually admitted informing nurses about this framework and how it worked in practice. One manager admitted that she never discussed with black African nurses about their professional development needs. An insightful comment was given by a black manager who said that nurses from abroad have to prove themselves and black nurses had to prove themselves a bit more. One manager admitted that it is possible to identify candidates applying for promotion from the data provided on the interview form and doubted whether equal opportunities are carried out the way they are intended to work.

Although equal opportunities forms are intended to eliminate discrimination they can also be used by some managers to discriminate against minorities. Black African nurses recounted

experiences of being discriminated against and said that equal opportunities were rarely implemented in practice.

Managers discriminated against black African nurses and other overseas nurses in the way they provided support for personal development and preparation for interviews. This ensured a nursing hierarchy in which black African nurses were at the bottom and is consistent with Rex's (1999) race structuration. The next chapter discusses findings from the previous three chapters and implications of these finding for practice.

CHAPTER 9

DISCUSSION AND IMPLICATIONS OF THE STUDY FINDINGS

9.1 Sub-Saharan Nurse Migration Explained

This study has presented motivational factors for black African nurses wanting to move to the UK and experiences of black African nurses once they have arrived and are working in the UK. The study has also discussed managers' perspectives on their experience of working with black African nurses. This chapter discusses black African nurses' migratory trajectories and their experiences in the UK as they relate to those migratory trajectories. I have argued in chapter 4 that black African nurses' migratory trajectories are embedded in historical, political and economic factors which resulted in part from colonisation of sub-Saharan Africa by Britain. After independence from Britain, the role of Britain in exploiting colonial states was taken over by multinational companies and international corporations like the World Bank and the IMF that have continued that exploitative role. It is acknowledged that other factors like famine, poor economic management and corrupt governments have contributed to poor economic conditions and poor infrastructures in sub-Saharan countries. However, the role played by colonialism and the uneven development between core countries and periphery areas which followed far outweighs other factors.

I have also argued in chapters 4 and 6 that immigration policies and practices of the British government are among the most important factors in the migration of black African nurses to the UK. British immigration policies and practices are regularly changed to either attract nurses to the UK in times of shortage or restrict their entry in times of recession. I have argued that UK immigration policies and practices are embedded in racism and are therefore big factors in shaping black African nurses' experiences in the UK.

Previous studies (Hardill and Macdonald, 2000, Buchan, 2002, Kline, 2003, Allan and Larsen, 2003, Buchan et al, 2003, Chikanda, 2005, Smith et al, 2006 and Aboderin, 2007) reported that overseas nurses are motivated to come to the UK for financial reasons. These studies were mainly descriptive and lacked in-depth analysis of the economic factors that cause nurses to migrate to the UK. In addition, the above studies concentrated on micro (individual) factors to explain migration. The current study indicates that, while micro factors are important, macro factors such as the role of governments and international bodies in facilitating migration are responsible for the unprecedented migration of sub–Saharan African nurses to the UK during the 1990s and early 2000s.

Migration theories often focus on demographic, economic and social characteristics of migrants (Ravenstein 1885, 1889, Massey et al 1993, Todaro, 1976 and Stark, 1991). Some include factors that differentiate migrants from non-migrants, together with theories concerning motivation, decision making, satisfaction and identification (Stark and Taylor, 1989, Wallerstein, 1974, Massey et al, 1993 and Cooke, 2005). In order to understand the economic factors that cause nurses to migrate to the UK in search of employment, historical, political and social factors need to be taken into account. The current study confirms that there is no single theory that can explain migration. Richmond (1994) states:

> "an absolutely clear distinction between the economic and the socio-political determinants of population movement is not appropriate. A multivariate approach is necessary. There may be cases where both the underlying and the precipitating causes can be identified as 'purely' economic or political. However, in modern states where states, religious leaders, multinational corporations, and super-state agencies (such as the IMF and the World Bank) are involved in decisions that affect millions of people, the majority of population movements are a complex response to the reality of a global society in which ethnoreligious, social, economic, and political determinants are inextricably bounded together" (p. 58).

In the present study black African nurses articulated in their own words that their decision to move to the UK was relative to opportunities found in their own countries. This study supports Papastergiadis (2000) who states:

> the parameters of choice and coercion are difficult to define. Is the decision to leave made out of individual aspiration or collective needs? Do migrants go to foreign countries to offer economic assistance to their parents or to provide their children with greater educational opportunities? The constraints of the past and the responsibilities of the future are carefully weighed in every decision to migrate. From such a perspective the question of personal choice may simply seem like the wrong question. It gives too much attention to the individual's present action, and blurs the complex networks of responsibilities that link a person to the past and the future. (p. 60)

Miles (1982) explains that migration stems from labour shortages in developed capitalist economies which are unwilling or unable to resolve that shortage by creating a new reserve army of labour from among the sections of the population within the national boundary and not then involved in wage labour. A solution is to encourage migration from outside the country, usually from developing or periphery countries which are not able to provide full employment for their population. Developing countries are therefore dependent on developed countries economically, partly as a result of direct exploitation which resulted from colonialism. Immigration is encouraged by the state, which sets specific conditions of employment.

Black African nurses stressed that they would like to stay and help patients in their own countries. However, their situation was so desperate that migration was a strong choice. Initially, black African nurses were attracted to move to the UK because of high salary differentials between the UK and their own countries. The effects of globalisation such as information technology and the availability of cheap air fares, allow nurses first to become aware of opportunities in the UK and then to move to the UK and take up those opportunities. I have argued in chapters 2 and 4 that globalisation, while beneficial for developed countries, has brought some detrimental effects for developing countries: such as rising poverty. The

IMF and the World Bank have made the situation worse by imposing ruinous conditions for Loans given to "support" sub-Saharan countries. The result has been to weaken further those countries' economies and make their governments unable to develop their health services and infrastructures. Professional migration of health care workers such as nurses has produced a 'brain drain' in sub-Saharan countries, and continues to worsen the condition of health care services.

According to the world systems theory of migration (Wallerstein 1974), colonisation led to cultural exchange between the coloniser and the colonised. Economic domination by the coloniser resulted in an unequal exchange of resources with a large net of capital flowing from the colonies to the coloniser. This economic domination continues to the present in the form of multinational companies and powerful international bodies like the IMF and the World Bank. Multinational companies and corporations are interested in pure profit, which means they are unlikely to be sensitive to the interests of developing countries.

Papastergiadis (2000) argues that globalisation can be linked to historical forms of polarisation, marginalisation and regulation, and that globalisation was initiated by the expansion of world trade, the transformation of political structures and reinscription of cultural norms under colonisation. From the late Fifteenth century the European powers embarked on a project of exporting their own cultural practices and exploiting resources of people across the world. Therefore colonisation laid the routes for globalisation. Papastergiadis (2000) further states that 'the current discourse of new personal freedom and global interconnection masks complex forms of bondage and displacement. Despite the relative freedom of movement of capital and information, labour is subjected to increasing restrictions on entry and settlement' (p. 76-77).

The current study indicates that, among all other factors, the main factors influencing nurses to migrate to the UK are the UK government's immigration policies and practices, which allow and promote nurse migration in times of shortage and restrict their entry in times of recession. This is consistent with Dual Labour Market Theory (Castles and Miller, 1998) which posits that rich countries can choose to have a reserve army of labour in developing countries which is called upon in times of high-labour demand to perform low-status jobs shunned by the local population. It has been pointed out in chapters 4, 7 and 8 that, although nursing as a profession is not shunned by the British population to the same extent as unskilled jobs, migrant nurses are recruited to fill a subordinate position in the nursing hierarchy regardless of their skills or experience.

For most people in the third world, globalisation is not associated with greater access to commodities and communication but with increased deprivation and exploitation. One contradiction of globalisation is that, despite the relative free transfer of capital and ideas, there is no nation which is encouraging mass migration. The patterns of migration in the age of globalisation have become more complex and covert as policies on migration are more selective. This is exemplified by the code of nurse recruitment practice (2001, 2004) in the UK which favoured certain countries over others (countries with nurse shortages of their own).

I have argued in chapter 4 that government policies and practices rank highly among factors in facilitating nurse migration from sub-Saharan Africa. The current decline in nurse migration following a change of migration policies affecting nurses illustrates this point. It is a contradiction to Castles and Miller's (1998) survey, which cited economic deprivation, cultural intolerance, availability of formal and informal mechanisms, opportunity for

settlement in the destination country and threats of expansion as the main factors of migration. This study supports Papastergiadis (2000) who states that nation-states have considerable power in the regulation of exchange and movement across their borders.

9.2 Cultural Difference or Cultural Domination

Once in the destination country, migrants face different challenges in terms of culture, language, racism and discrimination. In the case of professional migrants such as nurses, there is the added challenge of different professional practices. Black African nurses in the current study reported having difficulties in adjusting to a different culture in the UK. This was corroborated by their managers. Although sub-Saharan countries were colonised by the British for a long time, most local cultures survived intact. This is in contrast to the Caribbean, where slaves on plantations were forced to abandon their culture to adopt that of their masters. It could be argued that this situation is being replicated in miniature for black African nurses as they are asked to adapt to British culture. British nurses, it appears, are not asked to understand the culture of black African nurses. The British government reinforces this practice by insisting that those applying for British citizenship must learn the British way of life, and a test has been devised to ensure that this does happen.

Wetherell and Potter (1992) argue that culture takes over some of the same tasks as race. 'It becomes a naturally occurring difference, a simple fact of life and a form of self-sufficient explanation' (p. 137). In the current study it appears that British nurses had problems with black African nurses' culture and values. British culture and nursing practice were perceived as advanced and desirable, while black African nurses' practices were seen as backward and undesirable.

It could be argued that both black African and white British nurses viewed differences mainly in terms of cultural differences because it is better to think in terms of culture. 'Culture has this aura of niceness, of progressiveness and humanitarianism. It covers over the messy business of domination and uneven development through advocacy of respect and tolerance for differences. Colonial history can be reconstructed as a story of clashing values, the modern against the traditional, as opposed to a story of conflicting interests, power and exploitation' (Wetherell and Potter (1992 p.137). This is demonstrated by the fact that black African nurses perceived the care of the elderly in the UK as particularly problematic, and white British nurses were described as lacking respect for the elderly. The same problem has been highlighted by the media and prompted the government to set up several initiatives to improve the care of the elderly, including a commitment to abolish mixed-sex wards. However, when black African nurses are being asked to adapt to a British culture which has caring problems, it is illustrative of a deeper problem. The commitment of the NHS to valuing diversity falls flat on its face when the only diversity that is valued is the British one. Clearly there are values that can be learnt from black African nurses that would benefit patients in the British NHS. This is unlikely to occur if African nursing is seen as backward and undesirable.

9.3 Technical Skills and Power Control in the Nursing Hierarchy

Black African nurses spoke of their concern at not being allowed to practise technical skills in the course of their daily practice. Nurses were concerned that they were losing technical skills, but at the same time they were being asked to train for skills they already possessed. McNeil-Walsh (2008) suggests that, in the case of South African nurses, deskilling occurs because of employment in a different nursing branch or speciality, and that deskilling rarely occurs in nurses who remain in the same job. However, O'Brien (2007) found that overseas

nurses were prevented from performing technical skills until they had undergone the prescribed period of training, for which they sometimes had to wait for over 18 months. Although it is a common practice in the NHS for nurses from different trusts to be reassessed in technical skills, black African nurses perceived allocation of this training to be discriminatory. Studies by Allan and Larsen (2003) and Smith et al (2006) found that some British nurses questioned the idea of mentoring overseas nurses who were more qualified than they were. Some even felt intimidated at the prospect.

The current study does not support McNeil-Walsh's (2008) finding. Black African nurses interviewed in this study said that, even when they were employed in the same branch of nursing or speciality, they were not allowed to utilise their technical skills until they had attended a specific UK course for that skill. The data also indicate that the assertion by McNeil-Walsh (2008) that South African nurses' skills are specific to the social context of South Africa is not well founded. Nurses in the current study described situations where patients had to wait for procedures that black African nurses could perform, but were not allowed to perform, due to NHS bureaucracy. Nurses described poor infection control practices and a culture of wasting resources in the NHS. These are universal practices in nursing.

The current data support O'Brien's (2007) finding that overseas nurses are wrongly assessed when it comes to their skills and experience. Although O'Brien (2007) interviewed overseas nurses from fairly well-equipped countries in terms of both human resources and equipment , the current study suggests that technical skills are an important part of nursing skills around the world, including the UK, which funds extra training for post registration nurses to acquire these skills. In the UK technical skills have become especially important since the

Government's decision to reduce junior doctors' working hours (Working Time Directive 2009)

The current study indicates that black African nurses found it difficult to go on courses for technical procedures, as the attendance on these courses was at the discretion of managers. In some cases financial constraints were to blame. However, there was a perception among managers that black African nurses were not motivated to attend courses and that they were in the UK to work and earn money and had no interest in developing themselves. This attitude may have influenced the allocation of development resources among nurses, and may have led to discrimination of black African nurses.

Preventing African nurses from practising their technical skills could therefore be seen as a way of placating British white nurses. In a system where technical skills are the preserve of senior and specialist nurses, it could be argued that preventing black African nurses from practising their skills is a way of keeping them in their place at the bottom of the nursing hierarchy: a situation which is well discussed by Marks (1994), which was operated by nursing administrators in apartheid South Africa.

Nurse education in sub-Saharan Africa takes into account the fact that the number of doctors is limited, so nurses are trained to carry out procedures traditionally carried out by junior doctors. The reduction in junior doctors' hours in the UK and European working directives has also made it necessary for UK nurses to be trained to perform these procedures. However in the UK this is termed 'specialist training' and is normally done at post-registration level. As a result the possession of these skills carries a certain prestige within the nursing

hierarchy. In addition, promotion to some grades is dependent on possession of these technical skills.

The current study suggests that the practice of preventing black African nurses from using their skills is enshrined in a power struggle within the nursing hierarchy. Managers failed to assess black African nurses adequately, and denied them opportunity to attend courses that would enable them to practise their skills in order to maintain UK nurses and managers' positions in the nursing hierarchy. Possession of technical skills by black African nurses could be perceived as threatening to white nurses and their managers, as they would be eligible for promotion to higher grades. O'Brien (2007) reported that managers in that study did not allow overseas nurses to practise their technical skills for fear of undermining British nurses. This undermining presumably includes the prospect that overseas nurses could be promoted and could therefore end up supervising white British nurses, a role for which they were not recruited (see chapters 4, 6, 7 and 8).

The above situation demonstrates that advanced nursing skills are increasingly important in the UK, especially with the reduction of junior doctors' working hours. It is therefore in the UK's interest to assess overseas nurses' skills adequately and to allow them to exercise their scope of professional practice so that their skills are effectively utilised. This will also prevent wasting resources by training nurses who already possess the necessary skills.

Managers indicated that black African nurses were not properly assessed for their experiences and skills, and agreed that this resulted in duplication of training and loss of skills for nurses. It appears that, when it came to assessment of overseas nurses' skills and experience, the scope of professional practice of the United Kingdom Central council of Nursing, Midwifery and Health Visiting (UKCC 1992) was not put into practice, probably for the fear of lowering British nursing standards (Smith et al 2006).

9.4 Suitability of Nursing Homes for Adaptation Courses

Black African nurses reported that most adaptation courses were carried out in nursing homes which did not meet their needs. This finding is consistent with Smith et al (2006), who reported that nursing homes were not suitable places for adaptation courses. The current study found, however, that some black African nurses were being prevented from seeking adaptation courses in hospitals by some nursing home managers, who threatened them that they would not be registered by the NMC.

Gerrish and Griffith (2004) found that managers and stakeholders measured the success of an adaptation programme by how long it took for nurses to get registered with the NMC, and not by the experiences of nurses themselves. The current study indicates that the majority of black African nurses were not satisfied with their courses, as they were carried out in nursing homes where nursing the speciality was different to that in their own countries, and different to the practice in hospitals. Where adaptation courses were done in hospitals, it did not match black African nurses' experiences and skills. In addition, most hospitals had an inadequate number of mentors so that most of the time nurses were left unsupervised: an observation which was corroborated by managers.

9.5 Different Nursing Practices or Different Care Organisation

Previous research (Cooke 1998, Alexis and Vydelingum, 2004, Taylor 2005, Smith et al, 2006) found that overseas nurses experienced different practices of nursing in the UK. Differences centred on basic nursing care, such as feeding and bathing patients. In these studies, overseas nurses perceived nursing duties to be assessing and managing patient care, and not attending to their needs. Another difference was care of the elderly in residential and

nursing homes. Daniel et al (2001) reported that Filipino nurses found that elders were not respected in the UK.

The current study supports these findings; however, in addition, black African nurses indicated that fragmentation of care was the problem. Nurses said that they could not understand why patients had to wait a long time for certain procedures while they (black African nurses) had the ability to perform procedures like putting up IV infusions and taking blood specimens. Black African nurses said that this practice was disadvantageous for the patients, and also resulted in the loss of their skills.

Black African nurses in the current study reported differences in culture and caring attitudes between their own countries and the UK. Similar findings were reported by Matiti and Taylor (2005) and Alexis (2009). Managers corroborated this finding by saying that black African nurses were dedicated to patient care. Managers said that black African nurses often sacrificed their work breaks to look after patients. However, managers took this as a negative attribute. As managers did not say whether they provided relief for nurses to take breaks, it can be assumed that nurses took their own initiative and did not want to leave patients unattended. British nurses can learn from this example and make sure that patients are not left unattended, as it has sometimes been alleged by the media that this does happen in some NHS trusts.

9.6 A Question of Communication

In common with previous research, nurses in the current study reported communication problems which involved slang and different accents used in the UK. However, managers said that they did not have problems understanding black African nurses. One manager went

as far as saying that nurses from the EU have greater problems with English than African nurses, as in some cases they could not understand English or be understood (see section 8.2.4). Mangers agreed that adaptation courses need to include instruction on the local dialect and slang. Managers also agreed that all nurses whose first language is not English should take the International English Language Test.

This study argues that the practice of giving English tests to nurses from outside the EU, most of whom have their education in English, is discriminatory to those nurses especially as nurses from Europe, most of whom do not speak English, are exempted from the test. The practice is Eurocentric and potentially racist, as most of the nurses required to take the English test come from outside Europe and happen to have a different skin colour. In addition, the practice puts patients at risk when nurses from the EU, whose first language is not English, are allowed to nurse patients without taking the English test.

9.7 Relating Migration to Experiences of Racism and Discrimination

Black African nurses reported experiences of racism and discrimination from their white colleagues, managers and patients. Some black African nurses also reported racism from other overseas nurses. Miles (1982) emphasises that the history of racism is largely intertwined with the history of colonialism. British perceptions of previously colonised people are structured by pre-existing racist ideologies. Miles (1982) claims that the presence of an ideology of black inferiority and white superiority encouraged exploitation of countries to further the economic development of Britain; through slavery, for example. One modern outcome of colonisation is migration from sub–Saharan Africa. These countries are under-developed because of their colonial role to countries like the UK (Wallerstein, 1974). In times of labour shortage the UK can afford to summon migrant labour to meet needs for workers

not met by the indigenous British population. The nurse shortage in the NHS was one such example of this situation.

Miles (1982) asserts that migrants arrive in UK to find a climate structured by ideologies of white dominance. This situation still exists today (see chapter 3). Racism allows employers to organise migrant labour in ways which reinforce the systematic creation of minority disadvantage, but also which offer the white working class an obvious way of making sense of their disadvantage. Black African nurses, like any migrant workers, experience disadvantage and racism in the work place because of a racist ideology against immigrants and the system created by managers. Miles (1989) bases his argument in class formation. He notes that:

> … with racist ideology: Racism was not simply legitimacy for class exploitation (although it was that) but, more important, it constructed the social world in a way that identified a certain population as a labouring class. The problem that remained was to organise the world in such a way that forced the population into natural class positions: in other words reality had to be brought into line with that representation in order to ensure the material objective of production (Miles 1989 p.105).

The same point can be made about the position of black African nurses in the UK, because the nurses were recruited to a subordinated position to fill nursing grades that could not be filled by UK nurses.

The current study argues that, although black African nurses are professional migrants, they are recruited to the lowest grade of the nursing hierarchy and suffer racism because of the colour of their skin. This was articulated by nurses in their interviews and focus groups, and corroborated by managers. Moreover, Allan and Larsen (2003) reported that white overseas nurses in their study did not experience racism and discrimination to the same degree as black nurses. Shields and Wheatley Price (2002) also reported that black African nurses experienced more racism and discrimination in the NHS than any other group.

The idea that populations are divided into races genetically because of outward physical attributes has of course been discredited by biologists and sociologists. However, Miles (1989) argues that false ideas can be powerful to the extent that they justify explanations of social experience. Ideas of racism allow relations in the nursing hierarchy to seem reasonably acceptable and quite normal. For example, managers in the current study said that black African nurses had a harsh side to them, and that they were here to earn money and were not interested in developing themselves. This resulted in denial of developing opportunities to black African nurse as they were seen to lack motivation. On the other hand nurses from the Philippines and the Indian subcontinent were perceived as motivated.

Miles and Phizacklea (1980) and Miles (1982) contend that experiences of migrants in Britain are shaped by their joining a working class, and that by virtue of this situation migrants are expected to have similar working conditions and benefits as those of the white British working class. In the case of black African nurses, migrant nurses are professionals (Iredale, 2001) who are recruited to join the nursing hierarchy. However, recruitment policies of the UK government ensure that black African nurses occupy a subordinate position at the bottom of the ladder. This position is legitimated first by government recruitment policies and second by managers, in the way that they allocate tasks and responsibilities to nurses and health care assistants. Black African nurses find an established hierarchy which is regulated by, among other things, education and technical skills. Within this hierarchy black African nurses find themselves at the bottom regardless of their skills and experience.

Foucault (1980) has a similar perspective, and views power in terms of patterns of domination and organisation. He focuses on what he calls 'meticulous rituals of power' as the

interplay of rituals of power which are dynamic and have a momentum of their own. Modern power according to Foucault (1980), works through knowledge; it is less obvious, less repressive and coercive, less physical and more mental. Wetherell and Potter (1992) add that power develops through normalising certain behaviour and labelling others as 'deviant'. In reference to the current study, it could be argued that black African nurses' practices in terms of culture and practice may have been labelled as 'deviant' hence, the insistence of UK managers and nurses that black African nurses must adapt to British culture.

Miles (1982) and Castles and Kosack (1985) are reluctant to talk of an underclass, a disadvantaged position in which black people find themselves in Britain. These authors highlight the fact that class is of prime importance in the division of labour and capital in capitalist societies like Britain. They therefore locate ethnic minorities in the working class, and Miles (1982) emphasises similarities between "black labour" and other migrants as a distinct fraction of the working class. The current study argues that, however race is defined its effects on black African nurses in the UK are negative.

Phizacklea and Miles (1980) contend that migrant workers, regardless of their skin colour, form a sub fraction of the working class in Britain. Conversely, the current study involves professional migrants who are recruited to join the professional hierarchy of nurses in the UK. However, black African nurses' experiences here are similar to those of unskilled migrants in that they find themselves the target of racism and discrimination. The current data also indicate that, because of the colour of their skin and discriminatory recruitment practices by the British government, black African nurses may experience different levels of racism and discrimination.

Black African nurses' experiences are consistent with Rex (1999), who argues that black immigrants are at an added disadvantage because of the colour of their skin and colonial roles embedded in history. These roles include exploitation of colonial territories as a means of obtaining surplus labour. This exploitation is seen in this study as exploitation of black African nurses to maintain the low cost of running the British NHS as evidenced by black African nurses' employment at the lowest grade, regardless of experience and skill.

Previous studies (Hardill and Macdonald, 2000, Withers and Snowball, 2003, Buchan, 2002, Deeming, 2004 and Likupe et al, 2005), found that most overseas nurses recruited by recruitment agencies were exploited and charged exorbitant fees to get their papers processed. The current study supports this finding and argues that the NHS code of recruitment practice (2001 and 2004), although good in its intentions, may have been partly responsible for the exploitation of sub-Saharan African nurses. The code excluded almost all sub-Saharan African countries from recruitment on the account that these countries had nurse shortages of their own.

However, the code was advisory and agencies continued to recruit nurses from sub-Saharan Africa. Moreover, the code denied black African nurses their human rights to migrate. As a result it put nurses at risk as they were perceived by some to be illegal immigrants. This situation is consistent with Miles (1982), who states that "the British state has probably devoted more effort and resources to implementing racist immigration controls than implementing 'racial equality'… the state has played the role of legitimating racism in Britain by virtue of its implementation of racist immigration control" (p.124).

Henry (2007) stated that discrimination of black nurses on lower grades on the basis of race and nationality was less common than that on the managers' grade. Henry 's (2007) sample came from Ghanaian nurses and midwives in senior positions . The current study involved nurses on junior grades. The current data suggest that black African nurses on lower grades are discriminated against when it comes to allocation of nursing duties and professional development on the basis of race and nationality (see chapters 7 and 8). These findings are similar to Culley (2000), Lemos and Crane (2001) Shields and Wheatley Price (2002), Allan and Larsen (2003) Alexis and Vydelingum (2004) and Taylor (2005), Who reported that overseas nurses are denied training and career development. However These studies were descriptive and did not explore why overseas nurses were discriminated against.

This study demonstrates that experiences of racism and discrimination among black African nurses in the UK are embedded in their position as migrant workers (Phizacklea and Miles 1980, Miles 1982, Miles 1989 and Pilkington 2003). Negative representations of Africans in the literature and in the media throughout history (Hall 1980, Hall 1999), have also contributed to this. In addition, the current study suggests that race relations influence experiences of black African nurses in the UK which is consistent with Rex (1999), who asserts that, black workers in Britain occupy an underclass which is associated with their colonial role as unfree labour. It has already been discussed that although black African nurses seem to be free agents in deciding to come and work in the UK, the situation is more complex involving political, economic and social factors which result in their exploitation once they arrive in the UK.

Black African nurses migrate to the UK as professionals who have recognised qualifications, although some require a period of adaptation or supervised practice. It is recognised that inadequate training places for nurses in the UK, together with a rapidly ageing population, created a demand for overseas nurses (Iredale 2001 and Buchan, 1999, 2002). Black African nurses, like other overseas nurses, join an established nursing hierarchy in the UK. However, these nurses are exploited and downgraded to the lowest nursing grade regardless of their qualifications or experience. This downgrading is compounded by racism and discrimination, which ensures that they are forced to take instructions from nursing assistants. Consequently, black African nurses' experiences are shaped by this complex relationship. On the one hand black African nurses are migrant nurses who are recruited to a subordinate position at the bottom of the nursing hierarchy; on the other hand they are often better educated and experienced, and would like to be recognised for their education and experience. This relationship is often resented by nursing assistants and some qualified British nurses.

9.8 Implications for Practice

The use of a qualitative approach enabled me to understand black African nurses' motivations for coming to the UK, their lived experiences once they arrive and are working in the UK, and the experiences of managers. The findings revealed a number of issues pertaining to recruitment, employment and experiences of black African nurses in the UK in general, and in the NHS in particular.

First, that codes of recruitment practice should not be seen to be discriminatory by denying nurses their right to migrate. The UK code of recruitment practice (2001, revised 2004) was against recruitment of nurses from countries which had nursing shortages of their own. The

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code produced a list of countries from which recruitment was forbidden. Most of these countries were from sub-Saharan Africa with mostly black populations. It was therefore perceived as racist and discriminatory and denying nurses their right to migrate (Bueno de Mesquita and Gordon, 2005). Secondly, it is recommended that governments should assess their nursing needs and ensure that adequate numbers of nurses are trained to meet demand. This will prevent large international recruitment, together with the destabilisation of health services which it brings on developing countries. It would also prevent competition among overseas nurses in the UK, together with discrimination and racism that competition may bring.

The study recommends that the Government and employers implement their own policies and treat black African nurses on an equal basis to British nurses and other white overseas nurses. Managers need to be trained to recognise discrimination and its effects. Formal systems of promotion need to be in place and should be made transparent to all nurses. It is recommended that different forms of interviews should be devised where the nationality or ethnicity of the applicant is not identified. Online interviews would be one such example.

Black African nurses should be provided with support during their adaptation period, which should include the local dialect, cultural differences and emotional support to ameliorate the effects of immigration. They should be adequately assessed and employed in areas which match their skills and experience. A system should be developed to allow black African nurses to use their technical skills without undergoing unnecessary training. This would ensure job satisfaction and at the same time would save the NHS valuable financial resources.

The data indicate that it is possible to train pre-registration nurses to perform technical skills. Since these skills are clearly required in the NHS, it would be cost-effective for the NHS if nurse education was to incorporate technical skills in pre-registration nurse education. It would put the education of UK nurses on an equal footing with that of nurses in other parts of the world. Acceptance of black African nurses' cultural differences as well as black African nurses adapting to British culture should be encouraged. This would promote cultural diversity and understanding in practice. Training about different roles of health care professionals should include the role of health care assistants. The difference between nursing homes and hospitals should be explained to black African, nurses and nurses should be allowed to make an informed choice as to where they would like to work.

With regard to perceived racism in the work place, it is recommended that managers and nurses should acknowledge that racism may exist in the work place and that black African nurses may be affected by it. Following this recognition, managers need to be in the forefront of condemning acts of racism and harassment in the work place. A culture of zero tolerance to racism should be the norm rather than the exception. Where managers are perpetrators of racism a system needs to be in place where such managers are cautioned or disciplined. Managers need to promote an environment where black African nurses are encouraged to report acts of harassment and racism without fear of retribution. This study suggests that there is need to monitor development and promotion for black African nurses in the UK to ascertain the implementation of the Equality Act 2010. It also suggests that managers need training on how to interpret and put the act into action.

In order to limit the social impact of migration on the family, black African nurses should be provided with information on what to expect in the UK. This information should include

availability of jobs for spouses, safe neighbourhoods and school systems. This would lessen the shock that nurses experience on arrival.

9.9 Strengths and Limitations of the Study

A particular strength of this study is that both individual interviews and focus groups were conducted by the researcher, herself a black African nurse. This provided common ground between the researcher and the participants. The participants were therefore more free to talk about their experiences than they would have been had a white interviewer been used. The study is unique in that it uses two different frameworks which connect migratory trajectories of black African nurses to their experiences in the UK. Previous studies (Buchan, 2002, Allan and Larsen, 2003, Taylor, 2005 and Smith et al, 2006) discussed migratory patterns and experiences of overseas nurses, but reasons underlying these experiences were not explained and analysed.

This study has investigated experiences of black African nurses and managers. Nurses' experiences were corroborated by their managers, which further strengthens the results. A study by Smith et al (2006) interviewed overseas nurses and stake holders, but this corroboration between nurses' reports and their managers' reports was not made explicit. If managers are aware of black nurses' experiences in the work place, it should make it easier to convince managers to implement policies which promote diversity in the work place. Sadly, in the current study, some managers appeared to be perpetrators of harassment, racism and discrimination themselves.

The findings of this study are of course limited to the 4 NHS trusts in the North-east of England where the study was carried out. The small samples used mean that generalisations

are not possible. The generalisation excludes the fact that black African nurses are recruited to a subordinate position in the NHS, since this was practised by nearly all NHS employers. However, the results have research implications for black African nurses working in other areas of health care in the UK. Managers' interviews were carried out by the researcher who is an African nurse. This is a limitation as managers (all white except one) may have been suspicious of the researcher's intentions. It is proposed that, in order to get a better picture of managers' experiences, a white nurse should interview white managers and a black nurse should conduct interviews with black managers.

9.10 Suggestions for Further Research

The current investigation is focused on motivations for black African nurses immigrating to the UK, their experiences once they arrive and are working in the UK, and experiences of British nurse managers working with black African nurses. International nurse recruitment and nurse migration is of prime importance because it changes healthcare provision in both the sending country and the receiving country. In addition, it affects the nursing hierarchy and relationship dynamics in UK hospitals, as has been discussed. It is therefore recommended that further research should be carried out to investigate the following:

First, perception of white British nurses towards recruitment of African nurses and their experiences of working with black African nurses. This study may be able to establish causes of resentment and suggest ways of managing it. The study would also establish whether racism perceived by black African nurses has its roots in individuals. Second, a study needs to investigate attitudes of managers towards black African nurses in conjunction with how these attitudes influence implementation of antiracist and antidiscrimination practices. This would determine whether institutional racism is a cause of negative experiences reported by

black African nurses. Third, educational programmes designed to educate nurses and managers on different cultures could be implemented and evaluated to assess their effect on relationship dynamics between African nurses and white British nurses, nursing assistants and nurse managers. Fourth, career progression of black African nurses needs to be investigated, to establish if there is correlation with NHS equal opportunities policies. Fifth health care assistants could be interviewed for their experiences to establish what can be done to improve the working relationship with black African nurses. Experiences of patients need to be investigated, as patients have a greater influence on the job satisfaction of nurses.

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Advert for black African nurses to participate in research

Request for Black African Nurses to Participate in Research

My name is Gloria Likupe.

I am a PhD Student at the University of Hull. I am conducting a study into the experiences of black African nurses in the United Kingdom. I am looking for volunteers to come and talk about their experiences in the form of an interview in the next four weeks. Interviews will be in groups or individually, depending on availability. If you are able to participate, please contact me by phone on 01484 464600 or email me at G.likupe@hull.ac.uk. The interview will last approximately 30 minutes to 1 hour and it will be conducted in person at a place of your choice.

Advert for Managers

Managers Who Work with Black African Nurses to Participate in Research

My name is Gloria Likupe.

I am a PhD Student at the University of Hull. I am conducting a study into the experiences of managers who work with black African nurses in the United Kingdom. I am looking for volunteers to come and talk about their experiences in the form of an interview in the next four weeks. If you are able to participate, please contact me by phone on 01484 464600 or email me at G.likupe@hull.ac.uk. The interview will last approximately 30 minutes to 1 hour and it will be conducted in person at your place of work.

Appendix 3

Guide Interview Questions for African Nurses (Focus groups).

Introduction

Personal data: age, country of origin, place of work (to be kept confidential).

Number of years worked in own country, grade.

Number of years worked in the UK, grade.

Discussion

Please discuss why and how you came to the UK.

Let us discuss the recruitment process.

What did you expect the UK to offer?

Discuss your experiences of working in the UK.

What are your experiences of living in the UK?

What have been the advantages and disadvantages of living and working in the UK?

Appendix 4

Guide Interview Questions for Individual African Nurses.

Introduction

Personal data: age, country of origin, place of work (to be kept confidential).

Number of year worked in own country, grade.

Number of years worked in the UK, grade.

Why did you come to the UK?

What factors in your own country made you want to leave?

What was your experience of the recruitment process?

What expectations did you have about working in the UK before leaving your country?

What did you experience when you arrived?

What has been your experience of working in the UK?

Please tell me the similarities between working in your country and working in the UK

What are the differences?

What has been you experience of the transition process?

What are your plans regarding your work?

Describe the relationship between you and your UK colleagues?

Describe the relationship between you and your managers.

Describe your experiences regarding equal opportunities.

Appendix 5

Guide for Managers' Interviews

Guide questions for Managers

Personal data

Name:

Place of work: Grade:

Qualifications: No of years in practice:

How many black African nurses do you work with?

How were the nurses recruited?

For how long have you worked with them?

Tell me your experience of working with black African nurses.

How do you value the skills of the Black African nurse?

Tell me about any difference in practice that you notice.

What support do you give to black African nurses?

What is your understanding of equal opportunities?

Tell me how you make sure that opportunities are accessed equally on your ward.

How many of your black African nurses are attending or have attended any courses for professional development?

What are the advantages and disadvantages of working with black African nurses?

Appendix 6

Information and Consent Form for lack African nurses.

Produced on local headed note paper

Experiences of black African nurses in the UK

Information for nurses

Date: 4th April 2005

You are being invited to take part in a research study. Before you decide it is important for

you to understand why the research is being done and what it will involve. Please take time

to read the following information carefully and discuss it with others if you wish. Ask me if

there is anything that is not clear or if you would like more information. Take time to decide

whether or not to take part. Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to explore motivations of black African nurses moving to the

UK and their experiences while living and working in the United Kingdom.

Why have I been chosen?

You have been chosen to take part because you are a black African nurse and you fall into

the group I wish to include.

Do I have to take part?

There is no obligation to participate. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect your job.

What will happen to me if I take part?

You will be interviewed by Gloria Likupe to talk about your motivations for moving to the UK and your experiences as a nurse working in the UK. You will be asked to take part in a focus group discussion about your experiences of living and working in the UK. For this I will ask for your permission to audiotape the interviews, which will last approximately 30 to 60 minutes. You will be asked to keep a diary of critical incidents that you think have happened to you because you are a black African nurse for 4 weeks. This will be collected by the researcher for analysis.

What do I have to do?

Participating in this study will not involve any changes to your job and the interview will be carried out at your convenience.

What is being discussed?

You will be invited to discuss your motivations for moving to the UK and your experiences of working in the UK as a black African nurse. The conversation will be recorded on a tape recorder for analysis but it will not be made available to anybody else apart from Gloria Likupe and her research supervisor. The audiotapes will be transcribed as soon as possible after the interview and the tapes destroyed thereafter. You will be given the opportunity to see and approve the transcribed interviews if you wish.

What are the possible disadvantages and risks of taking part?

There are no disadvantages to taking part. I hope to identify if you are being discriminated against. This study may inform formulation of anti discriminatory policies. The study may also identify if you have received sufficient induction and orientation to your work place and whether more needs to be done.

What are the possible benefits of taking part?

The possible benefit is that you will be able to discuss your experiences with colleagues or with the researcher. However, the research is purely academic as part of my PhD study.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results will be used for my PhD thesis and may be used for conference presentations. Results may also be published in order to inform a wider audience.

Who is organising the research?

The research is being organised by the University of Hull. There is no outside funding for the project.

Who has reviewed the study?

The Local Research Ethics Committee and the Research and Development Department of the University of Hull have reviewed and approved the study. The study has also been approved by the Multi-Centre Research Ethics Committee for Scotland, Committee A.

Contact for Further Information.

Gloria Likupe, the University of Hull Cottingham Road, Hull, HU6 7RX (Tel: 01482 464600)

You will be given a copy of this information sheet and your signed consent form to keep.

Produced on local headed note paper

Experiences of black African nurses in the UK

Date: 4th April 2005

CONSENT FORM 4th April 2005

Title of Project: Experiences of Black African Nurses in the United Kingdom

Name of Researcher: Gloria Likupe

I confirm that I have read and understood the information sheet dated 4th April 2005

for the above study and have had the opportunity to ask questions.

 I understand that my participation is voluntary and that I am free to withdraw at any

time without giving any reason and without my legal rights being affected.

 I agree to take part in the above study.

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature

_____   _____   _____

Researcher   Date   Signature

1 for Participant; 1 for researcher

Appendix 7

Information and consent form for managers

Produced on local headed note paper

Experiences of black African nurses and their managers in the UK

Information for managers

Date: 4th April 2005

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not to take part. Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to explore the experiences of black African nurses working in the United Kingdom and the experiences of their managers.

Why have I been chosen?

You have been chosen to take part because you work with and manage black African nurses and you fall into the group I wish to include.

Do I have to take part?

There is no obligation to participate. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a

consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be interviewed by Gloria Likupe to talk about your experiences as a manager working with black African in the UK. For this I will ask for your permission to audiotape the interviews, which will last approximately 30 to 60 minutes.

What do I have to do?

Participating in this study will not involve any changes to your job and the interview will be carried out at your convenience.

What is being discussed?

You will be invited to discuss your experiences of working with black African nurses in the UK. The conversation will be recorded on a tape recorder for analysis but it will not be made available to anybody else except Gloria Likupe and her research supervisors. The audiotapes will be transcribed as soon as possible after the interview and the tapes destroyed thereafter. You will be given the opportunity to see and approve the transcribed interviews if you wish.

What are the possible disadvantages and risks of taking part?

There are no disadvantages to taking part. I hope to explore how black African nurses are adapting to working in the UK and whether they are adequately informed of equal opportunities policies. This study is in part fulfilment of my PhD study.

What are the possible benefits of taking part?

The possible benefit is that the study could identify any problems and improve the communication process between managers and black African nurses and improve patient care. It could also identify what sort of induction is necessary for black African nurses when they first arrive in the UK.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results will be used as part the fulfilment of my PhD study and conference presentations. Results may also be published in order to inform a wider audience.

Who is organising the research?

The research is being organised by the University of Hull. There is no outside funding for the project.

Who has reviewed the study?

The Local Research Ethics Committee and the Research and Development Department of the University of Hull have reviewed and approved the study. The study has also been approved by the Multi-Centre Research Ethics Committee for Scotland, Committee A

Contact for Further Information:

Gloria Likupe, the University of Hull Cottingham Road, Hull HU6 7RX (Tel: 01482 464600).

You will be given a copy of this information sheet and your signed consent form to keep.

Date: 4th April 2005

CONSENT FORM 4th April 2005

Title of Project: Experiences of Black African Nurses in the United Kingdom

Name of Researcher: Gloria Likupe

I confirm that I have read and understood the information sheet dated 4th April 2005

for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any

time without giving any reason and without my legal rights being affected.

I agree to take part in the above study.

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature

_____   _____   _____

Researcher   Date   Signature

                                        1 for Participant; 1 for researcher