

Lives of Malawian nurses: Stories behind the statistics

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Declaration

I, Astrida Grigulis, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed:

2010

Abstract

Malawi lost a significant proportion of its most experienced and qualified nurses to international migration between 2000 and 2005. The lure of overseas life and poor conditions of service at home caused an unprecedented wave of migration. This thesis is about the experiences and motivations of nurses who left Malawi, and of those who stayed behind. Using a qualitative biographical method to examine their experiences along a timeline of key life events, I develop a comprehensive picture of nurse migration.

The findings show that nurses' decisions and experiences have been shaped by demographic and political shifts and by a strong culture of family. Population growth has increased competition for higher education and caused a palpable shift in motives for becoming a nurse. Prospective students now see nurse training as a means to a guaranteed career, or to a marketable qualification which can lead to alternative employment. Working conditions have not improved despite numerous government initiatives, and nurses are still leaving for greener pastures. Many now move to Malawian Non-Governmental Organisations, but before 2005 nurses were able to take advantage of the United Kingdom's (UK) active recruitment strategy. Most were motivated by the prospect of educational opportunities and the financial survival of their families, who often encouraged them because of the status accorded to migration. Whilst nurses in the UK were pleased with their lifestyle improvements, they found it challenging to integrate into society and the workplace. Many also found it difficult to achieve their educational and financial goals, and the stigma of returning to Malawi empty-handed led them to extend their stay. The enduring high status of migration and its unparalleled benefits mean that the desire to migrate is still strong amongst nurses, and many believe that the recent decline in migration is attributable only to tighter UK immigration restrictions. *297 words*

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Dedication

For Mamma, Papa, and Fred.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BBC	British Broadcasting Corporation and British Bottom Cleaner
BSc	Bachelor of Science (degree)
BME	Black and Ethnic Minority (nurses)
CHAM	Christian Health Association of Malawi
CO	Clinical Officer
CoP	Code of Practice
CPD	Continuing Professional Development
DFID	Department for International Development (UK)
DoH	Department of Health (UK)
EC	European Commission
EHRP	Emergency Human Resources Programme
EHP	Essential Health Package
EN	Enrolled Nurse
EU	European Union
GATS	General Agreement on Trade in Services
GBP	Great British Pound
GDP	Gross Domestic Product
GHWA	Global Health Workforce Alliance
GN	Government Nurse
GOM	Government of Malawi
GTZ	Gesellschaft fur Technische Zusammenarbeit (German bilateral)
HAART	Highly Active Antiretroviral Therapy
HSA	Health Surveillance Assistant
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HSC	Health Services Commission
HW	Health worker
ICN	International Council of Nurses
IMF	International Monetary Fund
IOM	International Organisation for Migration
IRN	Internationally Recruited Nurse
IT	Information Technology
JLI	Joint Learning Initiative
JPoW	Joint Programme of Work
KCN	Kamuzu College of Nursing
KCH	Kamuzu Central Hospital (Lilongwe)

MDGs	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MIND	Malawi Initiative for National Development
MSCE	Malawi Schools Certificate of Education Examination
MHEN	Malawi Health Equity Network
MK	Malawi Kwacha (currency)
MoH	Ministry of Health (Malawi)
NHS	National Health Service (UK)
NGO	Non-Governmental Organisation
NMC	Nurses and Midwives Council (Malawi), Nursing and Midwifery Council (UK)
NMT	Nurse Midwife Technician
NONM	National Organisation of Nurses and Midwives (Malawi)
NSO	National Statistical Office (Malawi)
NT	Nurse Technician
OECD	Organisation for Economic Co-operation and Development
ON	Overseas Nurse
ONP	Overseas Nursing Programme
PhD	Doctorate of Philosophy
RCN	Royal College of Nursing (UK)
RN	Registered Nurse
SLA	Service Level Agreement
SWAp	Sector Wide Approach
TA	Technical Assistant
TB	Tuberculosis
UCL	University College London
UEE	University Entrance Examinations
UK	United Kingdom
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors (renamed the NMC)
UN	United Nations
UNIMA	University of Malawi
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organisation

Chapter 1

Introduction

This thesis is about the experiences and motivations of two groups of Malawian nurses, one which migrated to the United Kingdom (UK), the other which remained in Malawi. By 2008 a significant proportion of Malawi's most qualified nurses had relocated to the hospitals and care homes of the UK. This left Malawi with a pool of nurses grossly inadequate to deal with its burgeoning health needs, and ever-increasing workloads for the nurses who remained. The reasons behind the nurses' migration have been well described by researchers. However, little is known about their experiences and intentions and what happened to those who stayed. Through a qualitative exploration of nurses' lives, this study aims to fill this knowledge gap. The study describes and compares the experiences of migrant Malawian nurses working in the UK and those of Malawian nurses who remain in Malawi. It also examines their experiences further to assess how they fit into the broader context of the decisions nurses make about their lives. Life context is an important component of the research, as the role that context plays in migration decisions has been increasingly highlighted.

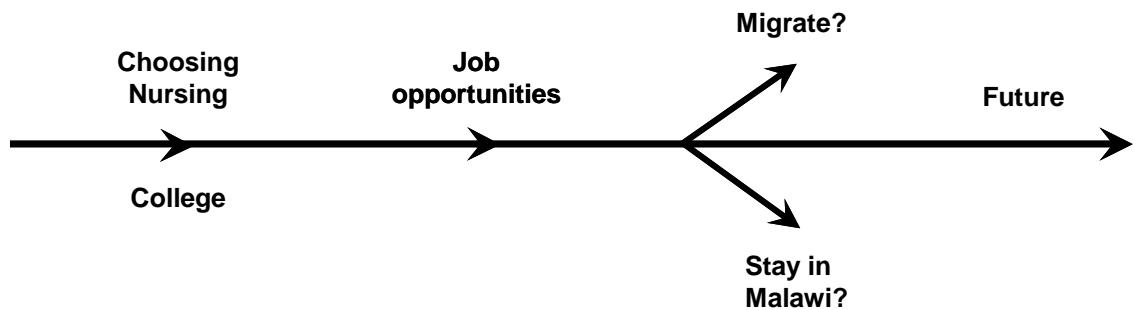
The thesis seeks to answer two main questions:

- What are the experiences of migrant Malawian nurses working in the UK, and how do they compare with those of nurses who remain in Malawi?
- How do the nurses' experiences fit into the wider context of individuals' lives and the decisions that they make?

Within these are a number of specific sub-questions, which follow a timeline of the nurses' lives from the beginning of their careers to their thoughts about the future (Figure 1.1).

- ⇒ Why did they decide to become nurses?
- ⇒ What opportunities were available to them after nursing college?
- ⇒ What factors affected their decision to migrate or remain in Malawi?
- ⇒ What are their experiences of working in the UK and Malawi?
- ⇒ What changes would they like to see in the field of nursing in Malawi?
- ⇒ What are their plans for the future, and the reasons behind their choices?

Figure 1.1 Timeline of the nurses' lives



The proposed outcomes of the thesis are understandings of:

1. The motivations behind becoming a nurse in Malawi.
2. How nurses' circumstances affect the decisions they make.
3. The experiences of nurses in Malawi.
4. The experiences of migrant Malawian nurses in the UK.
5. How these experiences influence decisions on whether to stay or return to Malawi.
6. The viability of return migration as a strategy for addressing the nursing shortage.
7. Recommendations on strategies which can be used by the Malawian government to address the nursing shortage in Malawi.

1.1 Structure of the thesis

The thesis begins with a literature review which introduces Malawi and the UK and describes the global human resources for health (HRH) situation. I examine Malawi's nursing shortage and describe its historical and political backdrop. I also introduce a sample of migration theories, but focus on the push-pull model used in the thesis to frame decisions made by nurse migrants. I conclude the chapter by presenting the rationale for the study and discuss reasons for a biographical research approach. The aim of Chapter Three is to describe the biographical method, evaluate its relevance to the study and present my methodology. Specifically, I discuss the data collection process, the sample of respondents, ethical and validity issues, and the method of data analysis.

Chapters Five to Eight present the findings, following the timeline of events in the nurses' lives. In Chapter Five, I begin by examining the reasons why each respondent chose to become a nurse, and look for connections between motivation and work-life intentions. This leads me to examine the decisions made by nurses regarding their employment destinations in Chapter Six. In this chapter I introduce the main employment options and examine the reasons behind each nurse's choice of workplace, focusing particularly on the decision to migrate. I draw upon the nurses' accounts to describe patterns of migration, especially in the peak migration years of 2000 to 2005. In particular, I describe what caused the nurses to migrate, who migrated and why those who stayed did so. I conclude the chapter by reviewing explanations for the recent decline in migration. Chapter Seven looks at the experiences of the nurses in Malawi and the UK. Through the UK nurses' experiences and the decisions they make about their lives, I assess the factors that influence return migration decisions. These decisions, along with the nurses' general plans for the future, form the basis of Chapter Eight. In the final chapter, I present my conclusions and contributions to the literature and theoretical landscape in the form of an amended push and pull model. I conclude the thesis by presenting some recommendations and research reflections.

1.2 Explanation of terms

Migration

- ‘Source country’ refers to the country of origin or habitual residence of the migrant prior to the migration event.
- ‘Destination country’ refers to the country to which an individual has migrated.
- A ‘migrant nurse’ or ‘overseas nurse’ is a trained nursing professional who is currently working outside their country of origin.
- A ‘returnee migrant’ is a person who had previously migrated but has now returned to the source country.

Health systems

- ‘Health workers’ or ‘human resources for health’ are defined as, “all people engaged in actions whose primary intent is to protect and improve health” (WHO 2007a: 16). They include health service providers, such as nurses, as well as those providing non-personal health services, such as health management (Beaglehole and Dal Poz 2003).
- ‘Good health services’ are defined as those which deliver effective, safe, good quality personal and non-personal care to those who need it, when needed, with minimum waste; be it prevention, treatment or rehabilitation delivered in the home, community or in health facilities (WHO 2007a).
- ‘The NHS’ refers to the UK National Health Service. Launched in 1948, it offers publicly funded health services and remains primarily free at the point of use to any UK resident. It currently employs over 400,000 nurses (NHS 2009). The NHS does not include private care homes.
- A ‘care home’ (previously a nursing home) is typically a residential setting where older people live with access to on-site care services (First Stop 2010).
- ‘Nursing grades or bands’ are the NHS clinical grading system for nurses and midwives. Historically, A grades represent lower cadres such as nursing assistants and grade I represents the top nursing positions. Grade D and E are the most commonly cited in the nurse migration literature. Grade D is given to all newly qualified nurses with little experience, or to those returning from a break. Grade E is given to staff nurses with some experience or a post-registration qualification (Monster 2010). Most migrant nurses start at the bottom of the pay scale in the UK (D grade), regardless of experience or length

of service (Winkelmann-Gleed 2006). As part of the NHS Agenda for Change, grades have been converted to bands, which refer to the salary scale of health workers. Each band has an associated number of pay points, starting at band 2 and leading up to the highest band in nursing, 8a-c (NHS Careers 2010).

- The UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) was replaced by the Nursing and Midwifery Council (UK) in 2002 to regulate and register nurses within the UK (NMC UK 2010). Malawi has its own equivalent council: the Nurses and Midwives Council of Malawi (NMC).

Additional conventions used in the thesis

- The term 'nurses' refers to both nurses and midwives. This is because in Malawi the majority of nursing graduates qualify as both.
- 'Migrant (Malawian) nurse' describes Malawian nurses who have migrated to work in the UK.
- 'Resident (Malawian) nurse' describes nurses who have remained in Malawi.
- I use the terms 'registered nurse' (RN) and 'enrolled nurse' (EN) to distinguish between the two main cadres of nurses in Malawi (explained further in Chapter Two). In recent years, 'enrolled nurses' have been renamed 'nurse midwife technicians'. In order to prevent confusion in the classification of different generations of nurses, I use the term 'enrolled nurse'.
- The term 'migration' refers to international migration, and not to internal migration unless otherwise specified.
- The 'migration years' refer to 2000 to 2005, which had the highest levels of nurse migration from Malawi.

Chapter 2

Literature review

2.1 Chapter introduction

The purpose of this literature review is to locate the experiences of Malawian nurses within the broader context of the global human resources for health (HRH) situation, as well as within the wider context of Malawi. To do this I draw upon nurse migration literature as well as current debates about the reasons for migration and its consequences. In this chapter I also present and evaluate the push and pull framework which will be used to assess the migration decisions made by Malawian nurses. I link this framework to patterns of migration from Malawi, and to initiatives aimed at regulating nurse migration globally and addressing HRH shortages within Malawi.

I am interested in examining the historical context of Malawi and assessing how historical events such as political changes have affected the lives of the nurses in my study. In order to do this I provide an overview of Malawi's history, health indicators, and HRH structure. I examine what conditions have been like for nurses in the past, how they are currently, and how they have affected the current nursing situation. By describing the current UK nursing situation I provide a context in which to examine the experiences of migrant Malawian nurses. A number of studies have investigated the experiences of internationally recruited nurses (IRNs) in the UK. These are discussed and evaluated with reference to key findings that may also be relevant to the Malawian nurse sample. I conclude the literature review by highlighting research gaps and offering justifications for the present study.

2.1.1 Process

I used multiple information sources, including books, professional journals, dissertations, newspaper articles and reports (published and unpublished). I accessed information through databases including PubMed, Google Scholar, the HRH Global Resource Centre and the World Health Organisation (WHO) Statistical Information

System. Key word searches included: international nurse migration, brain drain, Malawian nurses, health worker retention, human resources in sub-Saharan Africa and experiences of international/overseas nurses. Upon finding relevant articles I used a snowball approach to find additional literature cited in the references. I also accessed key publications from libraries and organisations within Malawi, including unpublished statistics and information from the Nurses and Midwives Council of Malawi. Historical information about Malawi was sourced through books published in-country, and facts were verified by key informants. No delimiting time frame was used, in order to capture the historical context of the research area.

2.1.2 Global human resources for health: an overview

The migration of nurses from Malawi is inextricably linked to the global human resources for health (HRH) situation. There is currently a severe shortage of health workers worldwide, with most countries experiencing shortages, regardless of whether they are low or high-income (Joint Learning Initiative, JLI 2004). The situation is most pronounced however, in low-income countries, especially those in sub-Saharan Africa. Of the 57 countries experiencing extreme HRH shortages, 36 are in Africa (WHO 2007a). Unfortunately, this region also faces a high disease burden. It shoulders 25 percent of the global burden of disease but accounts for only 1.3 percent of the world's health workforce (Commission for Africa cited in Baingana and Bos 2006).

Many factors contribute to health worker shortages. In Africa a key contributing factor is the international migration of health workers, particularly nurse migration, as in the African region nurses and midwives make up a significant proportion of the workforce (around 51 percent) (WHO 2006a). Globally, health workers are the largest group of skilled migrants, as they often share a global knowledge base which facilitates movement between countries (House of Commons International Development Committee 2008). In the last 30 years health worker migration from sub-Saharan Africa has become more complex and widespread (Connell et al 2007). Targeted active recruitment, revolutions in communications and transport, and intensifying economic forces have precipitated this change (Hollifield 2007), in addition to globalisation reducing barriers to human mobility (Martineau et al 2004: 2, Koser 2007). Rapid mobile phone expansion in Africa has increased global linkages and raised awareness of potential opportunities overseas (Pagett and Padarath 2007, Mitchell 2006), whilst cheaper transport has also made migration more feasible (Koser 2007). The decline in

the labour force of high-income countries is commonly cited as the key driver of migration (World Bank 2006 cited in Mitchell 2006). Inadequate nurse supply, combined with aging populations requiring long-term health care, has amplified the demand for health workers, especially nurses (IOM 2007a). To meet this demand, many countries, notably the UK, have recruited large numbers of foreign health workers (Liese et al 2003, Pond and McPake 2006, McAuliffe et al 2009, Eastwood et al 2005), making nurses a highly sought after commodity (Nelson 2004). Intensifying nurse migration has widened inequalities in health worker density between low and high-income countries.

As low-income countries attempt to find their own solutions to health worker shortages, innovative strategies have been developed to increase absolute numbers and stem the outflow of nurses to high-income countries. These solutions include codes of practice on an international scale, and HRH programmes such as the Emergency Human Resources Programme in Malawi on a domestic scale. These strategies rely on knowledge and information about the extent of the shortages, why they exist, and on the causes of migration. Researchers (including Muula 2005, Kline 2003 and Buchan 2006) have presented several reasons behind health worker shortages and nurse migration, both globally and in Malawi.

In Malawi, health worker shortages are caused not only by the migration of nurses but also by insufficient training output, loss of staff to illness and death, and resignations (Palmer 2006). The reasons that nurses are migrating from Malawi are common to many other sub-Saharan African countries and include poor working conditions and low salaries. Researchers often frame these reasons within a push and pull framework. This framework distinguishes between factors that push individuals from the source country and factors that pull them to the destination country (Buchan 2006). The framework links with other migration theories. In addition to examining reasons for nurse migration, researchers have engaged in wider debates about migration. Internationally, the debate has centred on the consequences of migration, examining the benefits (for example remittances), as well as its negative impact on healthcare delivery. On a domestic level in the UK the debate has centred on the situation of internationally recruited nurses (IRNs), and has stimulated a number of qualitative studies about the experiences of IRNs in the UK which are examined in this chapter (Aboderin 2007).

In the following section I present a brief overview of the UK. I then describe the Malawian context, looking at its history, political and economic situation, followed by an in-depth examination of the health workforce structure and current HRH situation.

2.2 The United Kingdom

2.2.1 Overview

The United Kingdom is a high-income country in Western Europe made up of England, Wales, Scotland and Northern Ireland, with a population of 61.8 million (WHO Global Health Observatory 2009). Christianity is the dominant religion at 71.6 percent (CIA 2010b). Its colonial history and relatively high-income status have attracted many migrants, who currently represent 10 percent of the population (UN Department of Economic and Social Affairs 2009). In recent years the country has been struggling to deal with immigration issues (BBC News 2010).

The UK's health and socio-economic indicators are good. Literacy rates remain at 99 percent, disease burden is low and life expectancy is high, at an average of 80 years (CIA 2010b, WHO Global Health Observatory 2009). However, the UK is not without problems, the average age of the population is increasing, and fertility rates are declining, leading researchers to believe that the workforce is shrinking (Mitchell 2006). Shortages in the nursing workforce are currently a reality (Kline 2003), as young women look elsewhere for careers and older nurses retire (Standing 2000). These shortages in combination with growing healthcare pressures and high-technology care have increased the demand for nurses (Serour 2009), prompting the UK to recruit foreign health workers.

2.3 Malawi

2.3.1 Overview

Malawi is a slender, landlocked country bordering Mozambique, Tanzania and Zambia in South-eastern Africa. It is divided into three main administrative regions, northern, central and southern, each with their own set of districts. The northern region is the least densely populated, whilst the southern region, home to numerous tea plantations, is the most populated. The central region has the highest farmland potential and

houses the capital city, Lilongwe (Conroy and Sachs 2006). With one fifth of the country occupied by Lake Malawi and a total land area of 11,484 square kilometres, Malawi is one of the most densely populated countries in sub-Saharan Africa (Conroy and Sachs 2006). Its population currently stands at approximately 13 million, with an annual growth rate of 2.8 percent (NSO 2008). Around 82 percent of the population live in rural areas (WHO 2009a), making subsistence agriculture (growing only enough food to feed your family) an important source of income for many Malawians. Agriculture, in particular tobacco exports, also represents a significant proportion of domestic income or Gross Domestic Product (GDP) (Tanner 2005).

Unfortunately, agricultural exports have not made Malawi a rich country. In 2005, it was estimated that almost 74 percent of citizens were living on less than 1USD a day (WHO 2009a). The country continues to rely heavily on economic assistance from donors such as the World Bank (CIA 2010a), and nearly 40 percent of its budget support comes from the international community (Banda 2010a). This reliance is exacerbated by numerous challenges, including high levels of wealth inequality, rapid population growth and limited natural resources combined with poor resource management (World Bank 2006, cited in DELIVER 2007). Despite these challenges, Malawi has had some successes. In 2009 it was ranked as one of the two most peaceful countries in Africa (Baatweng and Raditsebe 2009). In addition, literacy rates have consistently improved since the 1960s and educational enrolment is relatively high, currently 82 percent at primary level (NSO 2005), spurred by the introduction of free non-compulsory primary education (Muula and Chanika 2005). However, significant numbers of women still receive no education. Typically, uneducated women marry earlier than the median age of marriage of 18 years¹ and have six children (NSO 2005). Although the fertility rate has declined in recent years, it remains much higher than that of high-income countries such as the UK. High fertility rates link back to the time of President Banda (the first President of Malawi), who prohibited family planning and urged women to bear many children, claiming that “we have no natural resources here, our only wealth is our people” (King and King 2000).

The Christian religion dominates in Malawi, a legacy of the country’s missionary history. Christians represent 80 percent of the population, and Muslims 13 percent. Although the ethnic groups of Malawi can be split on religious lines, they are often divided geographically. The predominant group are the Chewa who live mainly in the

¹ The current legal age of marriage in Malawi is 16 years, raised from 15 in 2009 (Banda 2009).

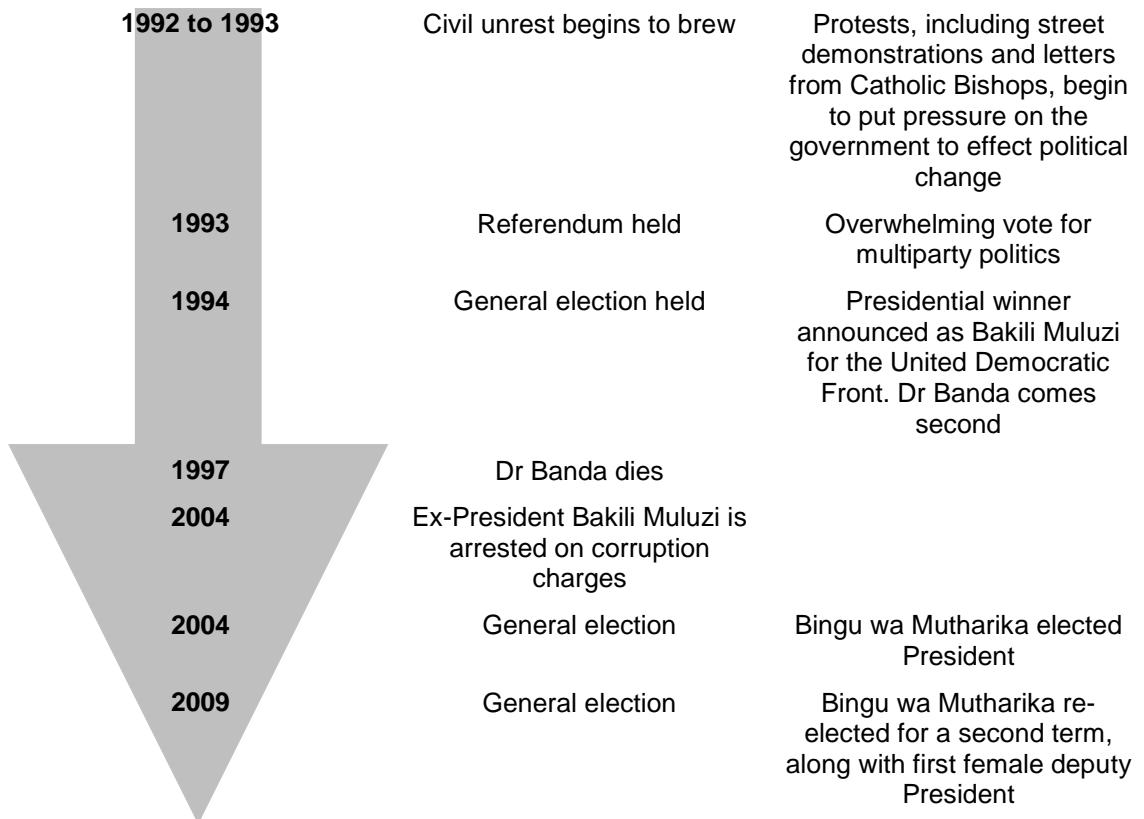
central region. Other ethnic groups include the Tumbuka (in the North), Lomwe, Sena, Ngoni, Ngonde and the Yao who live mainly along the south-eastern border with Mozambique (CIA 2010a). Although several languages are spoken, including English, Chichewa is the official language (1998 census, cited in CIA 2010a). Many of the challenges Malawi faces are a consequence of its history. Examining this history provides us with a context for understanding the roots of the HRH crisis, and allows us to examine the events that prompted nursing shortages.

2.4 History

The earliest known settlement in Malawi was in the 16th century. After this time, the country became inhabited by visitors from the southern African region, and eventually by the British who governed until 1964. After gaining independence, the country experienced three decades of one party dictatorship rule, the legacy of which is still felt today. Key moments in the history of Malawi are shown in Table 2.1.

Table 2.1 Key moments in the history of Malawi

Date	Key moment/migration	Details
1500 to 1700s	Earliest known settlement of Bantu-speaking Maravi peoples	Built major settlements and extensive political system
1500s	Portuguese arrival	First contact with Western population
1700 to 1800s	Malawi dominated by smaller chieftaincies	Chieftaincies included: Tumbuka, Chewa
1800s	Yao tribes from Mozambique settle	Settled in southern region, bringing Islamic faith and slaving connections which made Malawi a major slave trading route
1840s	Groups of Nguni speakers seek refuge fleeing Shaka in South Africa	
1859	David Livingstone arrives	He identified an area in the south of Malawi as a suitable area for European settlement and the gateway to Africa for 'Christianity and Commerce'. Later Scottish Presbyterian churches established missions, with an aim to end the slave trade
1891	Arrival of the British	Nyasaland (Malawi) becomes a British protectorate
1910	Missionary hospital network established	Government medical services become increasingly used by Malawian population
1915	Chilembwe uprising	First uprising against colonial government, demonstrating dissatisfaction with how the country was run. The desire for independence grows
1959	State of emergency declared in Nyasaland	This resulted from increasing political agitation from Malawian political actors, including Dr Hastings Kamuzu Banda
1961	First multiparty election	Malawi Congress Party wins all the seats
6 th July 1964	Malawi granted independence from the British	Dr Banda becomes President under a constitutional monarchy
6 th July 1966	Malawi becomes a republic	
1971	One party rule begins	Dr Banda becomes Life President



Sources: Catholic Institute for International Relations (1993), Mfutso-Bengo and Muula (2006), Muula and Chanika (2005), Lwanda (2007), US Department of State (2010), Conroy and Sachs (2006), Mkamanga (2000)

An important turning point for Malawi was independence from the British. Dr Hastings Kamuzu Banda's new government inherited the task of reshaping a country that was plagued by high fertility rates, illiteracy and impoverishment (Conroy and Sachs 2006). Yet despite these challenges, by pursuing agriculture-based, labour intensive development strategies, from 1964 to 1977 the economy grew (Harrigan 2001, Booth et al 2006). However, in the late 1970s Malawi experienced severe economic decline, partly due to exogenous shocks linked to the global recession (Harrigan 2001). In response to the decline, the 1980s became a period of economic reform guided by the World Bank and International Monetary Fund (IMF) through the provision of three Structural Adjustment Loans. This period failed to produce sustained economic growth (Harrigan 2001), and prosperity declined.

In line with the changing fortunes of Malawi's economy, Dr Banda's presidential rule was seen as a time of both growth and misfortunes. National growth included the development of a high quality educational system. However, only a few had access to the system and selection into secondary or tertiary education was highly competitive (Muula and Chanika 2005, Oderth 2002). Misfortunes were linked to the lack of civil

liberties (switching off your radio during Banda's speech warranted detention without trial) and human rights abuses under Banda's guiding rules of Unity, Loyalty, Obedience and Discipline (Mkamanga 2000). By the 1990s, compulsory contributions to the President were extracted from everyone (King and King 2000), even though much of the population was living below the poverty line (Mkamanga 2000). After increasing pressure from political activists and public dissatisfaction with the stagnating economy, Malawi saw a timely transition to multi-party democracy in 1994. However, because of political unrest, it remained burdened with an unstable economy. This led the new government under President Bakili Muluzi to prioritise private sector growth and liberalisation (Conroy and Sachs 2006). Despite the hopes for progress with these new priorities, the decade of Muluzi's presidential term (1994 to 2004) was characterised by corruption, abuse of power and domestic debts rising to unsustainable levels (Conroy and Sachs 2006). After a failed attempt by Muluzi to amend the constitution to permit him a third term, Bingu wa Mutharika was elected in 2004 (CIA 2010a), and is currently in his second term as President. Despite a number of moderately successful economic reforms by the current government, Malawi remains one of the poorest countries in sub-Saharan Africa.

The specific historical context to the current HRH crisis is explored in later sections, but a brief historical overview and introduction to the key players in Malawi's history, in particular the three Presidents of Malawi, is important to situate the research. Later in the thesis I examine the legacy of Malawi's first President - Dr Banda - in relation to opportunities for women, the closed nature of Malawi's links with overseas countries and the development of Malawi's first nursing colleges. I also examine the influence of Malawi's second President, Muluzi, whose term led to an expansion of links with overseas countries and improvements in communication. These factors, in addition to increasing dissatisfaction with wages and working conditions (seen in the numerous strikes during that time) precipitated the outward migration of nurses from Malawi. Poor working conditions and salaries for nurses persisted during the presidential term of Bingu wa Mutharika. Despite numerous initiatives to improve conditions, the legacy of the past decades has been difficult to undo and success in the recruitment and retention of nurses in Malawi has been slow. The nursing situation inherited by the current President is examined in later sections, in addition to the initiatives implemented by his government. Whilst political changes have affected the health status of Malawi's population (for example through funding cuts), health indicators have also been significantly affected by exogenous factors including the rise in HIV/AIDS.

2.5 Health in Malawi: an overview

Malawi's health and social indicators are amongst the poorest in Africa (Harrigan 2001) and the decline in life expectancy since the 1980s reflects this (Matchaya 2010). The country faces significant health challenges, including a high burden of infectious diseases, high HIV prevalence and high infant and maternal mortality rates. These health challenges are compounded by the fact that the average Malawian adult consumes less than 1800 calories per day, well below recommended requirements (Conroy and Malewezi 2006). Children are also consuming less than they need, and it is estimated that 50 percent of children under five are chronically malnourished (Banda et al 2006). In addition, access to improved sanitation and water sources are below 62 percent in rural areas (WHO 2006b).

The leading cause of disease burden in Malawi is HIV/AIDS by a huge margin, followed by lower respiratory diseases, malaria, and diarrhoeal diseases (Bowie 2006). In 2002, HIV/AIDS was responsible for 34 percent of deaths (WHO 2002). Even in children it ranks only below pneumonia, neonatal causes and diarrhoeal disease as a cause of death (WHO 2002). The current HIV prevalence rate for women and men aged 15-49 is estimated at 12 percent (NSO 2005). The UK estimate is 0.3 percent in males and 0.1 percent in females (Population Reference Bureau 2010).

Malawi's poor health indicators are well acknowledged and improving health is an important target of many initiatives, including those linked to the Millennium Development Goals (MDGs), a set of goals based on the world's main development challenges to be achieved by 2015. Key health-related MDGs are combating disease and improving maternal and child health. Currently, maternal mortality in Malawi is one of the highest in sub-Saharan Africa, standing at 1140 per 100,000 live births (Hogan et al 2010). The neonatal mortality rate is also high, at 76 per 1000 live births (NSO 2005). However, as a result of initiatives such as those linked with the MDGs, under-five mortality rates have declined from 123 per 1000 in 2005 to 100 in 2008 (World Bank 2010). Although Malawi still has one of the highest incidences of tuberculosis (TB) in sub-Saharan Africa, the country has seen some successes in its treatment, and the national TB programme has maintained good cure rates (Conroy and Sachs 2006). The health status of a population is dependent on an efficient and well-resourced health system, and on sufficient numbers of health workers. In the following sections I provide a description of Malawi's health system and introduce some of its key health programmes.

2.5.1 The health system

The Ministry of Health (MoH) is the main supplier of health services, along with the Christian Health Association of Malawi (CHAM) (DELIVER 2007). CHAM is a non-governmental umbrella organisation of Christian-owned health facilities (CHAM 2006). Historically, CHAM facilities charged a small user fee, but now have Service Level Agreements (SLAs) with the government to provide free health care services under government subsidy. Other health care providers include traditional healers and traditional birth attendants, who are found throughout rural and urban Malawi, and private health care facilities found primarily in urban areas.

The 1059 health facilities that provide formal health-related services in Malawi occupy six levels: health posts, health centres, rural hospitals, district hospitals, central hospitals and specialist hospitals (Kadzandira and Chilowa 2001). Of these, 86 percent provide primary care, such as maternal health services, whilst six facilities provide tertiary care, such as specialist referral care. Amongst these are Queen Elizabeth Hospital and Kamuzu Central Hospital in Lilongwe (KCH). Other government facilities include the Central Medical Stores, which distributes drugs and other health commodities to all the health facilities. In terms of health facility distribution, 73 percent are in rural areas, with the remaining 19 percent and 4 percent in urban areas and semi-urban areas respectively (MoH Malawi 2008). Health expenditure has risen steadily since the late 1990s, from 7.1 percent of GDP in 1996 to 14.6 percent (in 2007). The government funds 75.8 percent of this expenditure, with the remainder coming from the private sector (WHO 2007b). Health reforms and programmes form a significant part of the government's health expenditure.

During the last decade, the Malawian government has introduced several health sector reforms. These were developed in response to evidence that past investments had not produced significant gains in health status (Banda et al 2006). The National Health Plan (1999-2004) included the Essential Health Package (EHP), the Sector Wide Approach (SWAp)², creation of hospital autonomy, and the decentralisation of authority and responsibilities to District Assemblies (DELIVER 2007, UNDP 2002). The EHP and the SWAp still form an important part of the government's health strategy alongside a number of programmes, including the roll-out of free antiretroviral treatment (ART) (UNDP 2002). With a pro-poor slant, the EHP aims to deliver minimum essential health

² In particular SWAp aims to address funding distortions and to expand the resource base for services that have been neglected by donors (Banda et al 2006).

services to rural communities, free at the point of service (Banda et al 2006). The expectation of the EHP was that, together with the Sector Wide Approach, it would mobilise additional resources around a Joint Programme of Work (JPoW) (Conroy and Malwezi 2006). The six-year JPoW was launched in 2004 and comprises six components, including human resources, medical supplies, and infrastructure development. A key offshoot was the Emergency Human Resources Programme (EHRP) developed in response to the country's HRH crisis.

Several actors play an important role in implementing the health reforms alongside the MoH. These include CHAM, which has a crucial role because its facilities are often located in rural areas where the majority of the population lives (Banda et al 2006). In terms of HRH specific actors, the Nurses and Midwives Council of Malawi controls and sets standards for nursing education and practice. The council administers examinations to all students who successfully complete training to test their safety before giving them licence to practice. Another important nursing organisation is the National Organisation of Nurses and Midwives (NONM), which lobbies for nurses' rights. Established in 1979, the organisation grew from a membership base of 50 to over 5000 after it became a union in 2007. This expansion has increased its profile and activities, which include a care for carers programme (supporting HIV positive nurses) and advocating for increases in nursing salaries (personal communication, Ngoma 2009). One of its most high profile activities has been the placement of billboards in three cities in Malawi highlighting the severity of nursing shortages. The billboard (shown below) features a nurse with wings, with the slogan 'soon there will be no angels on earth'.

Photo 2.1 NONM billboard in Lilongwe, Malawi



2.6 Human resources for health in Malawi

2.6.1 Overview

The Malawian health workforce includes doctors, pharmacists, nurses and a number of unique cadres who work alongside 'traditional' health workers, including clinical officers (examined in section 2.11.3) and health surveillance assistants (HSAs). HSAs were formerly recruited as temporary smallpox vaccinators in the 1960s and have contributed greatly to the delivery of preventative health services in rural areas (Kadzandira and Chilowa 2001). They currently constitute 30 percent of all health workers (MoH Malawi 2008), and are employed in high numbers because their training costs are low. At the other end of the spectrum are doctors, who receive the longest, most costly, and most specialised training (comparable to training programmes in high income countries such as the UK). In between these cadres are medical assistants, pharmacists, dentists and nurses. The distribution of health workers in Malawi is highly uneven. Despite the fact that most Malawians live in rural areas, over 80 percent of skilled health staff work in urban areas (MoH Malawi 2004). Rural areas are dominated by HSAs and lower cadre enrolled nurses (MoH Malawi 2008).

2.6.2 Nurses in Malawi

Nursing in Malawi is defined as:

A profession, which offers services aimed at assisting individuals, groups and communities to promote and restore health and to assist with rehabilitative measures so that people can live productive lives within the social economic and cultural context.

NMC Malawi 2008a

There are eight different cadres of nurses and midwives (presented in Table 2.2), although nurses are commonly categorised as registered nurses (RNs) or enrolled nurses (ENs) (recently renamed nurse midwife technicians, NMTs). The differences between the cadres are based on level of training. The highest level is the registered nurse, who has completed university level training (previously a diploma and now a Bachelor degree), followed by the enrolled nurse at diploma level (previously certificate level). The RN qualification is internationally recognised, whereas the EN diploma is not recognised outside Malawi, meaning that ENs are not able to leave the country as easily. Partly because of this and the shorter training period, the government of Malawi has focused on training ENs, who now make up the majority of nurses. ENs (NMTs)

are typically one cadre but nurse technicians and midwife technicians also exist. This is purely a consequence of poor exam pass rates. Many students only pass half of their final registration exams, but because of high vacancy rates they are allowed to go on to practise either as a nurse technician or a midwife technician (although not as a full NMT as was intended), depending on which half of the exam (nursing or midwifery) they have passed (NMC personal communication 2009).

ENs are supported by auxiliary nurses, who were introduced to strengthen health worker numbers (Nation reporter 2007). The requirements to enter auxiliary nurse training are lower than the requirements for RN (degree) and EN (diploma) training, although most nurses will have completed primary and secondary level education (Muula et al 2006). At the end of secondary school students can sit their Malawi Schools Certificate of Education examinations (MSCEs), and grades obtained from these exams determine the level of nurse training a student can enter. To enter EN training, the student must have at least three MSCE science credits, including biology (personal communication, Banda 2009). For RN training, the student must have six MSCE credits including English, and pass an entrance exam. Enrolled nurses have the opportunity to upgrade to Bachelor degree level and become RNs after a period of employment.

Table 2.2 Cadres of nurses and midwives in Malawi

Title	Level of training
Registered Nurse	Four year training at degree level, Masters or PhD level
Registered Midwife	One year additional training in midwifery after completing degree level training
Registered Nurse and Midwife	Two years training in both nursing and midwifery
Nursing Midwifery Technicians (enrolled nurse midwife)	Three years integrated training in nursing and midwifery (diploma level)
Nursing Technicians (enrolled nurse)	Two years training in nursing (diploma)
Midwifery Technicians (enrolled midwife)	One year training in midwifery (diploma)
Psychiatric Nursing Technicians	One year additional training in psychiatric nursing after initial training
Community Health Nurse	One year additional training in community health nursing after initial training

Source: NMC Malawi (2008b)

The registered and enrolled nurse cadres derive from categories previously used in the UK. In the UK the EN cadre was established in response to the nursing shortfall in World War II, to provide patient care under the direction of RNs. The training was for two years as opposed to three years for RNs (Smith and Mackintosh 2007). The EN cadre was phased out in the UK in 1992 and subsequent years saw a dramatic shift in the scope of nursing practice. Tasks previously carried out by doctors were shifted to nurses, with the resulting care gap being filled by healthcare assistants (Iley 2004). All nurses with a diploma or degree in the UK are called registered nurses, and each RN follows a nursing career pathway which includes adult nursing, mental health and prison nursing (NHS 2010).

2.6.3 Nurse training in Malawi

Only after gaining independence did Malawi embark upon training programmes for nurses. During colonial times few Malawian nurses were trained, with the exception of a few elderly midwives trained in mission training hospitals in the 1930s, and a handful

of (female) nurses sent abroad for training (Lwanda 2007). Commonly, Malawians were only employed in the hospitals as orderlies, dressers and medical attendants (Chinkhatae 1999). This meant that post-independence Malawi had very few health workers, but as the demand for healthcare increased the need to train health workers was increasingly recognised. This led to the development of nurse training colleges under President Banda, with the first RN training college established in Blantyre (Chinkhatae 1999). Since then the number of nursing colleges has grown and there are now fifteen in operation (NMC Malawi 2008b). There are two main types of nurse training college: those run by CHAM and those run by the government. CHAM colleges primarily train ENs and graduate 80 percent of the total EN output, whereas government colleges mainly train RNs. Some colleges also offer specialist training such as psychiatry.

Currently, two institutions offer bachelor degree level training for RNs. These are Kamuzu College of Nursing and, more recently, Mzuzu University. Established in 1979 by President Banda to train female nurses to university diploma level, Kamuzu College of Nursing (KCN) is a constituent college of the University of Malawi. It is important to introduce KCN as this is where the majority of the nurses who migrated from Malawi trained. The current Bachelor of Science in Nursing programme covers four years, with several courses including community health, HIV/AIDS theory, and health services management. The curriculum is similar to nursing courses in the UK, a by-product of the commonwealth link between the two countries. In 1985, men were allowed to enrol into KCN for the first time (Simukonda and Rappsilber 1989). The admission of males met significant resistance (Chinkhatae 1999), but the subsequent increase in male nurses has done little to change the female dominated field of nursing in Malawi (MoH Malawi 2008). Despite KCN and Mzuzu offering degree level education, there are few specialist training institutions and until recently nurses were sent to South Africa or the UK to complete specialist training or Masters degrees. There are now several Masters programmes available in-country, including a midwifery and a public health Masters. However, fees are high; the midwifery Masters at KCN currently costs 8000 USD for one year (KCN 2009).

All University of Malawi degree level students, including those at KCN, are required to pay a financial contribution of MK 25,000 (approx 100 GBP) each year towards the cost of their education. However, numerous loans and awards are available, including financial support from the government as part of the EHRP (MoH Malawi 2007). The four-year course at Mzuzu is considerably more expensive than KCN, costing MK

350,000 (approx 1500 GBP) a year for Malawian students (private universities generally have higher fees, KCN personal communication 2009). An EHRP partnership agreement between CHAM and the government meant that, until 2010, nursing courses in CHAM were free for all students. The studentships were accompanied by a two-year bonding period during which the newly graduated student was expected to work only in government or CHAM services. However, observers have reported that there has not been strict enforcement of the bond (personal communication, Banda 2009). Although the impact of the subsidised fees has not yet been fully assessed, health workforce statistics suggest that student numbers are still insufficient and nursing vacancies remain high.

2.6.4 HRH statistics

It is widely recognised that Malawi is in a state of crisis regarding human resources for health. The health worker to population ratio is low and vacancy rates remain high for all cadres within CHAM and the government. As of August 2008, the vacancy rate for nursing was 77 percent, for doctors 67 percent, pharmacists 74 percent, and planning positions in the ministry 89 percent (MoH personal communication 2008). These figures may be misleading however, as the absolute number of health workers has increased in recent years (along with the number of available positions). The 2007 MoH HR census enumerated 33,470 health workers, including 190 doctors, 700 clinical officers and 2928 nurses (968 of whom were enrolled nurses and 428 auxiliary nurses), most of whom work in government (MoH Malawi 2007a). To put these figures into context, when converted into ratios of actively employed health workers to population, we are able to see just how understaffed Malawi's health workforce is. The 2007 census figures show that there are 3050 people for every nurse. The WHO estimates this to represent 0.6 nursing and midwifery personnel per 1000, far below the ratio of 12.8 per 1000 in the UK (WHO 2006b). The minimum number of nurses, midwives and doctors (threshold density) needed to achieve 80 percent coverage of basic health services is estimated to be 2.3 providers per 1000 (WHO 2006c). The UK has enough health workers to achieve this, but Malawi has severely inadequate numbers to meet even minimum requirements.

Malawi is not unique in its low health worker to population ratio: many of its neighbours (with the exception of South Africa and Botswana) are also experiencing shortages (shown in Table 2.3). In general, Africa has the world's lowest density of health

workers, at 2.3 per 1000 population, far lower than Europe at 18.9 per 1000 (USAID 2009). There are a number of common reasons for the shortages, including inadequate training output and poor staff retention. Each country also faces its own challenges; for example, Kenya was experiencing high vacancy rates even though many nurses were unemployed because of poorly managed recruitment systems (USAID 2009).

Table 2.3 Nursing and midwifery personnel density (per 1000 population) in Malawi compared to a sample of neighbouring countries and the UK

Location	Nursing and midwifery personnel density	Data year
Malawi	0.6	2004
Kenya	1.2	2002
Botswana	2.7	2004
Mozambique	0.3	2004
South Africa	4.1	2004
United Republic of Tanzania	0.4	2002
Zambia	2.0	2004
Zimbabwe	0.7	2004
United Kingdom	12.8	1997

Source: WHO (2010)

2.7 Why are there health worker shortages?

2.7.1 Overview

Several factors have contributed to health worker shortages. In this section I focus on those that specifically affect nurses in the Malawian context, although many may also apply to other health workers globally. They can be divided into three categories: factors relating to supply and training of nurses, factors relating to health challenges, and factors relating to the retention of trained nurses. Historical events have affected all the categories, particularly events relating to economic reform and government policy. Supply factors limit the number of nurses entering the workforce to begin with, and retention factors such as poor working conditions deplete the supply further by causing nurses to retire early or leave the workforce to seek greener pastures. The mechanisms for this include internal migration, usually from rural to urban areas or to NGOs, as well as international migration (MoH Malawi 2007b). Table 2.4 outlines the main factors contributing to the nursing shortage. Premature death, disease and dismissals also contribute indirectly to the shortage of nurses (Banda 2010b).

Table 2.4 Factors contributing to nursing shortages in Malawi

Category	Factor	Causes and complications
Supply issues	Inadequate numbers of qualified school leavers Inadequate output from training colleges Decreased funding of nursing schools Poor image of the profession as a career Increased career opportunities for women	Relates to issues of access to education Caused by insufficient tutor numbers and inadequate infrastructure Students face heavier financial burden Fewer students apply for nursing courses Reduces the number of applicants
Health challenges	Premature morbidity and mortality Aging nursing faculty and workforce	Linked to disease burden and HIV/AIDS/AIDS This aging workforce is being replaced at a slower rate due to insufficient new graduates entering the profession
Retention issues	HIV/AIDS Maldistribution of health workers Poor working conditions, low salaries and a lack of support Availability of other attractive jobs locally and internationally Dismissals from employment	As well as causing attrition of nurses through ill health and disease, nurses take time off work for funerals, caring for sick family members Increased workload burden due to increased number of patients Occupational risk of HIV transmission affecting morale Impacts on health service provision, as well as the work burden of health workers in poorly staffed areas Nurses leave the workforce to seek greener pastures or retire prematurely Nurses have alternative options for employment, for example with an NGO There may be a number of reasons for a dismissal, although some observers believe that poor working conditions and long working hours are causing nurses to make vital mistakes

Sources: Rolfe et al 2008, Martineau 2009, MSF 2010, ICN 2007, Standing 2000

2.7.2 Supply issues

Many of the factors summarised in Table 2.4 have arisen in a historical context of under-investment and problems in the education sector. In Malawi, supply factors can be linked to past investment shortfalls in pre-service training (Mwapasa 2005). In order

for sufficient numbers of health workers to be trained, there is a need for investment in both physical and human infrastructure (Kinfu et al 2009). Along with many countries in sub-Saharan Africa, Malawi experienced two decades of reforms which saw restricted public budgets and a freeze in recruitment and salaries (JLI 2004). Generally speaking, these reforms have been an important contributing factor to shortages of health workers in Africa (Liese et al 2003). Malawi was heavily affected by the public sector freezes that accompanied its three Structural Adjustment Loans in the 1980s and 1990s (Windisch et al 2009). These freezes meant that less money was available to invest in the training of health workers, in terms of infrastructure (such as the building of colleges) and manpower (tutors). The resultant high training costs and lack of training colleges have led to chronic underproduction of health workers (Chilopora et al 2007).

This underproduction can be linked not only to underinvestment in training colleges, but also to a lack of suitably qualified school leavers (Martineau 2009). The deficiency refers to both an absolute lack of students coming out of Malawi's secondary schools, and a lack of students with appropriate qualifications. During Muluzi's presidency the government introduced free primary school (Muula and Chanika 2005). This led to an influx of students, but many lacked the funds to continue to secondary school, which was still fee-paying. Despite 82 percent of children entering primary school, only 18 percent currently go on to secondary school (NSO 2005). The situation is compounded by socio-economic factors, which include high illiteracy and a lack of knowledge and interest in education in communities. It is thought that some parents openly discourage their children from attending school regularly because they do not see the value of education (Nsapato 2005). In combination, these factors mean that the numbers of students available to study nursing are limited. The situation is made worse by the lack of students leaving secondary school with adequate MSCE credits. Only 38 to 40 percent of students leave school with any MSCE credits (data from 2004 and 2008, Chimgwede 2009). Even those who pass often lack the vital science credits needed for nurse training, further reducing the numbers of adequately qualified school leavers.

Why are pass rates so low? The literature shows that from primary school up to tertiary (university) level, the standard of education available to most of the population is relatively poor. Issues with educational standards stem from the time of President Banda, who bestowed on the country a confused and corrupt education system (Mapanje 2002). Mapanje reports that the standard of education during Banda's rule was worse than in colonial times (when few Malawians had access to formal

education). Banda blamed the situation on teachers from the northern region, and claimed that they had sabotaged the educational system to make him look unpopular. In reality, the elite nature of the system meant that only a small minority of mainly upper and middle class students had access to good quality education, whilst the rest of the population had to make do with the educational 'dregs' (Lunda 2008).

Even after Muluzi introduced free primary education, observers commented that the lack of trained teachers, teaching materials and deteriorating infrastructure compromised the quality of education delivered (KCN, personal communication 2009). Many students continue to receive poor standards of education, often in overcrowded classrooms where the teacher to pupil ratio is currently 1:118 instead of the recommended 1:60³ (Nsapato 2005). In recent years, low educational standards have been linked not only to the shortage of trained teachers and poor infrastructure, but also to government activities. Increasingly, students and teachers are being pulled out of school and forced to attend Presidential and political functions (Nthara 2010), which, according to the Civil Society Coalition for Basic Education, is one of the main reasons that educational standards are declining. Investments in education continue to be inadequate and difficulties persist in retaining teachers as salaries are extremely low, at MK 15,422 to 17,203 (69-77 GBP) per month, far lower than current nursing salaries and far below basic living costs (Centre for Social Concern Malawi 2008).

Investments in university level education have also been inadequate, resulting in few places being available. In 2002 there were only 4000 places, of which 30 percent were occupied by females (Conroy 2006a). Kamuzu College of Nursing has not been immune to this underinvestment and the college's capacity has only been extended recently. Universities have also been plagued by political controversies, including the introduction of a quota system for university entrance in 1988 by President Banda on the grounds that students from the northern region were entering universities in greater numbers than students from other regions. Students from the northern region became desperate under the quota system, and this even led some students from the north to change their names so that they might appear to be from another region (Mkamanga 2000). Eventually a court challenge in 1993 led to the abolition of the system. However, in recent years the debate about quotas has been reignited because the current President is championing their reintroduction (University World News 2009).

³ For comparison purposes the current teacher to pupil ratio in the UK is 1:17 (World Bank 2010).

The lack of postgraduate training opportunities also posed significant challenges, not only for students but for the workforce as a whole. The lack of opportunities caused many nurses (and doctors) to leave to study overseas, and many who left did not return. This poor return rate depleted health worker numbers further, and is especially significant because of the loss of specialised and highly qualified staff. Researchers have shown that from a sample of 70 Malawian-trained medical doctors who went abroad for postgraduate training, only 34 returned after completing their studies (Mwapasa 2005). Historically, many doctors did not return from overseas because of the combination of poor salaries and distrust of the Banda regime (King and King 2000).

The limited output from training colleges both at degree and diploma level has led to inadequate numbers of nurses entering the health sector. These numbers have been limited further by additional factors relating to the career aspirations of students, especially women. According to the International Council of Nurses (2007), there has been a decreased global supply of students entering nursing colleges, partly because of a shift in the career aspirations of potential students linked to the poor image of nursing as a career. Career opportunities for women have expanded around the world in recent decades. In Malawi, women were traditionally led into a career in nursing, teaching or secretarial work. However, increasingly they are training to become accountants, engineers and lawyers, subjects traditionally only pursued by males (Mkamanga 2000).

2.7.2.1 The current training situation

Despite low secondary school enrolment and pass rates and shifts in nursing aspirations, there are still students willing to enter nursing. In recent years the enrolment figures for nursing colleges have increased, although numbers are still insufficient. This increase is attributed partly to the provision of financial support to students (MoH Malawi 2007a). Table 2.5 shows the numbers of students passing the registration exams of the NMC and qualifying as nurses each year. Although the figures represent the most accurate data available, they should be interpreted with caution as they do not distinguish between those upgrading to a new position (such as from enrolled to registered nurse), and those entering the workplace for the first time (NMC personal communication 2009). There are also no supplementary data to explain the dramatic fall in output of registered nurses and nurse midwife technicians (NMTs) in 2005 and 2006. One possible explanation could be funding problems within training

institutions. Although there are currently no data to prove the link for previous years, it was reported that in 2009 training programmes were disrupted in CHAM colleges because of funding disagreements between CHAM and the government. It was predicted that the temporary closures of colleges would affect NMC examination candidates (Kasawala 2009). The striking difference in NMT output could also be explained by fewer candidates passing both elements of the NMT exams, or just a consequence of data unreliability.

Table 2.5 Nurses and midwives who qualified between 2000 and 2008

Year	Registered Nurses	Registered Midwives	Nurse Technicians	Midwife Tech.	Nurse Midwife Tech.	Total
2000	47	8	-	-	178	233
2001	11	-	-	-	169	180
2002	42	24	-	-	88	154
2003	47	12	189	-	216	464
2004	27	9	199	-	79	314
2005	9	6	289	100	9	413
2006	4	12	96	161	6	279
2007	54	5	5	153	233	450
2008	87	32	11	150	447	727

Source: NMC Malawi (2009a)

Note that enrolled nurses are referred to in the table as nurse/midwife technicians

2.7.3 Health challenges

HIV/AIDS is by far the greatest development threat facing our nation today.

Dr Bakili Muluzi former President of Malawi (2003)

Health worker numbers decreased significantly between 1990 and 2000. The main reason for this erosion was death (UNDP 2002, Gonani et al 2005 cited in Tawfik and Kinoti 2006). In 2005, health worker deaths accounted for 41 percent of attrition of MoH staff; resignation and retirement represented a further 24 and 17 percent respectively (Bemelmans et al 2008). General poor health and an aging workforce have contributed to these high death rates, in addition to HIV/AIDS (Harries et al 2002) which caused over 10 percent of deaths within the MoH between 1995 and 2005 (Bongololo et al

2008). This proportion is unsurprising considering that AIDS is the leading cause of death in Malawi (WHO 2002)⁴. However, what makes the HIV/AIDS situation especially critical for health workers is that its effects on the workplace are considerable (UNDP 2002).

Firstly, HIV/AIDS increases the demand for care (Aitken and Kemp 2003). The epidemic has led to an increase in the number of chronically ill patients with long and frequent stays in hospital, straining the already limited available resources (HSC 2004). Currently, 70 percent of hospital admissions are HIV/AIDS-related (MoH Malawi 2005). This is a similar situation to other sub-Saharan African countries with high HIV prevalence rates; 86 percent of respondents taking part in a Ugandan study reported an increased workload because of the HIV/AIDS pandemic (Dieleman et al 2007). This burden is exacerbated by the demands of delivering HIV/AIDS services such as voluntary counselling and testing and antiretroviral treatment (ART). In 2004, free ART was rolled out to all public sector facilities in Malawi (Makombe et al 2007). Although this has had a positive impact (its introduction had led to a 75 percent reduction in HIV/AIDS related deaths, Nation reporter 2008), the provision of ART is labour intensive. Muula et al (2007) estimate that 4.7 to 16.4 percent of nurses working in the health sector would be required to adequately deliver ART to those clinically eligible.

Secondly, caring for HIV positive patients places not only physical demands on health workers, but also emotional demands (Dieleman et al 2007). Frequent exposure to the suffering of HIV patients has led to a high level of burnout within the health worker profession (Ijumba 2003, cited in Chirwa et al 2009). In addition to burnout, health workers are thought to lose status in their patients' eyes because they are unable to treat the disease (Aitken and Kemp 2003). The consequence of these demands can be poor treatment of HIV positive patients. A study conducted in a number of African countries, including Malawi, found that HIV positive participants experienced verbal and physical abuse and neglect. It reported that health workers were not universally accepting of their HIV positive patients and often believed that they "would die anyway, and so treating them meant that the resources in the hospital were being wasted" (Dlamini et al 2007:396). In addition to the emotional demands experienced in the workplace, health workers must also cope with caring for their own sick relatives (JLI

⁴ There are no data on the exact proportion of Malawian nurses who are HIV-positive (Bongololo et al 2008). However, it is estimated that between 15-30 per cent of nurses are HIV-positive in sub-Saharan Africa (Buchan 2006).

2004). HIV/AIDS has increased absenteeism and irregular attendance (Aitken and Kemp 2003), partly because of funerals and the demands of caring for family members.

Thirdly, caring for HIV positive patients is not only demanding but risky (JLI 2004). This refers to the increased occupational risk of exposure from events such as handling non-sterile injecting equipment or accidentally being exposed to infected body fluids (Tawfik and Kinoti 2006). The threat of exposure is real: estimates show that around 2.5 percent of HIV cases in health workers around the world are a result of needle-stick injuries (WHO 2002). A Malawian study reported that 52 percent of health workers had experienced an occupational exposure in the past 12 months, although only 26 percent went for testing, as they feared that their managers would see them as negligent in their duties (Bongololo et al 2008). In Malawi the risk of occupational exposure is exacerbated by inadequate supplies of protective equipment, including gloves (personal communication, Ngoma 2009). It is also heightened by unnecessary injuries and increased work pressures because of staff shortages (Mondiwa and Hauck 2007). A qualitative study based on the perceptions of the occupational risk of HIV infection among a small group of Malawian midwives found that the fear of infection led many to refrain from touching their patients, and many reported that it had led to a loss of interest in midwifery (Mondiwa and Hauck 2007). This is supported by the work of Mackintosh (2003), who found that potential exposure to HIV/AIDS at work contributed to midwives in Malawi leaving their profession. The stigma of HIV is an important determinant of work satisfaction. A cross-sectional survey of 1384 nurses conducted in five African countries, including Malawi, found that perceived HIV stigma was the strongest predictor of job dissatisfaction (Chirwa et al 2009).

In addition to increased work burden, emotional demands and occupational risk, HIV/AIDS is also said to be responsible for a 'secondary crisis' within the healthcare sector. In a letter to the Lancet, Kushner et al (2004) referred to the mass influx of money from overseas universities and NGOs earmarked exclusively for HIV/AIDS programmes. Although this investment is important, its indirect effect has been to draw 'record numbers' of staff away from government health facilities to work for these programmes, leaving behind a deteriorating health sector.

2.7.4 Retention factors

2.7.4.1 Overview

Nursing shortages originate from the underproduction of nurses from training colleges. Numbers are reduced further by deaths from HIV/AIDS and by resignations. A significant proportion of the literature on nurse retention in Malawi focuses on the reasons for these resignations. A large-scale study conducted by the Health Services Commission (HSC 2004)⁵ into the factors that influence health worker turnover used questionnaires and interviews to decipher what led to resignations from the government health service. It found that most health workers interviewed had lost interest in their jobs and were no longer able to work effectively because of a multiplicity of factors (HSC 2004). These factors were:

- The remuneration package is unattractive and insufficient in comparison with the cost of living;
- High patient to staff ratios and high workloads resulting largely from high staff turnover;
- Dislike of being blamed by patients and communities for the current state of affairs in the health facilities such as the erratic supply of equipment, drugs and supplies;
- Poor prospects for promotion, training and career advancement;
- Hostile and unsupportive attitudes of management teams;
- Lack of supervision and performance assessment;
- Risk involved in the occupation;
- Lack of transport.

The report findings are consistent with a number of other smaller-scale studies (Mackintosh 2003, Maseko et al 2005) which have found that resignations are often linked to poor working conditions or low and stagnant salaries (Bongololo et al 2008). In a small study, Kasenda (2001) found that in addition to the reasons listed above, nurses also reported long working hours which led to overwork. Other factors included the tendency to overload recent nursing graduates with administrative responsibilities, leading to burnout (Maseko et al 2005). When examining the reasons that nurses stayed in the health sector, the HSC study found that those remaining were sustained

⁵ The Health Services Commission was created by the MoH in 2003 to identify health worker retention factors.

by devotional factors and patriotism. Kasenda (2001) also found religious factors to be important for retention. Retention in service was also explained by nurses waiting to retire and obtain terminal benefits (Maseko et al 2005).

2.7.4.2 Working hours

Although the official working week for Malawian health workers is 42.5 hours, the HSC study found that 88.1 percent worked much longer hours, typically between 42.5 and 94 hours per week. A locum system was recently introduced and allows nurses in the public sector to gain additional income from overtime payments (MoH Malawi 2007b). Despite now being rewarded for extra work, observers report that these overtime payments have led to nurses working excessive hours. These long hours have been compounded by the introduction of a new night schedule which aimed to reduce the costs incurred in transporting nurses to hospitals at night. The shift is now three and a half hours earlier and some nurses now leave home as early as 1500 for a 1930 night shift as they have no transport. The change was not well received by the majority of nurses, and there has also been public outcry about a perceived decline in quality of care. Nurses view the current night shift schedule as too long and tiresome and the majority are not able to take a break (Chitsulo 1999).

2.7.4.3 Management issues

The HSC (2004) reported that supervision and management of health workers was erratic, with wide variations in the number of supervisory visits. Supervisory visits are especially important in rural health centres with only a few members of staff. Currently, performance appraisals are not being conducted in the health sector, and very few are conducted in CHAM facilities. Reports show that health workers who are considered high performers are often not recognised, and that there is a resultant lack of motivation to perform to optimum levels (MoH Malawi 2007b). Recent discussions at a meeting of Malawian nurse leaders coordinated by MSF (2008) identified that performance assessment within the nursing field was greatly lacking. They concluded that improving performance assessment within the workplace would be fundamental to improving staff morale and motivation.

2.7.4.4 Working conditions

Most health facilities in Malawi are characterised by a lack of equipment, drugs and supplies (HSC 2004, Gondwe and Brysiewicz 2008). These shortages have been attributed to the fact that, despite government financing, many hospitals do not have enough funds. This lack of funds can be seen in the reported 17 billion MK (approximately 70 thousand GBP) in unpaid bills for medical supplies owed to the Central Medical Services by district and central hospitals (Nyangulu-Chipofya 2009). In addition to lack of resources, abuse of nurses in health facilities has been reported. One study found that the common perpetrators were administrators, patients, doctors and guardians, with 25.4 percent of the 59 nurses and midwives in the sample experiencing physical abuse and 72.9 percent being verbally abused. Almost 90 percent indicated that the abuse had negatively affected their morale, performance and job satisfaction (Golati 2006).

2.7.4.5 Salaries

In addition to poor working conditions, studies emphasise low remuneration as one of the key factors in retention. Wages for health workers in Malawi have never been high, and this is particularly true for the lower cadres. Even in the 1970s and 1980s, many health workers had a second income-generating 'sideline' (King and King 2000). Through their observations of life in a Malawian hospital, King and King describe one nurse keeping chickens under her desk to breed and sell. Nursing salaries have actually decreased in real terms since the 1980s. In 1992 the real value of basic salaries for civil servants in general was about 50 percent below 1982 levels. This decrease has been attributed to high inflation rates and currency devaluation, which has intensified since 1994 (Anders 2002).

In 2001, dissatisfaction with salaries came to a head when health workers conducted a two-week general strike about low wages and professional allowances at the Queen Elizabeth Central Hospital (Mfutso-Bengo and Muula 2006). The strike was sparked by Muluzi (the President at the time) going back on his pledge to improve health worker salaries (Muula and Chanika 2005). In 2007, nurses went on strike again in protest against salaries, in particular against the MoH salary payment system, which reportedly offered professional nurses (RNs and ENs) similar wages to less qualified auxiliary nurses (Nation reporter 2007). 2009 saw another smaller scale strike, when nurses and

other staff in one hospital staged a sit-in in protest at low salary increments and the removal of allowances by their new Chief Executive (Somanje 2009).

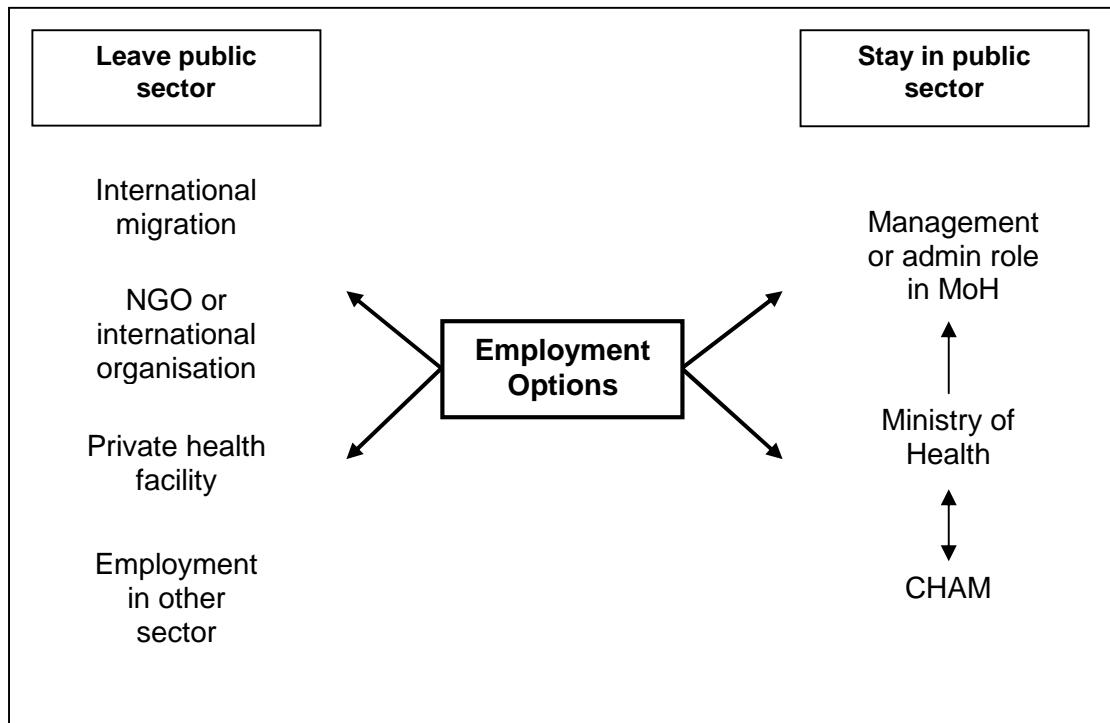
Current remuneration levels are considered insufficient. The HSC study found that health worker salaries are too low to sustain nursing livelihoods and that it was not possible to have a decent life in which all basic needs are met. These findings are supported by data from the Centre for Social Concern (2008), which carried out research into the monthly cost of living in Malawi's medium- and high-density urban areas. In 2009, the average cost of living for a family of six was MK 49,225 (220 GBP) a month in Lilongwe. These estimates refer to a basic needs basket which includes essential food and non-food items, but not minimum requirements for transport costs, health services, education, and clothing. In 2009, nursing salaries ranged between MK 32,893 and 37,275 per month (148 and 167 GBP) according to official statistics from the Centre for Social Concern. However, starting salaries of MK 14,000 were reported for ENs (personal communication NMC 2008). Nurses would struggle to meet the average cost of living if we assume that they are supporting a family of six (a reasonable assumption as Malawian families are traditionally large). However, when compared to other civil servants, nurses receive a relatively generous salary. Teachers receive MK 15,422-17,203 (69-77 GBP) a month, and at the lower scale, the monthly salary of a security guard in a private firm is MK 3000-5000 (13.5-22.5 GBP). The higher nursing salary is attributed to the 52 percent top-up introduced in 2005 by the Malawian government as part of the EHRP, which, combined with further increases, resulted in professional health workers being the highest paid civil servants in the country (McAuliffe 2008). However, according to Mwapasa (2005) the recent salary increase has not improved job satisfaction, mainly because salaries remain much lower than those offered in the private sector or outside Malawi.

2.7.5 Leaving the Malawian workforce

The threat of resignation linked to the retention factors described above is real: a study of Malawian health workers found that the majority had thought about leaving their job in the public sector in the past year (Manafa et al 2009). Upon resignation, nurses have a variety of alternative employment destinations, summarised in Figure 2.1. Mackintosh (2003) identified a hierarchy of alternative employment preferences based on the findings of her study on Malawian midwife retention factors. At the top of the hierarchy is international migration, followed by employment with an NGO, the private health

sector, and finally CHAM. Working in a completely different sector such as retail occupies the bottom slot.

Figure 2.1 Potential employment options for Malawian nurses



Migration features at the top because of the potential opportunities for greater remuneration and improved working conditions it offers (Mackintosh 2003). However, the past decade has seen a proliferation of NGOs and research institutions in Malawi, increasing employment options for nurses. CONGOMA, the council for NGOs in Malawi, currently lists over 330 NGOs on its members' website, although not all are health related (CONGOMA 2010). Their aggressive recruitment practices and high salaries have pulled many health workers away from the public health service (Koch 2009). International NGOs have been criticised for this and are accused of distorting the labour market by paying their Malawian staff high salaries (Carr cited in Barber and Bowie 2008). NGOs continue to attract individuals because they are seen as more desirable than the civil service with its poor salaries, high levels of corruption and narrow career prospects (Anders 2002). Despite this, promotion to a MoH managerial or administrative position is still an attractive option, especially as nurses are then removed from the pressures of bedside nursing but still able to benefit from a government pension (a nurse working for an NGO may not have the same benefits). The private health sector is an important destination for nurses who still want to work at

the bedside, but with a higher salary in a better resourced environment. The final, least tempting option according to Mackintosh's hierarchy is employment in a different sector. Little research has been conducted into the motivations and actual destinations of nurses who do this.

All these career destinations are not mutually exclusive, and nurses may move between them over their lifetime. For example, they may find it easier to migrate to the UK once they have acquired funds by working in the better paid private sector or developed international contacts in an NGO. The ability to pursue a chosen destination is dependent on many factors. These include availability of funds, appropriate contacts, and access to phones and the internet. If a nurse does not have access to these then his or her choice of alternative employment pathway can be limited (Kingma 2006). Employment with an NGO is particularly dependent on contacts as competition is high. One nurse interviewed by Manafa et al (2009) explained that she had been applying to numerous NGOs but without success. The decision to migrate also depends on a nurse having sufficient resources for travel or relocation (Mitchell 2006).

2.8 Migration from Malawi

Most countries are facing nursing shortages at the moment, so if you are an English-speaking nurse with an internationally recognised qualification, the world is your oyster, you can move where you want to practice.

Buchan 2006: 17S

Increased demand for health workers in high-income countries has led to a growth in career options for qualified health personnel (Aitken and Kemp 2003). Migration has become an important option for Malawian nurses leaving the public health service. Clemens and Pettersson (2008) estimate that around 17 percent of Malawian nurses were overseas in 2000, and a total of 633 nurses had been validated to work overseas by 2008 (shown in Table 2.6). These numbers may appear small, but they represent a significant proportion of nurses. Validation figures provide important data on intention to migrate and refer to those nurses requesting appropriate documentation to migrate. For nurses to gain employment overseas they must first seek validation (proof that they are practising nurses) with the Malawian NMC and then provide proof of qualification from their training institution (for example KCN). If they choose to work as RNs in the UK, they must register with the UK NMC, which ensures that all nurses are properly

qualified and competent to work in the UK (NMC UK 2010a). All migrant nurses working in the NHS and the independent sector (for example, a private care home) need to register with the UK NMC in order to practise (Winkelmann-Gleed 2006). Nurses from outside the European Union (EU) are required to pass the International English Language Testing System (Winkelmann-Gleed 2006).

Table 2.6 Numbers of nurses validated to work overseas 2000-2008

Year	Number validated
2000	90
2001	111
2002	90
2003	81
2004	85
2005	98
2006	30
2007	23
2008	25
Total	633

Source: NMC Malawi unpublished data 2009

The most common destination for nurses migrating from Malawi is the UK, followed by South Africa and the USA, which is consistent with Mackintosh's findings (2003). Table 2.7 details the numbers of nurses validated per country. It also presents the numbers of RNs and ENs leaving Malawi. Unlike an RN, an enrolled nurse is not recognised internationally. This may explain why fewer ENs have migrated. However, without further data we do not know where or how the ENs gained employment overseas (one possible explanation is that they upgraded to RN level in the destination country).

Table 2.7 Total number of Malawian nurses validated per country 2000-2008

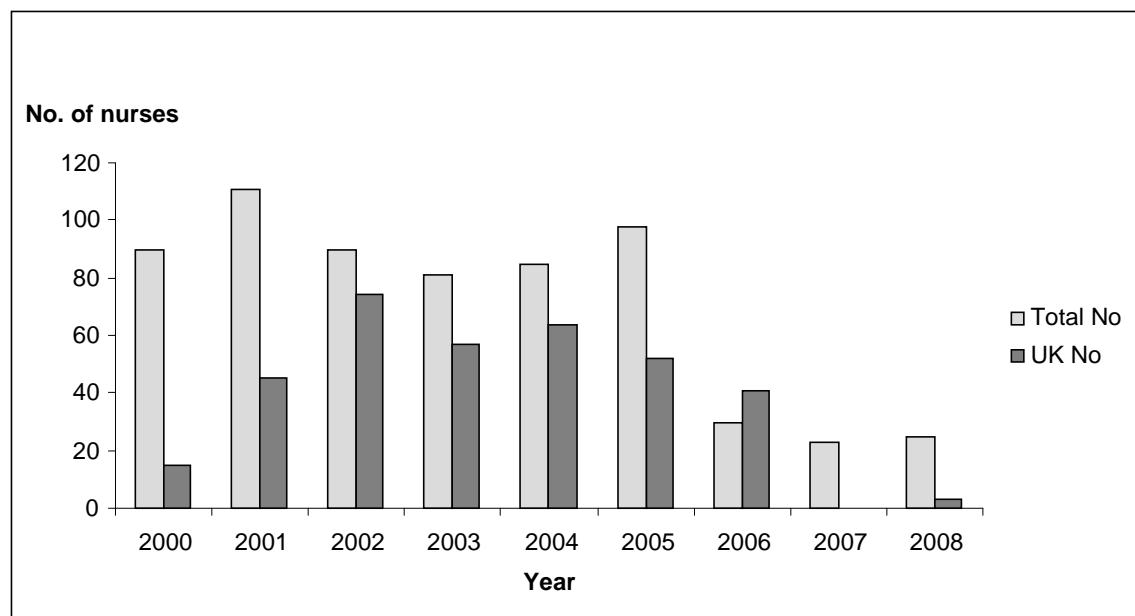
Country	Registered Nurses	Enrolled Nurses	Total
United Kingdom	490	10	500
South Africa	29	5	34
USA	20	6	26
Australia	15	1	16
Botswana	10	-	10
New Zealand	8	-	8
Ireland	4	-	4
Zimbabwe	2	2	4
Uganda	3	-	3
Canada	1	-	1
Columbia	1	-	1
Zambia	1	-	1
Swaziland	1	-	1
Kenya	1	-	1
Namibia	1	-	1
Total	587	24	611

Source: NMC Malawi (2008c)

Data obtained from validations provide only estimates of intent to migrate and not eventual migration. Anecdotal evidence from the NMC suggests that discrepancies have arisen because about 70 nurses validated to leave still remain in Malawi. Some only went overseas for a brief period of training, and others registered for more than one country (NMC Malawi personal communication 2009). Even within the NMC data figures conflict: Table 2.6 shows that 633 nurses validated to leave, whereas Table 2.7 reports 611 nurses in the same period. The data issues are consistent with the literature which argues that migration data are often inconsistent or incomplete (IOM 2007a, Ikenwilo 2007, Clemens and Pettersson 2008). This is partly because of the disparate range of data sources which include surveys, visa applications, border-point statistics (IOM 2007a), and because of limited up-to-date collection of information on health worker stocks and flows (Dovlo 2007). Discrepancies in migration data can also occur when a health worker does not work in healthcare upon arrival, works informally (IOM 2007a), or works in a number of countries (Dovlo 2007). In terms of UK data, there is no central record of the numbers of IRNs entering the NHS (Buchan 2007), making it difficult to estimate how many Malawian nurses went into the NHS as opposed to alternative employment in the UK. In addition, a nurse may have applied for

NMC validation in Malawi, but may opt to work as a nursing assistant in a care home and therefore not necessarily require UK NMC registration. According to UK NMC data, 351 Malawian nurses registered to work in the UK between 2000 and 2008 (Malawi NMC recorded 500). Graph 2.1 compares the total number of nurses validated by the NMC Malawi per year to those registering in the UK (there are no UK data from 2007). The fact that more nurses entered the UK in 2006 than left Malawi may be a consequence of inadequate data or represent a delay in UK NMC registration.

Graph 2.1 Nurses validated to leave Malawi compared to those entering the UK



Sources: NMC UK (2000-2008), NMC Malawi (2009b)⁶

2.8.1 Why the UK?

Research has shown that the destination choice of nurse migrants is based on several factors which link partly to available opportunities and admission policies. There are other potential reasons why the UK is the top destination for Malawian nurses. Firstly, the UK and Malawi have an established migration system because of colonial ties (Oderth 2002). International migration often occurs between countries with a common colonial history, such as between South Africa and Malawi (both former UK colonies), or between former colony and colonial power, such as Malawi and the UK (Oderth 2002, Ikenwilo 2007, Tanner 2005, Winkelmann-Gleed 2006). Colonial ties also mean that Malawian and British educational systems are similar (Oderth 2002). Even the

⁶ For data table see Appendix 1.

nursing curriculum in Malawi is based on the UK model, facilitating adaptation into the UK workforce (Buchan 2006). Secondly, distance between source and destination country is important (Buchan 2006), and may explain why nurses choose the UK over the US or Australia which are more difficult to travel to from Malawi. Thirdly, a shared language makes migration easier (Buchan 2006). The shared colonial history of Malawi and South Africa may explain why nurses also migrated there, but this also may be explained by geographical proximity and a shared language (English). Lastly, the UK has sought to recruit Malawian nurses into its workforce through active recruitment strategies (Buchan 2007). Active recruitment is an important factor in destination choice and in some cases can be more important than the factors described above. This can be seen in the vast numbers of IRNs from the Philippines in the UK, which share no historical links (Winkelmann-Gleed 2006)⁷.

2.8.2 Destination UK

The UK has a long tradition of recruiting workers from overseas to meet NHS staffing targets and fill vacancies (Stillwell et al 2003, Vujicic et al 2004), which has led to large-scale migration of nurses (Culley and Mayor 2001 cited in O'Brien 2007). However, recently there has been a rise in the active recruitment of IRNs to fill vacancies. A number of key events have precipitated this rise (described in Table 2.8). In the 1990s around 10 percent of nurses new to the UK workforce came from another country, rising to 52 percent by 2002 (Buchan 2006).

Demand for IRNs fell in the 2000s (Buchan 2007), partly because of renewed investment in the training of new graduates (UNISON 2010) and the admission of nurses from the EU. This is seen in the removal of Band 5 and 6 general nurses (the most common IRN positions) from the UK Home Office shortage list, meaning that an employer must now have first actively tried (and failed) to recruit nurses within the UK or the EU before a non-EU IRN can be employed (Buchan 2007). After this change, the UK became less attractive for IRNs, causing about one third of the UK Philippines Nurses Association to apply for jobs in other countries such as Australia (Hamada et al 2009). The decline is also attributed to stricter NMC registration requirements seen in the introduction of the Overseas Nursing Programme (ONP). Before the ONP, IRNs were required to undergo a minimum period of three months supervised practice with a named mentor (Winkelmann-Gleed 2006), which made the process of adaptation to the

⁷ Although English is widely spoken in the country.

UK workforce quicker and less costly. The ONP, with its associated costs and time, has acted as a potential barrier to registration. Increasingly IRNs are entering the UK through private care homes as unregistered nurses (Clews 2009, Pike and Ball 2007). The continued inclusion of skilled senior care (home) workers on the shortage list suggests that there are still opportunities for nurses to come over from Malawi, although not to RN posts. The Nursing Times (2008) reported that many IRNs secure work permits to do unregistered work in care homes, hoping that they will be accepted for the ONP. In reality, many nurses find that they become stuck in the care home sector because of the shortage of ONP places.

Another important contributing factor to the decline in IRNs is the introduction of the NHS code of practice. The code discourages active recruitment from a list of banned countries that includes Malawi and its neighbours South Africa, Zambia and Zimbabwe, current recipients of UK development aid (NHS employers 2009). NMC Malawi data show a decline in nurse migrants to the UK in 2004, which coincides with the strengthening of the code, suggesting that it may have had a significant impact on migration patterns.

Table 2.8 Key events in the recruitment of overseas nurses to the UK

Date	Event	Implications
1970s to 1980s	Changes in immigration laws lead to a decline in IRN recruitment	By mid-1980s overseas recruitment is negligible
Early 1990s	A recession means that the number of funded places in pre-registration nursing education drops	Causing staffing shortfalls by the middle of the 1990s
1992	Enrolled nurse programmes end, move to one level of qualified nurse (RN)	Leads to a shortfall in suitable candidates
1992 to 1995	Training places for nurses and midwives fall by 28%	
1997	Change to Labour party government in UK	Sharp increase in health expenditure, and demand for qualified health staff
2000	Short term solution is to recruit nurses from abroad	UKCC (now NMC UK) report that 7361 foreign nurses and midwives registered year end March 2000. A 48% increase on previous year
	Active recruitment of overseas nurses by UK NHS is taking shape	Rise in IRNs to the UK
2001/2	This is the peak year for international entrants to the UK register	More than half of new registrants are IRNs
2001	DoH publishes code of conduct on the recruitment of overseas staff	NHS organisations instructed not to actively recruit from developing countries
2004	NHS code of practice revised	Amendment to allow independent sector organisations to sign up
2004 to 2005	Largest enlargement of the EU (eight central, eastern European countries)	Priority given to EU countries to fill nursing vacancies
2005	Change in NMC UK policy in response to quality concerns: all nurses from outside European Economic Area are required to complete Overseas Nurse Programme (ONP)	ONP seen to dissuade organisations from recruiting non EEA nurses because of costs and time involved
2006	General nursing taken off UK occupation shortage list by Home Office	Drop in IRNs to UK
	List of banned countries for recruitment of health workers developed	Malawi is included on the list
2008	Further restrictions on occupation shortage list	Only operating theatre nurses and critical care nurses remain
2009	Recession in the UK means GBP loses value	UK is less attractive to overseas workers

Sources: Winkelmann-Gleed (2006), Pond and McPake (2006), Iley (2004), Nursing Times (2008), UK DoH (2004), Meadows et al (2000), Clews (2009), DoH (1999), Hamada (2009), NHS employers (2009)

2.9 Consequences of migration

2.9.1 Overview

Researchers have established that nurse migration is associated with costs and benefits, which can be divided into those affecting the destination country, the source country or the nurse migrant. These are summarised in Table 2.9. Examination of the consequences of health worker migration, particularly in the southern African region, often relies on patchy and anecdotal evidence (IOM 2007a, Stillwell et al 2003). The theme of poor migration data, especially from sub-Saharan Africa, is common, and the literature examined below may not present the full story. In addition, the lines between costs and benefits are often blurred and highly variable between countries. This variability is most pronounced between low and high-income countries which typically represent the source and destination, respectively. Despite these data issues, there is still sufficient evidence to show measurable negative and positive impacts, especially when taking into account the key role of HRH in the delivery of healthcare services.

Table 2.9 Benefits and costs of international nurse migration

Benefits	Costs
For the destination country <ul style="list-style-type: none"> • ‘Brain gain’: filling domestic vacancies with minimal costs • Improved knowledge base 	For the destination country <ul style="list-style-type: none"> • Conflict between migrants and citizens • Integration issues
For the source country <ul style="list-style-type: none"> • ‘Brain circulation’: return migration can result in transfer of skills and knowledge • Remittances • Development of networks and Diasporas • Rise in income for source country nursing councils • Puts pressure on source country government to improve conditions and salaries for remaining nurses 	For the source country <ul style="list-style-type: none"> • ‘Brain drain’: loss of skilled nurses • Economic losses (fiscal losses and training costs) • Overwork of nurses, creating further pressure for migration • Negative impact on health outcomes
For the nurse migrant <ul style="list-style-type: none"> • Improved personal and occupational safety • Educational opportunities • Professional practice opportunities • Better working conditions • Improved quality of life • Personal development 	For the nurse migrant <ul style="list-style-type: none"> • Negative experiences in the workplace • Potentially abusive recruitment and employment practices • Vulnerable status of migrants

Sources: ICN (2002), Mitchell (2006), Buchan (2006), Tanner (2005)

Before I examine these costs and benefits in greater detail, it is important to introduce the term ‘brain drain’, which features prominently in the nurse migration debates. Brain drain refers to highly skilled migrant outflow which causes permanent, concrete losses to a source country (Tanner 2005). The migration of nurses from Malawi and other low-income countries is considered to be brain drain, in part because of the relative numbers involved, and because of the significant economic and health losses documented in source countries. A country such as Malawi will almost certainly experience losses more acutely than a high-income country, because of weaker infrastructure (Serour 2009). Negative effects are magnified when brain drain occurs within critical occupation sectors such as nursing. This often becomes a vicious cycle in weak African healthcare sectors (Tanner 2005), where the high workload burden resulting from the outflow of nurses prompts more to migrate.

However, the case is not one-sided. Brain drain becomes 'brain gain' for the country on the receiving end of the migration, bringing benefits such as relief of domestic vacancies. It can also lead to 'brain circulation' (or return migration) when highly skilled migrants return to their country of origin, bringing benefits not only to the destination country but also to the individual migrant and the source country. The health system of the source country can benefit from the transfer of knowledge, experience and specialist skills from return migrants (Robinson 2007). Whilst in the destination country, the migrant may promote cooperation between universities or businesses of the home and destination countries (Tanner 2005). The positive impact of this is limited by the fact that many health workers who leave sub-Saharan Africa do not return to work in their own countries (Eastwood et al 2005). Malawi is no exception, and few episodes of return migration have been documented (Oderth 2002). In addition, countries like Malawi may not have the absorptive capacity to benefit from new skills, especially if their technology is less sophisticated (Clark et al 2006, ICN 2008).

2.9.2 Benefits of migration

Destination countries stand to benefit most from nurse migration. The main benefit is that they gain skilled workers and fill vacancies without the financial and time costs of training new nurses (Kline 2003), a form of 'free riding' (Martineau et al 2004:3). On an average day the UK NHS employs 20,000 temporary or agency nurses, at a cost of 1235 million USD a year (Finlayson, Dixon, Meadows and Blair 2002 cited in Kline 2003). If it is able to fill these gaps with trained IRNs, this represents a big saving. Destination countries also do not bear the costs of old age dependency as migrants commonly return home when they retire (Koser 2007).

The potential benefits for the nurse migrant include improvements in wages, working conditions, lifestyle and opportunities for career development and further training (Buchan and Dovlo 2004 cited in Clark et al 2006). Nurses may also benefit from a safer working environment (ICN 2002), including less exposure to HIV/AIDS and appropriate resources and technology to perform their role. Evidence suggests that source countries also stand to benefit from nurse migration, albeit temporarily (Clark et al 2006), through return migration, remittances, or through subtle processes linked to the beneficial brain drain hypothesis. The beneficial brain drain model predicts that skilled migration can be beneficial for a source country as it creates incentives for

obtaining training, which then increase the country's supply of skilled labour (Robinson 2007) as not all graduates end up migrating (Legrain 2006). Some conditions need to be in place for this model to work effectively. Firstly, migration needs to significantly affect decisions to take training. Secondly, migrants should not be heavily screened by the destination countries (Kangasiniemi et al 2007). In reality, this is rarely the case, and it is difficult to assess the benefits of migration with the model. Other potential benefits include relief from overpopulation (Tanner 2005) and development of networks and Diasporas. Rising nurse migration also generates new incomes for nursing councils from issuing verifications (Buchan and Dovlo 2004 cited in Dovlo 2007). It may also contribute to the empowerment of nurses by forcing the source country to address salary and labour issues (Anderson and Isaacs 2007).

The main benefit to the source country is considered to be remittances. Remittances are defined as a form of international resource transfer from a migrant to other individuals, households or organisations overseas. They take the form of money transfers via a formal banking system or through an informal agent (Connell and Brown 2004). The remittance dimension is particularly important in nurse migration as data have shown that nurses are likely to remit more frequently and larger amounts than other migrants (Connell and Brown 2004)⁸. Remittances (not just those from nurses) were estimated to be 232 billion USD in 2005, making them the largest source of external finance in many low-income countries (Mitchell 2006). This figure may be an underestimate as many remittance payments are transferred outside the banking system (Martin et al 2002, Connell and Brown 2004). Remittances provide a source of income for families and communities that may not have access to other income generating activities. In Malawi, they have been positively associated with improvements in rural areas (Ramamurthy cited in Tanner 2005). Globally, many individuals are thought to rely on remittances, as shown in Mali by Martin et al (2002). One study estimated that a 10 percent increase in official remittances per person leads to a 3.5 percent decline in the share of people living in poverty (Adams and Page 2005 cited in Legrain 2006).

At a national level, it is estimated that remittance flows through official channels to Malawi accounted for 0.1 percent of GDP between 2000 and 2005, averaging about 1 million USD a year (World Bank 2006 cited in Robinson 2007). This suggests that in Malawi remittances, although important, may not represent a significant source of

⁸ There is currently no information available on the specific remittance amounts of nurses (Dovlo 2007).

external finance compared to Lesotho in southern Africa, where remittances represent 26 percent of GDP (World Bank 2006, cited in Robinson 2007), or the Philippines, whose economy is largely based on remittances from nurses and other labourers working in high-income countries (Buchan 2006). Because of the substantial remittance figures there is, however, a danger of exaggerating their impact and concluding that remittances mitigate the negative impacts of migration. Many authors warn that there is little systematic evidence for the benefits of remittances (Mitchell 2006, Robinson 2007), in particular in the southern African region (IOM 2007a) as it receives the least amount of reported remittances (Tanner 2005). In fact, a number of negative attributes have been associated with remittances:

- They may lead to an increase in sluggishness towards enterprise and excessive international dependency in the source country (Tanner 2005);
- Payments tend to be unevenly spread between low-income countries, and do not go to the poorest (IOM 2005 cited in Mitchell 2006);
- They create a disincentive for domestic savings and can cause currency appreciation (Mitchell 2006);
- The volatility and selectivity of payments make remittances a vulnerable source of income (Mitchell 2006). They may also diminish over the migrant's time abroad, due to destination country integration and citizenship (Tanner 2005).

These factors suggest that remittances may not mitigate the negative effects of migration, and inadequate information on their extent and use makes it difficult to estimate their real contribution to development (Connell and Brown 2004).

2.9.3 Costs of migration

Costs associated with migration are borne by both destination and source countries. In destination countries, citizens may perceive that migration reduces wages and increases unemployment, leading to hostility and racism (Mitchell 2006), which in the extreme can lead to civil unrest (such as the Oldham riots in 2001⁹). Although this consequence is important - especially when placing the experiences of Malawian nurses in the UK in context - in this section I focus on the costs to source countries, and to Malawi in particular.

⁹ For more information see: Ahmed, N., Bodi, F. Kazim, R & Shadjareh, M. (2001) The Oldham Riots: discrimination, deprivation and communal tension in the United Kingdom, Islamic Human Rights Commission.

2.9.3.1 Source country costs

Earlier we saw that brain drain can result in significant losses (costs) for source countries. In particular, it can lead to a loss of economic investment from expenditure in nurse training, loss of fiscal (tax) income, direct budget burden, and health system effects such as under-provision of healthcare services and increased pressure and workloads on those who remain (Ikenwilo 2007). The economic effects of nurse migration are felt by the source country in two ways. Firstly, the loss of the economic investment in the training of a nurse who then leaves the country (Serour 2009, Kline 2003); and secondly, the additional costs faced by the country to address the shortfall caused by migration (Mitchell 2006). Globally, low-income countries have spent an estimated 500 million USD training health workers who have then migrated (Kuehn 2007 cited in Serour 2009). Academics in Malawi estimate that for each RN who migrates, the investment lost ranges from 241,508 to 25.6 million USD at 7 percent and 25 percent interest rate per annum for 30 years, respectively (Muula et al 2006)¹⁰. It is difficult to measure the exact cost of the professional education of health workers because of data issues in sub-Saharan Africa (Robinson 2007). In any case, the economic loss can be significant since health worker training is costly because of its long duration and high material expenses (Connell et al 2007), and countries are often unable to recoup their investments (Pagett and Padarath 2007).

The country also faces an additional budget burden, through the recruitment or training of a replacement workforce (Tanner 2005). The hiring of expatriates to fill nursing or tutoring positions is a costly endeavour, even with donor support. Africa employs up to 150,000 expatriate professionals to fill general human resources gaps at a cost of USD 4 billion a year (Tebeje 2005). However, this solution is considered to be effective especially when workforce depletion is severe, and has even formed part of Malawi's Emergency Human Resources Programme.

The negative consequences of nurse migration are strongly felt in the healthcare system of the source country. They can be divided into those affecting healthcare delivery and those affecting remaining health workers. As health workers are a fundamental part of the healthcare system, any decline in number will have a profound negative impact (Paradath et al 2003, Clark et al 2006). A number of studies (including DENOSA 2001 and Yan 2002 cited in Buchan 2006) have found that when too many nurses migrate the health system in the source country is not able to function

¹⁰ The calculation also depends upon the interest rate, and principal amount invested.

effectively. In this situation, a population may be forced to rely on alternative ways to obtain healthcare, such as seeking treatment outside the country (Serour 2009). Inability to access treatment has far-reaching consequences beyond the health status of a population. Good health is widely acknowledged to be a critical factor in poverty reduction and economic development (WHO Commission on Macro-Economics and Health cited in Conroy 2006b).

In Malawi, the loss of nurses to migration has resulted in high vacancy rates, leading to inadequate healthcare coverage threatening the functioning of the healthcare system and the health of the population (Stillwell et al 2003). In many cases, educational capacity is not large enough to support increased out-migration and increased domestic supply (Vujicic et al 2004), contributing further to high vacancy rates. As we saw earlier, infectious diseases such as HIV/AIDS increase health care demands, placing an even greater strain on the healthcare system. There are concerns that the scaling up of ART in Malawi will be constrained by the lack of adequately trained nurses (Muula et al 2006). Staff shortages are also an important obstacle to the attainment of the health-related targets for the Millennium Development Goals (Rolle et al 2008, ten Hoope-Bender et al 2006, Gerein et al 2006), and observers have noted that if MDG 5 (maternal and child health) is not met, then neither will the other goals (Serour 2009). Success stories in the reduction of maternal mortality point to HRH as a crucial factor (Chilopora et al 2007, Dogba and Fournier 2009), as many maternal clinical interventions can only be successfully achieved within a functioning health system with skilled birth attendants and emergency back-up services. Maternal health is a vital component of health care services in Malawi, especially as 65 percent of the population are children under 14 or women in childbearing years (Burgess 1984). Despite ongoing interventions maternal mortality remains high and the sheer absence of staff and facilities is considered to be the most substantial barrier to progress to improving maternal health (Kachale 2007 personal communication, Bradley and McAuliffe 2009).

Not only is the capacity to deliver quality healthcare diminished, the net effect of out-migration is to increase the workload on remaining health workers (IOM 2007a). There is a strong consensus that difficult conditions and heavy workloads worsen when nurses migrate, and remaining health workers may deliver lower quality care because of time constraints (Kingma 2006, Muula et al 2006). The workload burden can also lead to demotivation and stress, and in turn encourage health workers to migrate or resign. Nurses may also experience difficulties in coping with the knowledge that their

colleagues abroad may be having a better life (Buchan 2006). In addition, migration can create an experience gap affecting the recruitment and training of health workers (Bach 2006 cited in IOM 2007a). The departure of teaching staff - often the most qualified and experienced nurses in the country - has caused a decline in the quality of education in nursing schools, and a lack of supervision and mentoring (WHO 2006c). The remaining teachers are often unable to cope with the demand, especially if training output is increased in response to staff shortages, as has been the case in Malawi.

2.9.3.2 Nurse migrant costs

I argued earlier that nurse migrants are often able to benefit from improved working conditions and salaries in the destination country. Migration can provide nurses with opportunities to develop their careers and improve living conditions for themselves and their families, but it has also resulted in negative experiences (Commonwealth Secretariat 2003). In this section I examine studies conducted on internationally recruited nurses (IRNs) in the UK that have highlighted these negative experiences.

Researchers agree that most IRNs have negative experiences whilst working in the UK (Likupe 2006) and many end up in vulnerable, inequitable work roles (McElmurry et al 2006). A number of these negative features consistently appear in the literature, summarised by Smith et al (2006) in their study of 93 mainly overseas nurses as:

- IRN skills and experiences are not recognised;
- Career progression is much slower for IRNs;
- IRNs face multidimensional discrimination in the workplace.

These findings are reflected in several studies, in particular in the influential work of Allan and Larsen (2003), who conducted focus group discussions with 67 IRNs working in the UK to examine their motivations and experiences. They found that IRNs had mixed experiences and although some benefited from a supportive environment many faced significant challenges in their working and personal lives. Challenges can begin even before arrival: Alonso-Garbayo and Maben (2009) found that IRNs often receive insufficient or inaccurate information during recruitment, potentially affecting their level of preparedness and skewing expectations.

Differences in the organisational culture between home and destination country may require the nurse to adapt to a new way of delivering nursing care (Smith 2004). Buchan (2006) noted that IRNs often experience difficulties in adapting to this new way

of working, leading to what Smith calls a 'culture shock'. One study suggested that IRNs found UK nursing to be restrictive and over-concerned with litigation (Allan 2007), whilst Moran et al (2005) reported that the 34 IRNs in their study associated UK nursing with large waiting lists and correspondingly large caseloads. The IRN must also adapt to a new culture and in some cases a new language. There is no doubt that having a shared language helps adaptation, but the literature has highlighted that even English-speaking nurses face communication challenges in the UK. These relate mainly to its numerous accents and colloquialisms, which can be difficult for a non-native to understand (Allan and Larsen 2003, Likupe 2006).

One significant cost to IRNs appearing frequently in the literature is deskilling, where nurses' past experience or expertise are not taken into account (Kingma 2006). In the extreme, 'brain waste' can occur when a migrant is unable to get a job suited to their level of training and experience because of factors such as language barriers (Mitchell 2006). Brain waste could be a reality for nurses coming from Malawi, as a significant proportion were senior and highly qualified (personal communication NMC 2008, Palmer 2006). Buchan et al (2006) found that African nurse migrants tended to be older, with many years of clinical experience. It would therefore be expected that these nurses would enter senior positions in the UK, but in reality many IRNs, despite their level of training and experience, enter the workforce at D or E grade, the two main grades for (non-senior) staff nurses. Nurses from sub-Saharan Africa, in particular, are often found to be employed at lower grades (Buchan et al 2006). This is consistent with findings from the Royal College of Nursing employment and working well surveys, which reported that fewer IRNs and black minority ethnic (BME) nurses are employed in better paid, senior grades (Pike and Ball 2007). As a result many IRNs experience deskilling and are prevented from using their technical skills in the UK (O'Brien 2007, Smith 2004), causing them to feel demotivated.

The literature highlights additional factors that may contribute to IRNs feeling demotivated. Firstly, they often do not feel appreciated or respected at their workplace (Allan and Larsen 2003, Alexis and Vydelingum 2005, Moran et al 2005). Alexis et al (2007) documented an example of this, whereby the relatives of patients bypass the IRN and seek information from UK nurses, despite the fact that the IRN is the one caring for the patient. However, this may not always be the case. Withers and Snowball (2003) conducted a study into the experiences and expectations of Filipino nurses working in an Oxford NHS Trust and found that they reported positive client interactions. IRNs also feel that their interactions with colleagues and managers are not

always positive. Aboderin (2007) reported that the Nigerian care home nurses in her qualitative study experienced discourteous, domineering behaviour from the white British carers. The black African nurses in Allan and Larsen's 2003 study also experienced negative treatment and described how they faced fear and stigma about HIV/AIDS from their UK colleagues. Poor treatment of IRNs can also extend to management and studies have pointed to the lack of trust between IRNs and managers, leading to the feeling that they are 'being watched' (Alexis et al 2007).

Nurses may also feel demotivated if their expectations of overseas working life are not met. This appears to be especially prevalent in care homes. The Nigerian nurses in Aboderin's study were disappointed with life in the care home sector as it delivered few opportunities for clinical nursing (Aboderin 2007). They also experienced a loss in professional and social status in the UK, exacerbated by the fact that none of them had chosen to work in the care home sector. A mismatch in expectations can also take place in the NHS. Withers and Snowball (2003) found that the majority of Filipino nurses in their study felt that their expectations in terms of wages, professional gains and standards of living were unmet. The black and minority ethnic IRNs in Alexis and Vydelingum's 2005 qualitative study also described a lack of opportunities for skills development and training, potentially limiting professional gains.

IRNs may also have expectations about their prospective salaries. The wage dimension is important, as studies suggest that economic motivations are often central to migration decisions (Mitchell 2006). Despite an increase in wages, nurses often find that the high cost of living diminishes the financial advantages of being in the UK (Likupe et al 2005). One study of IRNs in Ireland found that the high cost of living diminished salary values and reduced the amount that they were able to remit (Humphries et al 2009). In addition to the high cost of living, a number of researchers have reported that IRNs in the UK often earn less than domestic nurses (Kline 2003). This supports the earlier finding that IRNs are commonly on lower pay grades. Pike and Ball (2007) report that compared to white UK nurses fewer IRN and BME nurses are being paid for acting up to a higher grade, further compromising potential remuneration.

Aside from the practice of IRNs starting at the bottom of the pay scale in the UK regardless of experience or length of service (Winkelmann-Gleed 2006), the reasons that IRNs consistently remain on lower grades are unclear. One study has pointed to non-transparent informal promotion mechanisms (Henry 2007). Henry examined the

reflections of 20 older Ghanaian nurses and midwives on their career progressions in the NHS and found that many experienced difficulty in progressing into senior positions. This was blamed partly on cultural differences and gaps in knowledge, as well as on a lack of official support from senior staff (Henry 2007). Many nurses found it challenging to adapt to competitive promotion and were unsure how to undertake interviews or produce a good CV. This led them to withdraw from career development. The findings are supported by Dhaliwal and McKay (2008), whose study explored the experiences of black nurses (a group which included those of Asian and South American decent, but not necessarily IRNs). The respondents found it difficult to achieve promotion compared to their white counterparts, and had in the past been actively discouraged from seeking it. Even if IRNs do apply for promotion, studies report that they are less likely to be successful in their application for a higher grade than white or BME nurses (Pike and Ball 2007).

The nurses in Dhaliwal and McKay's study believed that discrimination had been a key factor in their non-selection. In the extreme form, discrimination can lead to acts of racism. A number of studies have highlighted the high prevalence of racism experienced by IRNs (Larsen 2007, Moran et al 2005, Likupe et al 2005). Pike and Ball (2007) found that IRN and BME nurses experienced racially influenced bullying and harassment, although this could be associated with the fact that more nurses from this group work in specialities characterised by higher levels of verbal abuse, such as mental health. Literature investigating the working experiences of BME nurses also reports significant levels of discrimination and racial harassment (Shields and Wheatley Price 2002 cited in Likupe 2006), suggesting that it is not the status of the IRN as a migrant or foreigner but their ethnicity that causes tensions. The migrant status of IRNs, however, can leave them vulnerable. Studies point to incidences of discrimination going unreported because of their status. Alexis et al (2007) found that many IRNs tolerated discrimination for fear of being thrown out with their families. The fact that there is commonly no safety net for IRNs may increase their vulnerability. If they are made redundant, they may not have access to housing benefit or jobseekers' allowance (Clews 2009).

Financial security and personal support can make IRNs less vulnerable to negative events and improve their quality of life. Allan and Larsen (2003) reported that IRNs found it psychologically demanding to be separated from their families, and felt socially isolated without personal support. The act of migration itself can be psychologically challenging, and studies have shown that migrants tend to have higher than average

rates of suicide and depression (Carballo and Mboup 2005 cited in Mitchell 2006). Even when living with their families, IRNs experienced challenges. The sub-Saharan African nurses in Likupe et al's 2005 study were particularly concerned about racism in their children's schools. Although the study did not focus on IRNs, McGregor (2007) examined the experiences of Zimbabwean care home workers and found that most were unhappy with their social life in Britain, particularly because exhaustion and anti-social hours gave them little time to spend with family and friends.

2.9.4 Conclusion

There are no absolute winners and losers in the nurse migration story, although destination country gains are significant. Remittances appear to benefit source countries, but there has been considerable debate in recent years about their actual impact (Koser 2007, Tanner 2005). Migration has exacerbated health worker shortages, and this has far-reaching consequences for health service delivery and conditions for the remaining staff. At the extreme, many believe that migration has not brought any continuous benefits or led to sustainable development in low-income source countries (Tanner 2005), but has only increased their dependency on high-income countries (Mitchell 2006:11).

According to Robinson (2007), despite examination of source country benefits, there is an overwhelming bias in the HRH literature towards migration costs. This bias means that the benefits of nurse migration to source countries (beyond remittances) are often overlooked, potentially biasing my interpretation and conclusions regarding costs and benefits of migration from Malawi. With regard to the effects of nurse migration on the source country health system, some researchers have questioned whether increasing health workforce numbers yields significant gains in health status. Standing (2000) drew upon the example of investments in health workforce expansion made in many low-income countries during the 1970s and 1980s. She reported that, with the exception of a few areas such as immunisation, health workforce expansion did not lead to an improvement in health outcomes. This suggests that there are many factors involved in improving health outcomes, not simply health worker density. Many low-income countries face additional challenges including increases in disease burden and inadequate financing from African governments (JLI cited in Tanner 2005), making it difficult to assess the impact of migration.

At the individual level, studies suggest that nurse migrants benefit through increased opportunities for pay, career development and improvements in lifestyle. However, UK IRN studies show that nurse migrants also face a number of negative experiences and costs. These costs include loss of community identity and human relationships as well as health effects (Mitchell 2006). When deciding whether to migrate, individuals may weigh up the costs and benefits (assuming that the information is available). Commonly, there are also a number of other factors involved in the migration decision, and these feature in the many migration theories and frameworks which I now present.

2.10 Theories of international migration

People have always moved around (Koser 2007), but migration has proven difficult to define and measure and resistant to theory building (Arango 1985 cited in Arango 2000). Attempts to develop a single theory of migration are hindered by the fact that it "is too diverse and multifaceted" (Arango 2000:283). Despite this, researchers have proposed theories and models to explain human migration. A sample of these are presented in Table 2.10.

Table 2.10 A sample of migration theories and models

Migration theory	Explanation
Neo-classical explanation	Emphasises the primacy of economic motivations in migration -Neoclassical microeconomic theory focuses on the individual's decision to improve well-being by moving to a place where the reward for their labour is higher -Neoclassical macroeconomic theory explains migration flows as the result of wage differentials and the probability of obtaining a job in the form of unemployment rates
Economic development with unlimited supply	Dual economies: modern sector and traditional sector coexist in equilibrium. The modern sector relies on outmigration of people from the traditional sector
New economics of labour migration	Refines neoclassical explanations to emphasise the migrant's context, and the role of family or household in migration decisions
Dual labour market theory	Migration caused by permanent demand for foreign labour because native workers in advanced societies shun low-paid, low-prestige jobs. Foreign workers are willing to accept such jobs because wages are usually higher than back home
World system theory	Migration is viewed as product of domination exerted by core countries over peripheral areas, migration stems from inequality. Sheds light on the observation that migration often connects countries linked in the past by colonial bonds
Cumulative causation	Migration induces subsequent moves through number of socioeconomic processes, most importantly the expansion of migrant networks (related to network migration models where migrants follow former migrants from same source regions)
Human capital theory	Regards migration as a holistic investment decision for an individual based on long-term and short-term benefits
Structuralist critique	The causes of migration are hidden from the gaze of the observer and require theoretical endeavours to determine what they are
Behavioural model approach	Conceptualises migration as a sequential decision-making process, and assesses the extent of economic considerations
Household migration models	Migration is a strategy to spread risk by working in different labour markets: the individual will then remit money to family back home

Sources: Arango (2000), Boyle et al (1998), Ikenwilo (2007), Oderth (2002), Keely (2000 cited in Portes and De Wind 2007)

Each model has strengths and limitations. Many are limited by the fact that they do not recognise the complexity of migration decisions (Mitchell 2006) or do not take into account potential barriers such as restrictive admission policies (Arango 2000).

Researchers increasingly recognise that migration decisions are embedded within the complexity of people's everyday lives (Boyle et al 1998). Although most present day

(voluntary¹¹) migration is broadly described as economic - propelled by the prospect of economic advantage to the migrant and their family - (Mitchell 2006) other factors including political forces, poverty, the migrant's age, past colonial and cultural ties, and existing Diasporas in the destination country are also important (Kingma 2006). Nurse migration is considered to be particularly complex and influenced by many factors including trade agreements, country level recruitment strategies, profit motives and individual factors (Bach 2003 cited in McElmurry et al 2006). Economic theories appear to limit explanations of nurse migration. They do not explain why it occurs even in the absence of wage incentives (Kingma 2006), such as the movement of nurses from countries like the USA, where wages are among the highest in the world. Even when there are wage incentives, one study found that the size of the wage differential between source and destination country did not correlate with the migration of health workers (Vujicic et al 2004).

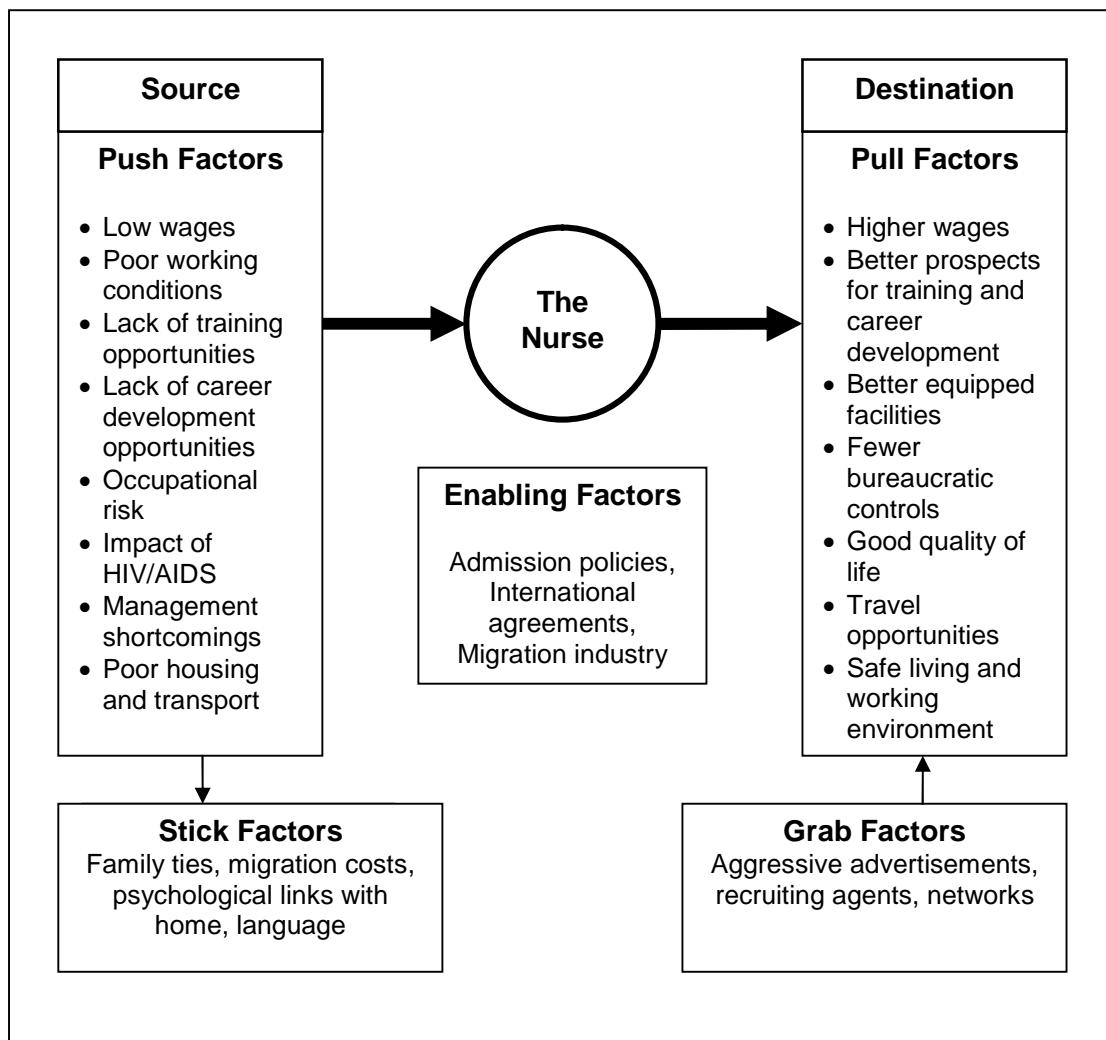
Researchers (Kingma 2006, Buchan 2006) have attempted to frame the decisions made by nurse migrants in the push and pull model (Dovlo 2007, IOM 2007a). The key components of the model are: (1) push factors, the influences in the source country that make a nurse consider leaving; and (2) pull factors, the features of the destination country that make it more attractive (Buchan 2006). Both push and pull factors are needed for migration to occur (Padarath et al 2003). The literature on health worker migration appears to agree on a number of key factors (Ogilvie et al 2007) shown in Figure 2.2. There may also be push and pull factors applicable to highly skilled worker migration in general, including overpopulation, inflation or currency devaluation, tribal or ethnic discrimination and rigid government employment systems (Tanner 2005 based on Zelinsky's push and pull framework 1971). These are not included in Figure 2.2.

A number of additional factors relevant to the framework have been identified and are described by Lee as intervening obstacles (or enabling factors) and personal circumstances (or stick factors) (Oderth 2002). Stick factors contribute to greater nurse retention and include family ties, migration costs, and other social and cultural factors (Padarath et al 2003). Nurses may decide to stay if they are unable to cover the costs of migration, or to prevent family disruption or loss of identity (Mitchell 2006). In addition, they may not migrate if they are satisfied with some aspects of their working life, for example high morale, rewards and incentives (Padarath et al 2003). These are

¹¹ As opposed to forced migration which refers to the movement of asylum seekers and refugees.

also considered to be stick factors. It is important to examine stick factors, as researchers have questioned why so few people migrate if there is widening awareness of opportunities for a better life and increased access to transportation (Koser 2007). Enabling factors play a guiding role in destination choice and aid transition to the new country (IOM 2007a). On an individual level such factors may be agents that facilitate migration, including labour recruiters, immigration lawyers, and immigration officials (Koser 2007). Private recruiters play an important part in enabling nurse migration, and are highly active in a number of countries, including Nigeria (McElmurry et al 2006). At a more general level, enabling factors can include the media or existing Diasporas and transnational networks which share knowledge about possibilities in the destination country (Tanner 2005) and financial resources. Research has shown that nurses from richer African countries tend to migrate more than those from poorer ones (Clemens 2007), suggesting that resources can play an important role in the migration decision. Another category frequently cited in the nurse migration literature is 'grab factors' (IOM 2007a). Grab factors refer to active or aggressive recruitment practices in the destination country (Paradath et al 2003). They may play an important part in motivating nurses to migrate: one study revealed that over 41 percent of migrant nurses to the UK came primarily because they had been actively recruited (Winkelmann-Gleed 2006).

Figure 2.2 Push and pull model of nurse migration



Sources: Muula (2005), Buchan et al (2003), Eastwood et al (2005), ICN (2002), Kingma (2006), IOM (2007a), Paradath et al (2003)

2.10.1 Patterns of migration from Malawi

Graph 2.2 shows how push and pull factors have contributed to the migration patterns of nurses from Malawi, and also highlights the importance of context, in particular historical, political and economic events.

2000 to 2001: migration peaks

Data from 2000 show substantial numbers of nurses migrating, peaking in 2001. Although no official records are held, information from the NMC Malawi suggests that migration levels were not significant before 2000. A number of factors may have contributed to the subsequent rise, and can be considered in terms of push, pull (or

grab) factors and enabling factors. An important push factor at this time may have been salaries. Although Vujicic et al (2004) showed that wage differentials were not impacting significantly on migration decisions, researchers maintain that salary considerations are an important part of the model. According to Mitchell (2006), migration has been shown to increase when there are high levels of income inequalities, such as those between source and destination countries. This is supported by a Ghanaian study which found that low salaries were important in motivating nurses to migrate (Mensah et al 2005). Around 2000, nurses in Malawi became dissatisfied with remuneration levels, leading to numerous strikes that continued throughout the Muluzi presidency (1994 to 2004). Nurses were also displeased with poor working conditions, especially as HIV/AIDS levels were rising. Poor working conditions are a significant push factor for many health workers in sub-Saharan Africa (IOM 2007a) and Malawi (Mackintosh 2003). HIV/AIDS is a key push factor in the nurse migration literature because of the workload and occupational risk (Buchan 2006, Aitken and Kemp 2003, Tawfik and Kinoti 2006).

During this period, a significant pull (or grab) factor was the introduction of active recruitment in the UK, which targeted nurses in Malawi through agents and internet communication. This also meant that UK admission procedures were geared towards permitting entry to Malawian nurses. 1994 saw the end of Banda's rule and the arrival of multiparty politics under president Muluzi. With it came unprecedented freedoms for Malawians, including greater access to communications and the media, especially in terms of knowledge about life overseas. Transportation links were also improving and air travel became more accessible. In previous years, access to communication and media may have hampered nurses' attempts to find information about opportunities overseas, and working conditions may not have been as poor because HIV/AIDS was not as prevalent.

Another important pull factor in 2000-2001 may have been the fall in the exchange rate value of the Malawian currency, making the prospect of a higher salary overseas more appealing, especially when remittance opportunities were considered. Remittances may be interpreted as a hidden push factor, whereby working overseas becomes an investment for the whole family (Larsen et al 2005). WHO data (2004 cited in Conticini 2004) show a steady annual trend against the Malawian Kwacha (MK), from 8.7 MK per USD in 1994 to 72.2 MK per USD in 2001. This coincided with a rapid decrease in Malawi's GDP growth rate.

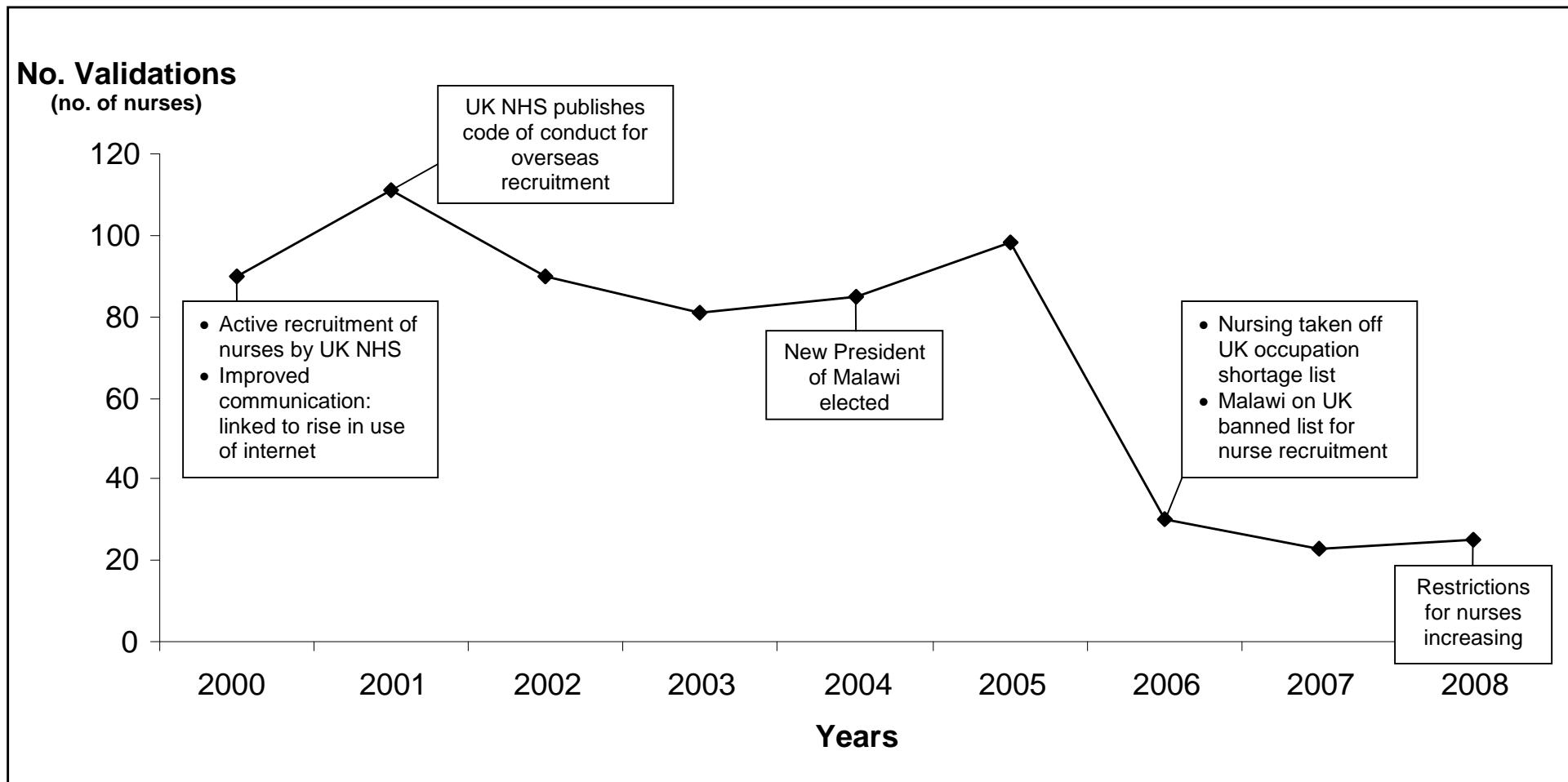
2001 to 2004: high levels of migration

It is likely that high levels of migration were maintained by the continued active recruitment of nurses, the proliferation of migrant nurse networks, and deteriorating working conditions with rising HIV/AIDS levels. With President Muluzi still in power, increasing corruption and rising debt may have strengthened the push from Malawi. As migration levels rose, work burden may have increased, causing nurses to feel stressed and undervalued (ICN 2009). Research has shown that the desire for a better life and education for children is an important push factor (Aiken et al 2004; Kingma 2001 and Stilwell et al 2004 cited in McElmurry et al 2006). Further nurse migration may have been propagated by stories from previous migrants about opportunities to improve their families' lives.

2005 to 2008: sharp decline in migration

Strategies implemented at this time to improve the salaries and working conditions of nurses may have contributed to reducing 'push factors' from Malawi. In addition, the introduction of the NHS code of practice and the removal of nursing from the UK shortage list may also explain the decline in migration. Hamanda et al (2009) found that the dramatic decline in migration of Zambian nurses to the UK since 2004 was likely to be due to increased difficulties in obtaining UK registration and work permits, suggesting that migrant numbers are determined mainly by policies of active recruitment and policies restricting migration.

Graph 2.2 Total number of NMC Malawi validations per year



2.10.2 Limitations of the push and pull model

We have to recognise that the push/pull is not just about a balance or an imbalance. It is actually something much more fundamental than that. It is about a nurse's place and status in some societies.

Buchan 2006: 21S

Many models fail to capture the complexity of migration, and the push and pull model is considered to be no exception (Lessinger 1995 cited in Brettell 2000). Despite its widespread use, it has a number of limitations which the literature commonly fails to discuss (Mackintosh 2003). Criticisms of the model relate mainly to its simplicity, and to the fact that it takes into account neither the circumstances of the migrant nor the dynamics between push and pull factors (Cohen 1996 cited in Oderth 2002, Boyle et al 1998). In addition, many have argued that push and pull factors are not mutually exclusive (IOM 2007a) and that they operate in both source and destination countries (Boyle et al 1998), making it difficult to assess their relative impact.

Enabling factors such as admission policies are often downplayed in the push and pull model despite their importance (Boyle et al 1998, Schiff and Ozden 2005 cited in Mitchell 2006). Research has shown that 'nothing shapes migratory flows and types more than admission policies' (Arango 2000:293). International agreements between countries have an important role in determining migration patterns and can either facilitate or discourage nurse migration. Whereas the agreement between the UK and the Philippines encourages migration (DoH 2007), the NHS banned list has potentially limited the numbers of nurses entering the UK workforce. The recruitment ban in combination with stricter immigration controls could potentially override other push and pull factors, as nurses can struggle to enter the destination country despite the strong presence of push and pull factors.

Another important factor overlooked by the push and pull model is the role of 'networks' (with the exception of some literature which places networks in the enabling factors category). Douglas Massey was one of the first sociologists to point out the importance of social networks in linking sending and destination countries (Massey 1987, 1998 cited in Hollifield 2000). Networks play a key role in structuring and moulding migration patterns (Arango 2000, Findlay 1992, Nash 1994 cited in Boyle et al 1998). They ease migration by providing help with work or other needs such as

housing, and acting as a basis for adaptation and community formation (Castles 2007). Networks also act as information conduits, for example passing on job market information (Tanner 2005, Boyle et al 1998). Their ability to rapidly exchange information means that such networks can easily bypass official efforts to suppress migrant flows (Portes and De Wind 2007). In fact, networks are thought to stimulate further migration (Bach 2003, Tanner 2005) through a multiplier effect (Arango 2000), especially as entry into destination countries becomes more difficult. Yet, despite the increased recognition of the role of networks in assisting migration, some commentators believe that their reach may be overestimated (Koser 2007).

Another limitation of the model is that it fails to consider that there is no single profile of a typical migrant (Lessinger 1995 cited in Brettell 2000), although researchers have attempted to categorise migrant groups. Kingma (2006) categorised different types of nurse migrants:

- Economic migrant: attracted by better standard of living;
- Quality of life migrant: interested in safety and wellbeing;
- Career move migrant: motivated by enhanced career opportunities;
- Partner migrant: following their partner;
- Adventure migrant: uses their nursing qualifications to finance travel to a destination country to gain new experiences.

Even within categories there may be individual differences. Research has shown that although nurses may have much in common, such as the low status of their profession and dissatisfaction with salaries, their reasons for migration can vary. This variability can result from an individual's context, such as family circumstances (Connell and Brown 2004), or from differences in the source country context (Kangasiniemi et al 2007). Studies (including Allan and Larsen 2003, Aboderin 2007, Moran et al 2005) have shown that (typically white) nurses from high-income countries commonly cite a working holiday strategy or travel as reasons for migration, whereas nurses from low-income countries are often motivated more by financial and familial obligations, and by professional development. Economic conditions are an important push factor in nurse migration from sub-Saharan Africa, as nurses seek to improve their financial situations. Slow or stagnant economic growth and Structural Adjustment Programmes have been shown to encourage greater health worker migration (Robinson 2007). This supports the earlier connection made between nurse migration and poor economic conditions in Malawi. Overall source country conditions, including economic conditions, are an important factor often overlooked in the push and pull

model. One study found that Zimbabwean nurses were migrating not only to improve their income but also because of the political and economic situation (Gaidzanwa 1999 cited in Oderth 2002). In addition, nurses may not wish to migrate, but circumstances give them little choice (Ogilvie et al 2007). This means that the circumstances can in some cases be more significant in the migration decision than other factors. The push and pull model does not allow us to measure the relative dominance of each factor.

2.10.3 Conclusion

When tracing patterns of nurse migration a number of factors including source country circumstances, individual circumstances, and enabling factors (such as admission policies) can affect migration trends. This suggests that the nurse migration is complex, and migration decisions may be influenced by multiple spheres of the migrant's life (Alonso-Garbayo and Maben 2009). Despite criticisms of the push and pull model for being too simplistic and not taking into account additional factors, there are currently few alternative comprehensive and solid frameworks available to assess health worker migration (Mackintosh 2003). In addition, the push and pull model has important strengths, such as its ability to take into account the many source country and destination country influences. This may explain why it is commonly used in the nurse migration literature. It is difficult to capture the complexity of migration in a definition, and even more so in a model. Therefore, I shall build upon the push and pull model as a framework through which to present my own findings about the migration of Malawian nurses.

2.11 Push and pull factors as solutions

One positive attribute of the push and pull model is that it provides a framework to determine which factors can be targeted to mitigate the negative impact of migration. The strategies developed by researchers and organisations to counteract the costs of migration include addressing the factors pushing nurses from a country and those pulling to the destination country. Factors pushing nurses are typically tackled on a national level (for example, with the Emergency Human Resources Programme), whilst pull factors are tackled at an international level (with codes of recruitment). The following section explores these initiatives, with a particular focus on the EHRP in Malawi.

2.11.1 Addressing the push

2.11.1.1 Overview of global solutions

A number of strategies have been developed which focus on source countries (the push). These include the six R's of restriction, retention, resourcing, recruitment, reparation (compensation), and encouraging return migration (Lowell and Findlay 2001). Although return migration can be a positive consequence of nurse migration, policies are notoriously difficult to manage effectively (Bach 2003). Eastwood et al (2005) propose a number of joint strategies between destination and source countries (sub-Saharan Africa in particular). These include establishing recruitment agencies that contract health professionals to high-income countries for limited periods, developing postgraduate and specialist training in the source country, and devising improved incentive schemes for recruitment and retention.

These strategies overlap with initiatives developed by source countries to improve health worker numbers, including task shifting. Task shifting refers to the reassignment of tasks to different cadres of health workers with the aim of making more efficient use of human resources (Callaghan et al 2010). Task shifting has ignited many debates: on one hand it has led to an improvement in access and quality of health services (Dovlo 2004, Walker 2005 cited in Lehmann et al 2009); on the other hand, for it to be a successful health sector reform initiative there is a need for increased financial commitment and political leadership (Lehmann et al 2009). The current emphasis of many HRH strategies is the domestic retention of health workers (IOM 2007a), for example training on HIV/AIDS in order to address health worker fears (Liese et al 2003). Such strategies require governments to make concerted efforts to deal with factors causing staff shortages.

2.11.2 Malawian solutions and the EHRP

2.11.2.1 Overview of solutions

In recent years the government of Malawi, alongside CHAM and donors, has implemented a series of initiatives to address the country's HRH issues (Windisch et al 2009). These include:

- The introduction of mid-level cadres;
- Hardship allowances;
- Continuing Professional Development (CPD);
- Locum allowances;
- The Emergency Human Resources Programme (EHRP).

In section 2.6.1, I introduced Malawi's unique mid-level cadres, including clinical officers (COs). The CO cadre was developed in 1976 to operate alongside other health workers to ease shortages, in particular in the area of surgery (Chilopora et al 2007). Although they often perform a similar role to physicians, COs have shorter periods of training, representing economic savings, and have lower entry requirements to increase the potential applicant pool (McAuliffe et al 2009). Their qualifications are not recognised outside Malawi, which aids retention. The introduction of COs is considered to have been a success. Studies have shown that outcomes of surgery performed by COs are comparable to those of medical officers (Chilopora et al 2007). However, the cadre has been criticised by Lwanda (2007), who argues that they represent second-rate care. The same criticism has been made of nurse auxiliaries, another cadre developed to ease health worker shortages. This cadre offers opportunities to those who may not otherwise go into semi-skilled employment as preference for positions is given to individuals already employed in hospitals, such as hospital attendants (Muula et al 2003). They are also less likely to migrate as their qualification is not recognised internationally (Palmer 2006).

Alongside the introduction of new cadres, in 2001 CHAM implemented several strategies to retain existing staff, including a salary top-up for doctors, hardship allowances for work in remote areas, and a tutor incentive package consisting of free accommodation and payment of utility bills. Despite the increase in tutor numbers within CHAM from 43 in 2000 to 100-108 in 2006, observers have questioned the sustainability of these packages, and how well they can compete with high NGO

salaries (Mhango 2006). Unintended consequences were that other cadres including COs felt unhappy that they did not receive the salary top-ups exclusively earmarked for doctors. The top-ups also strained relationships between the government and CHAM, because they caused many doctors to resign from government to work for CHAM, leading to the programme's discontinuation (Aukerman 2006).

In terms of migration-specific initiatives, advocates called for a reform of nurse training into a country-specific qualification that is less exportable (Windisch et al 2009). Locally relevant training decreases the marketability of graduates in the destination countries (Ahmad 2004 cited in Serour 2009) and helps retain nurses. However, the reform was blocked by the Malawi NMC. Another initiative is the Continuing Professional Development (CPD) programme. As studies have shown that training and career advancement are critical to retaining and motivating existing staff, the Malawi NMC has implemented a CPD programme (already widely used in the UK) to provide opportunities for in-service education and training. The mandatory CPD programme for all nurses and midwives was rolled out nationwide in 2010.

2.11.2.2 The Emergency Human Resources Programme

One of the most important HRH initiatives is the 6 Year Emergency Human Resources Programme (EHRP). The EHRP was launched in 2005 by donors and the government of Malawi in response to concerns from prominent members of DFID and USAID that HRH shortages would limit the success of the ART rollout (Palmer 2006).

The main objectives of the programme were to:

- Improve incentives for recruitment and retention of Malawian staff in government and mission hospitals (including improvements in staffing conditions and hardship incentives);
- Expand domestic training capacity;
- Recruit expatriate health workers to temporarily fill critical posts;
- Improve salaries for eleven professional and technical cadres, including RNs, by 52 percent

(Martin-Staple 2004, UCL Consultants Ltd 2009)

The EHRP is now in its final stages, and provisional results show that it has achieved some of its objectives (House of Commons IDC 2008). There has been an 86 percent increase in annual enrolment for pre-service training since 2004 (Malawi Health

SWAp Mid-Term Review Summary Report 2008), and it is estimated that the Malawian nursing workforce expanded by 288 percent between 2000 and 2004 (Robinson 2007). Yet, despite being heralded as a ground-breaking programme, the EHRP has drawn criticisms from several stakeholders and observers. These relate mainly to implementation difficulties, a lack of monitoring and evaluation during the early stages and issues surrounding salary increases. The top-ups were always contentious, as there were questions over long-term donor dependency (donors would initially finance the increases) and the risk of wage inflation (UCL Consultants Ltd 2009). Malawi would also not be able to match salaries offered in countries such as the UK. In reality, the 52 percent increase in basic salary did not translate into a 52 percent increase in take-home pay because of a decision taken by the government to remove the tax-exempt status of various allowances (UCL Consultants Ltd 2009), meaning that salaries were much lower than expected. A number of other EHRP initiatives have yet to be implemented, including an incentive scheme which included loans and advances, subsidised utilities and shift refreshments (MoH personal communication 2008). Plans to improve staff housing have only been partially implemented, and progress on the training and career development aspects of the EHRP has been slow (McAuliffe 2008).

2.11.3 Addressing the pull

2.11.3.1 Codes of practice

When examining which pull factors to focus on, it is important to weed out those which are not feasible; for example, we cannot decrease salaries in destination countries just to discourage migration from countries like Malawi. Pull factors most commonly targeted link to enabling and grab factors such as active recruitment. After receiving complaints from South Africa and the Caribbean, the UK NHS took steps to discourage active recruitment from a number of prescribed countries through the development of a code of practice (Pagett and Padarath 2007). The code was revised in 2001, and a more exhaustive list of countries banned from active recruitment was developed. It was revised for a third time in 2004 to include agency-recruited, temporary and locum healthcare organisations.

However, the code has drawn a number of criticisms, which relate mainly to the lack of a formal mechanism to ensure compliance, as it is not legally binding (Padarath et al 2003). A number of loopholes exist, so that many health workers are able to join the

NHS through the 'back-door' (through private care homes or agencies) (Kline 2003). Research has shown that the private health sector continues to recruit nurses from the banned list (Windisch et al 2009). Ultimately, although the code denounces active recruitment, it does not prevent migration as the NHS maintains that "international recruitment is a sound and legitimate contribution to the development of the health care workforce" (DoH 2004:7). Similar criticisms have also been made of other codes of practice. A review by EQUINET (the Regional Network on Equity in Health in Southern Africa) concluded that codes have in general been ineffective in stemming migration, as often the framework for their implementation is weak (Pagett and Padarath 2007). Despite their shortcomings, codes form an important part of the global effort to highlight unethical recruitment practices and mitigate the negative impacts of nurse migration. A number of national and international codes of practice have been developed in recent years and are summarised in Table 2.11.

Table 2.11 Codes of practice

Code of Practice	Date	Purpose	Status
NHS Code of Practice for International Recruitment of Healthcare Professionals	2001, revised December 2004	Applicable to the UK to guide the international recruitment of health workers (HWs)	Process is voluntary and private organisations only have to sign up to its principles, although the NHS has a mandate to deal only with recruitment agencies that comply with code
Melbourne Manifesto: A Code of Practice for International Recruitment of Healthcare professionals	May 2002	To promote the best possible standards of health care around the world; encourage rational workforce planning by all countries; discourage activities which could harm any country's health care system	It comprises of a list of recommendations
Commonwealth Code of Practice for the International Recruitment of Health Workers	Adopted May 2003	To provide governments with framework for international recruitment. The code discourages the targeted recruitment of HWs from countries experiencing shortages and aims to protect internationally recruited HWs and ensure that they are treated fairly in terms of pay and professional development	Not a legal document, it is hoped that governments will subscribe to it
Voluntary Code of International Conduct for the Recruitment of Foreign-Educated Nurses to the United States	May 2008	Includes a minimum set of standards for a number of laws including the equal pay act and medical leave act. Makes recommendations for best practices for the ethical treatment of IRNs	The code is not law in the US and subscription is voluntary
WHO Global Code of Practice for Health Worker Migration	Adopted at the 63rd World Health Assembly (WHA) in May 2010	The code aims to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel	Subscription is voluntary

Sources: Commonwealth Secretariat (2003), DoH (2004), Pagett and Padarath (2007), Alinsao et al (2008), Health Worker Migration Global Policy Advisory Council (2009), The Melbourne Manifesto (2002), World Health Assembly (2010)

Bilateral and multilateral agreements have also been developed to foster ethical recruitment, promote technical exchange between countries, and encourage circular and temporary migration whereby emigrating health professionals can return to their home countries to teach (Health Worker Migration Global Policy Advisory Council 2009). Important agreements include the multi-lateral agreement on Trade and Services (GATS Modes 1-4 health services) of the World Trade Organisation, and the memorandum of understanding between South Africa and the UK (2003) (Pagett and Padarath 2007). In 2009, Malawi and South Africa signed a bilateral agreement to promote cooperation in the field of public health, including the technical and professional training of health workers through exchange programmes (MoH Malawi 2009).

The development of these codes and agreements testifies to the considerable interest in health worker migration (Martineau et al 2004), and has led to a number of regional and global responses to migration and health worker shortages in general. These include the establishment of the Global Health Workforce Alliance (GHWA) in 2006 to identify and implement solutions to the health workforce crisis. The GHWA acknowledges that migration of health workers is a reality, but calls for appropriate mechanisms to shape the market in favour of retention (WHO 2008). The 2008 GHWA meeting led to the Kampala declaration, a framework for coordinating, expanding and supporting health workforces over the next decade (Koch 2009). The G8 (a group of eight high-income countries, including the UK) has also supported this declaration (G8 2008).

When discussing codes of practice it is important to consider the debate on the rights of migrants and rights to health. According to the Universal Declaration of Human Rights, article 13, the freedom to migrate is a fundamental human right (UN 2010), suggesting that it is inappropriate to prevent nurses migrating from Malawi. Many observers, including the ICN (2002), have highlighted the need for balancing a migrant's human rights and concern for the health of the source country's population. In reality, it is difficult to achieve this balance, and this is becoming a greater challenge in light of widening health worker density disparities (Health Worker Migration Global Policy Advisory Council 2009). To protect the rights of health workers, debates have focused on ethical recruitment policies. The International Council of Nurses (ICN) issued a statement calling on governments and employers to adopt principles on ethical recruitment (ICN, 2002). There have also been repeated calls to ensure that the social and economic costs and benefits of migration are

equitably distributed between source and destination countries (Pagett and Padarath 2007). Despite these debates, some observers argue that no effective policy has yet been developed to solve the global shortage of health workers or diminish their maldistribution (Van Rijckevorsel 2005). The Health Worker Migration Global Policy Advisory Council (2009) has argued that in order for policy solutions to be effective there is a need for increased dialogue and coordination between nations. The Council maintains that there is still a need to recognise the consequences of an over-reliance on internationally trained health workers from source nations with their own HRH crises (Health Worker Migration Global Policy Advisory Council 2009).

2.11.3.2 General destination country solutions

The recognition of an over-reliance on internationally trained health workers is especially applicable to the UK. Eastwood et al 2005 have commented that the UK needs to urgently review why, in contrast to many European countries it continues to rely on low-income countries for health workers. The authors propose a number of solutions for destination countries, including an increase in domestic training and encouraging health worker return. One way to support source countries is for the destination country to provide compensation such as a tax paid per health worker recruited (WHO 2004a, Mwapasa 2005). This option was first discussed in the 1970s (Martineau et al 2004), and has been intensely debated since because it is unclear who should pay, how much and to whom, especially if health workers work in different countries during their lifetime. No mechanisms exist currently to provide compensation (Pagett and Paradath 2007), and observers have suggested that compensatory payments are unlikely to be successful, especially as many high-income countries lack the political will to make a formal commitment (Nullis-Kapp 2005 cited in Pagett and Paradath 2007, Eastwood et al 2005).

2.12 Chapter conclusion

In this chapter I introduced Malawi and the UK, the backdrop to the experiences of the nurses in this study. In line with global trends, both countries are experiencing nursing shortages. The UK has been able to fill its vacancies with overseas nurses, whereas Malawi - despite a number of initiatives to address its HRH issues - remains burdened by large vacancy rates. There are many reasons for Malawi's predicament: HIV/AIDS with its heavy toll on the health status and work burden of nurses, political and

economic factors that have led to both inadequate output of nurses and poor retention, and nurse migration. Low salaries and poor working conditions often push nurses to migrate. These are two examples of common push factors in the push and pull framework used to assess reasons for migration. Other components of the framework are pull factors in the destination country and enabling, stick and grab factors. The framework has been useful in highlighting areas to target to compensate for the negative consequences of migration. These consequences include health and economic costs to the source country, and costs for the nurse migrant. Despite these costs, nurses are migrating globally in larger numbers than previously, as nursing evolves into a highly portable profession (Kingma 2006). The high numbers are especially significant as nurses tend to make up the largest proportion of any health workforce (WHO AFRO 2006), making it important to understand their patterns of migration, motivations and experiences.

2.12.1 Research justification

The global movement of nurses has far-reaching consequences. Destination countries tend to be the biggest winners from migration as they are able to fill their vacancies with little investment. The losses for source countries, and in some cases for nurse migrants, are significant. From the individual point of view, nurses may face negative experiences such as discrimination. From the point of view of Malawi, nurse migration has compromised an already fragile health system. Although recent data suggest that the numbers of nurses leaving have decreased, the cause of this decline is unclear. For example, is it due to increased satisfaction with working conditions, tighter immigration controls in the UK or the influence of migrant networks? This uncertainty makes it difficult to prevent repeated large-scale nurse migration from Malawi in the future. In this thesis I identify potential strategies to mitigate the negative effects of nurse migration on Malawi. In particular, I examine nurses' perceptions of the impact of the EHRP, as this has been the most important HRH initiative to date, and may provide me with a basis from which to make suggestions on how to improve migration and retention rates for Malawian nurses.

Earlier in this chapter, I related a number of global and historical events to patterns of nurse migration from Malawi. In order to get a fuller picture of migration decisions and experiences it is important to examine the personal and environmental context in

which nurses make decisions about migration. A number of key issues are examined in the thesis.

Why do individuals choose to enter nursing in Malawi? Migration decisions may link to decisions made earlier in an individual's life. Studies have shown that people are increasingly choosing health careers because they offer migration prospects (Connell et al 2007). This is supported by the beneficial brain drain hypothesis, which argues that more people will enter a profession if migration prospects are good (Robinson 2007). Many gaps exist in our understanding of the dynamics of entry into the health workforce in understaffed countries such as Malawi (Kinfu et al 2009). I wanted to explore the career trajectory of nurses, beginning with why they entered the profession and whether migration prospects affected their decisions.

The country-specific context. The IOM (2007a) found that, even when neighbouring countries share many characteristics, there can be widespread variation in emigration rates, suggesting that context-specific factors are important in determining migration patterns. According to Arango (2000:295), we can gain insight into migration processes by examining the historical and social context of the migration event. There has been little exploration of IRNs' socio-cultural, economic and professional home country contexts, and how these have shaped their migration motives (Aboderin 2007: 2239).

The role of networks in Malawian nurse migration. For many IRNs there may be a mismatch between expectations and experiences (Likupe et al 2005), but it is unclear to what extent nurse migrants relay this mismatch or even negative experiences back to aspiring nurse migrants in the source country (potentially affecting their migration decisions).

What are the experiences of Malawian nurses in the UK? Few studies have focused on the experience of African nurses in the UK (Likupe 2005), despite the important contribution of black and ethnic minority nurses in the NHS (Alexis and Vydelingum 2005). In general, "little work has gone into investigating the conditions of health workers in the destination country" (IOM 2007a: 12), and also into the motivations, expectations and experiences of international health workers (Moran et al 2005, Buchan 2008, Stilwell et al 2003).

Decisions about the future. Research suggests that there is a shortage of data regarding the intentions of migrant nurses. Health employers often rely on anecdotal data to understand the long term intentions of migrant nurses (Humphries et al 2009).

Return migration from Malawi. Researchers have been increasingly interested in return migration, but data on the characteristics and motivations of returnees are limited (Kingma 2006). Although data suggest that few migrant nurses have returned to Malawi, I met with some of them in an attempt to understand their reasons for returning and compare their experiences in both countries.

To examine these issues I have used a qualitative approach, partly to counterbalance problems with quantitative data in the field of migration. A common theme throughout this chapter has been that data on migration are often inconsistent and incomplete (IOM 2007a, Ikenwilo 2007), especially from sub-Saharan Africa (Clemens and Pettersson 2008). The lack of reliable quantitative data has also made it difficult to analyse and forecast HRH needs (Buchan 2008). Although gaps exist for the quantitative exploration of nurse migration from Malawi, researchers have called for this area of research to “move beyond statistical representation of the problem or promise of nurse migration and ... include the voices and concerns of the migrants themselves” (Kingma 2006: 215). In the next chapter I discuss in greater detail the rationale for a qualitative approach, and introduce the qualitative biographical method.

Chapter 3

Methodology

Statistics represent people with the tears wiped off. (Hill 1977)

It is the tears of migrant people that we often overlook and fail to understand.
(De Tona 2006)

3.1 Chapter introduction

A review of the literature highlighted several gaps in our knowledge of the human resources for health (HRH) situation in Malawi. Recent data also suggest that, despite a number of government initiatives, significant measures are still needed to improve the healthcare situation. Prior to finalising the study's research questions I spent time in Malawi discussing these issues with stakeholders. When I questioned them about barriers to improving health, they responded unanimously that HRH presented a significant obstacle. Many cited the shortage of nurses and low morale permeating the nursing sector as major contributing factors to the HRH crisis. Previous research had typically approached the issue from a quantitative perspective, and there was scope for further examination of the nursing situation in Malawi, particularly in light of widespread nurse migration exacerbating the shortage.

Going beyond a quantitative survey approach, I wanted to employ a research method that would allow a close examination of the nurses' experiences before and during this HRH crisis. The chosen method would need to explore their professional lives, but also reveal the influences of their personal lives to build a fuller picture. The approach that I considered best suited to this task was the biographical method, a qualitative research method which is used to understand the 'changing experiences and outlooks of individuals in their daily lives' (Roberts 2002: 1). The method would allow for exploration of the nurses' experiences during key moments in their lives in order to gain a deeper understanding of the nursing situation.

In this chapter I describe the biographical method, focusing on its history and how it is conducted. I evaluate its advantages in addressing the research questions,

particularly by comparing it to alternative methods such as phenomenological approaches and grounded theory. I present the processes of recruitment, data collection and analysis, and address ethical issues and trustworthiness. I conclude the chapter with reflections on the biographical method and its impact on the presentation of results.

3.2 The biographical method

No social study that does not come back to the problems of biography, of history, and of their intersections with society, has completed its intellectual journey.

Mills 1970: 12, cited in Roberts 2002

3.2.1 What is the biographical method?

The biographical method is a qualitative research method. Qualitative methods explore social or human problems, building up a complex and holistic picture through the detailed views of informants (Creswell 1998). Within qualitative methods, the biographical method is characterised by its focus on the life experiences of an individual (Denzin 1989). It seeks to understand these experiences and to interpret the accounts individuals give of their past, present and future (Apitzsch and Siouti 2007, Roberts 2002).

The biographical method takes a pragmatic orientation. Emphasis is placed on the purpose (gaining insights into individual lives) as opposed to dwelling on differences in methodological and theoretical assumptions (Miller 2000:18, cited in Roberts 2002), with the goal being to develop concepts and theories as close to the subject's account as possible (Roberts 2002). The biographical approach makes a number of assumptions. These include the fact that each person will have some turning-point experiences, that there are objective life markers, and that a life can be studied and written about (Denzin 1989). The primary data collection tool of the biographical method is the open in-depth interview (Plummer 2001, cited in Merrill and West 2009). Personal documents can also be used: autobiographies, biographies, diaries, letters, obituaries, life stories, oral histories and personal histories (Denzin 1989).

3.2.2 History of the biographical method

The origins of the biographical method can be traced back to oral traditions of story telling which have always played an important part in human communication (Merrill and West 2009). Oral traditions, including oral history, have traditionally served as prime sources of historical information (Vasina 1985, cited in Merrill and West 2009). However, in recent years, oral history has taken a new direction and has formed part of the wave of feminist research aiming to give a voice to marginalised groups (Merrill and West 2009).

Table 3.1 Key phases in the history of the biographical method

	Key Phase	Outcome
Time ↓	Oral traditions (oral history)	Origin of method
	Oral history and feminism	
	Chicago School of Sociology	First academic use
	Revived by German researchers	Method refined
	Current use in education, psychology, health studies, migration studies	Took on multidisciplinary approach

3.2.2.1 Chicago School

The academic roots of the biographical method lie in the discipline of sociology and are inextricably linked to the Chicago School of Sociology. In the late 1910s two Chicago sociologists, William Isaac Thomas and Florian Znaniecki, pioneered the use of the biographical method in their seminal work about a Polish peasant who had migrated to America. They used the biographical material to gain a deeper understanding of the lives of Polish migrants (Merrill and West 2009). Thomas and Znaniecki's methodology inspired the empirical research tradition of the Chicago School up until the 1920s, after which it was replaced by quantitative methods. The quantitative approach dominated American sociology until the re-emergence of the biographical method in the 1970s, reignited by a growing interest among researchers in Europe, particularly in Germany (Apitzsch and Siouti 2007).

3.2.2.2 Biographical research in West Germany

In the 1960s life history methods experienced a revival, although many researchers adamantly maintained that they were inadequate according to scientific standards because of generalisability issues and their reliance on the subjective interpretation of data. They also criticised the expense and time-consuming nature of the methods (Roberts 2002: 37). The resurgence was particularly strong in Germany, where the use of biographical research gained momentum in the context of intense discussions around scientific theory and methodology. Through these discussions the biographical method began to develop with influences from varied theoretical and methodological sources, including the Chicago School, symbolic interactionism and the French tradition of phenomenology (Apitzsch and Siouti 2007). Germany has had a central role in the development of the biographical method, with the first anthology of biographical research being published in 1978 (Rosenthal 2006). For German researchers, such as Fritz Schütze the main point of interest was the practical use of biographical material. Schütze refined biographical material usage, and in the 1970s he developed a model for an open narrative form of interviewing and a procedure for analysing narrative texts that is still widely used today.

Biographical research has an important place in the history of sociology (Riemann 2003 cited in Chamberlayne et al 2004). However, in recent years it has moved beyond its sociological home into diverse disciplines, including health sciences, social work and gender studies (Chamberlayne et al 2004, Kraul 1999 and Dausien 1996 cited in Apitzsch and Siouti 2007). This upsurge in interest is due to an increased recognition of the flexibility of the approach, and its ability to transcend conventional disciplinary boundaries for example, between anthropologists, social scientists, historians, and sociologists (Riemann 2003). Two fields of research in which the biographical method has featured in recent years are nursing studies and migration studies. Biographical, oral history methods were employed by the Royal College of Nursing to document the lives of nurses from the UK. Interviewees recalled everyday procedures, social change and developments in nursing education (RCN 2007). Early uses of the biographical method in the migration field include the work of Thomas and Znaniecki (1910) and Wolpert (1965) (Halfacree and Boyle 1993). The biographical dimension of migration processes became an area of great interest for German researchers in the 1990s (Apitzsch and Siouti 2007). In the following section, I explore this growing relationship and discuss the advantages of using biographical method in migration research.

3.2.3 Applications to migration research

In the interdisciplinary field of migration studies, the biographical approach is well suited to empirical investigations of migration processes because it offers us a way of empirically capturing the diversity, complexity, and transformational character of migration phenomena and of reconstructing them through biographical analysis.

Apitzsch and Siouti 2007:3

The use of the biographical method in migration research has grown steadily in recent decades, partly due to the advocacy work of researchers such as Halfacree and Boyle. The rise is also due to the growing recognition of the strengths of qualitative research methods in migration research. The field has been traditionally dominated by quantitative methods, and some researchers have argued that this has generated 'an impersonal, dehumanized approach in which flows replace people and the motives for migration are assumed rather than proven' (p. 4), and where 'individuals ... become lost' (p. 5) (Pooley and Whyte 1991, cited in Halfacree and Boyle 1993). It is thought that qualitative methods provide insights into migration processes that quantitative research alone cannot.

The biographical approach allows researchers to gain a fuller understanding of migration and the decisions made around it, by focusing on the experiences of the individual migrant (Brettell and Hollifield 2000). It contextualises migration within the individual's life and considers it to be part of the individual's entire biography (Halfacree and Boyle 1993 cited in Boyle et al 1998). This means that the migration event should not be considered in isolation, without acknowledging the migrant's life story and the periods before, during and after the move (Breckner 2002). In addition, as the migration event forms part of the life story, it should not be seen as a period of discontinuity when networks and family are disrupted, but rather 'as a continuity of special biographical projects' (Breckner 2002: 217).

In-depth investigations into the biographies of migrants allow us to better understand the migration process and the decisions and intentions associated with it (Halfacree and Boyle 1993). When examining migration decisions, the biographical method reminds us to constantly assess how life experiences and opportunities influence these decisions (Theakston 1997). Adopting a biographical approach allows researchers to look beyond simple self-contained reasons for migration. This was one

of my stated research objectives: to examine the underlying reasons for nurse migration, beyond simple economic explanations.

3.3 Comparison of the biographical method with alternative methods

In the above section I presented the case for the use of the biographical approach in migration studies, and assessed its suitability in addressing the research objectives relating to migration decisions. However, the research questions lie not only within the field of migration studies (why the nurses migrated) but also in the fields of health and nursing (what their working life experiences are), and in social science generally (what factors affect the decisions they make). It is important, therefore, to assess the appropriateness of the method in addressing all of the research questions, and to assess whether alternative methods could be better suited to the research topic.

When examining a phenomenon or event researchers can choose from a range of qualitative methodologies. They may choose to study the event by living closely with a population (ethnography), by exploring what the population understands about an event and building a theory as the research progresses (grounded theory), by exploring the lived experience of the event (phenomenology) (Lee 2006) or by using a case study approach. For this research topic, each method could potentially offer insights into the experiences of nurses. Each method has characteristics that could affect its suitability in addressing the research questions. The first method I shall examine is the ethnographic method. The role of the ethnographic researcher is that of a participant observer who studies a cultural or social group in its natural setting, with the primary aim of describing its patterns of behaviour and practices (Van Maanen, 1998, 1995 cited in Bloomberg and Volpe 2008). An ethnographic approach has many advantages in examining an event. These relate mainly to the time spent in the field with the population, which allows the researcher to gain an in-depth understanding of an event through the eyes of individuals. However, in light of my research questions, ethnography presents some limitations. Firstly, I was not able to experience the migration event first hand with the respondents, as I was not able to travel with nurses. In addition, although the respondents represent a cultural group ('Malawian nurses'), I would not be able to study them in their natural setting as migrant nurses are living in disparate communities and ethnographic observations of a larger sample of respondents would be difficult.

I was interested in examining nurses' experiences in relation to a series of life events, as opposed to their behaviour and practices. An interview-based study focusing on their life stories was more appropriate in this context. However, components of the ethnographic method have fed into my research, specifically during the development of the research questions which resulted directly from my period of field work in Malawi. Two alternative methods that could be used to address the research questions are grounded theory and phenomenology, since both use in-depth interviews to examine an event. They differ in the way data are collected and analysed. Table 3.2 compares the key features of the data analysis of these methods as compared to the biographical method.

Table 3.2

**The biographical method compared to phenomenology and grounded theory
(adapted from Creswell 1998)**

Data analysis	Biographical method	Phenomenology	Grounded theory
Describing	Describe objective set of experiences, the chronology of life	Describe the meaning of the experience for the researcher	-
Classifying	<ul style="list-style-type: none"> Identify stories Locate epiphanies 	<ul style="list-style-type: none"> Find and list statements of meaning for individuals Group statements into meaning units 	<ul style="list-style-type: none"> Engage in axial coding: causal condition, context, intervening conditions, strategies, consequences
Interpreting	<ul style="list-style-type: none"> Theorise toward developing patterns and meanings 	<ul style="list-style-type: none"> Develop a textual description "what happened" Develop a structural description "how" the phenomenon was experienced Develop an overall description of the experience, the "essence" 	<ul style="list-style-type: none"> Engage in selective coding and development of stories Develop a conditional matrix
Representing, visualising	Present narration focusing on processes and theories	Present narration of the "essence" of the experience. Use tables or figures of statements	Present a visual model or theory. Present propositions

3.3.1 Phenomenology versus the biographical method

The second method I have chosen to assess and compare to the biographical method is phenomenology. The goal of phenomenological research is to describe a person's lived experience and its core essence in relation to what is being studied (Balls 2009, Bloomberg and Volpe 2008). There are different strands within the phenomenological approach: descriptive phenomenology uses the concept of bracketing (putting aside researcher knowledge) to achieve objectivity, whereas interpretative phenomenology relies on the assumption that it is impossible to approach research in a completely objective and neutral way, and maintains the use of our own experiences to interpret those of others (Balls 2009). This approach is popular in nursing research as it is thought to share the same intrinsic value as nursing, which is to consider a person as a whole whilst valuing their experiences (Balls 2009). Phenomenological approaches

have been used in several studies examining the experiences of overseas nurses in the UK. The core of the research questions, which focus on describing the experiences of Malawian nurses, lends itself to phenomenological study, especially as the method has been shown to be effective when researchers aim to describe a set of experiences.

An example of a phenomenological study is that of Riemen (1986 cited in Creswell 1998), who studied the psychological meaning of the caring interaction between a patient and nurse. In phenomenological studies the focus is usually on describing the essence of an event, in Riemen's case the essential structure of the caring interaction (data analysis involved analysing statements regarding what were caring and non-caring interactions). It is phenomenology's focus on the event as opposed to examining other factors that may influence the individual under study that make the biographical method more suitable to address the research questions. Rather than focusing on just a particular event, biographical researchers are interested in examining the experiences before and after an event (Seale et al 2006). Where the biographical approach and phenomenology also differ is in the focus of the interview. Whereas phenomenology examines the individual's interpretation of an event and focuses the interview around it, the biographical method gives freedom to the respondent to discuss what they deem to be important about the event (especially as the approach commonly doesn't rely on structured topic guides). This freedom can yield information about what else is important to the respondent. For example, although I was interested in the migration event, by allowing respondents to raise other issues I would be able to gain a greater understanding about what additional factors (such as family commitments) influenced nurses' decisions and experiences.

The aims of the research questions were not only to examine nurses' experiences, but also to consider them within the individual's life story. This focus on the life story means that the phenomenological method might not be a suitable method to capture the data and fully address the research questions. However, as with ethnography, components of phenomenology influenced the study. For example, I was solely responsible for the transcription of data. This is consistent with a phenomenological and ethnographic approach to analysis, in which the researcher uses the process of transcription to become immersed in the data (Balls 2009).

3.3.2 Grounded theory versus the biographical method

In a grounded theory approach, the researcher attempts to build a theory of a process or action grounded in the views of the research participant (Bloomberg and Volpe 2008). Grounded theory is characterised by the constant comparison method (Merrill and West 2009) and theoretical sampling of groups to maximise similarities and differences of information (Bloomberg and Volpe 2008). It uses systematic procedures of open and axial coding (Creswell 1998) during data analysis.

One example of a grounded theory study is that of Morrow and Smith (1995 described by Creswell 1998). They studied the coping strategies of 11 sexually abused women. The authors used open-ended questions to develop a visual model and a theory around a central event. Similarly to my study, the researchers were interested in describing respondents' experiences of an event, and what decisions (or in this case, actions) respondents' took in response to it. This suggests that the grounded theory approach could potentially be used to address the research questions. However, a number of features make it less suitable than the biographical method. Firstly, its emphasis on the fracturing of data during analysis has drawn criticisms from researchers (Charmaz 1995, cited in Roberts 2002). When examining individuals' experiences, the approach disaggregates individual narratives and then aggregates them with other material, and this may mean that the context and overall wholeness of the material may be lost (Merrill and West 2009). By respecting the entirety of the individual narrative, the biographical method can capture the factors that influence each individual's life more accurately without the risk of losing the individual significance of the experience (Merrill and West 2009).

Secondly, grounded theory differs from the biographical method in terms of its focus, which is on the generation of theory as opposed to the study of an individual. The focus on theory development suggested that the method might not be suitable for my research, as the development of a generalised theory was not intended to be a primary outcome. My research aims to capture life experiences recounted by the respondents, as opposed to building a theory regarding the life process and actions of nurses (although such a theory would be potentially helpful in developing policy recommendations). In grounded theory, a literature review is often conducted after the process of data collection, allowing the researcher to go into the study with an open mind (Creswell 1998). I chose to begin with a literature review as it allowed me to

develop my topic guide with an understanding of some of the key features that may have affected the lives of nurses.

Phenomenology, grounded theory and the biographical method share a number of characteristics, such as the development of themes in data analysis. In some cases there may be significant overlap between research methods; this is the case with the biographical approach and the case study approach. Case studies involve the in-depth study of a single case and data collection often involves detailed description of the single case setting and its participants (Bloomberg and Volpe 2008). The focus of the case study can be any subject, and it does not necessarily focus on the life story and experiences of an individual, as is the case with the biographical method. In addition, the findings of a case study are bound by place and time as the material is highly contextualised (Creswell 1998), meaning that it is difficult to generalise findings beyond the single case under examination. However, any differences presented here may be arbitrary, as biographical texts can also be referred to as case studies: Roberts (2002) calls the study of the Polish peasant (presented in section 3.2.2.1) a case study. Researchers have pointed out the confusing terminology of the biographical method; it has a number of interchangeable names, including autobiography, personal history, oral history, and the life story method (Merrill and West 2009).

3.3.3 Justification for the biographical approach

The biographical approach has advantages compared to the alternative methods because the use of life narratives allows the researcher to gain a greater understanding of the experiences of the individual and of the contexts in which they make decisions. The emphasis on individual experiences and the factors influencing them fit neatly within the objectives of the research questions. In particular, the nature of the topic guide, with its focus on key stages in the life of the individual, related well to the sequential life analysis associated with the biographical approach.

An important component of the research questions was the comparison between the experiences of Malawian nurses at home and in the UK. The biographical method allows us to compare life stories, as it seeks to compare features in an individual's life trajectory and evaluate how life situations or a pattern of actions are similar to or different from others (Rustin and Chamberlayne 2002: 9-10). The examination of life

stories provides a valuable means to explore the complexities of individuals' experiences (Wengraf 2001, Chamberlayne et al 2002), and the approach allows us to study a fuller life rather than glimpsing the individual through selective snippets, as is usually the case with other methods (Roberts 2002:167). The inclusion of multiple strategies for data collection in the biographical method, such as interviews, focus groups, observations, and personal reflections (Popadiuk 2004), lends legitimacy to the method in terms of being able to validate the results from a number of perspectives.

3.3.4 How the biographical approach was used

The research approach used within the biographical framework was multi-sited (in Malawi and the UK), comparative, based on a micro-approach and focused on a partial set of experiences.

Multi-site migration research involves collecting data in the receiving country and the sending country. This allows us to gain a fuller picture of the migration event, and also facilitates understanding about transnational networks (Apitzsch 2006 cited in Apitzsch and Siouti 2007). In the case of my research, these networks refer to nurses based in the destination country who assist other nurses to migrate. It was also hoped that having interviewed nurses both in Malawi and the UK, a more detailed picture of the nurse migration experience would be gained. Multi-site research also allows us to compare the experiences of nurses in Malawi and the UK. The comparative biographical approach is distinctive in that it regards biographies as case studies that can be linked together in order to test and evaluate theories relating to the subject matter (Theakston 1997). This approach was used to help elucidate the factors that influenced nurses to either stay in Malawi or migrate. It was also possible to look for similarities and differences in the context of the nurses' personal and professional lives.

Life stories were examined from a micro-approach, which emphasised the experiences of the individual and their decision-making process (Cadwallader 1989 cited in Halfacree and Boyle 1993). The approach is applicable to my research because of its focus on the nurses' personal narratives. I used it to build a picture of the nurses' personal and professional lives, whilst considering external influences such as family and community and the role of macro characteristics such as

socioeconomic environments and their impact on individuals' experiences (White 1980 cited in Halfacree and Boyle 1993). An example of a macro characteristic I examine is the history of nursing in Malawi. This is assessed in terms of how historical events affected the lives of the nurses. Finally, within the framework of the biographical method, my research focused on a partial set of experiences relating to the nurses' careers, decision-making processes and identity, whilst considering the broader influence of their personal lives and background.

3.3.5 Limitations of the biographical approach

A biographical approach allows us to focus on the experiences of nurses and to compare individual biographies. Some limitations need to be considered. Firstly, there is uncertainty in biographical research regarding sample size and representativeness. Biographical researchers' views vary on what is an appropriate sample size for examination (Merrill and West 2009), although samples tend to be smaller than is typical for natural sciences research. This is partly due to the time devoted to biographical interviewing and the importance placed on each case. Although small sample sizes are standard in qualitative research, single or small-case approaches have met resistance from the natural sciences (Chamberlayne 2004) and issues of representativeness are raised. Even biographical researchers question whether the individuals they interview can be considered as representative figures (Theakston 1997). This has led researchers to emphasise the importance of considering the individual within their context. I address this issue by highlighting that the research findings are not generalised to the wider nursing population beyond Malawi.

Secondly, biographical research can often be affected by respondent recall issues. Problems of recall, for example if an individual cannot accurately remember an event, can limit the level of biographical detail collected in interviews (Findlay and Li 1997). In particular, the study of migrant histories can be subject to problems of memory lapse (Halfacree and Boyle 1993), especially when a person is recalling old events (Denzin 1970 cited in Roberts 2002). Any resulting discrepancies significantly affect the accuracy of the results. Finally, debates exist about the transparency and credibility of data analysis in biographical research. Many researchers have called for a greater transparency and insight into how researchers work on their data, as often the process is only alluded to in publications, leading to insecurity about how data are

analysed (Riemann 2003). I address this final limitation by presenting an audit trail for my research (Appendix 3) and detailing my data analysis procedure.

3.4 Data collection methods

The primary data collection method was semi-structured, in-depth interviews. One interview lasting between one and two hours was conducted with each respondent. A token of appreciation such as a traditional Malawian cloth (Chitenji) was given to each respondent. Additional methods were employed to supplement findings: non-participant observation of Malawian healthcare facilities, document analysis of reports (such as nursing council reports showing migration trends) and a focus group discussion with first year nursing degree students in Malawi. Key informant interviews were conducted with respondents representing stakeholders and specialists in the human resources field in Malawi and in the UK. These interviews were conducted to verify information from the nurse interviews, and also to provide information on the Malawian cultural, historical and political context. Discussions with key informants revealed important information about the nursing situation in Malawi and how it may have affected the lives of the nurses interviewed. The interviews were analysed alongside the nurses' personal narratives.

3.4.1 Interviews

Data were collected in the form of biographical narratives using a topic guide to direct each interview (see Appendices 6 and 7). An open structure is often recommended for biographical interviews as it allows for the respondent to explore their own concerns (Wengraf 2001 cited in Paton 2003). However, I chose to impose some structure on the interview. This was because of the nature of the research questions and their focus on specific life events, which may have been neglected if I had opened the interview with the general question 'please tell me about your life', and did not use interview probes.

The interview topic guide followed a timeline of key events in the nurses' lives, beginning with the start of their careers and ending with their thoughts about the future. The topic guide also explored key events such as leaving nursing college. During the interview, respondents were asked about these events in addition to their personal circumstances at the time and thoughts regarding the event. The original

topic guide was amended in response to feedback from pilot interviews, and also throughout data collection in response to emerging themes, interviewees' reactions and key informants' input; this flexibility and openness to explore new questions is an important requirement of the biographical method (Merrill and West 2009).

Before each interview there was a period of informal conversation, during which I explained my background, motivation for the research and experiences of Malawi. I then went on to explain what kind of questions I would be asking in order to help make the respondent feel at ease. We then discussed the information sheet and ethical issues. I reminded respondents that the interview transcripts would be anonymised and that they were able to pull out of the study at any time. After taking verbal consent, I confirmed with the respondent that they were happy to be recorded. The interview began with a neutral question: 'what are you doing at the moment?' I then moved on to the remaining topic guide questions. Throughout the interview I followed the natural flow of the conversation, discussing events as they came up naturally as opposed to rigidly following the topic guide. At the end of the interview, I asked the respondent if there was anything else they would like to say, and this was followed by some more informal conversation. This 'wind down' period of informal conversation is an essential part of the biographical method, and can often yield significant additional data (Merrill and West 2009). I found that during this period, after the recorder was turned off, many respondents began to bring up sensitive topics such as HIV/AIDS. After checking that the respondent was happy for me to use this additional information, I took notes on our discussion.

Biographical researchers stress the importance of behaving appropriately when conducting an interview. Appropriate conduct includes developing a trusting relationship with the respondent, communicating reassurance and even likeability (Ackroyd and Hughes, 1992 cited in Rapely 2006). It is also important for an interviewer to explain why the research is being conducted and what led to it (Riemann 2003). The interviewer must constantly engage with the narrator by listening attentively and empathetically to evoke further narration of experiences (Rosenthal 1995). Throughout the interview I made sure that I supported and encouraged the respondent to talk openly and feel comfortable, so that they would feel confident about discussing their life story with me.

3.4.2 Focus group discussion

I conducted a focus group discussion with first year students at KCN to assess their opinions about the nursing profession in Malawi, and examine their reasons for entering it. Focus groups involve group discussions around a single theme in order to create candid conversation about the issue (Morgan 1997; Kreuger 1988 cited in Bloomberg and Volpe 2008). Researchers believe that within such an atmosphere “a more complete and revealing understanding of the issues will be obtained” (Bloomberg and Volpe 2008:84). I felt that conducting a focus group discussion with students could supplement the in-depth interview data and provide a way to assess the views of many students new to the nursing system.

3.4.3 Study setting

Interviews took place countrywide in Malawi and the UK. The most common locations in the UK included Glasgow, Nottingham and London, and in Malawi the most common interview location was the capital, Lilongwe. The location of the interview was selected by the respondent and took place at a time that suited them. In the UK, the interviews took place in respondents' homes, with the exception of two which took place in a café and a shopping centre food court.

In Malawi, the research was conducted primarily in the capital, Lilongwe, which is home to the main nursing college, Kamuzu College of Nursing (KCN), and the Kamuzu Central Hospital, one of the three tertiary level hospitals in the country¹². Interviews also took place in Mchinji, a medium-sized town on the border with Zambia. Most of the interviews took place in respondents' workplaces, which ranged from hospital offices and wards to NGO offices.

3.4.4 The sample

The sample was composed of Malawian nurses working in the UK and Malawi. The study included different cadres of nurses, from RNs, who until recently held a diploma but now hold a university degree, to enrolled nurses, who had graduated from nursing college with either a certificate or a diploma. The sample also included key informants ranging from representatives of professional nursing and midwifery bodies such as the

¹² A tertiary level hospital is defined as being the main referral hospital for that particular region, and offers the most specialist care.

Nurses and Midwives Council of Malawi, to stakeholders from the Ministry of Health, and other healthcare professionals working in Malawi and the UK.

3.4.4.1 Inclusion and exclusion criteria

The inclusion criteria for respondents were individuals (male or female) who were born in Malawi, had lived there for at least sixteen years, had trained as a nurse and were now working as a nurse in Malawi or the UK. This included nurses who had completed their initial training in either Malawi or the UK in order to take into account the significant number of individuals who left Malawi to train as nurses in the UK. The criteria also included nurses who had migrated to the UK but had now returned to Malawi.

3.4.4.2 Sample size and characteristics

Forty-six nurses were interviewed – 34 working in Malawi and 12 working in the UK. Key informant interviews were conducted with 25 individuals. The characteristics of the sample are illustrated in Table 3.3. All of the respondents interviewed in the UK had been living there for more than six months. This was to allow respondents to have had significant time to reflect on their migration experiences.

Table 3.3 Demographic characteristics of respondents in Malawi and the UK

Characteristics	Malawi	United Kingdom
Number of nurses interviewed	34	12
Age range	18 – 50 (approx)*	24 – 65
Number of males	8	4
Number of females	26	8
Registered nurses	13	12
Enrolled nurses	10	0 **
Nursing students (university degree level)	11	0
Number of key informants interviewed	18	7

*In Malawi it is considered impolite to ask an individual their age and so the ages of the respondents are an approximation based on information from other sources, such as calculations based on years of nursing service.

** The reason why there are no ENs interviewed in the UK is that ENs intending to migrate would need to upgrade to RN level first in order to be employed as nurses in the UK.

3.4.5 Recruitment process

A purposive snowball sampling procedure was used to select the respondents.

Purposive sampling involves selecting information-rich participants with the objective of gaining an understanding of the subject under study (Bloomberg and Volpe 2008). I used a purposive sampling strategy to maximise heterogeneity of the respondents.

Respondents were identified through snowball sampling. This strategy entails asking respondents if they have any contacts who would be willing to be interviewed.

Snowball sampling can be especially useful when researching hard to reach groups (Merrill and West 2009). As Malawian nurses in the UK are considered hard to reach, this strategy was appropriate, especially as I had no access to records of Malawian nurses working in the UK. However, a number of pitfalls with snowball sampling have been identified; these include the potential bias in the sample arising because respondents are drawn from a particular segment of society. Snowball sampling can also introduce a response bias because interviewees will be linked to each other through social networks, and may therefore have similar views to each other and exclude others with dissimilar views and experiences (Jacobsen and Landau 2003). In addition, using this sampling strategy in a small community can increase the risk of revealing potentially damaging information to other members of a network.

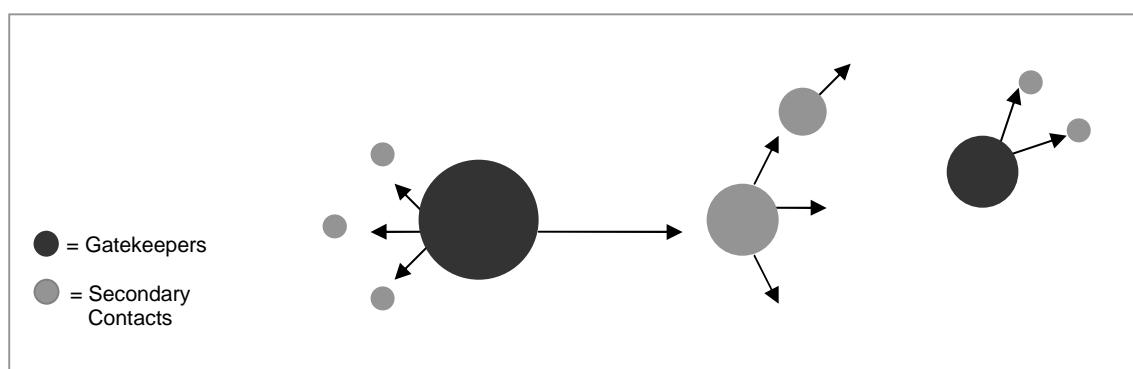
In order to minimise this bias and to ensure representativeness, I used a number of different starting points in the sampling (Bloch 2004). I made contacts with nurses throughout the UK and through different channels, for example through Diaspora groups in the UK and the friends of contacts I had made in Malawi. I also made sure that I did not reveal any information to the respondents about previous interviews. In addition, when checking the validity of findings with key informants I did not reveal any information that may have revealed the identity of the original respondent.

Respondents in the UK were contacted initially by telephone. During the conversation I explained the study and after a period of informal discussion an interview was arranged. A follow-up text message or email was sent to remind the participant that they could contact me if they had any further questions and to confirm the time and place of the interview. In Malawi, the interviews were arranged in person (or over the

phone if initial contact was not possible). I visited the respondent in their workplace and explained the study to them using the information sheet (see Appendix 4). I then asked to arrange a suitable time for an interview with them. All of the respondents took part in the study on a fully voluntary basis.

In Malawi, because nurses were easier to access than in the UK, I was able to use more of a purposive sampling approach in which I asked respondents if they could direct me to friends or colleagues who had direct experience of migration. This strategy was particularly useful in identifying the few nurses who had been previous migrants to the UK (there was no documentation held on return migrants). I approached general nurses mainly through the managerial team of the main hospital in Lilongwe. I was given consent to approach and interview consenting nurses in the wards. Over a period of weeks I returned to the hospital to meet with nurses, first checking if the timing was suitable (returning later if it was not). In Malawi and the UK, I met with nurses until a saturation point was reached with the data and few new themes were emerging.

Figure 3.1 Snowball sampling



3.4.5.1 Challenges in recruitment

During the initial stages of my recruitment phase, I faced difficulties in finding nurses to interview. A Malawian doctor in the UK whom I consulted about this issue in the early phases of the study told me that in his opinion no Malawian nurses would want to be interviewed. Another migrant Malawian doctor explained to me that nurses felt guilty about leaving Malawi and therefore did not wish to be identified as migrants. The nurses' hesitancy to be interviewed appeared to be symptomatic of the vast amount of media and research attention which the brain drain issue has received

since 2000. As nurses are the largest migrant health worker group they are particularly in the spotlight. Several past studies focusing on the brain drain issue portrayed migrant Malawian nurses in a negative light. Many nurses cited a documentary by Journeyman Pictures, called 'Africa's deadly brain drain', which had contributed significantly to feelings of distrust and even anger among nurses. In the documentary, scenes of empty hospital wards were juxtaposed with images of Malawian health workers enjoying the 'good life' at a banquet in the UK. The nurses understood that health workers in the film were depicted as deserters of their country who had the sole intention of making money for themselves. Research and documentaries such as this have led to nurses feeling suspicious about the motives of researchers and film-makers. This led to many being worried about how they would be portrayed if they became involved in future projects. These perceptions affected my recruitment process, and led me to develop an acute awareness of the nurses' concerns and to take them into account when approaching potential respondents.

With the help of a Diaspora group working in Scotland and contacts in Malawi, I was able to develop a network of trusted contacts within the Malawian nursing community. In doing so I had to be open about the motivations behind my research, about the kind of questions I would ask, and also about what I would do with the data. In addition, I kept in regular contact with the respondents after the interviews, partly to reassure them that they could get in touch with me any time and that I was still accountable.

The difficulties I experienced are not uncommon in research with migrant groups. A number of researchers, including Yu and Liu (1986 cited in Sheridan and Storch 2009), found that their Vietnamese refugee participants were suspicious of the researcher motives, which led to recruitment difficulties. Little is known about successful strategies to recruit minority subjects; however, in any case it is important for recruitment strategies to be sensitive to the ethnic, cultural, and socioeconomic differences of the target populations (Shawkat 1999).

3.5 Research Governance

3.5.1 Ethics

Ethical approval for the study was granted from University College London Research Ethics Committee (ID 1533/0013) in the United Kingdom and from the National Health Sciences Research Committee (Protocol # 580) in Malawi.

A number of ethical issues relating to the study were identified and appropriate steps were taken to address them. One issue relates to the potential status of the nurses working in the UK as 'vulnerable migrants' with reference to their visa status or process of entry into the country. To protect the respondents I ensured that the interviews were anonymous by removing any personal identifiers such as their place of work from the transcript and by changing their names. No record was held of their name and personal details in hard copy format. Care was taken to never reveal the identities of respondents to other respondents or to key informants (with the exception of making contacts through the snowball sampling process, where prior permission to pass on the name had been granted). I also demonstrated awareness of the vulnerability of the nurses' migrant status by not asking for personal information beyond the scope of my topic guide and by not discussing politically sensitive issues unless the respondent raised them and showed that they felt comfortable doing so.

Before the interview I informed the respondents, both verbally and in the information sheet, about the following:

- That they were under no obligation to take part in the study;
- That they did not have to answer a question if they did not wish to;
- That they had the right to withdraw from the study at any time;

Respondents were encouraged to contact me at any time if they had any concerns or questions. In the UK I followed up the interview with an email to the respondent to check that they were satisfied with their involvement in the study and to ask if they had any further questions; in Malawi I made the same checks in person. Any soft copies such as the interview recording were securely stored on a password protected personal computer. Information given by respondents has been treated as strictly confidential in accordance with the UK Data Protection Act 1998.

3.5.2 Informed consent

This study requested verbal informed consent from the respondents (see Appendix 5). The key reason behind this was to ensure anonymity for the respondents. Preliminary research revealed that changes to immigration laws in the UK had led to heightened sensitivities with regard to Malawian nurses' migrant status and discussions with respondents prior to the interviews revealed that they would feel very uncomfortable giving written consent. I felt that asking respondents to sign a form could put them in a

position in which they might feel under pressure or perceive that their status in the UK could be jeopardised. By asking for only verbal consent, respondents were reassured that there would be no hard evidence to trace them back to the research project.

A number of researchers argue that signing a consent form can undermine trust between researcher and respondent. Trust, rapport and mutual commitment, all of which are paramount to the success of an interview, can be eroded when confronting the respondent with a legalistic form (Gerson and Horowitz 2002). Sheridan and Storch (2009) found that when interviewing migrant women the formality associated with signing a consent form became an important issue and led some to feel uncomfortable with the legalistic document. Martin (2007 cited in Sheridan and Storch 2009) also found that her research participants were uncomfortable with a legalistic document requiring a signature, and felt disempowered with the entire interview process. As I had already faced significant challenges in recruiting respondents, I did not wish to further exacerbate their worries, and decided to ensure that all the issues of informed consent were handled verbally.

3.6 Data collection phases

After ethical approval was granted, the process of data collection began. The data were gathered during the period October 2007 to September 2009 throughout Malawi and the UK. Data collection took place in seven phases described below (a detailed audit trail of data collection activities is presented in Appendix 3).

Preliminary phase

In the introduction I briefly presented my pathway to defining the thesis. In this section I present my work in Malawi leading to the development of my research questions. In March and April 2007 I conducted a retrospective evaluation of a maternal health project in three districts in Malawi. My work involved meeting with health workers and stakeholders and observing health facilities. This gave me an insight into the healthcare situation in Malawi and the issues affecting it. In October 2007, I returned to Malawi and conducted additional interviews with stakeholders with the aim of examining key issues affecting the improvement of healthcare in Malawi. During these interviews the respondents revealed that human resource shortages presented a significant barrier to improving health in Malawi. After analysing and evaluating my interviews and observations, I was able to develop my research questions. I decided

to focus them on nurses as they represent the biggest proportion of frontline health workers in Malawi.

Pilot interviews

To test whether the content of the topic guide was appropriate and understandable to nurses, I conducted a series of pilot interviews with British healthcare professionals working in the UK. Subsequent feedback and comments from these pilot interviews led to the refinement of the topic guides.

Recruitment phase

The recruitment of respondents took place throughout data collection using the snowball sampling procedure outlined above.

Phase 1 (UK)

I carried out interviews with Malawian nurses working in healthcare facilities throughout the UK and also with a number of key informants, mainly in Edinburgh and Glasgow. I identified additional respondents through snowball sampling and I built and maintained contact networks.

Phase 2 (Malawi)

During five months fieldwork in Malawi, I conducted all the nurse interviews, eighteen key informant interviews, and a focus group discussion with first year nursing students at the main college of nursing in Lilongwe (Kamuzu College of Nursing).

Phase 3 (UK)

Interviews in the UK recommenced after new contact networks were established in Malawi. The interviews continued until the point of saturation, when relatively few new findings were emerging.

Phase 4

Data management and analysis were conducted in this final phase. These are described below.

3.7 Data analysis

3.7.1 Data management

Interviews were recorded onto a Sony digital voice recorder and saved onto a computer to be transcribed into Microsoft Word documents. In the interest of confidentiality I personally transcribed all the interviews. This also had the advantage of familiarising me with the content before analysis (Bong 2002). The interviews were transcribed verbatim, and I decided to keep pauses, hesitations and laughter. During transcription, all transcripts were anonymised (and changed to other appropriate Malawian names) and any identifiers such as workplace or people's names were removed. I also removed the names of any key informants from the interview transcripts, and because of confidentiality issues (especially as some of the topics discussed with key informants were of a sensitive nature) I have not included many details about the key informants in the thesis. These transcripts were checked upon completion by listening to the voice files whilst re-reading the document. The verified transcripts were then imported into NVivo software for qualitative data analysis. Out of the 71 interviews, four (three key informants, one nurse) were not recorded, either because of the nature of the interview (informally conducted in a café), or because of the respondent's choice. In these instances, notes were taken by hand during and after the interview. These files were entered into NVivo along with the voice file transcripts.

3.7.2 Data analysis method

Analysis helps us to make sense of a person's story but also to move beyond description, as important as this is, to refine understanding in more systematic and sustained ways.

Merrill and West 2009: 128

It is often argued that there are no fixed rules to guide qualitative data analyses (Yates 2004), and that data analysis is not 'off-the-shelf, but custom-built' (Huberman and Miles, 1994 cited in Creswell 1998: 142). This is particularly the case in biographical research, which has no prescribed method for conducting analysis (Merrill and West 2009, Apitzsch and Siouti 2007). There are, however, basic building blocks of qualitative data analysis which use a coding approach to the data (Yates 2004: 192). The coding of interview data has a number of advantages (Lee and Fielding 1996

cited in Bong 2002), but qualitative researchers have cautioned that one must not "over code" the interview texts, as this may lead to "analytic madness" (Seidel 1991: 109 cited in Bong 2002). Biographical analysis employs a coding approach, but also has some specific characteristics which set it apart from other forms of qualitative inquiry. The overarching aim of the analysis is to reveal structures of personal as well as social processes of action (Gültekin et al 2003). During the research process there should be no pre-selection of potentially relevant categories, with analysis proceeding sequentially to allow for the emergence of new themes.

There is an ongoing debate among users of the biographical method about whether to let the data speak for itself (with minimal interpretation, as in some feminist work), or to use data categories (Merrill and West 2009). I take the middle ground in this debate by presenting the respondents' stories with little interpretation throughout the thesis, and developing research themes alongside them to allow for comparisons between the individual narratives. My data analysis method builds upon the one proposed by Merrill and West in their 2009 book on biographical methods. The analysis is based on a concrete thematic analysis, but incorporates components specific to the biographical method such as presenting summaries of the respondents' biographies. Thematic analysis is characterised by the identification of key themes or concepts within the interview texts. This type of analysis is driven by the content of the interviews and pre-set research questions, and also the researcher's own 'style' of doing things (Merrill and West 2009). My data analysis approach also brings in components of Schutze's sequential single case analysis approach for biographical research, which involves a formal textual analysis, in which the interview is segmented into its thematic parts, in addition to its narrative, argumentative and descriptive parts (Schutze 1983 cited in Apitzsch and Siouti 2007). The stages of analysis are outlined in below.

Analytical stages based on Merrill and West (2009)

- Preliminary analysis of interviews during data collection;
- Initial reflections on interviews were written down (Kazmierska 2003);
- Transcription and removal of identifiers;
- Transcripts were transferred to Nvivo software;
- Transcripts were read several times to familiarise myself with the texts;
- Organising the data in chronological order;
- Parts of stories that are relevant to research questions were highlighted;

- Comments were added to the transcripts about potential themes;
- A summary was written about each person;
- Themes were identified and coded in the text;
- Common themes and issues across stories were identified;
- Descriptive parts were identified in the transcripts;
- The themes were related to other literature and existing theory;
- New themes were identified.

During all of the phases of data collection, the interviews were followed by preliminary data analysis. This allowed for the refinement of the topic guide as well as for reflection on emerging themes and development of familiarity with the texts. After the preliminary analysis, the transcripts were read several times. After becoming familiar with them, I arranged the biographical data from each interview text in chronological order with the aim of understanding where crucial decisions or events might have occurred. This is considered to be an important stage in biographical analysis (Breckner and Rupp 2002: 297). However, as life stories can be complicated and non-linear (Gültekin et al 2003), I have chosen to focus only on the sequence of key events as opposed to sequencing every biographical detail.

3.7.3 NVivo

Thematic analysis was conducted with QSR NVivo version 8 software. NVivo and other qualitative computer programmes are helpful tools to manage and code interview texts (Grbich 2007). NVivo allows for systematic coding of the transcripts through the creation of free nodes (codes) which are then grouped into tree nodes. In the NVivo software a new project was created, and each interview text was copied into the software as individual documents along with field notes and observations (typed into MS Word from a field notebook). Sections of the interview text were assigned preliminary codes based on results from the preliminary analysis stage when transcripts were read manually, and pieces of the text were assigned comments and preliminary codes. To begin with these codes were defined as free nodes, but as analysis continued these developed into tree nodes, which acted as parent nodes to child (free) nodes. Examples of these tree nodes included motivations to enter nursing. There was no superimposed thematic structure, and analysis took place in several stages alongside discussions with my supervisors. I also made use of many visual mind maps to initially brainstorm all the emerging research themes. I then

reduced the themes to the key research themes which corresponded to the NVivo tree nodes.

During data analysis I compared the interviews looking for shared experiences and patterns between the respondents. These shared patterns allow individual stories to become collective ones, drawing out the collective nature of life experiences (Merrill and West (2009). However, although comparisons of the interview texts formed an integral part of the data analysis, I also considered the interviews separately to examine how the nurses' backgrounds and circumstances impacted on their experiences. Throughout data collection, a series of observations were made after each interview and during periods of non-participant observation in health facilities and HRH-related meetings. These observations included notes on the behaviour of the respondent. Based on a framework described by Graneheim and Lundman (2004), I was able to divide the observations into meaning units which would accompany the coded texts during analysis. For example, I made sure that I noted when a respondent was nervous in the interview and took this into account when analysing their transcript.

3.8 Evaluation of the research

3.8.1 Social desirability effect

Social desirability refers to the tendency of people to deny socially undesirable traits and to admit socially desirable ones (Phillips and Clancy 1972). It is based on people's inclination to endorse statements on the basis of their implicit social desirability rather than on their actual content (Edwards, 1953, 1957, 1959; Dohrenwend, 1966; Phillips and Clancy, 1970; cited in Phillips and Clancy, 1972). A social desirability bias may affect the validity of investigators' results and researchers have discussed how this bias has influenced their findings. Bleek (1987) found that women in his research sample had lied in a survey to present themselves in a way that would make the nurses carrying out the survey respect them; for example, by saying that they were married when in reality they were not. However, Nachman (1984 cited in Bleek 1987) contests that lying is in fact a strategy to safeguard "social survival" and may provide a respondent's only escape from potential embarrassment.

I was aware that a social desirability bias may have featured in my research in a number of ways. Firstly, in a professional sense, nurses may have felt obliged to present themselves as altruists when asked about why they became a nurse. In addition, when questioned about their reasons for migration, the nurses may have a legitimate fear of being judged, and may have resisted saying that they were interested in earning more money as a primary motivating factor¹³. I employed a number of strategies to address these issues. I was aware of the need not to press for answers, especially as a few of the interview questions may have been perceived as being of a sensitive nature, for example why they migrated. My strategy was to time the questions so that they fell naturally after the respondent had “warmed up” with more neutral questions. I also reiterated to the respondent that the interviews were anonymous and they did not have to answer a question if they did not wish to. However, in reality, it was difficult to gauge the impact of social desirability bias on the research findings.

3.8.2 Timing of interview

It is important to take into account when the interview takes place in relation to the timing of the migration event (Boyle, Halfacree and Robinson 1998). This is because the timing of the migration is intrinsically linked to the length of time that the individual has had to reflect on their experience. For example, if the respondent is interviewed about their recent migration, they may be more hesitant and less objective in discussing their experience compared to when the same individual is interviewed later on. In order to take this into account, I interviewed respondents who had been in the country for more than six months (for consistency), and I noted details of exact migration timings and analysed them according to the respondent’s narrative. Interview timing may also be associated with recall problems that may affect the credibility of the results, especially if the migration event was a while ago. It was difficult to control for this in the research process, because of the reliance on the information that the respondents gave; however, it is still important to acknowledge the existence of memory recall issues and their potential impact on the findings.

¹³ In reality most respondents were comfortable talking about the financial motivations behind their migration.

3.8.3 Criteria for trustworthiness

If you find something that doesn't fit in with everything else, don't throw it away, it might just be true ... that's important.

Key informant, doctor in Malawi

It is important to address issues of trustworthiness throughout the research process and during interpretation stages to ensure that the qualitative research is of high quality (Stiles 1999). The three components of trustworthiness as defined by Bloomberg and Volpe (2008) are:

- Credibility: how accurately the respondents are portrayed;
- Dependability (or reliability): whether one can track the methods used to collect and analyse the data;
- Transferability: whether or not the study used a representative sample.

Transferability can also relate to 'generalisability', in terms of the extent to which the data can be applied to different populations or settings. However, generalisation of the results to other settings outside Malawi was not an intention of the study, and I have chosen to focus on issues relating to the transferability of the data as opposed to ensuring absolute generalisability. The steps taken to ensure that all three components of trustworthiness were addressed throughout the research process are outlined in Table 3.4.

Table 3.4 Steps taken to ensure trustworthiness

This table is based on trustworthiness criteria developed by Bloomberg and Volpe (2008) and by McLeod (1994)

Component of trustworthiness	Steps taken	Details
Credibility	Maintaining reflexivity	<ul style="list-style-type: none"> - Disclosure of assumptions and personal characteristics such as gender, ethnicity and profession, which might have an impact on the research process (Mays and Pope 2000) - Acknowledging expectations and then setting these aside to ensure objectivity
	Non-participant observation in Malawi	<ul style="list-style-type: none"> - Prolonged involvement in the field to allow for an in-depth understanding of the phenomenon (Bloomberg and Volpe 2008)
	Member validation	<ul style="list-style-type: none"> - Checking findings with key informants and respondents
	Triangulation	<ul style="list-style-type: none"> - Collecting data from a variety of sources including documents, key informant interviews, non-participant observation
	Presenting variation in results and negative findings	<ul style="list-style-type: none"> - Including cases that might not conform or challenge emergent findings (Bloomberg and Volpe 2008, Graneheim and Lundman 1994)
Dependability	Developing relationships with informants	<ul style="list-style-type: none"> - Creating rapport with respondents to encourage the disclosure of important data (McLeod 1994)
	Presenting an audit trail*	<ul style="list-style-type: none"> - Providing a detailed description of how data were collected and analysed
	Consulting others during data analysis	<ul style="list-style-type: none"> - Consulting supervisors during coding stage of data analysis, verifying codes
Transferability	Ensuring systematic data collection**	<ul style="list-style-type: none"> - Taking notes during data collection on all the research steps
	Including thick description	<ul style="list-style-type: none"> - Presenting rich descriptions of context and cultural background - Situating the research in its historical and social context, for example the history of nursing in Malawi
	Including a representative and diverse interview sample	<ul style="list-style-type: none"> - Interviewing respondents from diverse backgrounds, representing different cadres, and living in different locations. This allows for the research question to be explored from various positions (Patton 1987; Adler and Adler 1988 cited in Graneheim and Lundman 1994)

*The audit trail is presented in Appendix 3

**As agreed by the British Sociological Association Medical Sociology Group (1996)

3.8.4 Reflexivity and the researcher's position

Reflexivity refers to the influence of the researcher on the data and interpretation and is an essential component of the qualitative research process. Reflexivity and transparency in the report of fieldwork activities is thought to be the only way to control biases resulting from the status of the researcher, as well as their gender, age, and social status (De Tona 2006). There has been a call for researchers to locate themselves within the research process and to discuss the influence of their social background on data collection and analysis (Roberts 2002:13). This has become an important issue in migration research (Sheridan and Storch 2009) especially as cultural differences may exist between the respondent and researcher. In the following paragraphs I expand on the reflexive process briefly described in Table 3.4. I present my position as a researcher by stating my cultural background, profession and gender; and assess how these may have affected the research study, in particular during data collection.

I am a young white female of European descent, working as a PhD researcher with a background in biological anthropology. I am not a member of the Malawian respondents' ethnic community or country, and I have not trained as a nurse. This may have influenced the way in which respondents perceived the study and my involvement. For example, I may have been perceived as having money (when in Malawi), or as representing a link to authority (when in the UK), which would not be favourable in light of issues relating to vulnerability of migrants. Also, not being a nurse may have affected the ways in which I interpreted the results and how the nurses' perceived me. In order to overcome this last issue, I was in regular contact with an English nurse working in the UK and Malawi, who was able to check and verify the results and explain any nursing issues that I may not have been familiar with.

It is difficult to assess how gender may have influenced the research process, as being female may be a limitation or an advantage depending on the situation. In this research project being a female may have been an advantage in that the majority of the respondents were also female. Many feminists believe that it is beneficial for women to interview other women because of a shared understanding of experiences

(Merrill and West 2009). However, my status as a female also meant that in some cases the male respondents were given the wrong impression about my intentions to interview them, despite going through the formal process of the information sheet and informed consent, and this led to feelings of discomfort. The misunderstanding surrounding my research aims relate strongly to Malawian cultural systems, where men would not expect a woman to be travelling alone to conduct interviews.

Throughout the research these cultural issues may have affected not only the way in which I was perceived by Malawian respondents, but may have led to some cultural bias during the interpretation of the data. Cultural differences are particularly important in migration research as problems can occur when the research is carried out by researchers from a different culture to that of the respondents (Halfacree and Boyle 1993), in that the researcher may not understand fully the background of the respondent under study. I attempted to address this issue through a prolonged period of fieldwork during which I was able to learn about aspects of Malawian culture. I also read literature about Malawian culture and drew on the experiences and advice of Malawian friends and contacts.

Despite the challenges outlined above, my position as a White European may have also been an advantage, as the nurses may have perceived that I had no affiliation to their local or host communities. Storch and Sheridan (2009) found that being considered an outsider in national cultural terms put them in an ideal position to create a platform for their interviewees to describe their migration experiences and to freely express their thoughts about the host culture without fear of retribution. My position as a researcher also affected the way in which I have presented the research findings. In line with the biographical method I have chosen to give an appropriate level of authority to the nurses' voices over my own. I present two edited interview transcripts before presenting the results (as well as including various summaries of key events in the nurses' lives), which allows the respondents voices to come before any form of interpretation.

3.9 Reflections on the biographical method

The biographical method allowed key events in the nurses' lives to be examined and the use of the timeline gave an effective template to structure the interviews.

I employed a certain level of interview structure, which is not usually associated with traditional biographical methods, as they typically begin with the question, 'tell me about your life'. The decision behind this relates to the focus of the research questions on key life moments as opposed to the overall life story. However, as the biographical method is being used in various disciplines, its uses are increasingly adapted to the research aims. The method has a good fit with the interdisciplinary nature of the research questions (incorporating features of migration research and nursing research) and proved an effective way to address the research questions, especially through its focus on individual experiences within the context of the respondents' personal and professional lives.

However, it would have been beneficial in terms of the requirements of the biographical approach (which advocates repeated and prolonged interviews) to spend more time interviewing each respondent, as this would allow for a deeper understanding of their experiences. In addition, as the timing of the interview in relation to the migration event might have influenced the findings, it would be interesting to revisit and interview the respondents after a period to see how they present and reflect on their life experiences. This approach is useful when tackling sensitive questions. Since the biographical method gives a certain level of control to the respondent in terms of what is discussed, the respondent may feel that they are able to ignore questions that they do not feel comfortable answering and elaborate on the parts of their lives they feel more comfortable discussing.

In terms of the sample composition, registered nurses and those working in urban areas were overrepresented in the research, primarily because they were the ones who were able to migrate as nurses. I attempted to counteract this bias by interviewing as many enrolled nurses as I could in Malawi. Although the findings are not intended to be generalised to all nurses in Malawi, the shortage of enrolled nurses interviewed working in rural areas means that the thesis misses their insights and experiences, potentially affecting the applicability of my recommendations for improving the nursing situation in Malawi.

3.10 Conclusion

This thesis uses qualitative biographical methods to examine the experiences of Malawian nurses working in the UK and Malawi. The use of the biographical method

in migration and health research has been gaining momentum in the past decade, partly because of the increased recognition of its strengths. Biographical methods present an effective way to conduct in-depth exploration into an individual's experiences and locate them in the broader context of the individual's life.

In-depth interviews were conducted with a sample of 46 nurses and 25 key informants, along with document analysis, observation and a focus group discussion. Issues of trustworthiness were addressed through a number of methods including member validation (verifying findings with respondents) and triangulation. The interview data were analysed with a thematic approach using NVivo 8 software. The findings are presented in a format most appropriate for biographical research. Following the presentation of two edited transcripts, key themes that emerge from the stories are discussed alongside extensive quotation of the narrative material and summaries of key events in the nurses' lives.

Chapter 4

Results overview

In the following four chapters I present the findings from 46 in-depth biographical interviews, one focus group discussion and 25 key informant interviews. As I follow nurses' experiences along the timeline of key events in their lives, I describe the historical context in which events took place. A sequential timeline is used for simplicity and for comparison and does not assume that life events followed a linear sequence. For example, although I have placed migration decisions after college in the timeline, I do not assume that respondents only thought about migration after graduation. Each chapter represents a section of the timeline, and within each I detail the experiences of the nurses, their decisions and the factors that influenced them. I then link these to historical and political events and to the wider literature. As many moments in the nurses' lives were influenced by historical events, I briefly introduce key moments relating to nursing. These are summarised in Figure 4.1, which is segmented into three different presidential terms: 1964-1994, 1994-2004 and 2004 to present.

4.1 Key historical moments

Understanding well where the country is coming from, in economic, social and political terms, is essential for appreciating where it is likely to go in the future and what kind of help it needs. We suspect that several of the legacies of the way Malawian society and politics have been formed are under-appreciated.

Booth et al 2006: 4

The historical accounts I present are primarily based on respondent reports. Although I have presented the most consistent versions of historical events, there are issues that can potentially affect their accuracy. Firstly, there is the issue of recall bias, whereby the recollection of an event is affected by the respondent's memory of it. Secondly, personal bias may influence the interpretation of past events. I was particularly aware of this bias with regard to descriptions of the nursing situation in the Banda years. Malawians are divided in their opinion of President Banda. Although

most respondents agreed that the discipline and unity that Banda instilled were positive, a significant proportion associated his presidency with severe political repression and a lack of personal freedom. This negative opinion may have influenced their descriptions. Conversely, respondents who regarded Banda as the hero who restored order to Malawi after years of colonial rule may have described the Banda years positively. Many Malawians believe that they were the country's best (especially because of the subsequent tumultuous years of President Muluzi), and the four cornerstones of his presidency - unity, obedience, discipline and loyalty - still hold great appeal, especially in rural areas (Booth et al 2006). Nurses in particular felt that Banda had a strong affinity for them, witnessed by his commission of the building of Kamuzu College of Nursing (KCN). I have attempted to account for the biases by verifying historical accounts with several key informants, and by referring to the literature.

4.1.1 President Hastings Kamuzu Banda

Authors argue that the Banda dictatorship was a turning point in Malawi's recent history, particularly from a political point of view (Booth et al 2006). Banda's presidency also had a number of implications for nurses. In terms of the working environment, lower HIV/AIDS levels and a relatively well-implemented health system meant that work burden was far lower than in the following decades. Although salaries were low, decent working conditions and availability of resources led many respondents to believe that the Banda years were the 'good years' for nursing. However, with few opportunities for free speech and little power accorded to nursing unions, nurses felt that they did not have any say in how nursing was managed. The recruitment freezes that accompanied the structural adjustment programmes towards the end of Banda's presidency made nurses feel even less empowered, and for the health system the freezes signalled the beginning of the decline in Malawi's nursing situation.

4.1.2 President Bakili Muluzi

When the government changed to Muluzi's era, everything just collapsed. You worked in the ward there wasn't a bed sheet, there was nothing.

Sarah, 1992 RN GN

A deterioration in the nursing situation characterised the presidency of Bakili Muluzi. Although Muluzi brought democracy, international agencies and political freedom to the country, he also brought a lack of accountability, corruption and civil discontent. He attempted to distance himself from the Banda regime through his policies. However, they were often marred by challenges indicative of the poor economic state of the country that had resulted from his economic mismanagement. Amongst his strategies was the ill-planned introduction of free primary school education, which led to a decrease in educational quality and left a legacy of poor exam pass rates. As the government began to de-prioritise healthcare, nurses' working conditions and salaries suffered. The underinvestment in healthcare, combined with the neglect of HIV/AIDS under Dr Banda, left the country severely underprepared for its emerging HIV/AIDS epidemic (see Box 4.1). As the ministers responsible for health never personally needed Malawi's health services¹⁴, observers claimed that they were oblivious to the decline of the health system (Chirambo 2002). A number of benefits that nurses previously enjoyed were also stopped, ostensibly for financial reasons. These included scholarships to undertake specialist training overseas. One nurse felt that this contributed to the slow decline in nursing standards, as those with specialist knowledge retired and were no longer replaced by nurses with equivalent skills. Respondents were unanimous in their belief that 'many things went wrong after Banda', reflected in Sarah's statement above. Emma described how the life of a nurse went from one of relative financial comfort to one in which nurses could no longer afford basic necessities:

If you ended up working in the civil service, after 94 you didn't get much, people were struggling. My mum trained as a nurse like me, but she had a house... she could afford everything. I wasn't poor, I wasn't rich but we were comfortable we had everything. We could afford to go outside the country for holidays. But when I qualified [1994] I could not afford those things, the salaries were down.

Booth et al (2006) describe how by the end of Muluzi's second presidential term Malawi was at the edge of an abyss. The declining living and working conditions for nurses precipitated the rise in migration between 2001 and 2005.

¹⁴ Ministers commonly flew to South Africa to access healthcare treatment.

4.1.3 President Bingu wa Mutharika

Many respondents believed that, because of greater investment in healthcare, things had improved significantly for nurses since the election of President Bingu wa Mutharika. Yet the healthcare system continues to feel the legacy of Muluzi, evidenced primarily in the persisting nursing shortages that resulted from the migration years. Insufficient numbers of nursing tutors have hampered government plans to increase training output to correct these shortages. Whilst HIV/AIDS levels remain high (see Box 4.1) and the population continues to expand, the demand for healthcare continues to outstrip available human resources, even though fewer nurses are migrating. This means that Malawi continues to have a high disease burden and significant discontent within its nursing workforce.

Box 4.1

HIV/AIDS and the nursing landscape in Malawi

As the issue of HIV/AIDS features repeatedly in the interview themes, I briefly present a selection of key events relating to HIV/AIDS in Malawi. Although Malawi's first case of AIDS was diagnosed during the time of President Banda in 1985 (Cheesbrough 1986 cited in Lwanda 2002), there was little awareness amongst health professionals and the public about its imminent effects. According to reports, health workers and the Ministry of Health were forbidden to keep records of HIV/AIDS cases, and any journalist found to be reporting on HIV/AIDS was treated as if they had committed an act of treason (Booth et al 2006). Many observers believe that this suppression of knowledge contributed to a rise in AIDS deaths towards the end of the 1990s (Lwanda 2002). By this time HIV/AIDS had dramatically changed the landscape of disease burden and nurses were faced with increasing numbers of chronically ill patients. Yet, because of the silence regarding the epidemic, little was known about how best to treat them. The ways that HIV/AIDS manifested in patients led to even greater confusion and complications of treatment as patients began to present with diseases that many nurses believed were no longer prevalent, such as tuberculosis. Antiretroviral therapy (ART) used to treat HIV positive patients was still years away from being a reality in Malawi. Without ART (or any knowledge that it even existed), nurses commonly talked about how helpless they felt and about the stress they

experienced in watching patients in the advanced stages of the disease dying in front of them.

Although public awareness improved significantly after President Muluzi came to power, hospital conditions were still inadequate to handle rising numbers of patients (Lwanda 2002). Despite international agencies working with the government to combat the epidemic after 1994, nurses recalled that there were widespread resource shortages, and there was a growing concern amongst nurses about occupational transmission. ART is now administered without charge in Malawi, but resource shortages persist and many nurses believe that there is little to protect them from the 'killer' disease to which they are exposed to on a daily basis:

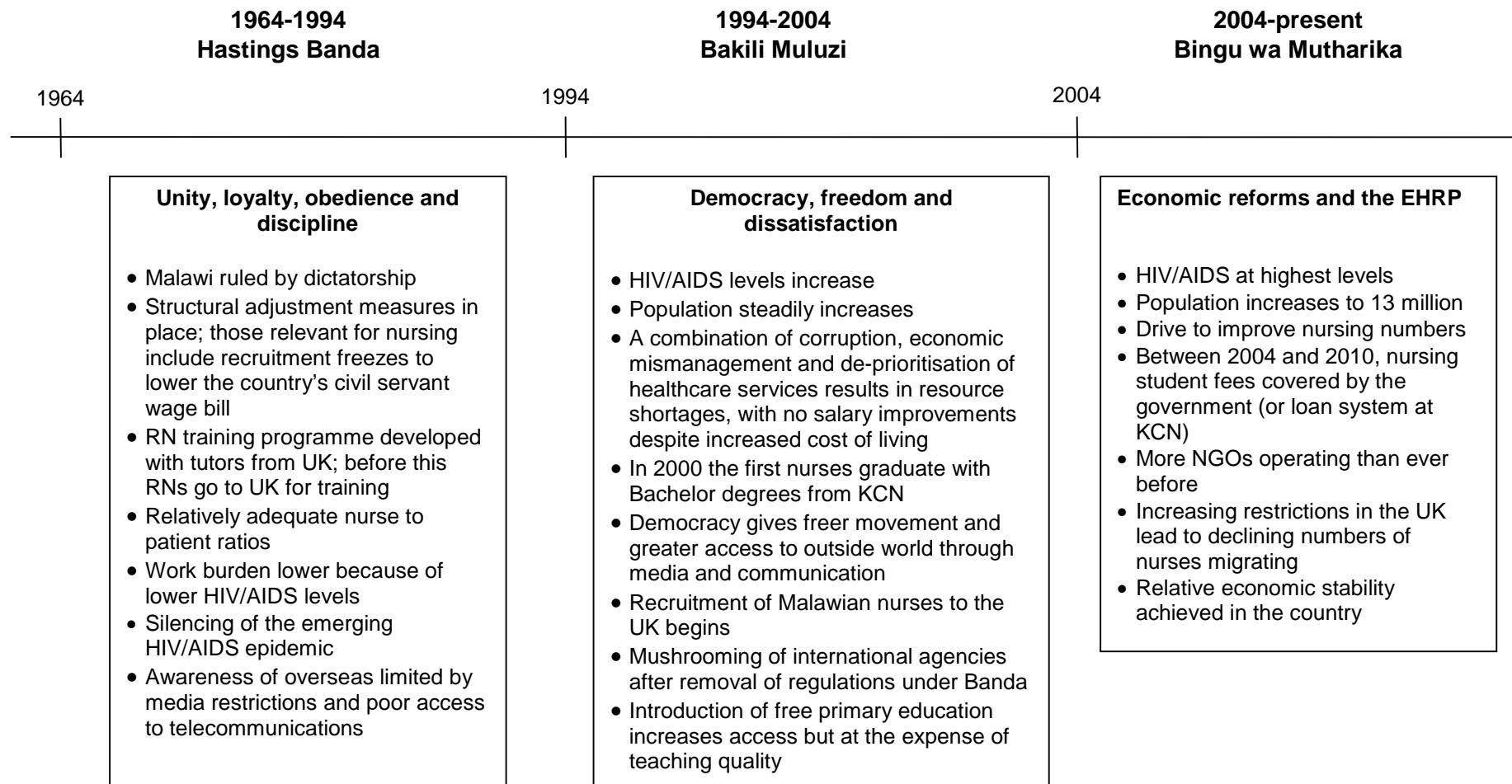
We [care for] many people with [our] bare hands... we wash with soap and pray to God, please protect me: that's the only thing [we have]. (Catherine, 1990 EN government nurse, GN)

4.2 Presentation of results

The themes discussed in the following chapters are accompanied by interview quotes and summaries of the respondents' experiences. To give a sense of how respondents expressed themselves in the interviews, I present illustrative excerpts from two interview transcripts, the first from Chimwala, who trained as a RN and works with an NGO in Malawi, and the second from Alfred, also an RN, who left Malawi in 2004 to work for the NHS in Northern England.

Accompanying each respondent quotation is their anonymised name as well as year of graduation, their cadre (either registered nurse or enrolled nurse), and their current workplace location (either the government, CHAM, an NGO, or in the UK). For example, for Catherine, quoted above in Box 4.1, I mention the year of her graduation (1990), her cadre (EN) and her workplace (the government, GN).

Figure 4.1 Key events in Malawi's history relating to nursing



4.3 Transcript: Chimwala (1991 RN NGO), Malawi 2009

4.3.1 Why she became a nurse

When did you first think about nursing?

I never thought of nursing, I came from a background where we didn't go to school. All my relatives are Muslim but my mother went into Christianity because of my father, we are the only Christian family [in my community]. All my other relatives were not encouraged to go to school because at that time the only schools were Christian, Catholic and they were afraid that they would be converted into Christians, so they just went to learn to read and write. My grandfather he encouraged me to go to school. I did not know the professions. All I knew was my teacher. When I was selected to secondary school, I was searching for what I would be and made my mind up to be a teacher.

But then...

My very best friend had an accident, and we had to go to hospital. The way she was handled [by the nurses] within minutes, they took her to theatre. They were very fast and very nice to us. This nurse dressed in theatre attire was beautiful, smiling... I was amazed how they could save a life like that, I wanted to be part of that. Then when I went back to school I said that's what I wanted to become... that was the motivation: to save the lives of people.

How did your family feel about your decision to do nursing?

My family was happy that I could assist them when they are ill. That's what I have tried to do in my profession, my two aunties have cataracts, I motivated them to come to the hospital as they didn't have trust in my village to go to hospital.

People would say nursing is a low status career, you will be receiving a very miserable salary, and your life will not progress, it's difficult for a nurse to marry a rich husband. Then I said 'I am coming from a miserable life from the village and then I become a nurse and continue to be miserable. No. After all this education I will be miserable!' so I changed my mind and applied to become a teacher. The second choice remained nursing. When it came to selection they selected me to go to KCN.

I was not upset. When I got selected to KCN I thought if this is what God wants, then this is what I would do.

Was nursing popular?

I don't know. It was easier to go to KCN when it comes to selection for university, so people would say if I fail here, I would go to nursing. I don't think it was that popular or that people were looking forward to going there.

4.3.2 Workplace decisions

What did you do after graduation?

That year, as there was no bond we were given choice where to go. Me, maybe because of my Christian background, I thought my services would be appreciated more in CHAM. So I didn't choose to work in government. Most of the CHAM facilities are in the remote, rural area. This one was very rural, so I thought 'ah, town life is better than this', because I had stayed in [a big town] for secondary school, and Lilongwe for university. Then I said: 'I stay here [in the rural area] after being in an educational system with water, toilets and electricity inside? [here] you have to carry water on your head!'. They gave me a nice house, but the toilet was far away, I had to draw water from a bore hole, so that was a big difference in my quality of life. I had to go a long way to go to the market; there was no transport readily available, I had to walk. That was a very hard life for me, I was not happy.

So I worked for five months, and then I went politely to the administrator [and said], I want to work in another hospital. I said '[here] I will not make it', she said I understand what you are talking about. I worked for another two, three months and came to work [near the capital], then I got married when I was working there.

That's when I joined the government. There was more autonomy in the government which made me grow quickly in the profession, I liked the way I worked in government, I was in charge of a ward. If the matron wasn't there, they would entrust me with that office. In terms of resources CHAM was better, but salaries were the same. But working under CHAM, we had a matron and a doctor, I felt I was working under somebody, you can't make a certain decision. But in the government you participate in meetings with matron to make decisions together.

4.3.3 Migration story

After working with government...

When I finished my [second Bachelors] degree I went to (Europe) and stayed there for eight months but that was about the church, it was about families. It was a good experience I liked it very much. So I thought if I go to work in a European country and my children would be going through this kind of education, this would be good. But on the other side it strengthened my idea of not going to serve outside, when I saw the Africans, the way they live there. Maybe I was looking at a different type of people, I didn't come in contact with black persons working in a hospital or doing any professional work. All I could see were these men and women in the street, selling things in the street. Why can't they go home and work in the garden, as opposed to selling cigarettes here? So I think even at home I can make a better life, I can go into the field and work and sell. So for me, it was two forces, go to Europe and you will have this type of life, I was living in a good house, my family I could see the Africans looking at us when we were going shopping in the streets they were admiring us. I was with my husband and children. But it is better I remain at home. So for me I am ok to stay there...

What happened around 2000?

During that time there were lots of adverts for work (overseas) they were offering better salaries. During that time you saw a lot of openings. It was some of us [who went], I never thought of going to work outside, I am kind of uncomfortable to work in a strange environment, but also I am convinced that money, for me, it's not the answer to all the problems. I can have money, but when I have a lot of money my problems don't go away. I can find better food but in general I am comfortable that I am still saving the poor people in the country. I wouldn't say that I am not attracted [to the UK] at some point I am attracted, the education of my children. I don't have a house, I need to have a house now that I am growing up, maybe if I go to the UK I will find better but to really make up my mind to work somewhere else to build a house? I still hesitate, I don't know maybe I am a coward <laughs>... I feel good to be at home.

What about friends in the UK?

I have some friends who think that life is too hard [in Malawi], their life is much better [in the UK]. There are hard things of course. It is difficult to adapt and maintain the fast life there, they have to have two, three jobs but all in all the life is better, they can afford to buy a house here, they can send help to their parents. The quality of life for their

parents is better; they have built houses for their parents. I admire them but I can't make the decision to go.

4.3.4 Future plans

And what is your plan now?

The [NGO] project is finishing in 2011 so I hope to stay till then. The challenge here is I cannot grow, they cannot sponsor me for my Masters, [but] they are happy with my present performance. NGOs usually don't upgrade you, which means that I have to look for my own sponsorship and it's not easy to find sponsorship. After serving an organisation for all this time since 2004, I would appreciate if they helped me to move a step forward in my career. My mind is occupied to look for sponsorship for my Masters. I am trying to apply for two [one in the UK and another in Scandinavia].

I would like to stay here in the NGO community, as much as I want to go to the UK because of the money, the better working conditions, it's not that I don't want that type of life, it's only that I want that type of life here at home. So if I work in the NGO I am serving the Malawian people but at the same time I am able to have food up to the end of the month. I don't have a house yet, but I am saving a little bit every month so that I can have a house over 10 years. It's important to have a home and to be able to pay school fees for my children and give them food. These three things I am able to do now, to save for my house with my husband and send our children to school and find food. Otherwise in nursing [in the government service/CHAM] at the tenth of the month my salary was finished and yet I couldn't find food for the whole month, and I would go to work on an empty stomach, it's hard. For those people who go to the UK it's hard and maybe I am still here because I have found this job here [with the NGO] otherwise maybe I would have thought of going there.

4.4 Transcript: Alfred (2002 RN UK), UK 2009

4.4.1 Why he became a nurse

I wanted to ask how you came to be at KCN?

This is very interesting....

My first choice was engineering, my second one was environmental sciences and technology and then pure sciences. But I had a weakness: my maths grade was not as good. And the reason why I didn't have a very good background in maths was because we had problems with mathematics teachers in my school... So, all of a sudden with the UEE [University Entrance Exams], I did very well but my numerical skills weren't up to the right standard, I discovered that I had been offered a place at KCN.

Even though it wasn't one of your options?

Yes, it wasn't your option. Because you failed to meet the criteria of the course that you applied for but there is a vacancy on another course, they would still - if they consider you to be university material - offer you [another] course. So, I had two options, either to reject that offer or re-sit the mathematics so I can make up the grades. I wanted to re-sit but my parents said "well just go and do it for the first year, and find out how it is going, and after that is when you may decide what to do, after the first year". It was possible, what you call faculty transfer, depending on what your scores were and the vacancies. So that was the plan.

What did you think when your parents said that?

I didn't agree... I don't want to work in hospitals. [They said] "No, go give it a go, try and see what you think." So I went there and after the first year, I found that it was very interesting and very exciting but after making a survey: that you can graduate with a degree in chemistry, physics, engineering, but there aren't many jobs in Malawi that would employ you in these sectors. And I came to understand that with nursing you just go straight into the private sector or government, or CHAM or whatever you want to do. So I thought I would have more chances [if I] stay in the healthcare service.

Do you think that nursing in Malawi opens a lot of doors?

Yes, but it depends on how industrious you are.

I was giving examples to some of my colleagues, if you look at a nurse you see that they probably are somebody who is not regarded highly in the community in general, in

society, you think he is not very intelligent. But the way I look at it as a nurse you can do anything. I can do a Masters in business administration soon after my nurse degree. I can run an NGO, I can do research, I can teach. The sky is the limit, if you don't confine yourself to the concept that this is a nurse who stays in the hospital.

Did you know about all this before you started the course?

No not really, I think that I discovered all this during my course, through experiences, through contacts with different people.

Was there this concept that as a male you wouldn't necessarily think of becoming a nurse?

It was an issue in the first place. It was one of the issues that created a big problem psychologically. Most of us were worried that probably society would not accept us males being nurses. And if you interact with people from other colleges they will laugh at you. So a lot of people still have got negative attitudes to male nurses, that it is a female profession there is no way that a man should do nursing.

4.4.2 Migration story

What was your plan for coming to the UK?

I think I started planning coming to England after my final year of my university training and because by then in Malawi we had no post-graduate training for nursing and if you wanted to do a Masters in nursing you would have to go either to South Africa, Australia, United Kingdom or USA. And my plan was to do a Masters as soon as possible simply because we were graduating in large numbers, and for you to get funding to pursue the studies it was probably a question of grace, or if you are not a Christian you would probably call it luck.

If I was going to go to UK and Australia, I should be able to work for one, or two, three years and then I should be able to raise a little bit of money to sponsor myself to do post-grad training either in nursing or another field of health, which would equip me with knowledge and skills to go back and do research.

You mentioned earlier about your expectations; did you have any expectations before you came about what it would be like here?

Of course I expected it to be a little bit busier than what it was in Malawi, because you hear stories about people doing two, three jobs a day, so I probably knew that it would be hectic, and at the same time I also anticipated the shock of landing in the UK, different culture, different people. But I wasn't frightened because my nurse degree had already prepared me.

And what about good stories?

Some good and some bad, people who are 'pro' coming to this place will talk about good things: you live a comfortable life, life is a little bit cheap in some areas, you earn a good amount of money and you can invest. And those who are 'against it' [say] you will be reduced to auxiliary nurses and carers, you will only be allowed to touch the elderly.

And did you think there is pressure on nurses to go to the UK?

I think that mainly it's to do with money. People think that you will come back with lots of money. [But] they have changed all the rules. I think that they are giving chances to the British citizens first and then the EU and then people from Africa. Which practically is equivalent to saying that we are barring you, because even if you have a Masters when you come here they don't consider your Masters, they will look at you as a beginner. To me what it means is that the door is slammed on your face, but because there is still a shortage of staff I understand that they are still recruiting.

4.4.3 Life in the UK

I appreciate that things must be different in the workplace, but in terms of lifestyle do you think that you had a change in lifestyle compared to what you had in Malawi?

Oh yeah definitely. I think I was more relaxed in Malawi, because after work you would go straight back home but here after work I have to think about three, four things including my own part-time education. And on the other hand because I have met different people with different backgrounds, I have adopted a new lifestyle all together.

In general, what is the working environment like for you?

I think both good and bad. It's a very good environment because I think you get all the resources you need most of the time as compared to what we had in Malawi and the

other thing is the pay is much better as well so that kind of motivates you but equally there are quite a few frustrating things. Like stress levels are much higher here than in Malawi.

I had a very bad experience, where I am working now. She [the manager] used to look down upon whatever suggestions, ideas I would bring. I think I don't blame her because probably she had this delusion that probably nothing good can come out of Africa. And that you don't know anything since you come from Africa. You can't suggest anything, you can't say anything. I found it very hard especially during the first year to settle down because whatever you do, she would rubbish it, overturn any decisions that you're going to make.

I think to sum it all nursing is a little bit different in Malawi to here. So when you come you have to adjust and adapt to the needs of British society. Nursing both in Malawi and here has seen some ups and downs, but that is life. In life there is no such thing as probably everything going on smoothly, you always meet hiccups. And probably you just need to realise your strengths and weaknesses and capitalise on your strengths, seize opportunities as you go along and take everything as a challenge.

You always hear that there are 'more Malawian doctors in Manchester than in Malawi'... is Manchester a common place for Malawians?

It is yes. But I have to dispute this fact because [there] are only two Malawian doctors that I know in Manchester. Those were I think stories that were fabricated by people for their own personal reasons... just to exaggerate the kind of brain drain, the degree of brain drain, but it's not true. ... To be quite honest people they do exaggerate so that they can make it news but the numbers simply don't add up.

And how do you feel, with all the media reports?

Yes they make you feel guilty but at the same time they only give me energy to say hang on a minute, you have your facts wrong because your figures don't simply add up. There was a documentary on YouTube about brain drain. They took pictures and videos of some people partying in London and they said they were Malawian doctors. It is a lie. A total lie. If there were doctors, they interviewed only 1 or 2; it was a party, probably most of them were Malawian, but not doctors.

4.4.4 Future plans

Do you think that you could stay forever in the UK?

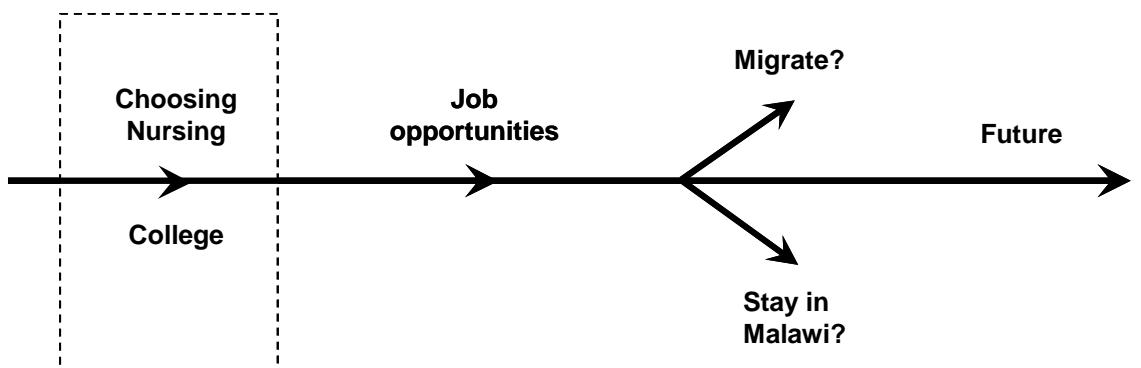
It is my intention not to live here forever, but to live here for a significant number of years, and after working to go back. But what I have decided is to never be detached permanently from Malawi. I will still maintain my Malawian passport if I am to stay here longer.

Would you see yourself going back and being a nurse?

The only thing that I am not sure about is whether I would work in the nursing sector, as I said I am more into research. I don't want to go back and work on the ward anymore. If I go back I will be involved in charity work [NGOs] and in the area of diagnostics, to provide hospitals with expertise on how to diagnose. Still the poor peasant will benefit from the skills I have not learnt in Malawi, but actually in the UK.

Chapter 5

Becoming a nurse in Malawi



Chapter 5

5.1 Chapter overview

My first research question looks into the reasons that respondents chose to become nurses. Through examining their rationale I begin to build a picture of nursing in Malawi and also look for connections between the motivation to become a nurse and work-life intentions. From a practical point of view, understanding what attracts people into the nursing profession can help understand ways to attract more nurses and retain them. I was also interested in looking for potential links between motivations and migration intentions. The literature review described the theory of beneficial migration, which included the premise that the opportunity to migrate incentivised people to join a profession. In this chapter, I examine the extent to which migration opportunities affected choice of nursing as a profession. The main focus, however, is on the more general reasons for entering nursing. In the interviews I did not probe directly about the influence of migration when questioning the respondents about why they entered nursing and, in fact, many of the answers did not directly relate to migration. In this chapter, I present the decisions of the nurses in their cultural and historical context. The interviews revealed that these contexts, as well as their families, played an important role in the decision making processes of aspiring nurses. The most important influence on motivations appeared to be the historical context. With high levels of consistency, nurses who trained at the same time gave similar answers. Therefore, to take into account the natural patterns in the data I present the nurses' responses according to the eras in which they graduated.

To examine the reasons why people enter nursing is to make the assumption that students are able to make choices. From a high-income country perspective, it is assumed that most children will have access to education and then have the freedom to enter a profession or job they are interested in and suitably qualified for. We cannot assume that this is the case in Malawi, where educational and employment opportunities are more limited than in countries such as the UK. Before looking at why people enter nursing, I briefly discuss who can enter the profession, and the barriers they may face.

5.2 Who becomes a nurse in Malawi?

Where I am working in the health centre you have a school, there they are still sitting on the floor, they don't have books, a library. All they have is limited resources. Do you expect these kids even if they want to become nurses to learn, expect them to have the knowledge that they can go into the colleges?

Stella, 2006 EN government nurse (GN) rural area

Income levels for the majority of Malawians are low. This is partly because much of the population is rural and engaged in low-pay subsistence agriculture. Whilst 75 percent are farmers, nationally only 9 percent of individuals are employed in the formal sector, which includes nursing (MoH 2001, cited in NSO 2005). Formal employment is mostly concentrated in cities, and this explains why they tend to have almost three times higher income than rural areas¹⁵ (NSO 2005). As well as low income, rural areas face additional difficulties in accessing electricity, safe water and transportation. These resource challenges have important implications for nursing and influence who is able to enter the profession.

5.2.1 Barriers to entering nursing

To be eligible to enter nurse training, a student must pass their final secondary school exams (MSCEs) with adequate grades. Although primary school education is free in Malawi, secondary school education is not. One key informant believed that although government secondary school fees were relatively inexpensive they were still too costly for most Malawians. According to Davison and Kanyuka (1992: 464): "the rural Malawian smallholder has little surplus ... to pay for basic commodities such as cooking oil, matches, and clothing, let alone education". In addition to cost, places at secondary school are limited. Because of these barriers the majority of children do not continue to secondary school (NSO 2005). A significant proportion of the population (those unable to get a place in school or to pay fees) are excluded from pursuing nursing at this early stage.

Even if a nurse aspirant is able to enter secondary school, the next hurdle they may face is the quality of education. Many Malawian schools are blighted by poor learning conditions caused by inadequate resources and physical infrastructure as well as

¹⁵ The average annual household income in Malawi is about MK 50,000 (approximately GBP 220). Household income is an aggregation of income from salaries, agricultural activities, non-agricultural enterprises and other benefits such as remittances (NSO 2005).

demotivated and poorly trained teachers working with high teacher to pupil ratios (Booth et al 2006, Malawi Scottish Network 2008). These issues are often more pronounced in rural areas. Whilst in most urban schools the teacher pupil ratio is 1:120, in rural areas it is 1:150 (Commonwealth Education Fund 2010). In general, these factors contribute to the lower literacy levels seen in rural areas (NSO 2005). Observers have suggested that, as well as poor teaching, students are unable to gain the required science grades because of poor physical infrastructure for science teaching (such as laboratories). Alice, a nurse working in a rural health centre, explained that many families are forced to send their children to urban schools with science facilities:

Somebody in the village who wants to become a nurse, but because the school she has gone to does not cover the necessities of entry into college she will suffer. She won't get the grade unless she moves away from the village into town, so she can have access to a good education.

Even if an individual is able to study at secondary school, shortcomings in the quality of teaching and resources may translate into insufficient grades, especially in the sciences.

The next hurdle the nurse aspirant may face, especially in rural areas, is accessing information about the application procedure for nurse training. Although schools will typically assist with university applications, nursing colleges often rely on radio transmissions and newspapers to announce selection. Newspaper distribution in rural areas is often compromised and media penetration is limited (Booth et al 2006). Rural areas also encounter problems with electricity. Whilst a third of urban households have electricity only two percent of households in rural areas do (NSO 2005), restricting radio and television use. This also restricts mobile phone use, as does the poor cellular network. Together these can hinder people's chances of knowing about study opportunities and whether they are successful if they do apply.

5.2.2 Barrier implications

On the basis of these barriers, we could assume that the typical nurse would have parents or guardians with sufficient resources to pay for an adequately resourced school and good communications access. However, in practice, many key informants, including senior KCN staff, described the backgrounds of students both at KCN and other nursing colleges as mixed: from poor, rural to wealthier, urban backgrounds.

They contended that many students from poorer backgrounds had been able to overcome the hurdles presented above. As 82 percent of the population are rural (WHO 2009a), if opportunities and the desire to be a nurse were similar we would expect to see a similar proportion in nursing college, but we do not. Although it is claimed that nurses' backgrounds are mixed, in reality rural students are underrepresented.

To get their children into college many parents from poorer backgrounds struggle: "if you were poor you would sell your only goat to pay for your child's education". A senior faculty member recalled the story of a boy who was able to enter KCN despite being orphaned. He funded his education by doing piecemeal work in his neighbour's fields, although he still faced financial challenges: "he can't afford a tablet of soap and can't afford transport to go home". Chimwala came from a poor background and struggled to pay for her education, relying on donations from civil groups. Although she was able to gain a place at KCN, she continued to face difficulties in paying for her upkeep:

During holidays I would do piece work, but the money would not last a whole term. Instead of toothpaste I would use soap, it's a terrible taste, that's how bad it was.

Chimwala and others from poorer, rural backgrounds were able to pursue nursing in part because of government initiatives to support tuition fees. Previously, students were required to pay a compulsory contribution and if they could not pay (or find sponsorship) they would not go to university. However, as part of the EHRP, both EN and RN training fees (a 25,000 MK contribution) were covered by the government, in the form of a loan which would be paid back by the nurse when they graduated. In reality, according to senior KCN staff, nurses have not been pressured to repay these loans because of inadequacies in the system. Financial support does not extend to living expenses and, as shown by the example of Chimwala, students from poorer backgrounds can find it challenging to get by. Unfortunately, there are no data to show whether these challenges forced students to drop out. In the case of the nurses I interviewed, the three from poorer backgrounds made it through college by working in the holidays and evenings (for example selling items in the market).

Another significant obstacle students may face is language. Most of the nursing programme is conducted in English. Despite it being taught in primary and secondary schools, English is often not spoken at home (especially in rural areas), as Eleanor explained: "on the wards, with friends, family you talk Chichewa so you wouldn't be as strong in English". Nurses reported that there was little support for those who struggled

with English, meaning that those with less fluency would experience difficulties with the course. One nursing tutor said that some students struggled to understand English but rarely admitted it. She added that when you looked at their exam scripts you could see that they really didn't understand at all. This not only has implications for whether the student may pass, but may also affect their motivation to continue with nursing.

Whilst students may face barriers to entering the profession because of their background, other factors, such as culture, family and historical events may have an equally important role in determining who goes on to be a nurse in Malawi. In particular, they influence the decisions made by individuals regarding which career to pursue. In Box 5.1 I briefly discuss the two main nursing cadres, as differences between them have implications for why nurses enter the profession. In the next section, I go on to explore the decision to choose nursing.

Box 5.1 Comparisons between registered and enrolled nurses

The two main nursing cadres are primarily distinguished by qualification. ENs make up the majority of nurses in Malawi and are expected to deliver bedside care¹⁶. They will not generally be promoted to high managerial levels, which are typically reserved for RNs. In much of the literature, 'Malawian nurses' are treated as a single group. This is inappropriate because of inherent differences in their career trajectories and experiences. The main differences between RNs and ENs are:

- **Type of training:** According to key informants there is a significant difference between the training of the cadres, in that ENs are trained to refer to RNs.
- **Visibility:** ENs have a much higher visibility because they are in the majority and because of the bedside nature of their work (as opposed to the RN's management work, which commonly takes them away from clinical tasks).
- **Salaries:** The EN's starting salary is approximately 14,000 MK a month, raised to 20,000 if they have a diploma. For RNs it is 27,000 to 30,000 MK a month (NMC personal communication 2008). This can have a significant effect on the respective lifestyles and buying power of the cadres.
- **Status:** Because of the nature of the RN qualification and the roles they typically assume, the status of RNs is higher than that of ENs.
- **Migration opportunities:** As the EN qualification is not marketable overseas, only RNs are usually able to migrate as nurses.
- **Job opportunities:** ENs typically have fewer promotion opportunities. Training opportunities may also be limited as many are posted in rural areas.

A number of nurses spoke about the implications of differences in status between the cadres for marriage. Marriage is still considered an important stage of life in Malawi, and society expects that people will marry and have children (Davison 1993).

Respondents believe that RNs usually attract wealthier, well positioned spouses, giving them a better quality of life from a financial point of view, as Victoria (1970s, RN retired) explained:

Marriage is still a value. So a lot of them [nurses] have got married. RNs get married to very educated husbands as well. So the husbands have a good house, and they live with them.

¹⁶ Bedside nursing refers to providing direct care to the patient whether clinically (for example administering drugs) or non-clinically (for example feeding).

Nurses attributed this not only to the status of degree level nurses but also to the greater opportunities RNs have to meet 'higher calibre' spouses. These opportunities refer both to other degree students they may come into contact with and to increased opportunities to meet people with good jobs because they train in cities as opposed to in rural areas where most EN training colleges are.

5.3 Why become a nurse?

It is nearing the end of your secondary school studies and you have to decide what you will do when you leave. If your grades are good your teacher will have given you an application form which gives you three choices of courses offered at the five colleges of the University of Malawi (UNIMA)¹⁷. If your grades have not been good, you may choose to apply privately to other colleges including CHAM nursing colleges. Representatives from KCN may have come to the school to talk about the nursing degree programme and you may have spoken with a careers advisor (although you have probably not). Maybe you know already which career you would like to take up, or maybe your choice is motivated by factors other than desire to enter a specific career.

This is a typical scenario described by the respondents. Most had little information to help them select a course for further study. Several factors influenced their decisions, including their families, friends and current environment. Interview findings revealed that, of all these factors, the current environment or historical context had the greatest impact on career choices. Although I have organised the findings by historical (presidential) era, this arrangement does not assume that there is no overlap in people's motivations between periods. The reasons common to all three time periods were wanting to do good, helping the country and wanting to work with people. For five of the nurses, past experiences of seeing nurses at a hospital, whether as a patient or visiting a friend or relative, motivated them to enter the profession. Rose (1984 EN GN) said, "I was thinking if these nurses hadn't helped me I would have died." A minority also felt motivated to enter the profession because they admired family and friends who were nurses. These responses are consistent with the findings of previous studies, including Larsen et al (2003), who found that the career decisions of 495 American

¹⁷ The five constituent colleges of Malawi are: Bunda College (agriculture), Polytechnic (engineering and applied sciences), College of Medicine, Kamuzu College of Nursing and Chancellor College (law, humanities, social science and education) (UNIMA 2010).

nursing students were often based on past experience of being ill or having a family member or friend who was a nurse. Other studies have shown that the desire to help others and serve society is a common motivator for nurse aspirants (Barriball and While 1996; Boughn and Lentini 1999 cited in Buerhaus et al 2005). A small study on the retention of nurses in one Malawian district conducted by Mtengezo (2008) found that the main reasons people chose nursing were to help the sick, job availability and the white uniform. The attraction to nursing because of the white uniform also featured repeatedly in my research and across the generations. Many spoke of how smart and well-presented nurses looked:

Even the President of Malawi, he said that 'nurses when you are dressed you look like angels...'

KCN female student, focus group 2009

5.4 Choosing nursing in the time of Banda: 1964-1994

The reason that the nursing uniform had so much appeal for potential aspirants may relate to what it represented, especially during the early Banda years when nurses were well respected in society. Grace and Alinafe, who both graduated in 1977, recall being called "Doctorlala (Miss Doctor)". They added, "they respected us. They thought that we know more. It was a noble job." Many interviews were dotted with references to the high respect accorded to nurses at this time:

In the past, the community used to respect nurses. At the T junction, if a nurse was dropped there [by a minibus] and they start walking, people with cars would easily pick up the nurse and drop them off at the hospital, because people had that respect.

Sarah, 1992 RN GN

Nurses already form part of the small and exclusive group of people who have gone onto tertiary education. This exclusivity, as well as the status accorded to education (see Box 5.2), meant that they had high standing in society. This was especially true in the early Banda years when opportunities to pursue education were limited for females as school places were often allocated preferentially to boys (Mkamanga 2000)¹⁸. Opportunities to study abroad were limited, and overseas travel was far beyond the

¹⁸ Recent statistics show that this is no longer the case, literacy rates for females and males are now similar (NSO 2005).

means of most Malawians, and those who were able to go abroad were well respected. Previously, RNs were trained abroad in the UK and South Africa. Even when the first RN training college (National School of Nursing) was founded in 1965, there were still numerous overseas study scholarships available. It was not uncommon for RNs to go abroad for further study. In the 1970s, Julia (1972, RN retired) was able to complete her degree and Masters in the UK. The fact that there were fewer RNs at this time made such opportunities more feasible. There is a possibility that they may have incentivised nurses to join the profession, although none of the interviewees spoke about the opportunities in this way.

The exclusivity of the nursing profession also meant that families were proud to have a child who was a nurse:

In those days, getting a chance, being trained as a nurse, you would call yourself a lucky one. It was very important, and many parents in the villages would say I want my child to become a doctor, I want my child to become a nurse.

Anna, 2002 RN UK

This finding is supported by a 1992 study of 80 Malawian primary school students which found that the majority of parents wanted their daughters to become nurses (Davison and Kanyuka 1992). The authors explained that during this period the attitude of parents and the broader community was that females should pursue careers associated with nurture and domesticity. Pride in having one's child become a nurse was often linked with how they behaved. During this time, nursing was synonymous with the qualities of kindness and empathy, as Anna explained: "when people saw the nurse they had the hope they would at least feel that they would get something from her, they were not associated with anything that was bad, maybe we should say she was like a lamp that would shine". Anna's words appear to echo the image of Florence Nightingale (the Lady with the Lamp), who made nursing a respectable profession for women and set an example of how nurses should act: with compassion and dedication (Florence Nightingale Museum 2010). The qualities portrayed by Malawian nurses also fitted neatly with Banda's four cornerstones (obedience, discipline, loyalty, and unity). It was discipline, instilled in nurses by society and through their training, that many believed made the profession meaningful and respected. This image of nurses is consistent throughout the interviews, and many looked upon this generation of nurses with admiration.

Because I remember when I was doing my training (1992) we had nurses, when they go to work they were so serious about their work and they just had that passion to do that work. There were some lovely nurses who would just want you to be a good nurse, so they just teach you, help you, and support you in every area. They were lovely...

Florence, 1996 RN UK

The image of well-mannered nurses is consistent with reports that working conditions at the time were acceptable and the nurse to patient ratio manageable. This finding is supported by the HSC study (2004), which found that 81 percent of nurses thought that health service work was better during the Banda years than in 2003. The reasons cited included the fact that there was no HIV/AIDS, greater promotion opportunities and a greater regard for work ethics. Reports claim that under Banda the entire civil service, including nursing, was well run, with staff being professional and motivated (Booth et al 2006). In combination, these issues would have made the working environment for nurses more attractive to potential aspirants.

Despite the favourable conditions, observers argued that there were still not many nursing aspirants. Some key informants and nurses believed that this was because nursing had always been seen as a dirty job, mainly because it entailed activities such as wound dressing. They disputed the image of nursing as respected, and claimed that because nursing was exclusively female, the profession would never have warranted great respect, the status of women being traditionally lower than that of men in Malawi. Low remuneration also diminished the value of the profession. Nursing salaries have never been high, leading people to assume that nurses were 'poor people'. According to respondents, you could redeem yourself by marrying a rich husband who would be able to support you, as Eleanor explained: "it is fine to work as a nurse if you have a rich husband but otherwise it is difficult to survive". Nevertheless, women who wanted to be autonomous and pursue a career would have had few options other than nursing, teaching or secretarial work. According to respondents, nursing was often the most appealing, in part because of the white uniform. Secretarial work was often deemed the least appealing. Grace (1977, EN NGO) said, "if you became a secretary, people thought you were loose". Grace had wanted to be an air hostess, but because there was no viable career path she opted for nursing because college places were available. However, as the country shifted to democracy, opportunities for women expanded.

5.5 Muluzi and the shift in nursing motivations: 1994 -2004

The Muluzi years were characterised by expanding freedoms and opportunities, but also by the deterioration of working conditions and salaries. De-prioritisation of healthcare services, rising population levels and growing HIV/AIDS prevalence all contributed to the decline. Accompanying these changes was a palpable shift in the motivations of nurse aspirants. According to my findings, nurses were no longer drawn into the profession because of its status or by the drive to emulate the manner of nurses. Poor working conditions acted as a disincentive to aspirants and, with a declining economy, students' career strategies changed. Students became more focused on the potential benefits of a nursing qualification.

5.5.1 The declining interest in nursing...

No, in Malawi, if you are not into it, I don't think that there would be anything that would attract you [to nursing]... also when you first qualify if you are not married they will send you to Chitipa [most northern town in Malawi]... people will be like 'if I train they will send me to villages where there is no bus, no telephone' things like that.

Martha, 1993 RN UK

The increasing freedoms in society emerged against a global backdrop of shifting career options for women (Buerhaus et al 2005, Magnussen 1998 and Staiger et al 2000 cited in While and Blackman 1998). In Malawi, schoolgirls increasingly began to opt for careers they had previously been discouraged from, including the traditionally male fields of accountancy and law (Mkamanga 2000, Mtengezo 2000). According to respondents, there was also a decline in respect for the profession. Sarah claimed that people no longer stopped to offer a lift to a nurse as they once did. This finding is consistent with the 2004 HSC study which found that health workers felt unappreciated by society and by their families as they were not able to support them adequately. Poor remuneration became an issue for RNs. Alfred (2002, RN UK) explained that nurses found it troubling to leave university after completing as many years of education as those in other professions (such as accountancy), but ended up on far lower salaries and with much less respect:

The government, they don't respect the nurses or they don't support them... even when both of you are working in the same government, you feel that the other one gets more salary or more status.

This common perception, in addition to increasing options for women, led to a rise in interest in other careers. Nursing applicant numbers remained low.

5.5.2 ... a rising interest in other careers

KCN became an unpopular choice amongst students. According to Emmanuel (2005, RN), people became increasingly focused on institutions such as Chancellor College, which offered the most popular courses of business administration, social sciences and accountancy. Accountancy is still considered to be the most popular course in Malawi, as accountants are well paid, respected, and office-based.

Chisomo's (1994, RN GN) first choice on her university application form was accountancy. She explained that, "when you are an accountant you receive a lot of money, I am coming from a poor family so I wanted to make some money to take care of my relatives". However, her MSCE points were too low to be awarded a place on the accountancy course. Eventually she accepted a place on the nursing course, her third choice, with the intention of changing to another degree in her first year. The high grade requirements for accountancy meant that many, like Chisomo, were unable to make it onto the course. During the Muluzi years, high grade requirements were introduced in response to applicant numbers exceeding the number of places available. However, not all courses had high applicant numbers, and some were left with places unfilled after the yearly round of selections. One such course was nursing at KCN. This is how Chisomo ended up in nursing: by default.

5.5.3 The default choice

While most enrolled nurses entered the profession because they chose to study nursing, the majority of RNs fell into it because they were offered a place in nursing and not on any other course. Like Chisomo, Monica (2001, RN NGO) had chosen accountancy initially. Emmanuel had wanted to be an engineer, as had Alfred. Lindiwe and Emma - RNs in the UK - had both wanted to study social sciences. Most had not even put nursing on their university application form, but all of them ended up at KCN. This was made possible by the UNIMA application procedure. University officials allocated courses to students on the basis of their university entrance exam results (UEE), MCSE grades, choices and how they performed at interview. As nursing did not get enough first choice applicants they often filled the places with students who had not

been accepted on other courses but had passed the UEE adequately, even if they had not put nursing on their form¹⁹. Findings from a study by Mtengezo of first year degree students at KCN in 2000 mirror those of this study, suggesting that entering nursing by default was a common occurrence. However, they were not obliged to take up their place, so what made them accept? Emma (1993, RN UK) recalled:

My first choice was social sciences but I didn't get the choice and my third choice was nursing. I told my mum I wasn't going to go, I said I couldn't bear the blood and I didn't want it. And then my mum said 'if you don't go, what are you going to do?' She said she couldn't afford to pay for private university so I had to go to my third choice. I tried to transfer but it was a long process and very difficult. In the end I gave up and I thought ok, I will just do nursing and finish.

Alfred (2002, RN) did not even put nursing on his university application form but was nonetheless offered a place:

My first choice was engineering, my second one was environmental sciences and then pure sciences. But I had a weakness: my maths grade was not good... I think it made me fare badly during the competition because I think that the entrance exams is taken by over 20,000 people but they only take about a 1000, so the competition is very stiff...I discovered that I had been offered a place at KCN. So, I had two options, either to reject that offer or re-sit the mathematics so I can make up the grades. I wanted to re-sit but my parents said 'well just go and do it for the first year, and find out how it is going, and after that that is when you may decide what to do'...So that was the plan.

For Emma and Alfred the risk of declining their place at KCN and then not being accepted elsewhere was too great, especially as university places in Malawi were limited, so they decided (with a push from their parents) to accept their places. Like Emma and Alfred, most nurses accepted their place and stayed on the course to gain a degree because of its high value (see Box 5.2). For the other nurses it was common to accept a place with the intention of trying to transfer to another course, on the assumption that it was easier once you were in the university system. Chisomo wanted to change to her preferred degree, accounting, after completing a year at KCN, partly because she found her first year as a nurse hell. She explained, "in those days there was a lot of congestion and lot of people dying, after seeing all the dead people I said no I want to leave the profession, I didn't like it". However, she was not able to change, and as she had few other options she decided to stay. Other students also struggled to adapt to the course. Data from Simukonda and Rappsilber (1989) suggest that despite the perception of nursing at KCN being the 'easy course' to get onto, the curriculum

¹⁹ In recent years, KCN has been aware of the shortfall in the process and as the number of applicants has risen they have been able to set the policy of selecting students only if they have chosen nursing as their first option. However, many years of students came through the system before this was in place.

was difficult and required more hours of study and clinical practice than other university programmes. Despite their mixed feelings, many respondents ended up enjoying the course and subsequently felt enthusiastic about pursuing a career in nursing.

Box 5.2 Education: the way out of poverty

I think in Malawi education is just a gateway from poverty. So you are trying to work hard, in order to go to school, work hard to finish so you can go to university, because you know at the end of the day you are going to get a good job, and at least there won't be any poverty.

Lindiwe, 2002, RN UK

Nurses referred to the strong culture of education in Malawi and the gateway out of poverty it provides, as illustrated in Lindiwe's quote above. Having an education in Malawi opens up doors in terms of employment and higher wages, and the more you are educated, the more doors open up. Education also translates into respect. For women, the respect gained through education is especially important. Victoria said, "in a country where it is hard for women, if you have a degree you get respect." This respect and better opportunities for employment may explain why students are determined to pursue degree level nursing despite never wanting to be nurses.

Students increasingly became aware that it was easier to gain a place at UNIMA if they put nursing as one of their choices. Lindiwe and Monica, for example, put nursing on their application forms, even though they did not want to pursue it, so that if they were not accepted for their desired courses at least they would have a chance for a degree. Monica explained:

Initially I wanted to be an accountant. I changed because of my grades. If I clung to those very good courses [accountancy] I wouldn't have a chance to go to college. So I thought I could put a weaker course that I would like... nursing was my third choice, but I put it deliberately if those first choices could not work.

5.5.4 It's a definite job

Respondents may have accepted their places to obtain a degree, but a nursing degree had a number of additional incentives, the main one being almost guaranteed employment. According to key informants, the well-organised nature of nursing means that it is easy for nursing graduates to gain employment upon graduation. This was and still is especially true because of the high demand for nurses. However, the incentive of guaranteed employment is not new or unique to Malawi. Kersten et al (1991 cited in

Tomey et al 1996) suggest that employment opportunities and financial benefits were often key reasons for choosing nursing in Western populations. Most respondents only discovered these employment opportunities after they entered the course, as Alfred explained:

So I went there and after the first year I found that it was very interesting and very exciting but after making a survey to say that you can graduate with a degree in chemistry, physics, engineering, but there aren't many jobs in Malawi that would employ you in these sectors. You can be employed by government and stay in one place for ages. And I came to understand that with nursing you just go straight into join the private sector or government, or CHAM or whatever you want to do. So I thought probably I would have more chances if I stay in the healthcare service.

Although many believed that courses such as accounting and engineering led to greater success, they also found that nursing brought guaranteed employment. A nursing degree's marketability extended beyond government to other employment destinations. With Banda's departure, international agencies and NGOs streamed into Malawi. Muluzi also removed the bonds imposed by Banda which forced nurses to work in government service for a period. This meant that they were free to work where they wished as long as they paid their own fees. Nursing, especially at RN level, became a gateway to well-paying NGOs and jobs overseas, as examined in Box 5.3.

Box 5.3 Choosing nursing because of migration opportunities

The course will provide you with skills to provide nursing and midwifery care in Malawi and beyond.

Course description from Mzuzu University 2009

Nursing was traditionally seen as a good way out of the country because of the portable nature of the qualification. In the Banda years, whilst opportunities to migrate were scarce for the wider population, nurses were actively sent overseas to study and it was reported that a small proportion never returned. However, respondents said that most returned because of loyalty to the government which had supported their training. This is consistent with Fadayomi's belief (1996 cited in Oderth 2002) that African graduates whose studies are sponsored by their government are more likely to return because of a strong sense of duty. Whilst none of the respondents working in the Banda years were drawn to nursing because of migration possibilities, by 1994 Emma reported that most of her fellow students were doing nursing because they wanted to leave the country. Martha added that it became a culture of 'doing your training, and then getting out'. In 2000, the first nurses graduated from KCN with degrees, making them more marketable and attractive to overseas employers. The increased marketability of nursing changed many parents' perceptions of the profession from 'a traditional career for women' to one which could enable their children to work overseas. This appealing aspect of nursing led many to push their children into the profession, as one female student at KCN described:

My parents were like you have to join nursing, you won't find difficulties to find a job, you can even go outside to the UK and make a lot of money. I never wanted to do nursing; I wanted to do something like law or business administration. If I joined nursing I would be dressing wounds, seeing dead people, I hated that... I just wrote nursing for the sake of my parents.

5.6 Choosing nursing in the Bingu era: the current generation, 2004 - present

When I see new students coming in and joining nursing, they haven't joined nursing because of an interest, but because they are lacking in jobs. Some people, they just join nursing because they have nowhere to go.

Mrs Lunda, 1970s EN GN

The arrival of Bingu wa Mutharika's presidency signalled greater stability, but also greater competition for education and employment because of population increases. According to respondents, although there were still many who chose to enter the profession because they were committed to caring, choosing nursing at KCN as a means to gain a degree became a common strategy after 2004. Many nurses from Emmanuel's 2005 graduation class did not go to work in hospitals, suggesting that it was not their intention to work as nurses when they pursued the degree course. At EN level, the 'guaranteed job' aspect of nursing drew greater numbers of students to the profession. As competition for jobs increased, having guaranteed employment upon graduation became an increasingly important motivator for students. This may have reflected broader trends globally: a study by Buerhaus et al (2005) suggested that younger students saw nursing as a professional career with improved opportunities for continuing education and employment. Similarly, Leon and Kolstad (2010) found in their questionnaire study of 130 fifth-year medical students from three universities in Tanzania that many students were joining the profession without a primary interest in medicine, but rather because of its guaranteed employment.

Observers report that there are now more students applying for nursing than previously, even though, as the first year KCN students remarked, they are aware of the poor working conditions and salaries. The nurses interviewed in a study by Buerhaus et al (2005) believed that although nursing shortages increased stress, they would also lead to higher pay and greater job choices. In Malawi, nursing shortages led to government initiatives to support study fees. This financial support may have increased student numbers, as a senior member of CHAM explained:

The public sees it [nursing] as free. This has contributed to people scrambling to enter into that profession because they will contribute nothing, they will just learn and then finish. So that removes the aspect of whether people are really willing or it's their internal desire to become nurses.

Although this financial support was accompanied by a bond to work for CHAM or government for two years, many believe that this has not been a disincentive for potential nurses, partly because of poor enforcement: “the bond is not restrictive, it’s so loose” (CHAM key informant). With the continued expansion of NGOs and international agencies, employment opportunities increased, which incentivised more students to join the profession. As opportunities expanded so did nurses’ ambitions. According to a senior KCN faculty member, degree-level nursing students have many opportunities to study abroad. “If the students read that they will go to South Africa²⁰ for Masters and PhD level and now we are giving them bachelor degrees, the world is open to them.” She believed that most KCN students now want do a PhD and are attracted to nursing because they get to go abroad.

The years of Bingwa Mutharika have also been characterised by a rise in males joining the nursing profession. As ‘traditional male’ courses (such as accounting) open up to females and become more competitive, it is thought that male students, with their high grades in sciences and mathematics, are beginning to explore alternative, less competitive options such as nursing.

5.7 The male equation

In Malawi especially for males... when you say I am a nurse people laugh: ‘what a man a nurse, what is wrong with you?’

James, 2002 RN UK

Men have not always been part of the nursing profession in Malawi, and they have faced many challenges in finding their place in a traditionally female role (Simukonda and Rappsilber 1989). Before males were accepted into KCN in 1985, nursing was exclusively female, and women continue to outnumber men in the profession. This is especially true at EN level, although males are increasingly occupying RN degree level training places²¹. The wording ‘occupy training places’ is intentional, as evidence suggests that attendance at nursing school does not necessarily equate with working as a nurse. A widely held belief is that male nurses take the opportunity to study at KCN, but then do not stay in the profession. Nurse leaders claim that male nurses

²⁰ She is referring to the 2009 memorandum of agreement which facilitates study exchanges between Malawi and South Africa.

²¹ In 2004, 16 out of the 19 students at KCN were male (the reason given for the high male intake was because very few students that year had adequate grades).

commonly forgo bedside nursing to go into managerial positions or NGO employment soon after graduation. A senior matron said:

... that's where you find a lot of male nurses, they just want a loophole to get jobs in the NGOs. It's easy to find a job.

Members of KCN have evidence to back these claims. They traced a number of men who passed through the nursing programme to administrative positions in NGOs and managerial positions. They blamed the university admissions system, as in the past males were redirected (not through choice) into nursing because they tended to have higher marks in mathematics and sciences. Increasingly nurse leaders, including senior matrons, tutors and senior MoH officials have tried to discourage men from entering the profession. KCN has also limited the number of males accepted onto its degree level course.

We don't have many male nurses, for an intake of 100 we only take 20 males. We don't want men because they don't stay at the bedside of the patient. Most of the boys who have qualified as nurses have gone into the projects they are not at the bedside.(KCN senior member).

Many male nurses felt that even if they were accepted by KCN they faced several challenges. These difficulties were the main topic emphatically discussed by first year KCN nursing students during our focus group discussion. In the 2009 class, 24 out of the 105 students were male. Already feeling vulnerable and 'stamped upon' because they were in the minority, many of the male students believed that they were discriminated against by a system that favoured women. Examples of such behaviour included scholarships being awarded to more females than to males, and men commonly being the last to be promoted in the clinical area. Male nurses also faced discrimination from patients, with some female patients refusing to be cared for by them. Men also felt that, because the profession had long been dominated by women, the matriarchy was intentionally...

...delaying the progression of men in this profession. In the college less men hold high positions, if there are scholarships they go to girls with the aim of promoting girl child education.

Fellow female students also commonly perceived male nurses as disinterested in bedside care. One male student rationalised this by explaining that it was precisely this kind of attitude from other nurses, in addition to the nursing environment, that made them not want to stay at the bedside:

You are working with five nurses and you are the only male you feel like you are isolated. Most men prefer to go outside and be with NGOs.

A senior matron believed that male nurses did not stay in clinical care because of the white uniforms (precisely the thing that attracted many nurses to the profession). She observed that males often wore a white coat over their normal clothes, as a clinician would do, because they did not like to wear the classic nursing uniform. This behaviour may be related to the fact that, for many years, the only role models for males working in health care were white coat wearing doctors and clinical officers (Simukonda and Rappsilber 1989). A senior manager at the Malawi NMC found this behaviour very frustrating, adding, “they are not proud to be nurses! They would rather be seen as clinicians”. Many believed that male nurses had wanted to become doctors and were bitter because they could not.

What about the men who actively chose to pursue nursing? Interview findings suggest that there is more to the career trajectories of male nurses than the pursuit of a degree and a managerial level job. Firstly, leaving the bedside to work with an NGO is not exclusively a male activity, as many female graduates also follow this route. Secondly, it is important to assess the extent to which patterns of employment choice are determined by how male nurses are treated by a society which has strict gender identities and where males do not take on such roles. As Silvia explained, “in Malawian culture the caring role is done by the woman, so it is hard to accept a man as the carer. Even if their wife is sick the husband will not care for the wife, he will get female friends and relatives to look after her.”

Interviews with five male nurses revealed that they often faced discrimination from their colleagues, managers and patients. The quote at the beginning of the section tells a common story of how male nurses are received by their colleagues. Another nurse recalled that fellow health professionals would often deliberately call him sister in an attempt to tease him. Alfred believed that many people still held negative attitudes about male nurses and thought that men should not be nurses because it is a female profession. His understanding was that people thought that he was stupid and chose nursing because he could not do anything else. These findings are consistent with those of Simukonda and Rappsilber (1989), who found that male nurses at KCN experienced high levels of anxiety, particularly in relation to the role differences between nurses and other male health workers.

Aubrey felt that it was often the older generation of nurses who behaved inappropriately, whereas patients were far more accepting. He described an informal

study in which women in Malawi were found to prefer a male midwife as they were not under as much pressure to show that they were strong and not in pain. Alfred rationalised the negative behaviour of nurses as intrinsic to Malawian culture, in which females are used to being more submissive (for example following orders without making decisions), and this has grown to become a part of the nursing profession. Now that men were coming into the profession, people perceived their unwillingness to be submissive as rudeness. One male nurse who qualified in 2004 believed that male nurses had done little to elicit this type of treatment, and that it was a general movement of nurse leaders wanting to protect their positions from male nurses with degrees. It is unclear to what extent the discrimination that male nurses feel put them off from pursuing a career in clinical nursing and pushed them into NGOs. My findings suggest that there may be additional factors that both male and female nursing aspirants consider in their employment choices and in their career decisions. These factors are explored in the next section.

5.8 Factors influencing career choices

5.8.1 School environment

The academic environment, and teachers in particular, can play a pivotal role in influencing the motivation and career choices of pupils through guidance and support (Davison and Kanyuka 1992). Formal career guidance can also support students' career decisions, but the few nurses who had received such guidance found it unhelpful. This is consistent with Mtengezo's study (2000), which found that only a minority of first year KCN students accessed information from career guidance counsellors. The practice of UNIMA lecturers visiting schools to talk about their courses has increased in recent years, but the continued lack of careers advice has meant that nurses often felt unprepared for the nursing course. Because of the low visibility of RNs, especially at clinical level, people's perceptions of nursing were often based solely on seeing the work of ENs.

Peers and family appeared to have the biggest influence on career decisions. However, in most cases peers were not supportive of nursing. One KCN student's friends said that she would have to work at night looking after wounds and seeing dead bodies. They also told her she would die poor and unmarried. Chimwala's village community and school friends tried to discourage her from applying, telling her that

nursing was a low status career, dirty, with a miserable salary, and that she would find it difficult to get a rich husband. This is consistent with the decline in respect for nursing, and many believed that the 'dirty' element of the role meant that nurses were also exposed to a number of health risks.

5.8.2 The role of HIV/AIDS in career choice

Pray for me, so that the killer disease must not be in me, I am HIV negative. Yes it's a worry because it's popular, many patients I handle I can take it in me.

Catherine, 1990 EN GN

The HIV/AIDS issue is giving a chill to most of the nurses working in the hospital. They feel they will get it by working with the patients.

Key informant, KCN

The HIV/AIDS epidemic in Malawi has had a pervasive effect on nursing. Not only has it increased the workload burden, it has also made working conditions far riskier and potentially affected aspirants' career choices. Many people, nurses included, are hesitant to talk about HIV/AIDS because of the stigma associated with the topic, making it difficult to assess opinions. Those who did discuss it agreed that HIV/AIDS made people more hesitant to join the profession because of increased exposure risk. The 2004 HSC study also found that HIV/AIDS had led people to shun the profession. Aspirants were worried not only about exposure to HIV/AIDS, but also to other conditions associated with it, such as tuberculosis (TB). According to James:

There is too much exposure to TB in the hospital. Because especially when you are working in the medical ward, there are a lot of times you will see people that are coughing and you take the sputum and monitor them...

He added that because of low nursing salaries aspirants were concerned that they would not be able to afford good nutrition to keep healthy. It was TB exposure that caused Monica to decline a position on a medical ward upon graduation, saying that she preferred to work where there was no TB in the air.

The relationship between HIV/AIDS and family perceptions of the nursing career fell into two categories. Some respondents' family members were worried that nursing meant increased exposure, whereas other families were pleased to have a nurse in the family to help with their own health conditions (HIV/AIDS as well as other diseases). Anna's family fell into the former category and were keen to dissuade her from nursing.

Conversely, as HIV/AIDS levels peaked and the disease burden increased, families may have considered it even more useful to have a nurse in the family, which may have acted to push more individuals towards the profession. Chisomo explained that her parents “wanted me to be a nurse so I can be assisting them when they are sick”. When Mrs Nkosi became a nurse, her relatives began calling on her to help them when they were sick. In a country with such a high disease burden the value of having a nurse in the family cannot be underestimated.

5.8.3 The family

Anna wanted to become a nurse as she felt she needed to do something that would help others. She recalled that when she informed her parents they had said, “no, no, not nursing!” They were worried about the risk of her contracting HIV/AIDS, arguing, “there is HIV, and nurses they are the ones who are at high risk, they are looking after people with HIV/AIDS, and we don’t want you to get sick, we don’t want you to die, nursing is not a good profession.” She justified her choice by arguing that if everybody is sick and everybody is running away from it, who is going to help the sick? Despite their concerns, she applied for nursing at KCN but was not selected and took up teaching. When she was accepted at KCN on her second attempt, her mother and sisters congratulated her, but her father never said a word.

It was not uncommon for nurses to face resistance from their parents. James found that his parents saw no need to congratulate him when he was accepted at KCN, despite his strong desire to be a nurse. Research has shown that, in Western settings, fathers are usually less likely than mothers to support nursing as a career for their children, especially for their teenage sons (Buerhaus et al 2005:81). In Magnussen’s 1998 study, one nursing aspirant faced resistance from her father who perceived that the career was too vocational for a middle-class child. Family opposition makes pursuing nursing difficult and may serve to de-motivate the aspiring nurse or put them off applying completely. Respondents found it particularly challenging when there was an expectation in the family that they would follow a specific vocational route. Abigail’s family were all lawyers, and were surprised and upset when she announced that she wanted to be a nurse. She persisted despite their hesitations. In Anna’s case, the resistance from her parents, especially her father, was grounded in legitimate concerns for her health; as we saw in Chapter Two, occupational transmission is a reality in Malawi. However, the HIV/AIDS epidemic was precisely what was pulling her into

nursing as she felt that she could help those in need. Her story had a happy ending as soon after graduation she migrated to the UK and this made her family immensely proud and pleased, especially as she was able to send money home. According to Anna, her father “was still not really satisfied until when I said I am going to the UK.”

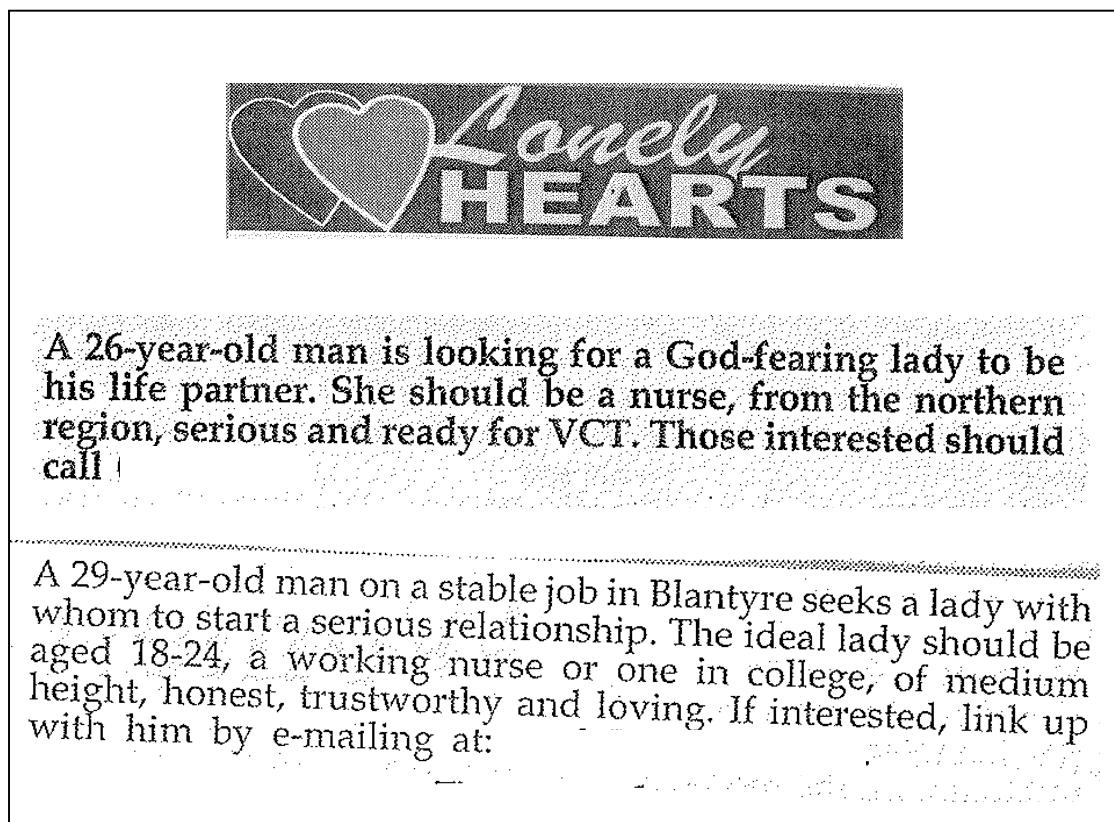
Some families were supportive and even encouraged their children to become nurses to benefit from healthcare assistance. When she announced that she was going into nursing, Florence’s parents were excited to have a nurse in the house, as was Lindiwe’s (2002, RN) father:

It was actually my dad, who said you know you can do nursing, nursing is very good, and I remember my granddad before he died... I used to take care of him and he liked me, he said you treat me like you are a nurse, so I want you to become a nurse. So when he died I was like I think I am really going to do nursing.

Encouragement was sometimes a little too strong. Although none of the nurses in the sample spoke of this, key informants suggested that it was not uncommon for parents to push their children, sometimes forcefully, into nursing. According to a senior member of the NMC Malawi, family pressure was a key reason for students to enter nursing. One senior CHAM member reported that “[EN level] students would actually tell you that they didn’t come because they wanted to, but their parents forced them to do so. They say: I couldn’t go to the university, it was probably expensive and we couldn’t afford it, but then this was the only option, I couldn’t stay at home.” Some parents may see it as an attractive (and affordable) pathway to guaranteed employment. A key informant described how he had encouraged his daughter to accept her place to study nursing, even though she did not want to become a nurse because of the guaranteed job and wage. The guaranteed wage seemed to be especially important for parents and he claimed that it was a tradition for a graduate’s first salary to go to them.

Parental encouragement may also link with the enduring belief in Malawi that girls in particular should enter nursing. Kamwendo (2010) showed that, even in 2010, the expectation persists that girls should choose career paths such as nursing and teaching that are ‘appropriate’ and associated with the feminine attribute of caring. Many still associate nursing with the traditional attributes of caring and professionalism, attributes which are particularly attractive to potential spouses. In 2009, whilst looking through the Malawian national newspaper’s lonely hearts columns, men were regularly seeking nurses as partners, as the two cut-outs from the newspaper demonstrate (Figure 5.1). The fact that the advertisements were placed by younger men suggests that nurses still hold a certain level of status and respect.

Figure 5.1 Newspaper clippings from the Nation, 2009



Despite the positive attributes of nursing, I found that nurses often did not want their own children to join the profession. None of the respondents (in the UK and Malawi) wanted their children to be nurses. Beatrice told her daughter, an aspiring nurse, to look for another career: "I have told my daughter she will die poor... we don't have money in our accounts to pay the school fees for my daughter, it's difficult." In many cases, their children saw how hard they worked and had already made their own decision to stay away from nursing. Rose (1984 EN, GN) explained, "they see me working 30-50 hours, they think I can't be a nurse, work for long hours, and work for three-four days in a row. No." These findings are not consistent with those of Mtengezo (2008). In her sample of Malawian nurses, 72 percent said that they would recommend nursing to a relative or friend, mainly because of the job security linked to guaranteed employment.

5.9 Chapter conclusion

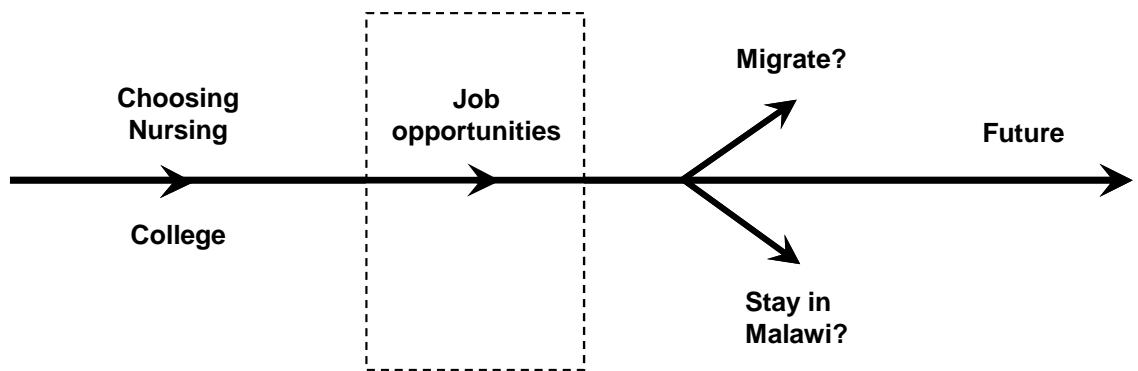
A significant proportion of the population is excluded from entering nursing because of educational barriers. Even if students are able to overcome these, factors such as family resistance and working conditions influence career choices. The main factors attracting nurses to the profession have shifted in response to political changes. The Banda generation of nurses joined with the hope of respectability and decent working conditions, and also because there were few other career options available to them. Nurses are still respected but many believe respect has declined. Students from the Muluzi generation began to see nursing at RN level as a way to gain a degree and have greater employment opportunities in light of population increases. The motivations of ENs are different because of the nature of their qualification, but the pattern is consistent with RNs in that students are increasingly attracted to the profession because of a guaranteed job and wage, a valuable asset in a country where only a minority are in formal employment.

Poor working conditions during the Muluzi years gave nurses less incentive to stay in the profession and many were attracted to employment overseas. Although migration opportunities contributed to nurses joining the profession after 1994, if migration is a key driving force behind career choice, we may see a decline in applicants because of declining opportunities to migrate. However, recent KCN and CHAM enrolment figures show a rise in applicant numbers, which suggests that it is not migration but degree and employment opportunities that have become the main driver. Selecting nursing without a desire to become a nurse has become an active strategy in response to greater competition for higher education and is aided by fee support from the government. The sustainability of this strategy is questionable, however, because of the reintroduction of a quota system for university and secondary school education in 2010. Under this system, institutions have to admit a set number of students based on district and regional quotas, changing the rules of university application in favour of less education-orientated districts (Nyasa Times 2010a).

Nurses make decisions about career choices based on a number of factors. Some of these may also influence the next decision they make about their lives: what to do and where to go upon graduation. I explore these decisions and career destinations in the next chapter.

Chapter 6

Decisions and destinations



6.1 Chapter overview

My second and third research questions examine the decisions made by nurses regarding their employment destinations. In this chapter I introduce the main employment options and assess the reasons behind each nurse's choice of workplace. As international migration has been a popular choice for nurses in the past, I dedicate the second half of this chapter to examining the patterns and causes of migration, focusing on what happened in the peak migration years of 2000 to 2005.

6.2 Post-graduation decisions

Each historical period has presented nurses with different employment options. As with career choices, decisions on which option to pursue were influenced by family circumstances, qualifications and available options. I begin this chapter by presenting the main employment options in the time of Banda, Muluzi and Bingu wa Mutharika.

Main options under Banda:

- Government service
- CHAM

Economic challenges and the ensuing structural adjustment programmes during the Banda years led to cuts in the civil service wage bill. This reduced the number of nurses the government could employ. As nurses trained by government were bonded to stay in the service upon graduation, few openings remained for CHAM graduates. Government employment was popular because of adequate working conditions and study opportunities, and many CHAM graduates like Alinafe (1979 RN NGO) ended up disappointed when they were not offered a position. Alinafe was left with few alternatives. There were few NGOs and only a handful of private practices, because of the bonding system for doctors. She eventually found a position with a private company. Alinafe reflected on the lack of choice in the Banda years, and maintained that career choices have improved dramatically under democracy, as now “everyone is free”.

Main options under Muluzi:

- Government service
- CHAM
- NGOs and international agencies
- Migration

‘Freedom’ characterised the Muluzi generation: graduates were free to take advantage of expanding career opportunities as they were no longer bonded to government. Whilst government vacancies shot up, aided by an increase in retirements and resignations in 1993 and 1996, (UNDP 2002), they no longer attracted graduates because of deteriorating salaries and working conditions. Chimwala recalled that

because of the high inflation rate her salary was devalued and without enough money to get through the month she began to go to work on an empty stomach. Like many nurses, she took on informal work and sewed things for friends in the evening. She recalled that “resting time wasn’t there, I was really tired...” She eventually left for an NGO. By association, CHAM also became less appealing, and neither government nor CHAM were able to compete with the high salaries of NGOs and private practices that had now arrived on the scene. Dinah (1993, RN UK) remembered most of her government colleagues looking for other careers. She also considered retraining as an accountant. Between 2000 and 2005, however, migration opportunities expanded and provided a way out for a considerable number of graduates and older nurses. This period became known as the ‘migration years’.

Main options under Bingu wa Mutharika:

- Government service
- CHAM
- NGOs

During the Bingu years (2004 to current), the story almost comes full circle: migration becomes less feasible, and the reintroduction of bonding means that graduates are ‘officially’ less flexible in their career choices. However, in reality, many continue to leave for NGOs as opportunities remain plentiful. According to James, NGOs are keen to attract KCN graduates because of their IT and community-based training. NGO positions, however, are not unlimited and RNs who are willing to accept lower salaries have been able to carve out desirable careers for themselves within government. Table 6.1 presents the main advantages and disadvantages of the employment options currently available. The table is based on the hierarchy presented in Chapter Two (Mackintosh 2003). I have excluded the category of ‘employment in other sectors’ as findings revealed that this option was not commonly chosen, although some nurses knew of colleagues who had left the profession because their husbands wanted them to change career.

It is challenging to assess how these options relate to where nurses are in practice, as there is no updated record of how many nurses are employed in each sector. My findings suggest that the current trend is for ENs to be in government and CHAM, and for RNs to be employed with NGOs, although to a lesser extent than previously. In 1994, the majority of Emma’s fellow KCN graduates went to work with NGOs.

However, by 2008, a senior KCN lecturer estimated that, of the 60 who graduated that year, only half went to NGOs and the rest went to government. She predicted that many of the current graduates would eventually navigate towards NGOs, especially as migration had become difficult. In the KCN focus group discussion, students admitted that whilst they wanted to spend some time doing bedside nursing, they eventually planned to work for NGOs. One student said, “there is much money there, I can enjoy my life.” Many still associate government employment with a hard life, especially after witnessing resource shortages in hospitals during their training. Also, after seeing their teachers no longer staying in government, one key informant (a Malawian doctor) believed that it was understandable for graduates to also want to work for NGOs:

I think for nurses at KCN that's a good thing, because that is what they are taught. Their teachers are doing surveys and research for NGOs...So why should they go and do nursing? Their teachers are not doing any nursing.

Table 6.1 Advantages and disadvantages of the main employment options

Sector	Advantages	Disadvantages
Leave Malawi		
International migration	<ul style="list-style-type: none"> • High salaries • Opportunities for further study • Better working conditions, better equipped hospitals • Nurse to patient ratio improved • Remittance opportunities • Exposure to new technology, experiences • Lower disease burden 	<ul style="list-style-type: none"> • High cost of living • Cultural differences, adaptation challenges • Long distance from family and community • Support system may not be in place • Pressure to achieve and support family • Potentially no security e.g. no unemployment benefits
Stay in Malawi		
Public health service		
Government facilities	<ul style="list-style-type: none"> • Workshop opportunities (for allowances and training) • Scholarships for further training and upgrading (e.g. from diploma to degree) • Practicing practical nursing care • Flexibility to attend funerals • Sick pay and job security • Locum payments • Government pension • Opportunities for career progression within MoH • In some cases: accommodation provided 	<ul style="list-style-type: none"> • Poor salaries • High workload • Shortage of resources • Allocation process (lack of choice) • Risk that you may be sent to rural areas • Night shifts • High nurse to patient ratios • Poor access to internet, computers and other technology • Occupational risk
CHAM institutions	<ul style="list-style-type: none"> • Higher starting salary than government • Provision of accommodation • Professional allowances 	<ul style="list-style-type: none"> • Often located in rural areas without electricity • Less opportunities for workshops • More rigid management structure (less autonomy)

Internal migration

NGO, research institution	<ul style="list-style-type: none">• High salaries• Transport provided• Medical schemes sometimes available• Exposure to international environment, with opportunities to travel• Typically office hours, no night duty• Work load burden may not be as physical• Access to internet, computers, and opportunities to improve IT skills	<ul style="list-style-type: none">• Potential for repetitive role• Pension schemes not always in place• Contract based, short-term nature of employment• Results and performance driven• Little support during sickness, attending funerals• If in low position e.g. research nurse drawing blood, salary may not be as high, experience gained may be limited• Little or no support for further education (e.g. Masters)• Job role may require IT ability
Private hospitals	<ul style="list-style-type: none">• High salaries• Good resource availability• Few staff shortages• Practicing practical nursing care	<ul style="list-style-type: none">• Potential for repetitive role• Limited opportunities for training and career progression

6.2.1 The government service

I love the idea of being a nurse and going back to government, but I'm too broke to go back.

Abigail, 1993 RN NGO

Whilst the trend for joining government has changed over the years, there are currently a number of advantages in being a government nurse. A main draw is the flexibility of service, particularly the ability to take days off for sickness or funeral attendance without facing repercussions. This is particularly important because of the country's disease burden (for example, prevalent malaria), which inevitably results in nurses requiring time off for sickness. Funerals are also unfortunately a common occurrence, partly because of the HIV/AIDS epidemic, and the expectation is that all community members will attend. Whilst conducting my research, respondents had to frequently rearrange interview times because they were attending funerals. Because many NGOs have a results-focused approach, there is less flexibility regarding non-attendance, and

nurses perceive that there is little tolerance for long absences. Stella and Alice (government ENs) told the story of one nurse who was fired by an NGO because of prolonged illness:

One time she was very sick resting in the ward and [the NGO] gave her the dismissal letter whilst she was in the bed: she was fired. After receiving the dismissal letter, she closed her eyes for good, she died. You wonder did she die because of the dismissal letter or just died. But if this nurse was working under the Ministry of Health, she wouldn't have faced that letter she would have been given sick leave.

The guarantee of a permanent job (even if you took time off) held a strong appeal for many nurses, especially because they would receive a small pension after 20 years of service. The idea that nurses are attracted to (and in part retained in) the government by job security and a retirement package is consistent with the work of Mackintosh (2003), who found that these along with training opportunities were the key factors that retained midwives. Another attractive feature of government employment was the autonomy given to nurses, especially RNs. Nurses recalled being able to progress professionally relatively quickly. Whilst the government service performed well in its pastoral care, it was overshadowed by NGOs in terms of salaries. The working conditions in hospitals, with their resource shortages and unsocial shifts, also went against the government service.

There are a variety of workplaces within the government health service, including health centres in rural areas, district hospitals (in medium sized towns) and tertiary hospitals in the cities. Each place has inherent advantages and disadvantages. For example, whilst in tertiary hospitals the workload is heavy (because they handle both serious referrals and local residents), respondents enjoyed working in such hospitals because they had 'interesting' cases and more physician support. However, because tertiary hospitals are in the centre of town, accommodation is limited and respondents often lived far away with high rent and transport costs. District hospitals were currently the most popular choice. Key informants revealed that this was because they offer the benefits of urban living, but because they are based in smaller towns accommodation and transport are cheaper. Mangham (2007) also detected a slight preference for district hospitals in her study of the employment choices of Malawian RNs. There was no disagreement that rural health centres were the least popular destination (see Box 6.1). These preferences have caused distortions in the distribution of staff. Chisomo said that even though she worked in a busy tertiary hospital ward, they only had five RNs compared to 15 in Mulanje District Hospital where patient numbers are lower. The numbers of nurses in health centres are even lower.

The government has attempted to address these distortions by sending graduates to where they are most needed via the bonding system. According to an MoH official, the ministry needed to disregard nurses' preferences because otherwise facilities would be unstaffed and would ultimately have to shut down. The official said that new graduates went to great lengths to avoid rural placements, often because they believed that they would not find anyone to marry there. Some would invent illnesses, arguing that such a placement was unfeasible because they needed to be close to a doctor. I recorded two cases of nurses going to the UK to avoid a rural placement. Emma was one of them. She believed that the government disproportionately sent northerners like her to rural northern areas, suggesting that the system was unfair and that the legacy of regional discrimination against northerners - prevalent under Banda - persisted.

Box 6.1 The rural option

This one was very rural, town life is better than this...They gave me a nice house, but the toilet was far away, I had to draw water from a bore hole, so that was a big difference in my quality of life. I had to go a long way to go to the market, there was no transport readily available, I had to walk...that was a very hard life for me, I was not happy.

Chimwala, 1991 RN NGO

Even though most of the population live in rural areas, rural health centres are notoriously difficult to staff. This is a global issue (WHO 2009b). Rural placements are unpopular with nurses (Lungu 2004) despite their advantages, including lower living expenses or even free housing. Their unpopularity relates mainly to the challenges described in Chapter Five, including poor electricity and transport. Most of the respondents felt that working in rural areas would compromise their lifestyle beyond the inconveniences of poor electricity and water access. The remoteness of rural areas often limited access to education for children and employment opportunities for spouses. When Dinah was sent to work in a rural area, her children and husband remained in their home town. Although the distance that separated them was not significant, poor transport meant that it took her nearly a day to reach them. She eventually left for the UK with her family, partly because of these barriers.

Working conditions are also a significant deterrent to employment in rural areas. Because of short-staffing, rural nurses often work longer, more undefined shifts than their counterparts in urban areas. Short-staffing also makes it difficult for nurses to take breaks, as Caroline explained: "patients do not understand that you need to have breakfast or take a shower, they ask why you cannot see them." Poor transport makes it difficult for nurses working alone to access timely support. Stella spoke of watching a patient die because an ambulance didn't get to her in time: "you see the woman dying, you are just looking at her, you don't have anything that you can do". The frustration nurses commonly felt was exacerbated by the perceived lack of compensation for their hardships. Health centre nurses complained that they received the same salaries as those working in district hospitals, even though they had better working conditions and opportunities to supplement their income.

6.2.2 CHAM

CHAM facilities are actually in very remote areas across the country....we are finding that now [CHAM graduates] are not willing to work with us, they would rather go to government.

Key informant CHAM, 2009

According to a CHAM official, the turnover of nurses had been high in recent years. She believed that this was partly because of the rural location of CHAM facilities, and partly because it could no longer compete with government packages as it lacked support from donors. In the past, CHAM offered higher salaries and was able to distinguish itself from government by better conditions and lower patient to nurse ratios because of user fees. However, since CHAM entered into a government agreement to provide free healthcare treatments under the Essential Health Package, patient numbers have increased. According to key informants, CHAM employees were not able to benefit from workshops as regularly as government staff. Workshops, which evolved as a measurable way to disperse donor funds, are popular amongst nurses for their generous per diem allowances. In some cases the allowances are so large that a four-day workshop might equal a clinical officer's monthly salary (King and King 2000). They are now a prominent feature in the nursing landscape but have been criticised for their allowances practices and for exacerbating staffing shortages (Meguid and Mwenyekonde 2005). The fewer workshops you attend, the less money you can make. Emmanuel said, "I was working in CHAM and my friends working in government health centres were making much better money [through workshops]."

For some nurses, however, CHAM remains an attractive employer. They argue that it is more responsive to patients and nurses are faced with shorter patient queues than in government facilities. Exit interviews conducted by CHAM revealed that the religious element of working life was a significant pull. This was partly why Emmanuel was drawn to work there. When Lungu (2004) compared Malawian nurses' preferences for CHAM over the government, he found that nurses were attracted to CHAM because of better workload combined with more holistic nursing care. Similarly to my findings, he found that opportunities for further study, the retirement package and increased autonomy and rule flexibility were attractive features of government service.

6.2.3 NGOs

I would like to stay in the NGO community, as much as I want to go to the UK because of the money, better working conditions. It's not that I don't want that type of life, it's only that I want that type of life here at home. So if I work in the NGO I am serving the Malawian people but at the same time I am able to have food up to the end of the month.

Chimwala, 1991 RN NGO

For many nurses, NGOs were the perfect combination of staying in Malawi and earning a good salary. Earlier I noted that working with an NGO could be a useful stepping stone to the UK because of opportunities to build up capital and connections. However, as migration has become more difficult, nurses are increasingly seeing NGOs as the 'next best' option. Some key informants saw this positively as they believed that NGOs helped to retain nurses in Malawi. Not everyone sees it this way and many accuse them of pulling nurses away from the government where they are needed most. Although NGOs do not typically offer a pension, the potential lifetime earnings for NGO nurses far exceed any government benefits. For ENs this was especially important as many felt that they would not be promoted to higher (better paying) levels within their own profession if they stayed in government.

NGOs attract nurses not only through salaries but also through the lifestyle they offer; for example, no night shifts. This has made NGO employment tempting, even to those dedicated to their government job, like Mrs Banda who was impressed by NGOs transporting their staff to work. However, NGO work has its risks. Whilst many nurses end up in rewarding, high level positions, others end up collecting routine data (for example, collecting blood samples). Although the pay for this role would be higher than an average government salary, according to Monica, if you are an RN and working in such a role:

Sometimes people would laugh at you, if you stayed in government maybe you would have become a matron, you are going into an NGO just because you saw the salary and yet your role there wasn't that good.

However, as one doctor explained, even with their benefits, "it's not just a straightforward thing that nurses will always go for the NGO". He added:

There is a group of people who know that NGOs are not the future, some of the nurses we have employed here [CHAM], maybe a quarter to a half came from NGOs. So they willingly gave up a much higher salary to come back to the system because they want

to do nursing. Nurses are not as particularly bad as we think they are. They come back and do some nursing. They were motivated by altruism.

The downsides to NGO employment include the contract nature of employment, meaning that there is often little support for further training and career development. Florence (now in the UK) left her NGO position because of this. Similarly, Emmanuel felt that he would not be able to advance within his NGO career and so joined CHAM. Jobs are also less secure, as Mrs Tembo explained: “if you have done something wrong [the government] first give you warnings but NGOs can just tell you have to stop working”. There were also concerns about NGOs’ dependence on external funders, with a senior informant warning that they might not be around forever. Signs of a possible decline included the report that a major NGO in Malawi fired over 30 employees in 2009 because of financial issues linked to the global economic recession (Chipalasa 2009a).

6.3 Section conclusion

Many informants believed that the current trend for NGO employment had negative consequences for the country’s ability to deliver care: “the impact is not so different than if they had migrated to another country” (key informant UK). However, in recent years the government has improved its service conditions to try to win back the nurses it has lost to other employers. In this section, I have rationalised the career choices of nurses based on the advantages and disadvantages of each career destination. Whilst these undoubtedly play an important role, personal circumstances also play a part in the decision-making process. Nurses often prioritised their families in their choices, a theme which runs through the thesis. Rural placements continue to be unpopular because of inadequate opportunities for families and NGOs remain attractive because they offer substantial salaries that can improve the lives of the whole family. Most respondents continued to believe that government salaries were insufficient to meet their needs, and were concerned about the effect this would have on the wellbeing of their families. One employment destination which continued to have many perceived advantages is employment overseas. In the second section of this chapter I take a closer look at why this is the case, and what has made migration a persistently attractive option.

The migration story

This is Malawi: we all want to leave.

Catherine, 1970s EN GN

6.4 Section overview

Although nurses have been leaving Malawi since Banda times, the numbers were small compared to the exodus between 2000 and 2005. During the 'migration years', 555 nurses (mostly RNs) left Malawi, primarily for the UK. In this section I examine what happened prior to, during, and after the migration years from the perspective of the nurses. I also draw upon their accounts to understand how their personal circumstances influenced their decisions to migrate or to stay. This perspective is important since, as one nurse said, "your career is only one part of your life, you think about family too when thinking about future plans and where you will be".

6.5 Pre-migration days

Table 6.2 briefly summarises the patterns of nurse migration from Malawi before 2000. Although we can only trace nursing movements back to the Banda years, Malawians have been migrating since colonial times. Many sought employment in the mines of Zimbabwe and South Africa, an activity which persisted during the Banda years and declined only in the 1980s because of home labour shortages (Oderth 2002). As general labour migration declined, the numbers of students (including nurses) sent abroad for study increased. Banda encouraged the training of health workers abroad partly because, according to key informants, he considered 'western education' far superior to that of Malawi²². As we have seen, some nurses extended their training period in the UK to a permanent stay²³, although most were compelled to return (partly from guilt or for family reunification).

²² Banda himself had trained in the UK as a doctor.

²³ Key informants suggest that nurses left at this time because of political repression and the desire to escape the growing strength of the dictatorship and its hardships (a finding supported by Namagoa 1997 cited in Oderth 2002).

Table 6.2 Nurse migration before 2000

Date	Movement
1960s	<p>This time was characterised by unrecorded instances of nurses staying in the UK after a period of study. There are no data on whether nurses stayed in the UK permanently, although, according to respondents, as they were often single many of those who stayed ended up marrying British citizens and settling permanently.</p> <p>Other nurses who migrated at this time went to join their spouses working or studying overseas</p>
1970s	<p>Statistics from 1971 show that no Malawian nurses migrated that year, but 149 of the 222 nurses in Malawi were foreign-born (Mejia et al 1979)</p>
1980s	<p>According to respondents, few nurses were thinking about migration. This was thought to be because there was little exposure to the 'Western world' through the media. Many believed that Malawi "was the best that we can have" (Rebecca, 1979 RN NGO)</p>
Early 1990s	<p>The change in government led to increased exposure of overseas life and migrant numbers slowly rose</p>
Late 1990s	<p>Migration became much easier as active recruitment to the UK began in earnest. According to nurses, after 1998 they were not required to complete an adaptation programme. From 2000 the NMC Malawi began to record the nurses validated to work abroad: "as numbers were not significant before 2000 no record was required" (NMC informant)</p>

6.6 2000: Setting the scene

Yes, that time was more like an exodus time for nurses in Malawi. I think 2000 to 2005, oh my God, many people travelled to the UK, everybody was complaining ...let me just get out of this system, I am just fed up!

Lindiwe, 2002 RN UK

I remember when I was teaching at KCN [2000 to 2002], I had a class, everybody was asking me: how do I go to the UK?

Abigail, 1993 RN NGO

In 2000 there was a dramatic rise in the number of nurses leaving Malawi. Shifts in the country and in the nursing landscape fuelled an unparalleled exodus, creating an

atmosphere of excitement and anticipation. I have collated the descriptions from several respondents of a typical work scene around 2000:

They arrive at work and see their colleagues crowded around a handwritten note on the staff notice board. Written on it are details of an agency in the UK that had successfully found employment for one of their colleagues. They begin sharing stories of others who had successfully left. Most had learned about placements in the UK through newspaper advertisements, and through friends and colleagues. Over the past year, the nurses witnessed one colleague after another clocking off for the day and never returning. Sarah explained that: “some would say I am going on holiday and they would never come back. But people would always know so and so, she has gone...”

It was common for nurses to receive no notice of imminent departure from their colleagues or superiors. Whilst on duty, Catherine (an EN) remembered the matron giving her the keys to the ward, announcing that she was going. Baffled, Catherine later assumed that she had left for the UK. Those who had left for the UK recalled seeing other nurses at the airport. Lindiwe said:

In Heathrow airport there would be millions of Malawian nurses coming...you go oh my God, all the nurses, who has stayed in Malawi?...Previously you would hear, oh so and so, maybe ten people in a month...I think that most of the people at KCN have actually come here.

Many of the 555 nurses who left between 2000 and 2005 did so either through direct contact with an agency or through friends and colleagues. They facilitated the process of registering in the UK, finding a job, processing paper work and arranging transport. Even KCN was part of the action. James recalled that around 1998, pamphlets describing working opportunities in the UK were distributed around KCN and talks were held in the college. He claimed that it was KCN's way of showing the government that they didn't "value these nurses". Many RNs were swept up in the excitement regarding opportunities to migrate (including tutors at KCN). My research suggests that the figure of 555 migrants underestimates the actual number of nurses who had planned to migrate. All of the RNs I interviewed who had stayed in Malawi had applied for registration with the UK NMC, the first step to working in the UK. Although this is by no means a representative sample of RNs, it suggests that the intention to leave was high at that time. 2000 appeared to be the 'magic' year when everything changed for RNs and the door to the UK opened.

6.7 What caused the rise in migration?

At this point nurses who were not able to leave as freely before left to other countries. There was chaos as they left in masses.

Key informant, Malawian NGO

6.7.1 The situation in Malawi

Although researchers refer to migration as a volatile event which is hard to predict (van Dalen et al 2003), a number of specific key events precipitated the rise in migration of Malawian nurses. First, along with many other countries in sub-Saharan Africa, Malawi experienced a decline in its economic status and a rise in migration intentions (Aboderin, 2007 describes this in Nigeria, Gaidzanwa 1999 in Zimbabwe). The economic decline was precipitated by the political and economic mismanagement of Muluzi's government, which led to a general deterioration in working conditions.

Chimwala captures the mood of the respondents at this time:

In 2000, something happened in my hospital, a change in government system... we were considered unessential so some of the benefits the health workers were getting as essential services were taken away. That meant that it was going to change a lot in terms of the quality of life of the nurses, especially housing. With the allowances we couldn't continue to live in the same houses, we were going to stay in smaller, cheaper houses in the high density areas where the quality of life was going to be really different. So amongst the nurses there was this, we were protesting that we were not happy with that.

The resentment caused by poor working conditions and lack of salary increases despite high inflation (Oderth 2002) led to the strikes described in Chapter Two. These strikes were further fuelled by inadequate and self-interested management. According to Dinah, the strikes were sparked by a matron accompanying a patient overseas to gain the associated allowances, even though it should have been the role of a nurse. Many respondents believed that the strikes signalled a turning point and propelled many to take the first steps to migrate. The promise of greater salaries in the UK, combined with a favourable exchange rate, played an important role in motivating nurses to leave. Students, many of whom were already aware of what was waiting for them upon graduation, were reluctant to go into government service and saw migration as a way out. Beyond the nursing landscape, respondents remembered the mood of the country being one of depression and denial. Although Malawi was now free of

dictatorship and its associated restrictions, the HIV/AIDS epidemic began to cause significant damage. One respondent recalled that people were shocked by the many deaths and constant funerals, prompting anyone who had ambitions to leave “as fast as their legs would carry them.”

6.7.2 Migration: an ‘easy process’

The salaries weren’t getting better for nurses, and life was very expensive. Everyone was looking for means of surviving and getting more money, so when these agencies started coming to Malawi and said ‘we can process flight ticket, we can help you settle there’. It was a big motivation for nurses.

Dinah, 1993 RN UK

The UK’s policy of active recruitment and the escalating presence of nursing agencies in the country were well timed. Discontent with nursing and with Malawi was growing. Nurses were looking for a way to leave, and agencies responded by providing the means. The UK’s interest in using Malawi’s nurses to fill its shortages coincided with the first nurses graduating with a Bachelors of Science degree from KCN in 2000. This contributed to making nurses marketable in the UK, especially as language and training links facilitated adaptation into its workforce. The necessity to fast-track nurses into employment meant that they no longer needed to complete an adaptation programme. Nursing agencies commonly completed the logistical arrangements and allocated positions, and the process was relatively straightforward. In some cases, agencies covered flight tickets with the expectation that costs would be recovered when nurses began working. Nurses had to meet the (non-refundable) fees for UK NMC registration, which assessed whether they were fit to work in the UK. The Malawi NMC and KCN also charged a fee for their services in the registration process (such as sending academic transcripts). Although most nurses were successful in registering, one respondent was not and was upset about the money she had lost. On hearing such stories, some nurses became cautious about applying because they did not want to take the risk of being unsuccessful and out of pocket.

Migration was facilitated by the UK immigration system. Because general nurses were on the Home Office shortage list, nurses were able to get work permits. In addition, between 2000 and 2005, Malawian nationals were able to enter the UK on a free tourist visa. As James explained, this meant that “you would just come in and visit and take advantage to apply for jobs... if you are accepted then [the] employer would apply for

your ‘out of land’ work permit.” Alfred found that this way was preferable to going through an agency, even though the process was lengthier (a year in his case). He believed agencies could only offer him a temporary job and would charge a fee: “I didn’t have the money at that time so I said I will look for a job on my own. So I just went to the NHS website.” Unlike Alfred, most nurses relied on agencies as well as on assistance from friends in the UK. Emma commented that she began to know the migration process intricately as she had helped so many people leave. Friends also served to encourage more nurses to come over, helped in part by the opening of communications and media channels, and nurses were now able to see what kind of life would welcome them in the UK.

6.7.3 Stories from the UK

Many nurses were drawn to migrate by the emails and phone calls of friends already in the UK (additional factors also pulled nurses to the UK, discussed in Box 6.2). Friends began by sending photographs of the local scenery (of shops and supermarkets), but eventually sent emails filled with offers to help them come over, telling those back home they were “wasting their time”. Dinah recalled one friend asking her what she was still doing in Malawi, “join us! So I said oh OK.” It was common for those in the UK to convey that they felt sorry for those ‘stuck’ back home, especially as they began to acquire more assets. Respondents began seeing signs of these in new houses and businesses. Emmanuel, like many others, began to believe “that if you go to the UK, you will make a lot of money.” He saw that nurses were able to sponsor themselves, even with high international fees, for Masters study. Nurses in Malawi also wanted to benefit from these successes, as Lindiwe described:

I would say what triggered people to come here is about what other people are able to afford to do, what they are sending back home. Let’s say at some point I am able to buy a car and then send it home, that encourages somebody who is also a nurse to say, that if I go, that means if my family is poor then maybe I am going to support the family. Look at them, their life has changed around. Maybe if you can go to the UK we will change our life around like that.

As nurses followed the progress of their migrant colleagues, inevitably some negative stories filtered back. These mainly related to the racist behaviour of patients and the need to work hard, which Rebecca referred to as ‘sweating for your pound’. Eventually, people began to learn about the ‘unglamorous side’ of migration, especially the nature of care work most nurses were engaged in. Students at KCN believed that “if you go to the UK you will be caring for grannies” or become a BBC (British Bottom Cleaner).

However, according to Lindiwe, those in the UK attempted to limit the negative stories for fear of not wanting to be seen as discouraging others. She explained:

They feel if they tell someone 'this is what happens', they think that they are trying to tell someone not to come here because they are doing well...and if they don't come, they will say I discouraged them and I am doing better, built houses, and I have got a car, and they haven't had a chance to come here because I told them it's a horrible place. How come I am able to stand this horrible place?

The power of negative stories can be seen in the study of Malawian health workers by Manafa et al (2009). One manager was put off migrating to the UK because of news that houses were expensive and you needed to work hard. However, Lindiwe warned that withholding negative stories made people unprepared for UK life. She recalled that after hearing only positive things she was surprised by the reality when she arrived and questioned her friends: "why didn't you tell me? I wouldn't have even bothered to come here." Restricting negative stories also served another function: migrants wanted to show that they had done well out of being in the UK. Monica said that it was important to show this as people back in Malawi expect something from a migrant:

You know a colleague went to the UK, and you know in the UK there is money, you wouldn't expect her to come back empty handed. You would want her to come back, for her to be better than you. They have to be different from the way they left otherwise we people who stayed in Malawi would laugh at them, why did you go to UK? What have you benefited? You left your family, how different are you? Either they have to go to school or they have to make some investments.

This finding is consistent with the stories of Ghanaian migrants in the West. Van Dijk (2002) describes how these migrants created a 'veil of disinformation' to hide the fact that life in the UK was hard, especially if their jobs were menial. Withholding negative stories helps to maintain respect for migration and may also serve to propagate migration within a community. Whilst stories helped to entice nurses to the UK (in addition to factors described in Box 6.2) those back home did not respond to the pull in the same way. Some chose to leave straight away, whilst others waited or chose to stay. Their responses were often influenced by individual factors including their family situation or ambitions. In the next section I draw upon the stories of respondents to explore the influence of these additional factors.

Box 6.2 Why the UK?

The UK attracted many nurses because of its 'open door' and the strength of its Malawian nursing community. Here I present some additional reasons building upon the discussion in Chapter Two. Firstly, as many RNs had studied in the UK over the years, this meant that they were familiar with the UK's culture and its nursing system. This made the prospect of going to the UK less worrisome for Silvia: she already knew the system and had old contacts from her previous studies. The fact that there was also an established history of Malawian nurses being trained in South Africa may explain, in addition to proximity, why it was the second favoured destination. A shared dominant religion (Christianity) may also have drawn nurses to the UK, as religion is often a key consideration in destination choice (Ehrenreich and Hochschild 2002). Active engagement in religious activities is high in Malawi. Even formal meetings usually begin with a prayer. Many of the nurses maintained their strong religious lives in UK churches. Religious institutions often assist with the adaptation of migrants, 'cushioning their roughest transitions' (Portes and DeWind 2007:19). Many Malawian churches have religious roots in Scotland, and many of the respondents lived there, although Eleanor believed that it was the lower cost of living which made Scotland more attractive. Other less common reasons why nurses chose the UK included the perception that they were still respected and adequately rewarded. Rebecca said that in Malawi nurses' salaries did not take into account good performance and "those who worked hard became frustrated because they were not rewarded and 'bad nurses' often got away with poor standards." She claimed that the 'good nurses' were the ones who went to the UK to be rewarded for their hard work.

Access to HIV/AIDS treatment was also reluctantly raised by a few nurses. Although ART is free in Malawi, many barriers affect its uptake, including the stigma of testing. Stigma is especially strong for nurses, and one informant explained that if their status is revealed they perceive that patients will refuse treatment from them. ART access through confidential services in the UK may have been an important pull. Although respondents were hesitant to discuss this issue, one nurse (after I had turned off my recorder) said that whilst accessing ART may not have been the main reason why nurses chose the UK, it meant that they would be more inclined to stay. They knew that once they returned to Malawi they would not get the same level of care. An English newspaper reported that a UK politician was fighting against the deportation of a HIV-

positive Malawian - her UK student visa had expired - claiming that she would not be able to access the same ART treatment back home (Carvel 2003).

6.8 The migration decision

People's decisions to migrate are often motivated by a complex assemblage of inter-related factors.

Izuhara and Shibata (2002)

Several factors featured in nurses' migration decisions, including family, societal perceptions and migration's relative benefits and disadvantages (shown in Table 6.1). Whilst the benefits included improvements in their working lives, the downsides were the long distance from family and cultural differences. Many of the benefits were consistent with push and pull factors, with a key pull being economic betterment, or as the nurses called it, survival. This finding is consistent with numerous studies (including Likupe et al 2005, Chappell and Glennie 2010, Alonso-Garbayo and Maben 2009, Chikanda 2004) that identify financial gain as a key driver in nurse migration. However, other factors played an equally important role.

6.8.1 Educational benefit: the story of Dinah

Probably most of the nurses felt like if we go to the UK we would have a chance to do some type of education, and then I would come back and be better with that.

Florence, 1996 RN UK

95% of people would come to the UK from Malawi they come with the intention of doing school... That's what you do in Malawi you do school and you get well paid and you get better in life.

Peter, RN UK

Although nurses believed that the quality of higher education was good in Malawi, there were not enough opportunities for further study at Masters or PhD level. This was because places and scholarship funds were limited. Some nurses faced administrative barriers, as Emmanuel found: "in [the] Malawian set up you can have good reasons to do further studies but you will find that somebody may not be willing to recommend you or approve it for you." Such challenges mean that migration could allow them to accomplish their education goals. Eleanor said:

I wanted to go further with education so I thought if I stay in Malawi it would be very hard for me to get a Masters, as I have seen people that have worked for ten years and don't have a chance to get a Masters, so I said I think it's better for me to go overseas as it will be easier.

The UK offers opportunities for higher study and scholarships. There is also status attached to gaining a higher degree overseas. A Masters has become a valuable way to distinguish yourself from other Malawians with degrees, as Alfred explained: "nowadays, there are too many graduates, too much competition, so the first degree is actually losing its substance." This prompted Alfred to make plans to study overseas even before completing his first degree: "if postgraduate training cannot be provided in Malawi, you have to find it somewhere else." The UK also offered specialisation opportunities. In Malawi nurses do not specialise (with the exception of psychiatric nursing), and coming to the UK allowed Martha to pursue her interest in mental health and benefit from specialist training and technology. Improved educational opportunities could also benefit migrants' children. A key informant commented that nurses were often drawn to migrate because of the 'better' education offered overseas (including smaller class sizes and adequate resources). Unlike Malawi, primary and secondary education would also be free. As a government nursing salary would preclude them from paying for private schools in Malawi, many felt that the prospect of good education from primary through to university level was a strong incentive to migrate.

Dinah's story

Dinah left KCN with a diploma in 1992. After working for six years as a government RN, she returned to KCN to upgrade to degree level as part of a German donor-funded programme. As part of this programme when she graduated in 2000 she was obliged to teach in a rural nursing college. Her unhappiness at being away from her family and the nature of her new role prompted her to consider migrating. Thoughts of the UK had been in Dinah's mind for some time, and whilst at KCN she successfully registered with the UK NMC because it was the trend to do so. "Everybody was excited at that time about coming to the UK. So I said that I would apply just as everybody else." She was offered a job in a care home shortly after and came to the UK in 2003 with the goal of completing a Masters and returning to Malawi.

Dinah's primary reason to migrate was improved educational opportunities, which was also the most common reason given by respondents. Education is highly respected, and it is common for nurses at degree level to aspire to further qualifications. This

finding is supported by the HSC (2004) study, which found that study prospects were a key driver of health worker migration from Malawi. Further afield, educational benefit was also a key reason why the Japanese migrants in Izuhara and Shibata's 2002 study went to the UK. Almost every nurse I interviewed (in Malawi and the UK) dreamt of completing a PhD, a challenging goal in Malawi.

6.8.2 The family influence: Sarah and Silvia's stories

Sarah also had aspirations for a Masters, but unlike most of her colleagues she was not swept up in the migration excitement. She recalled that it was only after her husband asked, "why aren't you applying? All your friends are going," that she felt obliged to complete her UK registration. As the process was easy at the time she felt that she could not refuse her husband's request. In contrast to her colleagues, she applied for three years study leave from her government position in 2003 to go to the UK. However, because of financial challenges, she ended up applying for additional years. After spending five years working in a care home and completing her Masters she returned to Malawi with her children to re-join her husband.

Like Sarah's husband, Silvia's family also encouraged her to 'temporarily' migrate. This time the goal was not to study for a Masters but to help the family's financial situation. Silvia had already been working for many years as a nurse and tutor when migration opportunities expanded. Although her husband had a decent salary, they found it difficult to finance their daughter's university education overseas, so in 1998 Silvia decided to request unpaid leave of absence from her job to go to the UK to make some money. She calculated that one month's salary in the UK was the equivalent of 18 months' salary in Malawi. She applied through an agency and was allocated a job in the UK NHS with a two-year working visa. In addition to working full time in a hospital, she did agency work in other healthcare facilities on her days off. After two years, her daughter had enough funds to complete her education and her husband called her back home.

The stories of Sarah and Silvia reveal an important theme: families often encouraged migration because of its potential gains. The migrant is often willing as they are fuelled by the prospect of being able to better support their families. There is a strong sense of responsibility to one's family and community in Malawi, as Milicia explained: "families support each other with what they have. My elder sister didn't earn very much but she

still paid for my education and I will do the same for my siblings." Research shows that those working in Malawi have an obligation to support other family members (Lungu 2004). If their immediate family joined them in the UK they could have improved educational opportunities and quality of life. Parents and other relatives would also stand to benefit from a nurse's migration in the form of remittances. All of the nurses interviewed sent remittances and some also built houses for their parents, whilst others set up businesses run by relatives. This supports the claim that the migrant's family is usually the key beneficiary (Connell et al 2007). For the Ghanaian families in Van Dijk's (2002) study, migration to the West had become a strategy for the whole family's economic success and survival.

For Sarah and Silvia, temporary migration meant that they could make money for their families without long-term separation (both husbands remained for the most part in Malawi). The majority of respondents had also intended to migrate temporarily, but ended up staying. This is consistent with findings from focus group discussions with Ghanaian nurses who saw migration as a temporary strategy to accumulate the capital needed to buy a car or house or start a business (Dovlo 2006 cited in Ogilvie et al 2007). Such intentions have implications on the decision making process, especially as the environment in the migration years often led nurses to make the decision to migrate quickly. According to Cecilia, "I think most nurses left without thinking, they left because their friends had left and they had no picture of how conditions are in other countries." If their migration was only temporary they may also have felt it unnecessary to weigh them up, especially when they could already see how successful their UK colleagues were. Florence recalled that: "they tell you how much they get and that was the only thing we were interested in." Evidence of quick decision making can be seen in the regularity of nurses leaving without giving notice to their employer. However, if migration was only intended to be temporary one might have expected more nurses to have requested a period of leave, as Silvia and Sarah did, to ensure that they would have a job to return to.

6.8.3 Respect for migration

The meaning of individual migration decisions cannot be fully appreciated without reference to people's value systems.

Findlay and Li 1997

The above statement applies to the value system in Malawi, particularly the importance of taking care of relatives. In many cases migration improved nurses' ability to do this, partly suggesting why the act of migration spread so quickly amongst them (in combination with the prospect of escaping deteriorating conditions). Another culturally significant value is respect. One major theme in the interviews was the cultural pride associated with migration. This served to make the nurse feel a sense of achievement if they had migrated. Stella (2004, EN GN) said, "it would be a great achievement for me and my family if I was able to migrate." It also contributed to making the family supportive and encouraging of migration, although not all families felt this way.

In the Banda years, since few people were able to migrate, those who did were highly regarded. Although transport and communication improvements have made migration easier, the ability to migrate to countries like the UK remains unattainable for the majority of Malawians. This has served to maintain the respect that Malawians have for migrants. Migration literature supports this finding, including Alonso-Garbayo and Maben (2009), who described the higher social status and respect assigned to the migrant nurses in their sample. Van Dijk (2002) described how the high respect accorded to migrants by their communities led many to develop an all-consuming desire to migrate. The pride seen in Malawi's communities was described by Aubrey (2004, RN):

When you go to the UK it's also an investment for your family so they would love it. I know my family was excited when I was going to the UK. It's pride culturally, when you come from a village and you say my son is in the UK it's a source of pride. And when you are there you are making money and remitting some home they will always be happy.

Whilst Aubrey described families as usually supportive, sometimes encouragement could turn to pressure. A key informant said that KCN students were often under pressure to migrate:

Most of them would be forced by their parents to go [to the UK]. They want their children to be rich. There is a lot of pride if your son or daughter went to work in the UK because you are sure of the income aspect, they would be sending you money, you would be going to the UK to visit them, see London, who doesn't want to see London?

Families tend to impart norms about the meaning of migration and familial obligations over time (Boyd 1989). In the case of Malawi, this meant that nurses were obliged to support their families whilst in the UK, even if they were experiencing difficulties.

6.8.4 Migration pressure

They end up relying on you and they expect money from you all the time so you are sort of the breadwinner for your family there. You have to pay your bills here and then you have to do it back home as well. It is difficult...that is why most people they have got their full time jobs but they do agency work as well or overtime bank. They end up doing extras every week to... send money home.

Emma, 1993 RN UK

Migrant nurses often felt pressure from their families because they had become reliant on their financial support. Although they did not resent the responsibility, some felt overwhelmed by it. This reliance also had implications on their return decision. Earlier we saw that migrant nurses often masked the difficulties they were having, presenting only a positive picture of their lives. This may have led those back in Malawi to believe that they were more financially successful than they actually were. Misunderstandings about the reality of UK life, in particular its high living costs, may also have bred expectations not just from the family but from the community. Whenever nurses returned, the community expected them to bring gifts and money. The type of gifts they expected often exceeded what the migrants could afford. Peter said:

When you are there [in the UK] and you want to come over [to Malawi] someone will ask you: will you just give me 50 pounds. So you're thinking 50 pounds that's a lot of money, but he is not thinking that way... Probably he has heard somewhere nurses [in the UK] get about 1.5 or 1000 so he is thinking 50 [isn't that much]... that you don't have bills and things to pay.

For some respondents, this expectation, and the financial burden of gift giving, put them off returning to Malawi for holidays.

6.9 'We are not angry': the feelings of the nurses who stayed

There is no stigma going to work outside. If anything people will say how did you get that job? Put me in touch with them.

Silvia, 1960s RN returnee migrant

Although news about the lives of migrant nurses was often distorted by what they chose to reveal, most remaining nurses believed life in the UK was good enough to keep nurses there. Rose said: "I know that they enjoy it there. If they weren't enjoying it there, they would come back home." Evidence shows that the departure of nurses contributed to the deterioration of working conditions for those who stayed. I was interested in examining what the remaining nurses thought of those who had migrated, particularly because of these negative consequences. One might expect that they would feel angry or bitter about their departure, especially enrolled nurses who were not able to leave as freely. The findings suggest the contrary. With few exceptions, the remaining nurses evinced no resentment of those who left, and many expressed happiness or admiration that they had managed to 'escape'. As one nurse explained, "they cannot feel guilty because what they were doing there is nursing patients... going to the UK is not a crime, you are going there for both things: one looking at your economy, and how you can assist your people, your relatives here, and the other thing is you are going to nurse people. They are also saving lives of people." Because they also acknowledged that conditions were so poor, the remaining nurses understood why the others left. Some respondents believed that it was the older generation of nurses, who had been used to the 'old way' of nursing, who may have been drawn to the UK as a way to return to high nursing standards. In general, respondents were far angrier at the persisting poor working conditions and directed their anger at the government rather than at individual nurses.

Interestingly, younger nurses were less understanding. Students at KCN believed that those who had left had abandoned their country: "in your country people are dying, you are saving others in the name of money". Cecilia also felt that many had put financial gain before their families:

People left babies, small babies, with their families. I would actually say, even one friend went there [to the UK] she was already expectant when she went. She worked hard to make ends meet. And when the time came she delivered, when the baby was three months old, she brought it back to the father and she flew out. I thought that was stressful for any baby.

Although this reaction was an exception, the feeling of the public captured in one internet forum suggested that many were angry at the nurses who were trained at public expense and then left: "we are not training you to go and work in England" (Nyasa Times 2010b). Such comments made some migrant nurses feel guilty about their departure. Chisomo said, "when you are talking to some they are feeling guilty about it, [they say] I am here because I want money". However, like many of the remaining nurses Chisomo understood that "we are living in this world for money, if you don't have money your life will be hectic."

6.10 Who left for the UK?

Maybe some will leave but there will still be some that say that they don't want to go.

Julia, 1972 RN returnee migrant

An examination of the migration literature reveals that although there is no single profile of a typical migrant (Lessinger 1995 cited in Brettell 2000), professional migrants often share some characteristics:

- Educated and unmarried (Bryceson and Vuorela 2002);
- Younger and less established (Fadayomi 1996 cited in Oderth 2002);
- Fresh out of university as opposed to midway through their career (Chappell and Glennie 2010);
- Those who had reached a particular threshold such as completion of school (Bryceson and Vuorela 2002);
- From a household with secure income (because of the costs associated with migration, Dinerman 1978 cited in Boyd 1989).

Nurse migrants often fit these characteristics. A report by Pike and Ball (2007) based on a survey of UK based overseas nurses found that they tended to be much younger and more likely to hold a degree than their UK counterparts. However, despite some of these characteristics being also true of Malawian nurse migrants (for example, having a degree), this research has found that because of the vast numbers of nurses who migrated and because of the strong influence of personal circumstances, there was no 'typical' nurse migrant' from Malawi (see Appendix 10 for a summary of respondent characteristics). Even the assumption that only degree level RNs migrated is challenged by NMC Malawi reports that ENs also found a way to migrate through care

assistant and auxiliary nursing jobs. A second assumption - that a migrant would need sufficient income to cover the migration costs - is also questioned by the respondents' claims that because of the assistance of agencies the financial equation became less important. Even registration costs were often financed through loans. Although the literature claims that migrants are often young, my sample had a relatively high number of senior, older nurses. James spoke about being surprised that the principal of a nursing college had left: "I have even seen nurses who have worked for 20 years come over here to start working, people you think would never because they are in such big posts." This finding is supported by Gaidzanwa (1999), who studied Zimbabwean health workers and found that the most experienced tended to migrate as they had the greatest chances of getting a high-level job abroad. An absence of records detailing exactly who left Malawi makes it difficult to get an accurate overall picture of the type of nurses who left. Even individuals who were not trained as nurses in Malawi took advantage of the demand for staff in the UK to migrate and retrain as nurses (see Box 6.3).

Box 6.3 Choosing migration and then nursing

I am just doing this nursing job because here is big money and then you earn at least better money. (Eleanor)

In the course of my research I discovered that a significant proportion of the Malawian nurses in the UK had come over to the UK with a non-nursing qualification and retrained as nurses in the British system. There is no record of the exact numbers who did this, although reports from UK Malawians suggest that they were significant.

According to one nurse, “many people came over to study for another course and then they would end up doing nursing, because that was the only course you had the chances to get the work permit to work.” Nursing was used by some Malawians as a way to stay in the UK through UK government-funded nursing programmes. I briefly present the stories of Eleanor and Peter, who left Malawi as an economist and an accountant, respectively. Neither had wanted to be a nurse in Malawi. Eleanor said, “no that was the last job I could do in Malawi.” It was their families who encouraged them to try nursing because training and employment opportunities were readily available.

Eleanor came to the UK to do an economics Masters in 2000 after completing her social sciences degree in Malawi. She decided to stay in response to pleas from her daughter and sister (who also lived in the UK and financed her studies). Her sister advised her to give up finding a career in economics, and told her, “this is the UK you won’t find a job easily, the only course you can do is nursing.” Even as an international student, Eleanor’s nursing studies were covered by a bursary. After three years she qualified and went to work as a rotational nurse. Peter also came over to the UK in 2000 to complete his degree in accountancy. However, he became frustrated with the profession, especially as he saw his friends working at much higher levels in Malawi. His mother suggested he try a different profession and proposed nursing. He applied for a course in Scotland and was accepted.

The stories of Peter and Eleanor suggest that many Malawians - not just nurses - were keen to leave in response to increasing country-level push factors. Peter and Eleanor already had family in the UK encouraging them to come. Other nurses who trained in the UK, had originally come over to join spouses and then took on nursing because of the training opportunities.

6.11 Who stayed?

Whereas the nurses described above were freely able to leave during the migration years, some of those who intended to migrate were not able to do so. Rebecca and Grace did not end up staying through lack of desire but because of administrative barriers. Rebecca had wanted to leave, but a delay in getting records from her nursing school in South Africa made the process long and complicated and she decided against it. Grace similarly had intended to migrate, but her employer would not sign a form providing proof of employment and her application could not proceed. There were also many nurses who actively chose not to migrate.

Now people have started to give feedback... so the group that was left behind started to weigh between the advantages and disadvantages and to evaluate what impact it has on those that left. People started to compare, most decided to say maybe just let me stay.

Cecilia, 1996 RN GN

Increasing knowledge about the disadvantages of migration may have served to discourage nurses. However, in terms of assessing what kind of nurse stayed in Malawi, research shows that there is little to distinguish migrants and non-migrants (Theakston 1997). Responses to migration triggers often depend on individual circumstances and families. The ICN (2007) suggests that the pull to migrate needs to be significant as overseas nurses often prefer to remain home, in a familiar culture, with their family and friends. This is consistent with one of the main disadvantages of migration shown in Table 6.1: being far from your family. However, the decision to stay was often forced upon nurses by their families even though they themselves wished to migrate.

6.11.1 Family pressures

It's the family that keeps me in Malawi.

Julia, 1972, RN

Although all the migrant nurses claimed that their spouses did not hinder their plans, many claimed that it was common for spouses to discourage their partners from migrating, especially if they had a good job in Malawi. Dinah said that "a few of my friends, their husbands had said 'no I am not going there', and some of them actually go back [from the UK] because the husband wouldn't join them." Even when spouses

did not discourage, some nurses were kept from migrating because of worries about what would happen to their relationship if they left and their spouse stayed. This was the concern of Monica, who after seeing a number of married men have girlfriends in Malawi (even though they had wives working as nurses in the UK), decided to stay with her husband-to-be. In the majority of cases, however, it was their parents who led nurses to stay. Mrs Banda was making plans to leave when her elderly parents asked her to wait until they died before migrating. Research shows that caring for elderly parents is a common reason for not migrating (Bryceson and Vuorela (2002). One respondent felt that she would be running away from her family responsibilities if she left. Christina felt this way and did not want to leave her orphaned nieces. She was also worried about what kind of life she would have in the UK if she did migrate.

6.11.2 Personal feelings

I wouldn't say I am not attracted [to the UK] I am attracted... maybe if I go to the UK I will find a better [life]... I still hesitate I don't know maybe I am a coward, I feel good to be at home.

Chimwala, 1991 RN NGO

Migration is not without its risks, and many nurses resisted leaving for the UK because of a fear of the unknown. This fear ranged from worries about the weather to differences in working conditions. "We don't know we haven't seen snow!" was the response of Lindiwe's colleagues when she told them to come to the UK. Others were more concerned with differences in technology and stricter regulations, fearing that they would be at greater risk of breaching nursing ethics and being prosecuted. This may suggest why those with experience of the UK were less fearful. However, in the case of Chimwala, prior experiences of overseas life actually dissuaded her from leaving. Whilst in Europe the only other Africans she saw were on the street selling cigarettes, never in respectable jobs. The possibility of her sharing such a fate made her determined not to migrate. Nurses often felt they would be more appreciated at home. This was partly linked to the recognition from those who stayed that Malawi needed their services more acutely, as Emmanuel (2005, RN) explained:

In a developing country we don't have services that people deserve and then you are running away, that really concerns me, it is better to be maybe among the few that remain and provide quality service, that reason makes me stay although there isn't a lot back home.

6.11.3 Taking advantage of the gap

One unexpected benefit of migration was that nurses willing to stay were able to take advantage of the increased employment opportunities, especially in senior positions. Whilst nurses like Emmanuel sensed the gap in care provision, other nurses including Cecilia and Monica saw openings in the workforce because of the departure of nurses in high-level positions, and calculated that their career advancement would be much better in Malawi than overseas. Whilst the UK became increasingly saturated with Malawian nurses, the demand for RNs at home meant that they were valuable to both government and NGOs. Monica asked:

Should I go to UK? Miss my family, work in a nursing home, not in a supervisory role. And yet here I can work on an upper level and improve my professional career. If you are in government like me a RN, it's easy to become a matron, a district nursing officer. So people sometimes weigh the salaries are little but you are exposed to so many opportunities and you get extra money from those.

For these nurses, staying in Malawi was an intentional strategy, and they felt increasingly happy with their decision in light of the stories coming back of nurses being stuck in low-paying care home jobs in the UK. Cecilia was very pleased about her choice, which she attributed to a degree of professional ambition that she felt was lacking in the nurses who left. She said that "if you strategise your own professional growth within the system you can do it. I am a good example." Cecilia had graduated from a mature entry degree course in 2001, and found that she had a succession of promotions to enter the highest grade. She explained that to achieve this in 12 years as she had done would have been rare in the past. Such strategies may become less successful in the future as fewer RNs are able to migrate.

6.12 The decline in migration

From 2005 up to now, we have not had major exoduses like in that period [2000 to 2005].

Cecilia, 1995 RN GN

Despite the fact that migration offers unparalleled salaries and educational opportunities, the number of migrants has declined since 2006, particularly to the UK. Whereas around 80 to 90 nurses migrated each year from 2000 to 2006, this dropped to 30 in 2007 and to 25 in 2008. No official statistics have been released for 2009 and 2010, but respondents report that migration to the UK continues to decline. They claimed that their observations are reliable because the community of RNs (especially

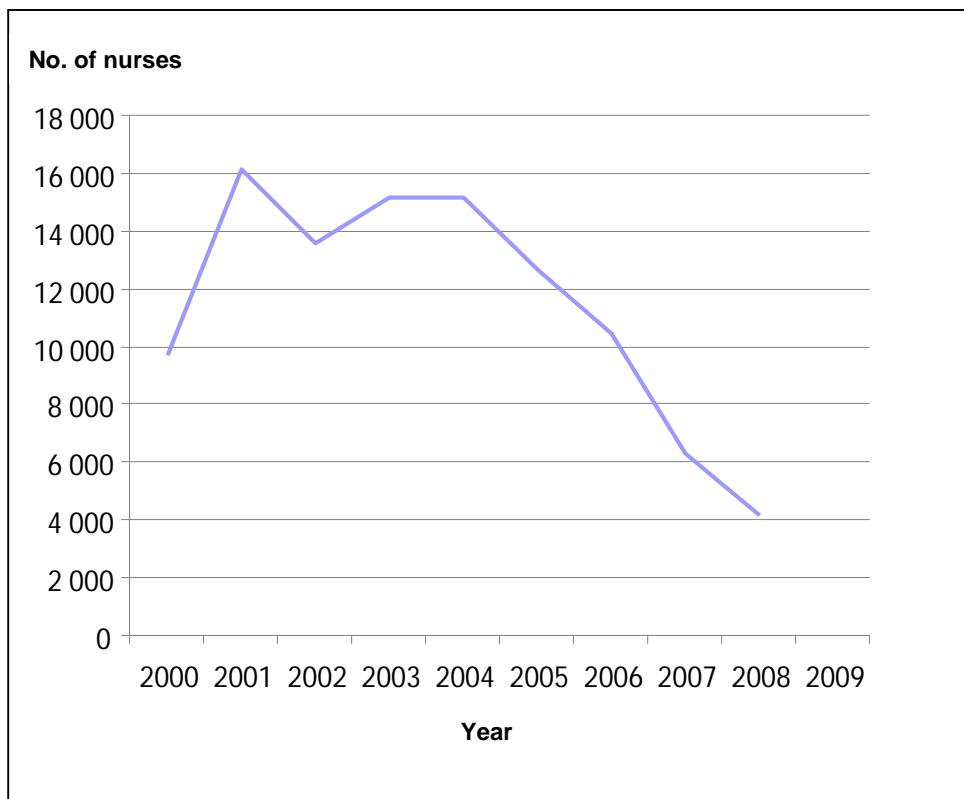
the KCN alumni) at home and in the UK is relatively small and they can keep track of each other. However, some respondents, like James, claimed that more nurses are leaving than is acknowledged:

Most politicians won't want to admit the reality, but those working at the airport, at the border, see a lot more Malawian nurses leaving and there are some people that I don't know are here. It's a surprise 'oh she is here', [they] are still coming...things are still happening.

Dorothy added that nurses now 'silently' leave without validating their qualifications, and find whatever employment they can get in the UK, usually in care assistant roles.

However, UK data (shown in Graph 6.1) illustrate that fewer overseas nurses are coming, not just from Malawi. This suggests that something is happening within the UK to contribute to the decline. In Chapter Two I proposed that tougher entry into the nursing workforce, including the code of practice and removal of general nurses from the shortage list, played a key role in reducing migration. Many respondents felt that these events symbolised the door of the UK shutting. In terms of events in Malawi, some nurses believed that now conditions have improved and HIV/AIDS rates have stabilised, nurses were in less of a hurry to leave. No one from Emmanuel's 2005 KCN class had left for the UK and he believed that it was because of the 52 percent salary increase. Additional reasons relate to the concerns of new graduates about ending up in low status jobs in the UK. A senior matron recalled that, whilst the pull of the UK was still there, nurses were now taking their time to decide whether to migrate. As many migrant nurses have gone before them, they may also be better informed about the disadvantages and think twice. Some also believed that the growing sense of pride in Malawi, particularly amongst young people, had also contributed to the decline. According to a key informant, nurses now wanted to stay and do their part to develop the country. However, most were convinced that it was the UK's 'closed door' that played the biggest role in reducing migration rates.

Graph 6.1: Migration flows of overseas nurses to the UK 2000-2009 (OECD 2010)



6.12.1 Barriers to UK migration

The door is slammed on your face.

Alfred RN, 2002, UK

When the upgrading started of enrolled nurses (to a diploma) many of them were pleased and said that now they could go to the UK. They are still eager but the restrictions to enter the UK are why the numbers of nurses leaving is down, they are not necessarily staying because they are happy.

Key informant, MoH

Migration is highly respected in Malawi, and this keeps the desire to migrate strong amongst nurses. The majority of respondents believed that many nurses wanted to leave Malawi but found that they could not. They questioned the logic of those who believed that improved conditions meant fewer nurses wanted to leave. Florence said that her friends felt sad that they had missed the chance to migrate: “they still admire me, and sometimes I feel like not phoning them because they will always be ‘oh I wish I had a chance to come over there’ because now it’s not so easy.”

Whilst nurses were previously greeted with job opportunities and assistance, the process for potential migrants changed dramatically after 2005. Firstly, the immigration procedure became more challenging, even just to visit the UK. It was not uncommon for nurses in the migration years to come to the UK directly to arrange their employment, as James (who left in 2002) and Alfred (2005) had done on their tourist visas. As the number of nursing agencies in Malawi declined, respondents believed that this strategy (to go to the UK to develop contacts) became increasingly important. As Chisomo said, “you say that you are going there for a visit and then you go over and use your connections.” Malawians are now required to pay for a visa in advance, the cost of which in 2009 was equivalent to two months RN salary (a single trip is 67 GBP, a skilled worker visa is 265 GBP: UK Home Office, 2006). These prohibitive costs, in combination with difficulty finding employment and a work visa, have acted as a strong disincentive to potential migrants. This is consistent with the findings of Hamanda et al (2009), who showed that the dramatic decline in migration of Zambian nurses to the UK since 2004 was most likely to be due to increased difficulties in obtaining UK registration and work permits. Their data suggest that the number of migrants is determined by recruitment policies that either restrict or encourage migration. Arango (2000) argued that entry policies are much more influential in determining migration than wage differentials.

Secondly, UK aspirants now also need to provide proof that they will undertake the Overseas Nursing Programme (ONP) and that they have funds to cover their living expenses during training (UK Home Office 2010). The ONP fee is prohibitive on a government nursing salary, which according to Alfred can be anything up to 5000 GBP²⁴. However, some nurses have been able to find a way to pay, as Lindiwe explained:

It's amazing how people can do that, because you are talking about Malawi, people cannot afford much but they are still coming up with that money. Maybe borrowing from people after saving for a long time, even selling big things because they have got the idea that if I go there, I will make that money in three months, and they can even rebuild what they have sold.

Thirdly, even if a nurse has enough funds, he or she may face the hurdle of finding a place on an ONP. This hurdle prevented Chisomo from migrating:

²⁴ However, in 2009 there was a programme in Scotland to support overseas nurses' entry into the Scottish NHS (Glasgow Caledonia University 2009).

I was supposed to go there and do the adaptation in the hospitals. But I couldn't find a place, so the time elapsed and then I couldn't go, I just stopped. It was hard for me because I had already paid some money, I had to pay £90 for the English examinations. I had to pay £70 at the NMC only to fail last minute, you couldn't get the money back.

Such stories, especially those about financial losses, were often shared within the nursing community and served to dissuade potential migrants. Many respondents felt that this financial element dissuaded people most of all. Alfred said, "some people would rather stay in Malawi ... because it involves a lot of money, and it involves a lot of planning and waiting as well." Whilst previously Emma had helped many friends come over, she had not registered anyone since the introduction of the ONP.

6.12.2 Feeling unwelcome: nurses' responses to the restrictions

Respondents understood the reason for the ONP (to ensure nurses were up to UK standards), but many felt that the other restrictions were discriminatory. In particular, several respondents felt that UK nursing shortages still existed and did not understand what stopped the country hiring Malawian nurses. Tougher regulations also made it more difficult for nurses to bring their families over to the UK. Eleanor struggled to bring her family over and commented that many now left their families and went off to earn some money before joining them back home. Tougher regulations and the code of practice (CoP) contributed to the perception that nurses were discriminated against (although few actually knew what the CoP entailed). Some felt that the negative media representation of nurse migration was partly responsible for this discrimination and for the restrictions²⁵. Chisomo recalled:

I think it has happened to a lot of people [that they cannot get to the UK], it's since the time of the BBC (British Broadcasting Corporation), there were a lot of nurses from Malawi going to the UK and they were showing the patients here without nurses, that was the time when they started to be strict... I remember that year the BBC were here taking photos in the hospital.

A minority felt that this coverage had improved nursing conditions in Malawi, and that it was these improvements that caused fewer nurses to migrate. Another suggested reason for the decline was that Malawians no longer saw themselves as welcome in the countries that traditionally hosted them. This idea was formed whilst reading reports of xenophobic violence against migrants in South Africa in May 2008, sparked by

²⁵ In Chapter Three I examined the link between this media coverage and hesitance amongst nurses to participate in my research.

unemployment and the belief that immigrants were taking jobs. In the space of a month, 62 people died and tens of thousands were displaced as a result of the violence (Worby et al 2008). A number of Malawians were amongst the displaced. At the end of May, newspapers reported that two bus-loads of Malawians had left South Africa (Africa news 2008), and that a Malawian had died in an anti-foreigner attack (Chiumia 2008). Whilst the violence in South Africa subsided, in the UK the election of two far right politicians (who were against immigration and ethnic minorities) into the European Parliament in June 2009 sparked fears that UK immigrants were becoming less tolerated. From the late 1990s immigration has been considered by many in the UK to be one of the top issues facing the country (Somerville et al 2009). Although none of the nurses raised this as a potential deterrent to migration, a Malawian doctor supported the association between perceived hostility and less migration:

They are getting less and less comfortable in foreign countries. Because foreign countries are not exactly as welcoming as they used to be. Even in the UK people feel that you don't belong; even if you are not ill-treated. People push you around.

6.12.3 An alternative way?

It has been heard that the recovery of the nursing situation in the UK has meant that there are more nurses now in the UK and that the conditions that Malawian nurses face are no longer favourable and so they leave from the UK for other countries such as the USA.

Key informant, NMC

NMC statistics and key informants report that the US, Australia and Botswana have become more desirable migration destinations in light of UK restrictions. These countries share many characteristics with Malawi which help migration, including language and colonial ties. Australia lists registered nurses as eligible for temporary and permanent skilled migration (Department of Immigration and Citizenship, Australia 2010). One might expect that, if the desire was still strong to migrate from Malawi, nurses would be leaving for these destinations. However, the reduction in migration has occurred across the board, not just to the UK. One potential reason for this is that during the migration years the backlog of discontented nurses leaving meant that migrant numbers were comparatively large. It is plausible that the numbers of migrant nurses declined naturally because the stock of RNs fell. Whilst there are still RNs remaining in Malawi, other factors may explain why they have not left for alternative destinations (in addition to their personal circumstances). Firstly, other than the UK no country has engaged in sustained active recruitment of nurses from Malawi. To work in

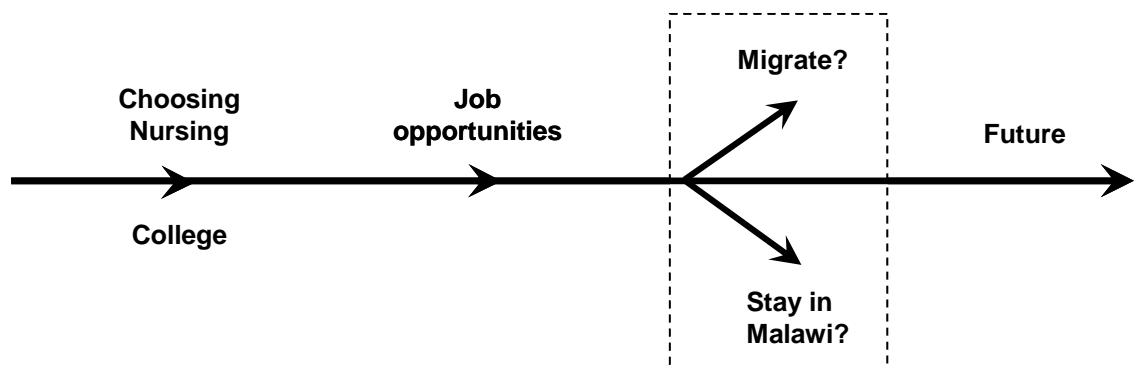
most US states nurses need to pass a licensing examination and secure a permanent residency visa (Nursezone 2010). Abigail had spent six years working and studying in the US and found it difficult to pass the exam. She also found it hard to gain a work permit and ended up working in a care home without one. In the case of Australia and Botswana, nurses were put off by lower exchange rates compared to the British Pound. South Africa also no longer seemed a viable destination because, in addition to being seen as unwelcoming, a Southern African Development Community agreement between the two countries made migration difficult. In light of restrictions to migrate globally, the main alternative to working in the government service has become NGO employment. This was supported by most respondents and by the work of Mangham (2007). Rebecca said, “when nurses were migrating to the UK there weren’t that many NGOs. Now there are more and with stricter rules for entry to the UK, nurses now go to NGOs.”

6.13 Section conclusion

This section has focused on the rise and fall in nurse migration from 1964 to 2010. Whilst previously a few nurses left Malawi on the back of study programmes, the period between 2000 and 2005 saw unprecedented nurse migration, catalysed by widening employment opportunities in the UK. Respondents attributed the subsequent fall in migration to the decline in opportunities to migrate. Should this decrease be seen as positive? In light of the negative consequences of migration, we would believe so. However, growing restrictions have not necessarily retained nurses in the government. Nurses have increasingly begun to settle on employment with a well-paying NGO as the best alternative to migration. Persisting positive associations with migration including high respect and unparalleled opportunities for financial gain suggest that thoughts of migration have not diminished in the nursing population. Many respondents firmly believed that given the chance more nurses would migrate. One nurse who had previously resisted migration because of commitment to her country and family actually ended up migrating in 2009, suggesting that even the most ‘dedicated’ can leave. In fact, all the RN respondents who remained in Malawi had at some stage applied to work in the UK, but stayed because of family pressures or in some cases the discovery of improved career opportunities. This finding confirms the presence of a strong culture of migration amongst nurses.

Chapter 7

Life in Malawi and the UK



Chapter 7

7.1 Chapter overview

In this chapter I examine the experiences of nurses working in Malawi and in the UK. Many of the experiences of those remaining in Malawi have been shaped by the migration years, which brought about nursing shortages and shifts in the nature of care provision. While nurses who migrated to the UK attempted to escape working conditions in Malawi, many arrived to face a whole new set of difficulties. Although RNs back home enjoyed increased freedom in their career choices, migrant nurses saw their freedoms restricted, especially as they came to terms with the challenges of life outside work in the UK. In the second half of this section I explore these challenges, especially those relating to the decisions nurses in the UK made about their lives.

The nursing situation in Malawi

[When there are no resources] how do you do your job? You might as well stand back and say 'why should I die for other people'? You are not in the army. The army is the one place you die, but you are a nurse.

Emma, 1994 RN UK

The main fall-out of the migration years was an intensification of the nursing shortage in Malawi. Whilst the remaining enrolled nurses continued to form the backbone of the nursing system, there was an acute lack of higher-level nurses, especially in teaching positions. This shortage had several indirect effects on the nursing landscape, including shifts in the careers of enrolled nurses and in care provision. I also examine how nursing has been shaped by the human resources initiatives introduced in Chapter Two.

7.2 The post-migration fall out

The group that were left, even if we were so few up to 2005... there was too much work to be done but I personally didn't feel exhausted. And I had some nurses, I can't imagine, they would come on the Friday, day shift, and night shift, stay over the weekend. Come Monday they were on duty. You ask them 'how you feel?' they say I can't leave when my patients are dying... they are the ones who stayed and they are still there.

Cecilia, 1995 RN GN

The consequences of migration on low-income countries can be both positive and negative. In Malawi much of the fallout was negative in terms of increased workload - as shown in the quote above - which is reflected in many of the nurses' accounts. There were also some positive consequences, such as the career advantages nurses like Cecilia and Monica were able to benefit from.

7.2.1 The nursing vacuum

Although the remaining nurses were overworked and continued to face the same conditions and poor salaries that caused nurses to leave, both cadres of nurses were able to benefit from the rise in senior vacancies. There were also greater NGO vacancies, leading Monica to remark:

Us health personnel we are enjoying ourselves, with this shortage of staff... in hospitals, nursing schools. The NGOs are also looking for health personnel... you have the freedom to choose where to go at the moment. We are enjoying because we can jump from one organisation to another.

Monica felt that nurses continued to be 'in demand' (as shortages persisted), and commented that NGOs were even raising their salaries to try and attract them. However, despite these opportunities, for some nurses persisting inadequacies in management meant that they grew even more frustrated. This is what happened to Chimwala, and after her management refused to acknowledge her Masters experience, she left to work for an NGO. Inadequacies were fuelled partly by the hasty appointment of inexperienced and unprepared nurses into management positions because of the shortages.

Although enrolled nurses faced the brunt of the migration years they were also able to benefit from the vacancy rises. In the absence of RNs enrolled nurses were increasingly promoted to managerial positions that they were previously ineligible for. Mrs Nkosi, an EN in a central hospital, described how she had been in charge of two wards and had also run a clinic. She was also able to benefit from increased training opportunities. As part of a government initiative, ENs became able to upgrade their qualifications to earn more money. Alfred had worked with many ENs who had upgraded and were now in senior positions. He told the story of a nurse who had been managing a public health unit with only a certificate in nursing, when "the hospital decided to send her to Kenya for a diploma in community health. She came back, worked extra hard and got a [UK] scholarship to study [for] a Masters. At the moment she is managing healthcare programmes." Earlier I spoke about male nurses often facing discrimination. Some respondents believed it was these recently promoted ENs who were the most anxious about male nurses. Respondents believed it was because they feared that they would lose their high positions to the newly graduated RNs, especially to the male graduates seen as more career-driven and management orientated.

7.3 Making changes

7.3.1 The current situation

They are trying but they [the government] are not trying hard enough.

Abigail

Another consequence of the migration years was the introduction of the Emergency Human Resources Programme (EHRP). Its objectives included expanding training capacity and improving incentives and salaries. Despite some successes (including the expansion of training output), retention and training output have been inadequate. One key informant noted that graduate numbers continued to lag behind population growth. Health facility observations revealed that, in 2009, older enrolled nurses continued to prop up the nursing system, suggesting that issues with retention and recruitment remained. Whilst more RNs have been trained, they continued to be absorbed into managerial positions or NGOs. Most respondents supported Abigail's view (above) that conditions have not improved enough, but some nurses like Mrs Nkosi believed that the resource situation had improved considerably since the Muluzi years: "there are big changes, things have improved very much in Malawi and we are enjoying working, because if you want something and ask our big bosses, they do buy for us."

Persisting shortages have helped to stall initiatives to improve working conditions. Catherine, an EN working in a central hospital, often worked alone and felt like she needed to 'divide' herself just to stay on top of her workload. One senior key informant commented that "they struggle, and they work very hard... they work 24 hours without rest, without food, taking care of 72 sick people alone." She believed that nothing much was happening and, in many ways, as life had become more expensive, the quality of nurses' lives was actually declining. One example of this can be seen in the higher cost of transport which has meant that nurses, especially in cities, currently have little option but to walk long distances to work. According to a senior source at the MoH, money issues have also limited the implementation of HRH initiatives, and many of his plans had stalled because there was no budget. Financial issues have also hampered strategies to recruit retired nurses back into service (Somba 2010), and fee support initiatives (see Box 7.1). On a larger scale, persistent financial troubles led to the closure of a number of hospitals in 2009, including St John's Hospital in the northern region.

Box 7.1 The fee issue

The reintroduction of fees in 2010 (previously covered by the EHRP) sparked anger and debate amongst stakeholders. A situation analysis conducted by the Nurses and Midwives Association of Malawi (NONM) found many students struggling to pay the fees despite having (cheaper) non-residential options, and many were forced to drop out (Phiri 2010). The Nyasa Times reported that because of the removal of fee support, CHAM students were paying 335,000 MK (2,300 USD) per year using their own funds. They added, “this in a country where the per capita income could hardly sustain such a personal investment.” (Nyasa times 2010b). Observers predicted that these fees would reduce the numbers of health workers by approximately 50 percent, leading to a shortfall in 2011 and undermining the gains made by the EHRP (MSF 2010). Because of these findings, NONM began lobbying for policy change. Partly because of this advocacy work and public outcry, on June 7th 2010, the government announced that it would reintroduce fee support measures.

Fee support has been criticised for attracting students only interested in ‘free training’. Although this strategy has improved nursing output, whether it translates to an increased workforce remains to be seen (as retention issues persist). Other strategies which have made clear improvements to nursing numbers include the locum system.

7.3.2 Locum payments

We are enjoying doing locums. If you do locums you will become happy because you will earn a small amount of money. Without locum it's really very bad, you can't manage to keep up to the end of the month.

Rose, 1984 EN GN

Nurses were unanimous in their enthusiasm for the locum system, and the quote above summarises many of their feelings. Whereas previously they would not be paid overtime, they were now paid for taking on extra shifts as part of an initiative to fill shortages. Nurses claimed that this system makes “everybody interested to work” (key informant). Locums served not only to motivate nurses and supplement their incomes, but also became a key strategy for managers desperate to fill the nursing gaps. As Chisomo said, “here the services are working because of the locums, if we didn’t have

that we would be in trouble.” However, the system is only a temporary measure to address shortages, and is expensive to maintain according to a MoH official, implying that nurses should not get used to the payments.

The nurses’ only criticism of the system was that, in some smaller health facilities, locum opportunities were scarce and in some cases the allocation of shifts was too bureaucratic. Key informants were much more critical. Some maintained that locums had not improved the quality of nurses’ lives, but merely allowed them to get by, as basic salaries remained low. They also claimed that because nurses had become so keen to supplement their incomes they often worked many shifts in a row. I was told the story of one nurse who turned up to work with a suitcase containing two weeks worth of clothes so that she could work continuously on locums. Chimwala claimed that “now with the locum, instead of being off, they are on locum and it’s making them even more exhausted, they are not resting but they have to do that in order to survive.” Silvia said that when nurses were tired they could not function and that this had contributed to problems with care delivery. Even though there is a policy to prevent nurses from taking on too many shifts, “they are able to locum continuously, because we don’t have the people to fill those positions” (key informant). Nurses have also begun to benefit from the allowance system. The HSC study (2004) revealed that nurses who claimed that the situation had improved in Malawi attributed this primarily to the introduction of allowances and improved workshop and training opportunities. The reliance on allowances and locums suggests that salaries remained inadequate, despite the EHRP salary top-ups.

7.3.3 Salary improvements

In Malawi, nursing is seen by government to be more of a calling than a profession. They are the angels, so they don’t need to be rewarded as much, they consider that the job is intrinsically rewarding.

Key informant, KCN

Despite salaries being raised by 52 percent under the EHRP package, most nurses continued to feel dissatisfied, although most acknowledged that they had improved, especially when compared to the absence of annual increases under Muluzi’s government. None of the nurses identified the rise, however, with the EHRP, but rather saw it as a sign from government that they were now more committed to improving their situation. Grace commented, “because he [the President] has introduced the raising up of civil servant salaries every July since 2004... so they are saying that the

civil service now at least it's better". Cecilia shared Grace's enthusiasm: "when I compare my pay slip from 2001 and now, it's by far a huge sum of money." In the early stages of its implementation there was a great deal of excitement about the top-ups. Respondents believed that the prospect of higher salaries was the main reason why the majority of graduates from the 2004 KCN graduation class went into the government health service and why many students entered KCN that year.

Nurses had long accepted that their salaries were low, but had always found ways to cope. Even at senior levels, it was common for them to supplement their incomes with activities such as farming or running small businesses. Although some felt that these activities were a thing of the past, the majority accepted that they continued. Evidence of this is seen in reports such as that of informal vendors (of which many are health workers) who continued to operate from hospitals, selling things like imported clothes and household wares (Van Kamande 2009). The struggle to survive was commonly mentioned by the respondents, and evidence of continued dissatisfaction could be seen in the resumption of strikes. In 2007 nurses went on strike in protest against the MoH salary payment system, which reportedly offered professional nurses similar wages to less qualified auxiliary nurses. 2009 saw another small-scale strike, when nurses and other staff in one hospital staged a sit-in in protest about low salary increments and the removal of allowances by their new Chief Executive (Somanje 2009).

7.3.3.1 What went wrong?

A 52 percent increase in salary seems like a significant rise, so why were nurses dissatisfied? The main arguments are that 52 percent of an already low salary does not make much difference, that expectations were mishandled, and that outside events served to diminish the real value of new salaries. Nurses had expected to receive a certain amount, but the removal of the tax-exempt status of allowances lowered the amount they received. In some ways the focus on improving salaries may have distorted expectations: although nurses are now amongst the highest paid civil servants in Malawi, most believe their salaries are still too low (this may also be symptomatic of that fact that all civil servants salaries are inadequate). Discrepancies in graduate salaries have contributed to the feeling that salary structures within Malawi are inequitable. When RNs compared their salaries to those of others with degrees, they felt that "the amount of money we were receiving was really peanuts, I couldn't really manage to survive at the end of the month" (Emmanuel). The KCN graduates felt

that as their salaries were lower than those of other graduates they were being taken advantage of.

Another reason nurses felt the rise was insufficient was rising living costs. In response to the pay increases many businesses raised the prices of commodities, which diminished the value of the new salaries. A key informant said:

Here we have a problem, whenever the country announces civil servant salary increases... businessmen they increase the prices of everything, transport. By the time we had got our rise it was just nothing. Sometimes we think maybe it would be better if it was just the same.

All of the nurses interviewed commented on how expensive commodities, transport and housing had become, making it difficult to get through the month with enough to eat. The situation is not exclusive to nurses. A survey revealed that 77 percent of households were affected by the large rise in food prices, and many now had inadequate food consumption (NSO 2005).

The salary top-up and locum allowances were the main initiatives to ease shortages that respondents identified. A few were aware of others, such as the expansion of training, but felt that they did not affect their lives directly. The recruitment of expatriate volunteers as a short-term solution did ease the workload burden, but enrolled nurses in particular were dissatisfied with inequalities in salaries and with the higher volunteer allowances. These negative feelings extended to how respondents (especially those at higher levels) felt about expatriates. It was often speculated by key informants that the salaries of the eight expatriate technical advisors brought in to assist with the EHRP amounted to the annual salary budget of all the nurses in Malawi. Some of the shifts in the nursing landscape were not the direct result of government initiatives. One such shift was the rise of guardian assistance (see Box 7.2).

Box 7.2 The culture of guardians

Whereas in the UK the physical and psychosocial needs of patients are primarily met by nurses or other health professionals, in Malawi this is the job of the patient guardian (usually a relative or friend of the patient). Officially, the guardian's role is to describe the nature of the patient's problem and to help implement home-based care. However, in reality, the guardian will clean, feed and dress the patient, leading some to comment that nurses have become too reliant on them, and now just seem to spend their time dispensing drugs.

The increased number of guardians 'assisting' in hospitals poses logistical problems. Although in practice guardians are meant to stay in a campus shelter and only come to the patient when they are needed to prevent congestion, in reality there are few shelters and most stay at the patient's bedside. A newspaper reported that in addition to having nowhere to sleep, support was lacking for guardians, so much so that in one case 45 guardians were stuck at the main hospital in Lilongwe because they could not afford the transport to get home after their patients had been discharged (Chipalasa 2009b). The hospital administrator claimed that providing support was challenging as the hospital could not identify true guardians from the overwhelming number of those pretending to be guardians to get hospital food.

7.4 The quality of care

The respondents' biggest concern was the decline in the quality of care provision and the low standards permeating the health care sector. There was strong agreement about this amongst the older generation and those in senior positions. The older nurses felt that many traditional nursing practices had been "thrown away to the dogs" by nurses who were no longer in the profession to care, but for a job and salary. A loss of work ethic has been observed throughout the country, especially when compared to the disciplined days of Banda. Booth et al (2006) reported that the loss of professional ethics in the Malawian civil service had caused those with the ability and motivation 'to do a good job' to leave. They pinpointed a number of causes including loss of morale from resource constraints, corruption and mismanagement. This is consistent with earlier findings that often it was hard-working nurses who migrated because they were frustrated with the poor standards of their colleagues. In addition to being frustrated

with their behaviour, nurses increasingly felt that they had to pick up the slack of their 'less dedicated' colleagues, as Mrs Lunda said, "if your friend is not doing anything you have to go and help the patient."

7.4.1 Evidence of decline: nurses' accounts

James believed that it was difficult to measure the decline in quality, as there were no approved standards. The respondents' belief in the decline was primarily based on their observations and comparisons made with the nursing system in previous years.

Common observations included:

- Nurses generally having a bad attitude (Chisomo);
- Nurses not working hard (Mrs Lunda);
- Nurses only thinking of drug administration, no longer other practices like checking vital signs, hygiene care or feeding (Chisomo, Grace, Alinafe, senior NMC officer);
- Poorer infection control (Mercy);
- Matrons staying in their offices chatting without going on ward rounds (key informant).

The respondents were unanimous in their belief that it was the younger generation who were the biggest 'perpetrators' of poor standards. Grace said:

It's true we cannot deny the truth. When we qualified in our days, nursing was perfect and good. And patients were being cared for. But nowadays patients are being cared for by the guardians.

The rise of guardian assistance appeared to have contributed to a shift in the nursing culture whereby nurses felt that they had served well by just by turning up for their shifts (Mrs Banda). Sarah found that whilst in the past nurses would never leave a ward unattended because their shift had finished, nowadays this was common practice. She acknowledged that there were a number of contributing factors to such behaviour, but "at the end of the day, it's very unprofessional for you to leave the ward because time was over. There is a pledge for nurses, if you really mean what that pledge says these things can never happen."

7.4.2 Evidence of decline: reports

To begin with, let us admit that the nursing profession in the country has never cut an enviable image. Nurses and midwives, especially in government hospitals, are seen as lazy and lacking compassion when treating patients.

Nkhoma (2009)

A number of reports have focused on the conduct of nurses, in particular a NMC case regarding eight hospital deaths which were thought to be caused by the negligent practices of nurses in the facility (Nkhoma 2009). One article about nine newborn deaths (attributed to the actions of a nurse) included the comment from a relative, "the nurses are not helpful here. They are rude and many people have lost their children due to their behaviour" (Nyasa Times 2009a). This reflects wider perceptions about nurses, including that they no longer have the characteristic nursing traits like empathy. In terms of the general decline, the Nyasa times reported that 77 health clinics had been closed down by the Medical Council of Malawi because they did not comply with standards, and that some were staffed by people with no medical training (Nyasa Times 2010c). Healthcare literature also revealed findings of poor standards. A small-scale qualitative study by Yesaya (1999) reported that patients in a Malawian health facility had problems in interacting with nurses as they found that they often showed a lack of interest in caring and helping. The patients also said that nurses commonly made harsh and threatening remarks.

A revisit to the 2004 HSC study also revealed an increasing disregard for work ethics. These reports reflect the growing number of malpractice suits against nurses in Malawi. Respondents believed that this developed into a culture whereby nurses felt that if you had mismanaged a patient and the government sacked you, "you can go in court and hire a lawyer. Maybe you will be on the good side of the case; the government is going to pay more" (James). In other words, the system would always protect you, so you had little to risk. Earlier we saw that some were hesitant to go to the UK because they felt that they would lose this support and be at greater risk of legal action. Although cases of improper practice are increasingly handled by the NMC Malawi, one key informant argued that because nurses are on the front line they are easier to blame for the mistakes that are actually generated by the system. She gives the example of a nurse who was held responsible for the death of a patient, whereas she was left alone to handle a number of wards, making it impossible to properly attend to each patient.

Aubrey felt that the NMC often did not protect or support nurses in such cases. They were “left out on their own”, and many could not afford lawyers.

7.5 Explanations for the decline

I visited a rural district hospital, I was so shocked to see that the nurse is sitting in the hospital while knitting a cardigan, and the patients are there, and I am like ‘oh my God there is no such time in England to do that, you couldn’t even knit a cardigan’. But they have got all the time, a patient comes in and they will say ‘just wait for the doctor to come in’... For them it is normal.

Eleanor

When Eleanor returned to Malawi she was surprised by the sight of a nurse knitting. She asked, “is it that nurses in Malawi are so burnt out that they don’t care, or is it something else that was instilled whilst they were training, the culture, or was that just a unique incident that she had witnessed?” The most common explanation given by respondents was the lack of staff, in combination with poor working conditions.

7.5.1 General situation

There are so many complaints on the attitudes [but] you also need to remember the conditions the nurses are working under, it’s pathetic. There are too many patients, very few nurses; you know it takes something away from you (even if you are passionate). You have 200 patients where do you start from; you can only do so much.

Abigail

The high workload preventing nurses from giving patients adequate care was acknowledged by respondents. Many also talked about burnout. Grace said, “they are tired and hungry; you don’t expect anything from the nurse because the nurse is a human. That’s why the nursing has gone down.” When Rose (1984, EN) traced the shifts in standards over the years, she blamed the increased workload:

I can remember during my training days... we were able to give total patient care, give them a bath, you have time to chat with the patient, if they have a problem they share, but now you don’t have time. We want [to give perfect care], but can’t because of time. Nowadays the patients only see you once in their place, and then they see you again, they think you are ignoring him, that’s the problem there are too many.

There is support for the link made by the respondents between low standards and poor working conditions. Mutizwa-Mangiza (1998 cited in Chikanda 2004) attributed falling standards of care, including uncaring attitudes of nurses, to low morale resulting from

an excessive workload and the stress of dealing with many dying patients. Chikanda (2004) also highlighted the link between staff shortages and the decline in quality of care in a study of Zimbabwean health worker migration. Support for this also comes from the observations of Rebecca, who explained that although Malawian nurses are not seen as hard working, when they go to the UK or work with an NGO they do work hard. So it is the “system that makes them behave that way”.

7.5.2 Contributions of the nursing system

Some respondents believed that the system also propagated poor standards of care. Despite increased legal cases, there remains a belief that there is little accountability. Booth et al (2006: 19) claim that that the relationship between employer and employee in Malawi often resembles a family relationship with mutual obligations of protection. In such a situation poor performance is no reason for dismissal; instead, the “mediocre performance of a poor employee is concealed by colleagues and supervisors, who treat him like a younger brother, to be shielded and advanced.” At a meeting of senior nursing figures in 2009, there was agreement that it was difficult to ‘get rid of’ bad staff. This relates to the thoughts of Anna, who felt that standards had declined partly because the NMC Malawi no longer conducted inspections: “the inspections, it was instilling some fear into the nurses, they knew that they were going to be reported. But now there is nothing.”

On the other side, there was a refusal amongst many senior nursing figures to...

Accept the excuse that there is high work burden. You need to assign priorities when there are so many patients.

Senior NMC officer

A comment in the Daily Times (Nkhoma 2009) also argued that working conditions should not become an excuse for nurses not to perform. Informants explained that nurses had become used to being told that their conditions were bad, leading them to believe that they would never fulfil their targets. In the words of one informant, “why should they bother?” Such behaviour may be related to the ‘tall poppy syndrome’, common in Malawi, where excelling beyond your colleagues is frowned upon. Booth et al (2006) explained that those who do excel will be ‘cut down’ to the same level as

everyone else in the peer group²⁶. This culture gave nurses even less of an incentive to perform. It is also self-propagating: informants believed that new graduates would not stick their necks out and do extra-work as they wanted to behave like their colleagues to fit in. Many felt that new nurses would often adopt the old ways they saw in the hospital even if they had been trained differently.

7.5.3 Generational differences and career choice implications

You can see the way they work it's very different to we, the old nurses. We are dedicated to our jobs. These ones are lazy, and you can see that they are lazy because they choose not to work at all. They refuse to do dressing, a long time ago we would do any jobs, bed pans, but now... they just want to work in the offices not caring for the sick. Some they are just coming for money, they are not very serious about their career.

Mrs Lunda, 1970s EN GN

Senior nurses claimed that the generational shift in motivations to become a nurse was responsible for the decline in the quality of care. They felt that younger nurses were no longer motivated to care and were not passionate about their profession. Chisomo observed that “it’s had a lot of impact [on motivation], the way the nursing care was in the past with these days, these days there is no nursing care.” Mrs Banda questioned whether those who went into nursing primarily for financial reasons would really deliver services in the same way as someone who had really wanted to be a nurse. Whilst the older generation became the yardstick by which to measure nursing performance, the generation of nurses who ‘chose nursing for the qualification’ have, for many, come to represent the values seen in the quote above from Mrs Lunda.

The strong motivation for many young RNs to go into management positions was also seen to contribute to the shift in quality. Whilst many younger RNs have been able to enter managerial positions relatively quickly because of the nursing shortages, and the nature of RN training, many claim that they are too inexperienced and unprepared. A senior figure in the NMC commented, “they do not know the processes for example, how many people should be put on each shift.” Another key informant believed that sometimes such promotions are not the will of the nurses. She claimed that it was unfair to promote a nurse on the basis of their qualifications without any preparation, as they enter the positions not knowing what to do.

²⁶ Although this apparently contradicts the culture of gaining extra qualifications, it primarily relates to not ‘showing somebody else up’ whereas the former is linked to higher salaries and respect.

7.5.4 Training situation

Whereas the number of nursing graduates has increased, many argue that the infrastructure to support their training, especially in terms of support for their clinical practice, is lacking. There are still not enough tutors. One teacher at KCN explained that they advertise for positions but get no response (he believed this was because salaries were too low). Because of the shortages, tutors are primarily occupied with training in colleges and are not able to join their students in the wards during clinical practice. Ward nurses (usually ENs) have become the ones supporting the students. While this is adequate in theory, in practice the system has a number of shortcomings; for example, RNs are trained by ENs, which many believe limit the abilities of new nurses.

For both EN and RN training, nurses felt that they were not prepared for the work burden when they first went into the wards. Often the practices they learnt could not be implemented because of high patient load and resource shortages. Nursing colleges are usually well resourced, enabling students to learn how to treat patients with the correct equipment. When they reached the clinical setting they found that the resources and equipment were not there. Emma described how ill-prepared she felt when she graduated: “when you leave you go to the hospital and you are shocked. I couldn’t cope and that’s why I ended up in a private hospital.” The frustration extends to tutors also. Christina recalled teaching students how to do certain tasks with set equipment, but when she arrived in the clinical setting she found that “they can’t set a trolley as you taught them in the lab. Students ask you, ‘Madam taught us ABCD but it’s not there, how can you provide care?’ So then you say, ‘you can just improvise’. Is this the care you are supposed to advocate?” Christina had to encourage the students to be innovative, but in terms of consistency of teaching and expectations of students, both students and tutors wound up frustrated.

Whilst student nurses were left to improvise, they often picked up shortcuts and inappropriate behaviour from the ward nurses. Because the nurses themselves were overworked, in some circumstances students would be left unattended. In other African countries where recruits are often left to carry out work without supervision there is a risk that they may make incorrect diagnoses or perform duties that are beyond the scope of their role (Awases et al. 2004). Chisomo believed that the current arrangements for students on the wards were both inadequate and dangerous:

You find the enrolled nurse who is already tired; she doesn't care, so this enrolled nurse is relating whatever they are doing. So when she [the student] is qualified she will be practicing this. That's why the standards are going down... I am worried, especially in maternity, it's very sensitive... In the labour ward we have [many students], there is a lot of traffic and sometimes you find more staff than patients.

The issue of traffic on the wards has become much more important since the student intake was increased. A meeting of nursing leaders in June 2010 revealed that the large intake was having negative repercussions on health facilities by causing congestion. Increased numbers also made it difficult for the students to reach their targets. For example, midwifery students are required to perform a set number of deliveries in order to qualify. Students now scramble to get cases, and in some instances the resultant rush compromises patient treatment. Such situations also led to nurses cheating to fulfil their targets. In August 2010, a Malawian newspaper reported that 26 midwifery students had been expelled by KCN for 'cooking up figures', reporting that they had performed the set number of 20 deliveries required by the NMC Malawi to pass the course when in reality they had not (Mpaka 2010).

In addition to the potential explanations examined here, some respondents believed that younger nurses would always be considered less competent than senior nurses, who were thought to be nostalgic for the older generation of nursing and its inherent discipline and respect. Misunderstandings between generations may also arise because of differences in training. One informant believed that quality declined because older nurses no longer acted as role models for newer students. He believed that students often entered the wards very keen but became disillusioned not only after experiencing poor working conditions but after observing other nurses' behaviours, for example seeing them taking extended breaks and not working hard.

7.6 Section conclusion

Although conditions were difficult for nurses who remained in Malawi during the post-migration years, some were able to take advantage of improved job vacancies and government initiatives to address the shortages. With the exception of the locum system, respondents believed that government initiatives had done little to improve conditions for nurses in Malawi. In fact many believed that in recent years the quality of care delivered had declined. The key reasons for this decline were linked to the shift in motivations of new graduates, as well as to a health system infrastructure that was unable to support the increased output of nursing graduates. Although those who

migrated were able to escape this decline and persisting poor conditions in Malawi, they faced a number of challenges in their new workplaces as well as in their personal lives. In the second half of this chapter I examine what happened to nurses after they migrated. I follow their stories from arrival in the UK, through adaptation to the workplace, to life at home.

Life in the UK

7.7 Decisions and expectations

Any migration process is filled with expectations and decisions. The steady stream of nurses leaving during the migration years had armed prospective migrants with stories of UK life. Many expected to find employment easily but expected to work hard. They also anticipated culture shock, or, as Alfred predicted, a “different culture, different people.” Like most migrants, nurses relied on the assistance of friends to cushion the transition and provide necessities from food and shelter to recreational and emotional support (Boyd 1989, McGregor 2008).

Whilst most employment decisions were made on behalf of the nurses by nursing agencies or by friends who organised placements for them, a few such as Alfred and James decided where to go and where to work on their own. Emma settled on London because she had completed her adaptation course there, but many relied on joining friends or relatives already in the UK, as James did. Alfred felt that he had made a false start by going to a northern city following a job offer as he found himself cold and isolated, with only one other Malawian there. Like the majority of nurses, Alfred eventually sought comfort in a larger, multi-cultural city where he could benefit from having Malawian friends and a ‘diversified social life’. Most nurses were keen to avoid rural areas because they felt that as ‘Africans’ they would not fit in. Emma explained that as there were few black people in such areas there was more racism.

7.8 Arriving in the UK

Although prepared with stories and advice, many nurses were shocked by the life that greeted them in the UK. Florence was surprised by how expensive everything was and how hard she would have to work “just to get enough”. She said that “at first when I

came I thought oh I better go back,” but her husband encouraged her to stay. Cecilia felt that because everything had been done for the nurses before they left, they were unprepared for UK life, and only when they arrived, “that’s when they realised that it’s not always that rosy.” Julia said that those who had never travelled did not cope well. She noted that it was common for Malawians to “quickly move from one place to another. If they met resistance... they easily resigned and moved elsewhere.” This was also Lindiwe’s experience.

7.8.1 Lindiwe’s story

I met quite a few people who had worked at the same place and they said you were there? Oh my God that place is terrible!

Lindiwe, RN 2002 UK

When Lindiwe arrived in the UK, her agency sent her to work in a care home. She was greeted by a home that was not yet open, and by an owner who told her she must help with the painting, adding, “everybody is doing it, everybody who is going to be working here.” Lindiwe was surprised by this, “this is not what I expected”. So she told him that she would come back in the morning, but instead she packed her bags and left on the bus to visit a relative in the UK without saying goodbye. Lindiwe recalled, “I didn’t know the UK. That was my first time going to Europe, but I had to do it, I said no I am not allowing this man to take control of my life like that. I just saw his attitude.” The fall-out from her departure was that her mother in Malawi began to receive aggressive calls from the agency demanding to know where she was. She remembered, “my mother was in tears because she didn’t know what to do. She was like please call us, because these people have threatened us.” Lindiwe quickly had to find another job, as she was supporting her sister’s education, and within a week she went to work in another care home.

Although these events were traumatic, it was not unusual for nurses to face unexpected situations upon their arrival. Often when agencies allocated jobs, nurses had little idea about where they would go and what they would end up doing. Many were also unaware of their rights, and unlike Lindiwe they stayed because they felt an obligation to the agency that had brought them over. This situation is not uncommon. McGregor (2008:602) explained that the Zimbabwean professionals in her UK study were vulnerable because they had ‘inadequate information on reputable agencies and

'their rights'. The type of experiences nurses had were usually dependent on where they worked. Many stories - such as Lindiwe's- played out in care homes, often because they were not as regulated as the NHS. In the next section I look at the two main employment destinations for Malawian nurses: the NHS and care (nursing) homes. It was noted that some Malawian nurses also worked in private hospitals, although none of the nurses I interviewed did.

7.9 Employment destinations

The majority of nurses interviewed began their UK working lives in care homes. This was because most agencies that brought them over and gave them work permits recruited for this sector. However, for many nurses NHS employment was the pinnacle of success, and they used the homes as a springboard to employment there. Others remained in the care home sector either through choice or necessity. Those who went straight into the NHS were either directly recruited (through websites, like Alfred) or because they had either completed their training (like Martha and Eleanor) or adaptation in the UK (as Emma had). Many found the first route lengthy, and some (including Sarah) ended up working in care homes by default because the NHS took so long to respond to their application that they became nervous about their work permit. Both sectors have distinctive characteristics that influenced the choices nurses made about their employment destination. Table 7.1 shows the main advantages and disadvantages according to respondents.

Table 7.1 The advantages and disadvantages of NHS and care home sector employment

Sector	Advantages	Disadvantages
The NHS (Dinah, Emma, Eleanor, Silvia, Alfred, Peter, Martha)	<ul style="list-style-type: none"> • Higher salaries compared to other employment settings • Job security and formalised procedures • Support for training • Well respected sector 	<ul style="list-style-type: none"> • Fewer opportunities to supplement income • Recruitment procedures lengthier • More competition for positions and promotions • Nurses require specialist training for certain departments
Care Homes (Florence, Lindiwe, James, Anna, Aubrey, Sarah)	<ul style="list-style-type: none"> • Simpler recruitment procedure • Flexible shifts and overtime • More opportunities for jobs and promotions • Do not always require specialist training or computer literacy 	<ul style="list-style-type: none"> • Emphasis on drug administration and attending to patients' physical needs • Fewer formal procedures • Fewer training and specialisation opportunities • Stigma associated with care work

7.9.1 The NHS

Like the government service in Malawi, the security, career structure and training opportunities within the NHS made it an attractive destination for the interviewees. This is consistent with findings from the literature on nurses from other backgrounds.

McGregor (2008:603) found that Zimbabwean nurses aimed to work in the NHS because of its higher salaries and opportunities for training and career development. NHS salaries were for the most part much higher than those in care homes and many were able to supplement their income with NHS bank work (temporary or additional work similar to the locum system in Malawi). However, Eleanor complained that bank work did not pay as much as the agency system which foreign nurses were now exempt from. She felt that the NHS kept increasing the restrictions against IRNs. Although nurses specialise in the UK, respondents were often unable to work in specialist departments because the nature of their training in Malawi made them ineligible. However, many were content with the bedside nature of their roles. James felt that the regulated and formalised structure also meant that NHS employment was less risky. This is consistent with the responses of nurses in McGregor's study, who felt that the NHS had proper procedures for handling racism, unlike the private sector.

Despite these perceived advantages, many ended up working in care homes partly because of work permits, which were harder to get in the NHS. This pattern is common in the UK. Pike and Ball (2007) found that IRNs were more likely to be employed in care homes, and currently six out of ten UK care home workers are foreign-born (Centre on Migration, Policy and Society cited in Staines 2009). Although work permit issues and the bias in agency recruitment to care homes may explain why nurses ended up there, there are a number of reasons why they chose to stay.

7.9.2 Care homes

Most nurses don't have a dying ambition to work in care homes, it's not a career choice for lots of reasons, but need outstrips demand.

Care home manager, UK

The care home sector provides a fertile ground for nurses coming temporarily to the UK to achieve their goals. The flexibility of shift work allows them to balance work and study commitments and to take on extra shifts to supplement their income. Flexibility of service was also a major draw for those with families as it allowed them to timetable their shifts around child-care commitments (a finding supported by McGregor 2008). Whilst Florence would have preferred to work in the NHS, because of child care issues she stayed in the care home sector because, unlike in the NHS (which rotated its night and day shifts), she could remain on night shifts and look after her children in the daytime. Lindiwe was able to juggle child care and her Masters study around her care home shifts. The care home also allowed her to take time off (for example, when she had an essay due), but still keep her permanent position. Additionally, because the sector is unattractive to domestic workers there are greater opportunities to get a job, and then to be promoted. As Eleanor explained, whereas in the NHS "they are all wanting, fighting for the same position, they all want to go higher, and it is too competitive", it is easier to progress within the care home sector. James was promoted to the deputy manager position in his care home within a year of being in the UK. A year later he successfully applied for the position of manager and has remained in the position ever since.

Many nurses were unprepared for what care home jobs entailed, partly because Malawi does not have care homes²⁷. Dinah assumed that she would be nursing because of the title 'nursing home'. However, many found themselves administering drugs or attending to the physical needs of patients, a job that they were no longer used to because of the widespread use of guardians in Malawi. The repetitive nature of the role led Dinah to leave her care home for the NHS because she felt that she might lose her skills. Some nurses were prepared to compromise on the repetitive role because, unlike in the NHS, there was less reliance on technology and IT and they did not have to prove that they were computer literate. Eleanor said that nurses often felt "more comfortable with providing basic care, you don't have to prove that you are good with technology when you may not be." This also meant that they were unable to learn to use specialist equipment. Florence felt that by being in a care home, "I have restricted myself because I am not doing general nursing where I would be exposed to all of that technology." Many respondents also felt that because care homes were less regulated than the NHS, managers and colleagues were able to get away with inappropriate practices. Similarly, as the nature of care home work put off domestic nurses, it was also a source of shame back in Malawi. Care home work became synonymous in Malawi with BBC, a job that carried much stigma. As RNs are seen to be well trained, such a role was considered to be beneath them. It led Cecilia and Monica to question how well nurses were doing in the UK if they worked in such roles. The NHS was considered to be the most desirable employment destination by nurses both in the UK and at home.

7.10 Working life experiences

The relatively well-developed social networks linking Zimbabwean professionals to the UK public service labour markets do not mean that skilled migrants have had a smooth entry into professional employment in Britain.

McGregor 2008: 601

Despite the appeal of the NHS, nurses commonly experienced hardships both in the NHS and in the care home sector. As McGregor argued in the quote above, they found that entry into employment was not as smooth as they had anticipated. Although many

²⁷ The high level of responsibility for relatives in Malawi extends to taking care of older relatives in one's home, meaning that the care home culture is one that nurses were not familiar with.

claimed that they had positive experiences in both sectors, most stories of working life were negative. This is consistent with much of the literature regarding the experiences of IRNs in the UK (including Aboderin 2007, Alexis et al 2007, Likupe et al 2005)²⁸. As Allan and Larsen (2003) found, most nurses in the NHS were happy with the support they received. Silvia had many good experiences during her time in the NHS, especially as she was able to benefit from training. Florence also felt pleased with the training her care home offered. When comparing her new role to her previous one in Malawi, she was also pleased with the lower workload. Many nurses were satisfied that the pull factors that brought them to the UK were there in reality (such as good working conditions and better resourced and managed facilities). In the literature review the main areas in which IRNs had negative experiences were interactions with colleagues and patients (including non-recognition of qualifications), adjusting to differences in nursing style, difficulties with career progression, and unmet salary expectations. In the following sections I examine how the nurses' experiences relate to these areas.

7.10.1 Relationships with colleagues and patients

Julia left her job as a nursing tutor in Malawi for a care home job in the UK. Whilst she was willing to take a step down in terms of her job, she was not prepared for the behaviour of her colleagues in her care home, which she described as 'the house of horrors'. Employee behaviour included smoking illegal drugs. She found that:

There was so much hatred, [they would] ask: 'why did you come to the UK? Don't you have any jobs in your country?' I said that there are, but it's for education to travel and work elsewhere... It's like you are going there to steal their money. You must look that you are desperate... It's also a lack of understanding about what life is like in Malawi... This made me really to be so low.

Respondents found it difficult to cope with colleagues' poor attitude and lack of professionalism, especially in care homes. This is consistent with much of the literature in which IRNs repeatedly speak of poor treatment by their colleagues. This includes Aboderin's (2007) qualitative study, which found that Nigerian care home nurses experienced discourteous and domineering behaviour from white British carers. Commonly, the main perpetrators were junior staff members and respondents like Julia tried to rationalise their behaviour by saying that perhaps they weren't used to seeing a black nurse in charge. James felt that such behaviour resulted from carers being

²⁸ Although such a portrayal of UK life may be linked both to the social desirability effect (where nurses felt that they needed to say what was expected of them), or because nurses may have used our interviews as an opportunity to vent their frustrations and therefore were portraying life more negatively than it actually was.

frustrated because they were underpaid. He explained that some carers were highly qualified in their home countries (some even had PhDs), but ended up working in care homes on the minimum wage. They also rationalised that if they reversed the situation, they may not have known how to deal with foreign nurses in Malawi.

Unfortunately, a number of nurses felt that patients did not treat them much better. Commonly cited patient behaviour in both the NHS and care homes included refusing treatment and being abusive. Those working with older people often found that they were uncomfortable with having a black nurse care for them (younger people tended to be more open). Nurses also faced a minefield of potential slip-ups, which often caused patients and families to become impatient. The UK has numerous accents and colloquialisms which respondents commonly struggled to understand and can cause difficulties even for English-speaking nurses (Allan and Larsen 2003, Likupe 2006). Eleanor remembered a phone call from the family of one her patients. Whilst the name on the patient file was 'Elizabeth', the family were asking how Betty was doing. Eleanor did not know that Betty was a shorter version of Elizabeth, which confused her and frustrated the family. In addition to the challenges of overcoming the refusals and frustrations of patients, many older care home patients also had dementia and would sometimes be abusive or violent. Abuse from patients, however, was not limited to dementia patients. Martha and Emma also experienced abuse in their wards (mental health and cardiovascular, respectively). Emma found that "in the hospital sometimes you get patients who are abusive and they start saying things. And you think why I am working, doing this for a person who doesn't even appreciate?" Research suggests that Martha would typically be more at risk because she worked in a speciality characterised by higher incidence of verbal abuse (Pike and Ball 2007). However, Emma did not work in a high-risk ward but still faced abuse, suggesting that such behaviour is not limited to certain patient groups.

Beyond the inconvenience and potential embarrassment, patient refusals also had serious implications for nurses. Martha moved hospitals because too many patients refused her care (even though she had re-trained in the UK). Her coping strategy was to always ask a junior member of staff to join her, but her manager took this to mean that she was not a confident nurse and tensions developed between them. She felt that the patients refused her care because of a lack of confidence in her qualifications. Poor interactions with managers can potentially cause nurses to leave their jobs, as Lindiwe said:

If they don't like you they will try and make sure that they frustrate you to just leave.

Whilst NHS nurses may not have experienced overt bad behaviour from their colleagues, they commonly showed inappropriate behaviour by not recognising their qualifications. Respondents repeatedly said how uncomfortable their colleagues were with the fact that they had trained in Malawi, and often believed their training was inferior. Martha found that when she revealed that she had trained in Northern Ireland they would be relieved: "they would be ahh <sigh of relief>... you trained here... it's like if you trained somewhere else possibly they would be 'get away from me!'" Even though she had also trained in the UK, people assumed that Eleanor was not good with technology and computers. She found that when she arrived for bank shifts (in a different ward to her regular one) the managers would send her to the menial low-tech jobs as they assumed that by being African she could not work with specialised technology. On one occasion a manager cancelled her shift before meeting her because they saw her name and assumed that she could not work with technology. She explained that:

It is very frustrating to have to prove that you are not ill-equipped, unskilled just because you are a Malawian nurse. They look down on you, so you have to build up trust and confidence in these people to show them that you can do these things. You have to work harder to prove this.

The negative connotations of being an 'African' nurse followed Martha everywhere, and she began to find similarities between herself and her patients in terms of the stigma that they both shared. She explained that in her mental health nursing job:

I met people with mental health problems: they are exactly like me. Not in a bad way but it's the way I feel. Anybody with a mental health problem is stigmatised – he's mentally ill – myself, I am a foreigner – oh black – so we suffer the same kind of stigma... and when you look at them you are in the same boat.

7.10.2 Differences in practice

Whilst the respondents tried to come to terms with their perceived difference in status as black nurses, they also had to adapt to different nursing practices despite the suggestion that because of colonial links nurse training would be similar. All the respondents spoke about the burden of having to learn all the UK health sector standards and policies. Anna found that "sometimes it was scary, it was like you had to learn all these standards and audit by heart." Although nurses spoke about being initially surprised by the nursing role in care homes, most found it easier to adapt to because of its emphasis on basic patient care. The main differences nurses faced in

both settings were the lack of their own autonomy and the greater autonomy of patients. With the shortage of doctors in Malawi, some of the their duties were shifted to nurses. This meant that they were used to carrying out certain procedures such as setting up intravenous lines, which UK nurses are prevented from doing until they complete a specialist training course (O'Brien 2007). Alfred found it "frustrating to have to wait for a doctor when you know that you can do it yourself." Emma found this situation not only frustrating but insulting, especially as she had been working in her ward for eight years but still had to defer to junior doctors who had only been on the job for six months. Emma explained that because of the comprehensive nature of training in Malawi, where "you are trained to be a manager, the problem solver, the decision maker", she found the more 'theory orientated' UK nursing system at odds with the autonomous way of nursing she had learnt. Although the nurses were confident in procedures many domestic nurses 'had just read about', they were less confident in the use of technology, especially as many of the machines were not widely used in Malawi. Julia recalls that her colleagues had asked her why she wasn't able to use equipment which domestic nurses commonly used: "how can you be a nurse and can't use an ECG?"

Whilst respondents felt that the autonomy of nurses in the UK was limited, they were acutely aware of the shift in patient behaviour. Whereas in Malawi patients would not necessarily be knowledgeable about their condition or question the care they received, the opposite was true of patients in the UK, who were actively encouraged to learn about their condition and treatment. Because of this Silvia found that "you need to remain sharp and know what is going on." There were also more subtle differences which nurses had to adapt to. Sarah gave one example of how death is dealt with in the UK. She was not used to the practice of leaving a deceased patient alone quietly with their relatives in the care home. She explained that in Malawi the patient would be taken outside and there would be an intense display of grief: "the way we react if somebody dies: the whole building can tell there is a death." Such differences were, in some ways, harder to adapt to because, unlike standards for drug administration which they could read about in a book, there was no such resource for learning about the subtle cultural differences they experienced. They often learned through their mistakes.

7.10.3 Career development

An important theme identified in the literature review was the career development challenges faced by IRNs. Although my interviews were full of stories of friends who had not been promoted, few respondents had found it difficult to progress in their careers. As we saw, James had become a care home manager, Emma was acting as in-charge in her ward, and Martha found that despite her earlier difficulties with her manager, "I managed to get a senior posting whenever it was available." The respondents who did experience difficulties in their career development attributed them to inadequate knowledge of the promotion system or the preferential promotion of friends by managers. Only Eleanor felt that being an African nurse had stalled her career development. She explained:

It is very hard as black to get a promotion in the NHS, there are so many other ethnic British people in the system wanting to be promoted that they get all the chances first, as they have been brought up in this system and are seen to have the advantage. Especially when Malawian nurses have to learn how to do many things including communication, learning colloquialisms, when you go head to head for a promotion you know that the British person will get it ahead of you.

It is, of course, difficult to measure the extent to which racism is responsible for career progression difficulties (Allan et al 2004). For example, difficulties could result from a misunderstanding about the nature of the nurse's training. We saw above that despite nurses claiming to be confident with certain procedures, some were unable to handle commonly used technology, leading to confusion amongst their colleagues. The lack of appreciation of qualifications may also have been exacerbated by the practice of IRNs entering the UK workforce at low nursing grades.

7.10.4 Deskilling

It is sad when you get a trained matron who is good at her job in Malawi who then leaves to the UK to work in a nursing home, it is a wasted brain. A nurse leader from Malawi is now in a nursing home, it is downgrading her skills, but at least she can send her children to school. I do not blame them for wanting to go and get more money.

Key Informant, MoH

Even if many respondents did not feel that they were held back in terms of career development, many began their careers at levels incommensurate with their years of experience. It was common for nurses - especially those coming from senior positions - to be employed at a lower level than they had been in Malawi. Differences in practices

may necessitate a period of adaptation to the UK system, especially for those who came when adaptation programmes were not compulsory. However, nurses often found themselves working at levels beneath their capabilities, a process referred to as deskilling. In her study of UK IRNs, Smith (2004) found that nurses were bewildered to discover that their skills and experience counted for 'nothing' in the destination country. Similarly, respondents had to adjust to the drop in status, especially those in care homes. Julia explained that, whilst in Malawi, "you are very respected as an RN, you become manager, but when you go to the UK you are diminished to a lower level, so you have to adjust your life, I am not at home I am here. So I have to listen and act upon instructions." The feelings of such a drop in status and responsibilities were heightened by the fact that some nurses would be managed by untrained care assistants.

Whilst Julia, having been a lecturer in Malawi, accepted that she would not be able to work in an academic position (especially as she only intended to migrate temporarily to make some money), she found it difficult to hear her colleagues say that she was the most qualified nurse amongst them because of her Masters, even though she held the lowest position. Julia felt that if she had been in a more senior or academic position she would probably have wanted to stay in the UK and not return to Malawi as she eventually did. This suggests that whilst deskilling is both 'brain waste' and de-motivating and frustrating for the nurses, from a source country perspective it may encourage return migration.

7.10.5 Why not make a fuss?

It was an emotionally stressful time...because professionals undergo acute deskilling when they start work in the UK as overseas experiences is discounted and many suffer an acute loss of status.

McGregor 2008: 602

The process of adaptation to UK nursing, in combination with deskilling, was stressful. Although nurses had experienced difficult working conditions and high workloads in Malawi, they found that the coping mechanisms they used back home became obsolete in the UK. For some, the stress was made worse by the fact that they moved between care homes, often meaning that they had to repeatedly adapt to new circumstances. However, many felt that they had little option other than to tolerate firstly the fall in status and level of responsibility, and secondly the behaviour of their

colleagues and managers. Whilst there were procedures in place to make complaints about the latter, especially in the NHS, Lindiwe said that:

Nurses perceive that if they make any complaints to their employer, they will lose their job. People do not think about themselves, they think about their families and what would be the consequences if they lost their job and most importantly a work permit – you rely on your employer for that, so people put up with it.

Nurses felt especially vulnerable because their work permits were often tied to their workplace. I was told the story of one nurse who had lost her job at the same time as her UK visa had expired. Desperate to find a new job, she was struggling through the court system to fight to stay, but friends felt that the situation was not hopeful. With regard to the behaviour of patients, Eleanor felt that people did not complain because it was part of Malawian culture to ‘swallow it’ and just accept things. However, Martha felt that the situation was improving as people were increasingly exposed to individuals from overseas and were becoming more tolerant. She said that, increasingly, “you don’t feel uncomfortable or have to explain yourself before you do anything”.

7.10.6 The financial equation

Nurses were also reluctant to complain because they feared losing their salaries. As Lindiwe said above, losing a job and salary had consequences beyond one’s immediate life in the UK, with repercussions for family in Malawi. Despite stories of the high exchange rate and the financial success of previous migrants, some found that the reality did not match their expectations, and many grew to understand the meaning of ‘sweating for your pound’. Compared with other professions in the UK, nursing salaries are not high²⁹. Their value is further diminished when high UK living costs are taken into account. Many felt that, unlike in Malawi where you could potentially grow your own food or rely on the support of family, in the UK you had to have means in order to survive. As Cecilia said, in the UK you have to work to eat, whilst in Malawi “you have people not working but still eating.”

In order to meet living costs and the demands of family in Malawi, many nurses took on extra work through additional shifts or part-time jobs. This was also common amongst the Zimbabwean nurses in McGregor’s (2008) study. Silvia found that “my [UK] salary was not enough, I had to make sure I did some extra work. At the weekend I would find

²⁹ An annual general nurse salary on a middle grade (5) in the NHS is between 20,710-26,839 GBP (NHS careers 2010). A typical care home wage would be from 5.80 GBP per hour, although at managerial level it would be much higher (key informant UK).

something to do just to add that extra bit. So you find that you are a bit overworked... you don't have time to relax." As a result of the extra workload, many nurses including Silvia became burnt out. She recalled that at one point, "I was really exhausted, you become a workaholic, the only thing you are thinking of is, I have this amount of money in my account but you need more and you can't do it any other way than finding something in addition to my job. You don't even think of yourself anymore you are always on the run." Although those back home knew nurses had to work hard, many believed that only the nursing situation in Malawi caused such burnout. Very few were aware of how hard those in the UK worked to send money home.

7.10.7 Expectations

People hide the truth because people come to the UK and we pretend as if we are happy. You wouldn't go back to tell people that you have left behind... life is horrible, you would want to pretend as if life is so rosy here.

Lindiwe

Like Lindiwe, most respondents tried to hide their negative experiences and the lengths they had to go to earn money to survive in the UK and send enough home. This meant that, despite the sacrifices nurses made, families continued to expect remittances. Julia explained that "for a nurse in the UK, she would have to send money home. If she has nieces and nephews who go to school she will support them. That's the problem with the extended family life." Her colleagues would laugh at her bags full of presents to bring home. They would ask, "what do you do with all the shopping from your bags?" However, the extent to which the nurses sent remittances depended on the circumstances of their family in Malawi. For example, as Lindiwe's family were all graduates they were able to support themselves and did not need financial assistance. Not every nurse needed to have additional jobs, especially not those who had spouses in the UK bringing home a second income. Even those with additional jobs, however, were able to enjoy some of the benefits of UK life.

7.11 Personal life in the UK

7.11.1 The benefits

Outside work, life is nice. I feel so happy when I am home, and my home is my heaven... You can go shopping anytime ... you can just go and say today I going to buy shoes... but not in Malawi because the money here is much better than in Malawi so I really enjoy...

Lindiwe

When people go to the UK, they find life easier, you can get the things you need in life. In Malawi with the salaries people get, you can't go to a shop and buy a [TV] screen, you need to plan and save. Whereas in the UK you say I want this and you have it... All of sudden it's like wow – you can live life like this! For most of the people it's wow to say there is another side of life where people can live without thinking what are we going to eat?

Sarah

Respondents were pleased with the improvements in their lifestyle. They valued the financial freedom and access to commodities that would be considered luxuries in Malawi. Opportunities for shopping featured as a highly appealing aspect of UK life. In Malawi, people often rely on markets for their food and provisions, whilst supermarkets with their greater choice and Western provisions would be exclusively for expatriates and well-paid Malawians. In the UK one nurse remarked that "you can get pretty much what you want", and cheaply too. These freedoms also had their disadvantages. One was, as one nurse called it, an individualistic society that Malawians with their culture of extended families were not used to.

7.11.2 The challenges

What the British don't understand is we carry our culture to the UK.

Julia, 1972 RN ex-migrant

Most migrants face difficulties in adapting to life in a new country, especially if the culture is very different from their own. Colonial ties and a shared language facilitate adaptation to some degree, but do not necessarily translate into a shared culture. The need to overcome major cultural differences such as religious rules dominates the literature. However, it was often the subtle differences that nurses struggled with: interacting with neighbours, eye contact and dress code. Dress code was mentioned as a key difference, in particular the meaning of clothing items. For example, in the UK flip-flop sandals would be considered appropriate wear for summer, whereas in Malawi

they are used as shower shoes and should never be worn outside the house. Eye contact was also a potential stumbling block. In Malawi direct eye contact is traditionally seen as a sign of disrespect, especially in the context of meeting with a manager. Dinah explained that her manager thought that she was shy as she avoided eye contact. At the extreme, Eleanor reported that her manager perceived her to be rude because she wouldn't look her in the eye. Other examples of social norm differences relate to appropriate behaviour when meeting strangers. Whereas in Malawi it would be acceptable and polite to talk to your neighbour when travelling on a bus, such behaviour would be less common in the UK. Silvia said that it would also be normal to greet strangers in the street in Malawi:

Malawians speak freely to each other, you might not even be very familiar with them but you say hello, acknowledge that person. While in UK if you did that I feel people will look at you twice, why are you so familiar?

Many of these norms are generalised and not set in stone, especially as people behave differently. In addition, they may be less indicative of social norms and more of social reality. For example, if people are busy they may not have time to stop and talk to acquaintances. However, in Malawi, even when people are late they would still stop and talk to an acquaintance because of a different concept of timekeeping. Perhaps without fully understanding them, all the respondents felt that it was important to respect the rules of the UK and they attempted to take on the new social norms. Levitt and Glick Schiller (2007) believe that such a strategy helps adaptation and has been shown to help immigrants in the US move up the socioeconomic ladder.

Sarah did not enjoy socialising in the UK because she felt that "time is money". In Malawi social visits with friends and relatives are not usually prearranged. Sarah said that back in Malawi she visited her friends spontaneously, but in the UK she found that because of her own work commitments and those of her friends, they were "hardly at home and didn't have time to socialise." Dinah also found it difficult to adjust her social patterns after seeing friends and family every day in Malawi. Although they felt that socialising with friends was difficult, many felt that socialising with your neighbours was even more challenging. Whereas in Malawi interacting with your neighbours is encouraged, Mercy joked that if she went over to see her neighbour in the UK they might shoot her for trespassing. Many made a concerted effort to stop themselves or their families from behaving in a way that would be considered unsuitable. Martha spoke about stopping her mother (in the UK on a visit) from talking to all of her

neighbours and to people in the street. Silvia also had to try and not talk to people on the bus, but she found that she was:

A little uncomfortable and you would really have to discipline yourself not to speak, because it's not the norm... I think it's more stressful too.

In most cases, nurses sought solace in the Malawian or African community. In the space of the migration years the community in the UK expanded significantly and many nurses had relatives who supported their adaptation. Anna was pleased to be part of a community in her town and “part of a family”, as she had anticipated that she would be isolated because she had heard that “neighbours they don’t talk to each other... you just wake up, get out, go to work and then get back into your house. So I was thinking oh we are going to have no friends.” Others retreated into their private lives, especially because, like Florence, they found that they had little time to socialise because of child-care commitments and work shifts. Florence felt very isolated as she was working ‘anti-social’ night shifts. The nurses in McGregor’s (2007) study were also unhappy with their social lives in the UK because of anti-social working hours, which limited the time they could spend with family and friends. Others like Silvia accepted that there was little time left over to socialise as the primary goal was to earn enough money and then go home.

7.12 The family

A common goal was for nurses’ to help their families who accompanied them benefit as much as possible from their migration. This was primarily through improved access to education and healthcare. However, nurses had to make a number of adjustments to their new lives with their children and spouses.

7.12.1 Children

I am used to extended families at home, cousins, nieces, close family networks. It's difficult to be alone here just with your family and friends.

Dinah

All of the nurses interviewed brought their children to the UK. Most felt pleased with the new environment they were exposed to, especially in terms of education, access to travel and interacting with different cultures. However, the social norms of the UK often

conflicted with their own ideas about raising children. Combined with changes in the nurses' circumstances, they faced many challenges. Firstly, in Malawi several generations typically live together and share the responsibilities of childcare. It would also not be unusual to have a nanny or maid (finance permitting). In the UK the nurses found themselves not only lacking the support of families and nannies, but facing the financial burden of paying for childcare. Silvia explained that "having a child in the UK is difficult. I have seen people struggling to leave the baby at the crèche, running here and there." Strategies varied. Florence adjusted her shifts to look after her children in the day to reduce her childcare costs. Dinah rotated shifts with her husband so that at least one of them would be with their children. Whereas none of the nurses were put off from coming to the UK because of this challenge, McGregor (2007) found that the cost and difficulty of caring for children in the UK led some parents to not migrate from Zimbabwe. Nurses missed the practical support of the extended family and felt their absence in the task of child rearing. Like Malawian families, Somali parents in Finland found it difficult to adjust to the Western model whereby child rearing was not a collective matter for all the family but for the biological parents (Degni et al 2006). For migrant nurses, parenting had now become a matter for parents only, and with the loss of the extended family, they became acutely aware of their limitations in preparing their children for life in the UK. Because they had been socialised in Malawi some of their own behaviours were at odds with what their children were experiencing outside the home. Timera (2002) describes that the children of migrants often experience a contradictory process of socialisation as they learn social norms from their families (for example body language), but are then confronted with different kinds of behaviour in the new country. Respondents found that adaptation to UK life was particularly difficult for their older children. Nonetheless, they all reported that their children were pleased with their new lives, and most eventually found their place within it.

As children adapted to UK social norms, parents began to worry that they had lost some traditional Malawian values along the way. At the lower end of a scale of worries, nurses felt that their children had picked up some unhealthy UK habits. Sarah was concerned that her daughter had become used to coming home from school and sitting in front of the TV. At the other end of the spectrum, respondents felt that their children no longer behaved as Malawian children would, and they were worried about the implications of this if they returned to Malawi for holidays or for good. All the parents found that their children began talking back to them, a practice which is not acceptable in Malawi. Sarah explained, "in Malawian culture if you are talking to a child, they can't walk away, that's rude. In English culture, if a child is not happy they walk away. Those

are the things I can see in my house.” Dinah also found that although she was pleased that her “children had learnt to be more autonomous, to question things”, it led her to worry that they were too assertive and that their school was not disciplined. McGown’s study of Somali families (1999 cited in McGregor 2008) found that parents were fearful that they would lose their children to their peers. The respondents were also anxious about UK’s higher crime rates. Silvia and Sarah explained that, unlike in Malawi, you think twice about letting your child go out on their own in the UK. Sarah felt that this meant that she was now much more tied to her children. She explained that in Malawi:

Kids can go wherever they want to go, there is no ‘don’t talk to strangers’... I am not worried about my neighbour. While [UK] life is a bit different, many things happen. Kids are always enclosed unless you take them to someone you know.

7.12.2 The spouse equation

The challenges of raising children in the UK were often shared equally between parents. Much of the migration literature describes the need for migrants to reconfigure their traditional spousal roles in response to the challenges of the destination country. Many of these challenges related to child rearing and domestic roles. The literature suggests that the traditional female role has been changed by migration (Andizian and Striedd 1982; Kudat 1982 cited in Degni et al 2006), and that men (usually of necessity) increasingly take on the domestic roles traditionally assigned to women in their home country. The migrant Somali women in a study by Degni et al (2006) were pleased with the change in their new country because their husbands were now participating in household tasks. In Malawi, the husband would assume the role of the provider and would traditionally not engage in domestic and child caring duties. With the absence of extended families and domestic help in the UK, men were required to take on these traditionally female duties, a situation described in McGregor’s study of Zimbabwean migrants. Dinah’s husband had to leave behind traditional Malawian ways and accept that he had to care for his children whilst she worked night shifts.

Dinah’s husband was fortunate to find a job in the same profession and at a similar level to the one he had in Malawi, but other nurses’ spouses were not so lucky and were unable to find employment appropriate to their professional qualifications. When Mary went to study in the UK, her husband joined her expecting to find suitable employment. However, the only job he was able to get was in a local supermarket. This finding also emerged in the studies of nurses by Likupe et al (2005) and by McGregor (2008: 604), who found that marriages often came under strain when professional

women brought over husbands with non-transferable skills, who then failed to get regular paid work. The psychological implications of such employment challenges were significant, especially considering the traditional male role as the provider³⁰. Many experienced a loss of pride, especially those who had left a good job in Malawi, and it led many husbands to return home prematurely. This is what happened to Sarah. Her husband left after 18 months in the UK because he could only find manual work despite coming from a managerial position in Malawi. Similarly, Mrs Banda's friend remained working as a nurse in the UK even when her husband returned to Malawi to assume a high status job in the government. Such configurations relate to the broader literature on challenges facing transnational families³¹.

7.13 Measuring success in the UK

- ✓ Gaining a higher qualification
- ✓ Educating your children
- ✓ Financial stability
- ✓ Building a house in Malawi

The list above represents many of the achievements that nurses expected to accomplish. Most were able to achieve some financial stability, often by having several jobs. Every nurse sent remittances to their family, and in some cases financed relatives' education, as Emma was able to do with her sister's training course in accountancy. Lindiwe, James and Anna were all able to start businesses in Malawi. Alfred was in the process of building a house and felt that he was "contributing to the social economic development of the country" through all the taxes he was paying for the construction. Other nurses felt proud of their own professional achievements. For example, as a manager James was able to improve the rating of his care home from poor to good. Although respondents were able to see their children through primary and secondary education, those with older children found it difficult to finance their children once they got to university level. Florence's daughter aspired to be a nurse, but because of financial issues she settled on pursuing a different course. Such a situation made Florence acutely aware of the limitations of her care home salary, and

³⁰ None of the respondents knew of any wives of male nurses in the same situation.

³¹ Trans-national families are those that live some or most of the time away from each other but still manage to hold together a feeling of collective welfare and unity (Bryceson and Vuorela 2002), for more details see Bryceson and Vuorela (2002).

once the novelty of access to cheaper commodities wore off she felt that her salary could not sustain a high standard of living in the UK.

The nursing salary also stalled many of the nurses' plans to study for a Masters. As Eleanor explained:

Some people plan to go over and study and then they start working and they don't carry on with their studies because it is hard for them to work at the same time and study. It happens a lot because life is expensive as well, they have to pay their own tuition fees and then go to work to pay rent and you've got to study at the same time, and it becomes too much and then you give up studying and just work.

Although Sarah expected to work and complete her Masters within three years, she found that she had not raised enough funds and stayed for two more. Dinah also planned to raise funds by working in her first year in the UK to pay for her Masters, but was then faced with prohibitive international fees³² and decided to stay until she was eligible for home fees. Lindiwe relied on the money she was making from her business in Malawi (run by her husband) to cover her fees, and on her part time work to pay for bills and food. Eventually many of Lindiwe's friends ended up indefinitely postponing their Masters plans.

7.14 Section conclusion

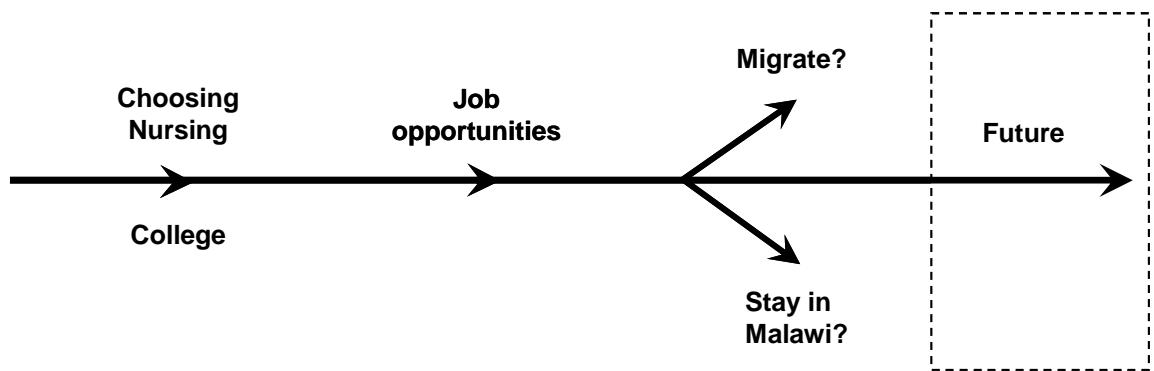
The findings presented in this section are consistent with much of the literature on IRNs in the UK. They describe the many challenges and negative experiences that such nurses face. Although most respondents ended up in care homes because of recruiting practices, many stayed because of the benefits of the work patterns and because of challenges in joining the NHS. Whilst employment with the NHS was considered a great achievement, nurses reported having difficulties with staff not recognising their qualifications and adjusting to new responsibilities. They also had to adapt to their new personal lives. Much of this adaptation was in response to new social norms and cultural values. The clash in cultural values was felt acutely in relation to spousal roles and child rearing practices. This situation was exacerbated by the common incidence of the nurse's husbands being unable to find employment commensurate with their positions in Malawi. However, most nurses were able to negotiate these difficulties and made significant achievements, most commonly evidenced in the businesses that they

³² To put this into context, the full time international student fees for one of the popular Masters for Malawian nurses in Scotland was 12,600 GBP per year (Queen Margaret University 2010). Such a fee would be challenging on a nursing salary in the UK.

had set up in Malawi. However, the goal of achieving a Masters sometimes eluded them, primarily because of financial issues. The promise of high salaries and opportunities to send money home was blighted by the reality of high living costs and much lower relative income. Ultimately the nurses accepted that UK life was hard work and not necessarily how they had imagined it.

Chapter 8

Future plans



Chapter 8

8.1 Chapter overview

In this chapter I address the final research questions of the thesis: what are the nurses' plans for the future and what are the reasons behind their choices? The decisions nurses make about their future have important implications for both the UK and Malawi, especially with regard to return migration decisions. From the perspective of the UK it is interesting to see whether the nurses who are now part of the system will stay, and, for Malawi, whether nurses lost to migration will return. I dedicate much of this chapter to the nurses' return migration decisions and assess whether return migration can be used as a strategy to fill nursing vacancies. To do this I examine the decisions that nurses in the UK are making about their future, and how they feel about return migration. I then examine the experiences of a sample of returnee nurses and identify what led them to return. This allows me to outline key factors in a revised push and pull model of Malawian return migration.

8.2 The nurses' future plans

8.2.1 Malawi

The choice of workplace can remain fluid throughout a nurse's life. However, few of the nurses interviewed in Malawi planned to leave their current employer, particularly in light of restricted migration opportunities. This was especially true for nurses working in NGOs, who felt that no other employer in Malawi could compete with their current employment package. They had also become dependent on their high salaries - for example, to pay for private school fees - and this made it difficult for them to return to the government system. Nurses like Sarah and Cecilia were content to stay in the government because of the seniority of their positions. Those at lower levels within government also planned to stay, but strategised on how to maximise their employment situation. Many hoped to take advantage of educational opportunities and to upgrade their qualifications to improve their income and promotion prospects. RNs also planned to study further to Masters level. Most of their plans focused on the near future. One nurse explained that, in a country where the average life expectancy is 37 years, it was uncommon to plan beyond the immediate future. Those who had already retired, like Silvia and Mrs Banda, also had plans for further study. However, Mrs Banda felt that if this did not work out she would become a birth assistant in her community and rely on donations from people to get by. She said that "it is good to be a nurse as you can be employed all the time". In light of the nursing demands in Malawi, most felt confident that their skills would always be required even if the conditions they faced were not optimal.

8.2.2 The UK

Like the home nurses, educational gain consistently featured in the future plans of those in the UK. Emma hoped to upgrade her diploma to a degree through distance learning, before applying for her Masters. Whilst Martha, James and Anna also wanted to study for a Masters, those already working towards it were considering doing PhDs. Most planned to stay in their current workplace and study part-time. Unlike in Malawi, the nurses' decisions about the future also had an extra dimension, namely whether to stay in the UK or return to Malawi. All the respondents regularly weighed up this decision and the considerations associated with it, such as their families. The rest of

this chapter examines the components of the nurses' return migration decisions and their implications.

8.3 Return migration: an introduction

Return migration involves a person returning to their original country of origin or residence (ICN 2008). The return is usually permanent, but can also be temporary (such as for a project). It can sometimes incorporate onward migration to a second destination, although none of the nurses knew of anyone who had done this. In the literature review, return migration was discussed in the context of being a potential benefit of migration. In theory, return migrants would bring back to their home country beneficial new skills, contacts and networks. However, it is hard to know what impact this has in practice as return migration data, especially regarding nurse movements, are scarce. On a global scale, it is difficult to estimate return rates as data typically measure flow in only one direction (Mejia et al 1979). UK data suggest that return migration rose in 2008 by 30 percent on previous years (Finch et al 2009). Such evidence has led researchers to believe that much migration has become temporary, helped in part by the transport and communications revolution, allowing freer movement of people (Haour-Knipe and Davies 2008). Whilst little is known about the way migrants make their re-migration decisions (Adda et al 2006), researchers have identified a number of shared characteristics and factors that correlate with an increased likelihood of return.

- The children or spouse of the migrant have stayed in the source country;
- They have strong ties and a sense of belonging to the source country (for example, if they are politically active there);
- The situation at home improves;
- They have economic incentives to return (for example, to start a business);
- They have achieved their goal;
- They do not feel that they are integrated in the destination country;
- They have been unable to adapt to their new working conditions;
- They are dissatisfied with life in the destination country.

Sources: Oderth (2002), King (2000 cited in ICN 2008), Kingma (2006), Chappell and Glennie (2010), Haour-Knipe and Davies (2008), Finch et al (2009)

In terms of UK-specific return migrant characteristics, it is estimated that most have spent less than four years in the UK (Finch et al 2009). This is consistent with much of the literature, which suggests that returning home becomes less probable over time as integration in the destination country deepens (Tanner 2005).

8.4 What happened to the nurses

Malawi is no exception in its paucity of data on return migration. Although the Malawi NMC records the (approximate) numbers of nurses who leave, it does not record how many return. Even though nurses are required to re-register with the NMC and undertake an orientation³³ if they wish to practise again in Malawi, informal NMC data suggest that only a few returnees go back and work as nurses (respondents knew of only one nurse who had returned to government employment: Sarah). One NMC informant explained that most returnees “either keep quiet or are no longer practising nursing”. Although there are no solid data, respondents suggested that a few nurses had returned. This is consistent with the predictions of Oderth (2002) who believed that a few Malawians have returned from the UK.

Five of the sixteen migrant nurses I interviewed had returned to Malawi. Briefly, the reasons for their return were:

- Emmanuel and Aubrey had defined goals to achieve their Masters in the UK (and had student visas). Although they could have stayed, as others did on their scholarship programmes, they both wanted to develop their careers back in Malawi.
- Julia and Silvia had a defined goal of making money and had left their children behind in Malawi because they never expected to migrate permanently.
- Sarah also wanted to obtain a Masters but was much more fluid regarding her situation. She even brought her husband and children over, implying that, although she never intended to stay permanently, she had made certain inroads into UK life.

All of the nurses’ stories were consistent with the characteristics described by researchers. They all went with clear objectives and, with the exception of Sarah, had been in the UK less than four years and had left their immediate family in Malawi. The

³³ A free course aimed at educating returnees about changes in the Malawian health system (four weeks for nurses, two for midwives).

other returnees whom respondents knew of had met their financial goals and returned to start businesses or to benefit from the houses they had built. Whilst economic motivations are important, a migrant's life stage is also thought to have implications for their return decision. Silvia explained that whilst older nurses migrated "to earn a few pennies", they were keen to return because they "would want to die at home." Julia also wanted to return to benefit from her Malawi pension. Younger nurses who left to make money to build "financial muscle" were often not as constrained by time and were much less likely to return after a fixed, short period than the older nurses.

Julia did not wish to stay because she did not like the bedside nature of her role in the UK and much preferred her lecturer job in Malawi: "I enjoy my job a lot, if I didn't like my job I would have gone to the UK forever and settle there perhaps, I would have been a citizen right now." Parris (cited in Kingma 2006) explains that for many migrant nurses their quality of life and working conditions, although better than in their home country, still have numerous deficiencies with which they are unable to cope, and so they leave. Although most respondents felt that their working conditions were not bad enough to make them leave, Eleanor felt that many nurses would want to return because they were unhappy with the nature of their care home jobs. She explained that increasingly nurses had to take on much lower level positions because of growing competition to find a job in light of greater NHS restrictions on overseas nurses³⁴. This meant that overseas nurses increasingly gravitated to the care home sector to secure work permits. Even those who trained in the UK like Eleanor and Peter felt that they were no longer guaranteed NHS employment. Eleanor had a number of overseas friends who had qualified in the UK but could not find jobs because the Home Office would not issue them work permits unless they found an employer to say that they were 'outstanding'. She concluded that "it's really hard now to find a job as a nurse".

Although Emmanuel eventually wanted to return to Malawi to work, his expiring student visa kept him from staying a little longer to make some money in the UK. One of the main unions representing nurses in the UK, UNISON, claimed that the new regulations (aimed at stopping active recruitment from certain countries) may leave 38,329 overseas nurses at risk and vulnerable because their work permits will not be renewed (UNISON 2010). This suggests that increasingly nurses may be forced to return to Malawi without a consideration of the other factors – such as financial ones - that

³⁴ Some are predicting even greater competition within the NHS because of planned nursing job cuts (Mooney 2009).

commonly feature in return migration decisions. Researchers believe that current return migration decisions tend to be primarily influenced by personal and family factors (Finch et al 2009: 4). Family considerations were a key distinguishing factor between the respondents who left and those who stayed.

8.5 Staying in the UK

Thank God most of the people that go don't come back from the UK.

Julia 1972, RN

Unlike Silvia and the other returnees, the majority of respondents felt that even though they would return to live in Malawi at some point, return migration did not feature in their immediate plans. These nurses shared a number of characteristics different from those listed above. With the exception of Lindiwe, they all had their spouses and children with them. Many also still had unachieved goals, and most had been in the country for longer than four years, which meant that they had formed significant ties to the UK and had built up 'insider-advantages' like knowledge about career opportunities (Fischer et al 1997 cited in Oderth 2002). They also had commitments such as mortgages on the homes they now owned. Florence explained that it had been a strategic decision to buy their own house, even though it meant that they were tied to mortgage payments, as they were able to escape the undesirable high-rise apartments they had previously been living in. Others were committed to sending money to their families, and staying in the UK allowed them to send more and even invest in property for their families in the UK and Malawi, as Eleanor described:

Most of the people they are already committed to some things, maybe some of them have got houses here, mortgages to pay and [you can't] leave that all of a sudden and go home when you know that there is nothing else that you can do. You just take what you have. You work here for a day; it's the whole [monthly] salary for nurses in Malawi. So, you are better off here, make money and save and do great things. We have seen nurses being very successful building houses, sending money home, helping out people.

After building up their new lives in the UK many felt less tempted to leave, especially as they felt that things had not improved in Malawi. This meant that, in spite of the challenges they faced in the UK, they were better off staying. Peter felt that the situation in Malawi was primarily responsible for keeping nurses in the UK: "a lot of people want to go back, they would, it's only unfortunately that Malawi is a poor country." With Malawi still 'poor', Beatrice, an EN in Malawi, questioned why anyone

would want to leave the UK: “why are they coming back here: coming here to suffer? We sleep here without food, without soap, without oil we just stay.” This led some to believe that only those with visa or work permit problems would leave. Return migration would also not make sense to those back home if the nurses had children with them who were also able to benefit from the UK system.

8.5.1 The family equation

Children and spouses contributed to keeping nurses in the UK in four main ways.

Firstly, as parents stayed longer to complete their goals families began to form ties with the UK. A prolonged stay often meant that children became more integrated into UK life and formed peer group relationships, making it harder for their parents to return home (Castles 2007). Although parents hoped to instil Malawian social norms and values, their children’s adaptation to the UK often came at the expense of ties to Malawi. One key informant explained that as Malawian culture became less familiar to children, they were less likely to want to go back, especially if they had come over at a young age (or were born in the UK). Haour-Knipe and Davies (2008) contend that families with young children are often nervous about returning and integrating their children into a ‘home’ country they barely know. This situation was exacerbated by the distance and expense of returning to Malawi for holidays, which meant that children were not frequently exposed to Malawian ways or its languages. Although English is widely spoken in Malawi, families and communities tend to communicate in their own language such Chichewa or Tumbuka. Children who spoke only English could have found it challenging to integrate into Malawian society, especially in rural areas. Those who tried to teach their children their home language experienced difficulties. Martha recalled that she was advised by a teacher to stop communicating with her daughter in her own language because she was falling behind in her education³⁵.

Secondly, from the point of view of educational opportunities, respondents wanted their children to benefit from the UK system, especially at university level where opportunities are far greater than in Malawi. Many like Dinah felt that they would only think about returning when their children had reached university. They felt that before this their children would not be able to fit in easily into Malawi’s education system. Florence predicted that her middle daughter would have to go back a year at school if

³⁵ There is much debate about the association between educational performance and speaking a second language at home. Some research suggests that bilingual learning actually improves educational performance (BBC news 2007).

they returned, and said that “even before thinking about going home I need to think about the timing, because it’s not to disrupt them.” Thirdly, parents also wanted their children to benefit from their higher wages in the UK. Staying longer meant that they could save more for their children, as well as make investments. James wanted to stay in the UK so that he could collect his pension for his daughter (which would be far higher than what he would ever have in Malawi). Finally, just having family around them kept the nurses in the UK. This was especially true for those with spouses who had good jobs and did not want to leave. Although Martha felt the pull to return, she didn’t want to leave her husband in the UK. Despite the challenges of returning to Malawi and the benefits of the UK system for their children, some respondents knew of nurses who had returned to Malawi because they did not wish to raise their children in the UK. Julia explained that her son returned with his family as he didn’t want his children to grow up in the UK environment. Although the respondents had reservations about the way their children were being raised in the UK, in all cases educational benefit for their children and for themselves acted as a key reason to keep them there.

8.5.2 Completing their goals

They find themselves still waiting to do something which they have not done.

Cecilia, 1995 RN GN

Unachieved goals were another key reason why nurses stayed in the UK. Florence felt that she could not go back as she and her husband had not achieved their goal of both having a Masters. She said, “we can’t all of us study at the same time, so he is studying. After he finishes I will probably [study]. If we happen to change our [visa] status we would stay a bit longer.” Like other respondents, Florence wanted to wait until she was no longer paying international fees. Staying longer also had the advantage of nurses qualifying for indefinite leave, which gave them freedom to come and go as well as security in terms of employment permits. Even when nurses did not wait to qualify for home fees, like Sarah, they still had to work for a significant period to save enough to cover their fees. The time it took them to save enough or to qualify for home fees often led nurses to form deeper ties with the UK, making it ultimately more difficult to leave, especially when family considerations were taken into account. Castles (2007) finds such a scenario common, whereby the difficulty in achieving predetermined targets (such as saving money or educational gain) often leads to a prolonged stay. Whilst the nurses’ unachieved goals kept them in the UK, they also put

them off returning to Malawi because they were nervous about what people would think of them if they returned without having made significant financial or educational gains.

8.5.3 The pressure to succeed, and the stigma if you don't

Most of them [back in Malawi] would want you to come back and see a change from you. If they don't see that change then you will be the laughing stock for them. They will be: 'you were just wasting your time. Why did you leave your country and go somewhere else and you come back the way you were?'... They will look down upon you. There is a lot of pressure. And sometimes you don't want to go back because you are not there where people put you [in terms of success] and you think oh God people will be laughing at me when I come back, I am much better staying here. You will find that one of your friends [who stayed in Malawi] that they have advanced, they have got good jobs, better lives and all that.

Eleanor

A strong theme running through the research is the expectation that nurses who have gone to the UK will succeed, either financially or through educational gain.

Circumstances in the UK mean that such achievements are not always possible, especially in the time frame that nurses initially predicted. According to Eleanor the pressure to be successful and the hard work it requires had led some nurses to give up and go back. The majority felt that they could not give up and return as just "an ordinary person" (Peter). If you returned without being successful, not only would you have nothing to distinguish yourself from the others (thus limiting your career prospects), but people would also consider you a failure ³⁶.

For nurses, the qualification element was particularly important to help them advance in their careers. Otherwise they risked returning "to the same bedside positions that they had escaped from" (Rebecca). This was especially important as many predicted that without extra qualifications they would end up in a far lower position at work, with their previous colleagues (even those of a lower cadre) in much higher positions. There would also be an expectation that whilst in the UK nurses had mastered complex technology. A key informant explained that it can be embarrassing for returnees to admit that they took a step down and worked in care homes without access to such technology. Even if a nurse did gain experience and qualifications, there would be no guarantee that he or she would be reinstated in the government service at a higher

³⁶ Cecilia also felt that if the nurses had stayed in Malawi, they may have been able to complete their Masters with government assistance, as some of the remaining nurses had done, making her question the real benefit of going to the UK.

level, especially because of the commonly cited practice of non-recognition of qualifications and skills gained overseas. The fact that even nurses with qualifications could end up at lower levels acted to dissuade them from returning, especially to the public health service.

Outside the workplace, there is often significant pressure on returnees to show that they have made financial gains and have helped their family and community. A study of Senegalese migrants showed that migrants gained prestige when they assisted with local development in their village of origin (Kane 2002). The same is true in Malawi, where a failure to invest in your family and community would be a source of shame and a sign of weakness. This is similar to the loss of social esteem and weakness assigned to Ghanaian migrants who are deported back home (van Dijk 2002). As nurses tended to report only positive stories to those in Malawi, they potentially fuelled and distorted expectations, aggravating the pressure to succeed. Respondents were strongly aware of what society in Malawi was expecting from them, and the embarrassment and loss of status they would experience if they returned without success contributed to keeping them in the UK, a trend which is common among migrants (Finch et al 2009). Nurses believe that this 'stigma' becomes less important in their decisions to return home as time continues, especially as they near retirement.

8.6 If the nurses returned...

Whilst the pressure to succeed and family commitments kept most of them in the UK, several nurses felt that they would return eventually because Malawi was their home (see Box 8.1). Although most said that they would only return much later, probably to retire, some had begun to think about what they would do if they returned whilst still in their working years.

8.6.1 ...What would they do?

Even if I go back to Malawi, I won't work as a nurse. Because the conditions are very poor, the money is crap. The nurses get nothing... Here [the UK] I am used to it... where they deliver high standards of care. They have got all the equipment, all the medicines... but the thing is that back home you will find that people will die just because they don't have IV fluids, just from dehydration, they will die. You won't have maybe enough gloves in the hospitals, so in a country that has high rates of infectious diseases as well it is very risky.

Eleanor

The resounding response from all the respondents was that they would not go back to work as government nurses. The key reasons are summarised above by Eleanor, in addition to the practice of managers not recognising overseas experience, limiting their career development if they returned to government. Eleanor's arguments relate primarily to the belief that nurses would not be able to readjust to the poorer conditions and lower standards of the Malawian health service after working in the UK. Florence said that although she would know the environment and its limitations, it would be frustrating to witness the Malawian work ethic, "where people go in the office, and probably they will just be on the computer, play games, and then go on doing nothing." James felt that he did not have the "appetite to work in the Malawian hospital with the way things are." He added, "there are no standards to deal with... And you are not monitored or supervised, and so you work for 15 years without someone talking to you about your concerns." After seeing the "other side" in the UK, he felt that it would be too frustrating to return to hospital work. Anna also felt that if she raised her concerns about low standards, people would think she was acting 'superior'. She said that they "will think this one has just come from the UK and thinks that they are somebody!" Martha felt that being back in the Malawian system would make her more sad than frustrated. She said:

Because whatever [resources] they have got, when I look it's not enough because I will be comparing to here [the UK]. It will just break me... People there are dying when they are not supposed to be dying, because we don't have ABCD... I couldn't cope... I wouldn't contribute properly. I would mess up everybody's way of working because they would say 'she is crying all the time, she is supposed to be working'. For them possibly it's normal, but for me that reality has been washed away by me working here [in the UK].

Martha felt that by staying in the UK, away from such conditions, she could "avoid the reality" of the situation in Malawi. Many others also felt that they could no longer provide a useful service to the government sector, and that perhaps they would be better suited to the NGO sector if they ever returned.

I think I cannot work in Malawi. But if I was to work in Malawi, it would probably be for an NGO, like nurses are doing.

James

Like James, all the nurses said that NGOs or international organisations would be their employment of choice. This was partly because of high salaries and partly because NGOs were seen as better environments in which to utilise their new education and specialist knowledge. Whereas the government was seen to lack the resources to tackle healthcare issues, NGOs could provide a platform for many of the nurses to put

into practice the specialist healthcare knowledge they had acquired during their further studies. Lindiwe had studied public health and wanted to use her skills in Malawi, Emma felt that NGOs could benefit from her knowledge in TB and HIV/AIDS, and Peter had chosen a broad Masters in clinical governance to allow him to “join any organisation.” Many had thought about how their Masters could eventually open doors for them back in Malawi, and, like Peter, had tailored their studies into an area that would be both helpful for their country and for their career development. Whilst NGOs could offer the nurses a decent enough life in Malawi, most felt that they still would not return until much later in their lives.

8.6.2 The retirement equation

I don't think that people will tend to retire and stay here [in the UK]. Most Malawians are like myself, I wouldn't want to be still around here when I am 45 or whatever.

James

The most frequently cited reason to return to Malawi was for retirement. For many nurses, this meant achieving their goals and making investments, and also having stayed long enough to see their children become adults and responsible for themselves. Why specifically retirement? Firstly, although the pull of ‘home’ is present, working conditions in Malawi remain unattractive and in most cases nurses do not wish to return to work there. Secondly, any investments made during their time in the UK (in GBP) would allow them to have a much better quality of life in Malawi because of the favourable exchange rate. Anna wanted to use the investments she had made in the UK to retire in Malawi. Others felt that even if they had retired they could still attend to the businesses in Malawi which they had started whilst in the UK. Finally, after witnessing how older people were treated in the UK, the respondents were determined not to share the same fate. Many were keen to return to Malawi where elder relatives are typically cared for by the family and community. Those who had worked in care homes in particular did not feel positive about the way older people were looked after.

I would rather retire in Africa. Because it's terrible to get old here, if you get old here they take you to nursing homes. Oh God it's hard... I would be better off, when I have got a house, and business running up I will be able to go and settle there [in Malawi].

Martha

The literature shows that returning home to retire is common amongst migrants (Koser 2007). Many of the cultural differences migrants feel exist between the source and destination country can become more pronounced at this time, such as the difference

in elderly care between Malawi and the UK. Izuohara and Shibata (2002) found that the Japanese female migrants in their study did not want to retire in British nursing homes, mainly because of the type of food served and a perceived inability to relate to the stories of others who had been brought up in British society. By retiring in their home countries, migrants were able to take advantage of both their investments and being back in their home culture.

Box 8.1 Where is home?

[When I leave Malawi for the UK] I am leaving something that is so dear to me. It's like I am being sent to a boarding school, that somebody is forcing me, but I know that it's only myself. (Lindiwe)

Understanding where nurses feel 'home' is can give us an insight into how they see themselves in the UK. A strong sense of the UK as home would suggest that they felt integrated into UK life and might also feel more inclined to stay there. In practice, all but one of the nurses interviewed identified Malawi as 'home'. This may link partly to the strong sense of Malawian cultural identity fostered by the previous President Dr Banda, and the perceived cultural differences between the UK and Malawi. Even though Banda had spent time living abroad, he still returned home, suggesting that a durable Malawian identity can be maintained by people even during prolonged absences. Although it is difficult to correlate Malawi as 'home' with a greater willingness to return there, many respondents said in the same breath that Malawi was home and that they planned to return. All kept strong links with family there, and some kept links through business engagements. These links made nurses feel upset about returning to the UK after holidays in Malawi. Such feelings are common amongst migrants. Al-Ali (2002 cited in Bryceson and Vuorela 2002: 18) describes how migrants look forward to returning to their roots and the familiarity of friends and family.

For those unable to return home for holidays, improvements in communication links meant that long distances no longer necessarily weakened links between them and their source country. Many felt that links were not as strong for their children. Some, like Martha, acknowledged that they wouldn't mind their children staying in the UK if they returned. She said, "they weren't born there [in Malawi] so it isn't home." Whilst Martha identified Malawi as home, she still felt torn between having her family in the UK (her daughter's home) and her family in Malawi. She explained that when she was in Malawi she felt uneasy, but when she was in the UK she felt that Malawi was home:

“if I am there [Malawi], I am not comfortable; I am comfortable in this country [the UK]... But then when I am here, I want to go back, recharge.” Bryceson and Vuorela (2002) interpret this feeling of belonging in two places as a ‘transnational’ way of living, whereby migrants try to negotiate their different levels of loyalties and choices of moving or staying.

8.7 The returnees

Many respondents felt that their working positions would be downgraded in Malawi, but Sarah and Aubrey’s stories suggest that this is not always necessarily the case for returnees. Likewise, although respondents claimed that they would never go back into the government service, both Sarah and Aubrey did so.

8.7.1 Stories of return migrants: Sarah

I never thought I wouldn’t come back, that’s why I took a study leave.

Sarah always planned to go back to Malawi, and her eventual return after five years in the UK was made easier by the fact that her husband had already been back there for a number of years. She had completed her Masters and was happy to go back into the government service because she was able to rejoin at a senior level and felt that she was helping her country. Whilst in the UK, she prepared herself for the ‘tough life’ and low salary she would have in Malawi by saving. She had also prepared her children for their eventual return by maintaining a strong Malawian culture within the home and reminding them that things would be different once they returned. She said that “I used to tell my kids ‘don’t expect to find computers at your school’.” However, after five years in the UK, both her children had become settled into UK life and her eldest son was desperate not to leave. Sarah recalled that “he didn’t say bye to his friends...my niece went to the same school as my son, and he told her to tell his friends that he had moved to another town in the UK... He didn’t take it well.” Whilst her son struggled with life back in Malawi, she also struggled to find her place as a returnee and deal with people constantly questioning her about why she had returned, especially to the government. Julia also faced the same questioning and had to listen to people telling her that she was stupid because she had returned. As all the returnees had made financial investments and had Masters degrees, they did not face any stigma as ‘unsuccessful migrants’, but people did not understand their decision to return. This

makes it difficult to assess what kind of stigma those who had returned ‘unsuccessful’ would have faced (although it is telling that none of the nurses without similar achievements had returned). Sarah was not downgraded in her position as respondents predicted would happen to returnees. Aubrey’s new qualification was also recognised and rewarded with a promotion by the Ministry of Health.

8.7.2 Aubrey

After finishing his nursing degree at KCN, Aubrey went to work in a district hospital with hopes of doing a Masters. He was awarded a scholarship and Aubrey went to study at a UK university. Although he was able to stay in the UK for three months after finishing his degree and find informal work as a nursing assistant in a care home (which did not require UK NMC registration), a condition of his scholarship was that he returned to Malawi. Back home, he returned to his previous government nursing position whilst looking for a job more suited to his new qualification. His Masters eventually earned him a high-level decision-making position within government. Yet, whilst his professional life was successful, he found it hard to get back into Malawian life.

Although it was nice to rejoin his family and friends, he found that he now preferred UK life and its benefits, and that in Malawi “the quality of life wasn’t nice.” Aubrey explained that if he had had family in the UK, “I would not have come back after a year, I would have stayed another five years.” He began to question his decision as he had always seen himself as patriotic. Although he was keen to return and help develop his country, seeing another side to life offered in the UK made it difficult for him. He added:

[The] prospect of a better life elsewhere is always more appealing so patriotism is better measured when you are out and if you decide to come back. Right here, people might say I love my country, I want to be here, because they don’t have an opportunity to try other lives, but if they try another pattern of life they might decide why should I spend my life there, I would rather be here. There are few people I have noticed that are very patriotic.

Although she was happy to be reunited with children and her “typically homebound Malawian” husband, Silvia found that when she returned it “was like riches to rags in terms of salary.” Such a downgrading of a migrant’s financial situation can have implications on their feelings upon return. It made Silvia feel that she could have easily stayed a few more years in the UK if it wasn’t for her family. On the other hand, as Julia felt that she had saved enough money from her time in the UK, she could just focus on

enjoying her hard earned investments³⁷. Like Aubrey, it is common for returnees to struggle to re-adapt to Malawian ways. One key informant (who was planning to return from South Africa) explained that it was difficult to return once you had experienced different things and made a different life for yourself abroad. King (2000 cited in Haour-Knipe and Davies 2008) noted that return migration is often associated with mixed feelings, in that migrants are happy to be back in their own culture and language (and are no longer treated as a foreigner), but sense that they have 'been away' and are now viewed differently by their community.

Elements of these stories conformed to the predictions of the respondents, including the changes in the quality of life upon return. Although respondents in the UK were not familiar with the experiences of returnees like Sarah and Aubrey, they had strong expectations about what they would give up in the UK by returning, but also what they could potentially benefit from by being back home. These factors form the key push and pull factors in the return migration decision.

8.8 Push and pull model of return migration

Return migration is usually driven by a complex mixture of economic, social, family and political factors.

Haour-Knipe and Davies (2008)

Like the initial migration decision, the decision to return is driven by many factors. These can be expressed in the push and pull framework, shown in Figure 8.1.

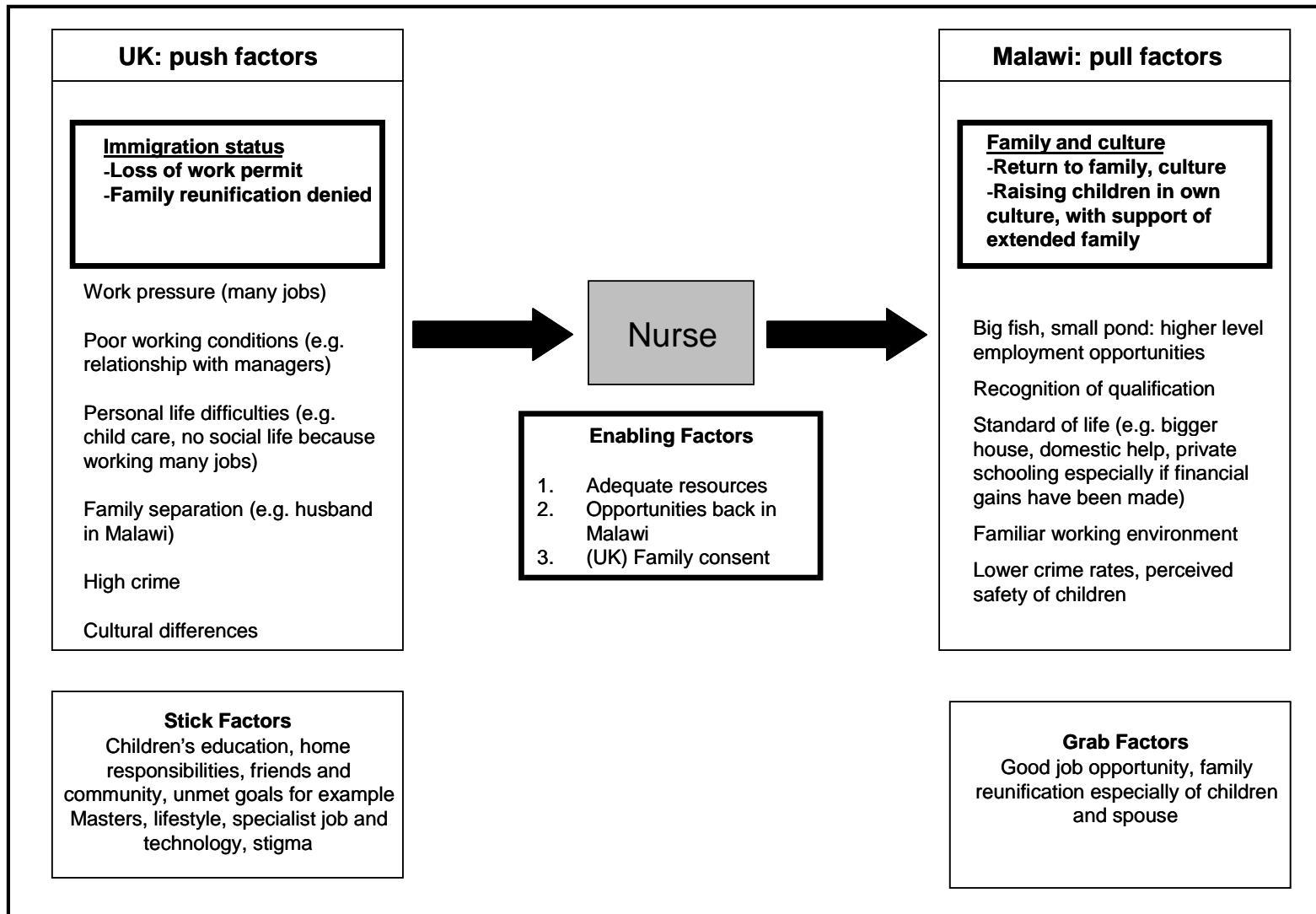
Whilst being back with their families and in their own culture were strong pulls for returning to Malawi, there were also a number of other advantages. Nurses with children would be able to benefit from help with childcare from their family or domestic help. Perceived lower crime rates would also contribute to a greater sense of security and in some ways freedom, as they would no longer be so tied to their children. According to a key informant, when migrants returned to Malawi and stayed in relatively good working positions (such as in an NGO), they could potentially have a much better quality of life than they ever would in the UK. She referred to the fact that,

³⁷ Jane was also busy making plans for a potential business to build care homes in Malawi for those who have the resources to pay for their elderly relatives' care.

with their UK savings, returnees could afford bigger houses in desirable areas, elevating their status in society. She added that such migrants become first-rate citizens in Malawi, whereas often they would be 'second rate' citizens in the UK. Lifestyle and status improvements, in combination with good job opportunities, have been shown to encourage the return migration of doctors. Namagoa (1997 cited in Oderth 2002) explains that doctors often return because of favourable working conditions in Malawi. This is consistent with the literature, which argues that the pull of home is increased if economic opportunities are available (Finch et al 2009: 4). Some respondents felt that the favourable aspects of working life in Malawi could also encourage nurses to return. A Malawian doctor said that "people are coming back to work here. It's much more fun working here, as a nurse too, if you really want to do that kind of work this is much better." Some respondents noted that there were more opportunities to progress into higher positions in Malawi than in the UK. This was firstly because they faced less competition from other nurses with similar Masters, and secondly because they would not have to face the career development barriers they would experience in the UK. This appears to run contrary to the predictions of the UK respondents, but is consistent with the experiences of Sarah and Aubrey. The literature cites a number of other pull factors, including homesickness and political pulls such as policies to encourage return migration (King 2000 cited in Haour-Knipe and Davies 2008).

The pushes to return include the difficulties that nurses face in their UK lives. Among these are the need to work hard to supplement a salary that is sometimes insufficient to meet the needs of families. Another key push lies in problems with immigration status. The key role of increasing restrictions or the non-renewal of visas is frequently highlighted in the literature (King 2000 cited in Haour-Knipe and Davies 2008). Families are another push factor, especially if reunification takes place by the return movement. Families can also be a stick factor when nurses want to stay in the UK because of their children. Stick factors also relate to the positive aspects of UK life and the negative ones of life in Malawi, such as the pressure to achieve and the lack of improvements in Malawi. Whereas enabling factors played a key role in the decisions to migrate to the UK, with the exception of having enough resources and family approval for the return migration decision, they no longer play such a key role, primarily because most have held onto their Malawian passports, allowing them smooth re-entry.

Figure 8.1 Push and pull model for return migration from the UK



8.9 Return migration: a strategy to fill vacancies

8.9.1 How it can be effective

The return of foreign nurses to their countries of origin is not a panacea to definitively resolve the problems of shortage and maldistribution of health human resources, but it can help.

Haour-Knipe and Davies (2008: 38)

The evidence suggests that the return migration of nurses can help alleviate staff shortages on the condition that they re-enter the systems in which they are needed most - typically the public health service - and that their skills are put to good use (Kingma 2006). In the first instance, their return means that there is now additional manpower without a renewed cost to the government for training. As many of those who left were highly qualified and experienced, their return would benefit the sectors that felt their loss most acutely, particularly nursing colleges. Filling this gap is especially important because of the time needed to retrain adequately experienced nursing tutors. A period of time overseas may also make nurses more sensitive to cultural differences, a timely skill given the number of international agencies working in the health field in Malawi. Emmanuel found that after being in the UK he had benefited from exposure to people from many other cultures, making him more understanding and aware of differences that can arise between them. Such a skill can potentially help to improve the coordination between the Malawian health service and international organisations (who often rely on overseas consultants). Even if nurses go to NGOs and are do not return to the government service, many believe that at least they are still providing a service to the country.

A number of challenges stand in the way of the returnee's successful reintegration into the workplace. To begin with, nurses would need to re-adapt to changes in their personal lives, for example loss of the easy access to the commodities they enjoyed in the UK. In the workplace nurses may also find that they do not easily fit back into the system which they left. The literature consistently points to difficulties in the transfer of technological skills gained overseas to the home country (ICN 2008), especially when there are resource shortages. In some cases returnee nurses are not placed in positions best suited to the newfound skills they have acquired abroad (Bach 2003 cited in Pagett and Padarath 2007). This is especially important if nurses find that, as

they predict, they return to lower positions than they are qualified for. Kingma (2006: 201) believes that, especially when migrant nurses have left without a 'leave of absence' from their employer at home, they may often be greeted upon their return by a demotion to a lower paid position and denied professional recognition: "the return migrant's only reward may be a different form of frustration and dissatisfaction that led them to leave in the first place." Even if they enter in a high position, they may become frustrated - as James and Anna predicted - with the difference in standards that they have become used to in the UK. In addition, King (2000 cited in Haour-Knipe and Davies 2008) warns that too many migrants returning to a system can depress wages through an over-supply of labour. Although the Malawian health system would probably not experience such an oversupply, a situation could arise in which there were too many eligible nurses looking for senior positions. An oversupply for such positions might cause nurses to leak out of the government system, meaning that return migration may bring little benefit to government.

8.9.2 Would it be a viable strategy?

In light of the research findings, the likelihood of many nurses returning to Malawi, despite increasing restrictions and visa difficulties, is low. Even those who do wish to return either plan to retire or do not plan to re-enter the government service. This means that the government would currently not be able to benefit from significant return movements. However, other countries have deemed strategies to encourage return migration worthy of investment. A number of programmes have been developed, most commonly in the form of financial packages to assist and encourage return migration. These include programmes in Turkey, Thailand and Taiwan, and regionally by the International Organisation for Migration (IOM) (Kingma 2006). In the UK, the IOM implemented the Reintegration Fund to support failed asylum seekers to return to their countries of origin. Between 2002 and 2007, nine individuals from Malawi were among the 6300 they assisted (IOM 2007b). Many of the returnees used the assistance to purchase supplies to set up a small business. Yet programmes specifically targeting return nurse migration are rare, and Kingma (2006) finds that source countries are surprisingly reluctant to establish policies to facilitate return. A possible reason could be that such policies are often 'difficult to manage effectively' (Bach 2003: 27), especially as they may be only financing those who had planned to return anyway. Bach believes that retention investments may be much more cost effective. In light of the current reality that few nurses are naturally returning, and few would consider returning to the

government service (even if conditions did improve in hospitals), return migration strategies may be ineffective for Malawi. Financial incentives to encourage return may also fall flat, partly because economic motives are not as important as family ones in nurses' return migration decisions. This is especially true if they already have adequate investments and savings.

With a consideration of the reality that many Malawians wish to stay in the UK but still have strong links to Malawi, and a desire to help their country, a group of Malawians living in Scotland set up MIND: the Malawi Initiative for National Development. The programme, currently coming out of its pilot phase, helps Diaspora Malawians return to Malawi on three-to-six-month volunteering projects in the fields of education, health and secure livelihoods. Amongst the volunteers who went to Malawi during the pilot project between October 2009 and January 2010 were four Malawian nurses (MIND 2009). Such a programme may be a fair compromise which allows nurses to assist their country without them forcing them to make the decision to re-migrate. However, the project has been criticised because its placements are not long enough, especially in the field of nursing which requires sheer manpower more than anything else. Critics also argue that the programme may be used by Diaspora Malawians as a 'cheap' way to return home (travel and living expenses are paid), and once they arrive they will not engage in the job but rather go and visit friends and family. MIND contends that this is not the case, and that although longer placements would be preferable it is difficult for working Malawians to take more time off from their jobs (personal communication, MIND 2009).

8.10 Chapter conclusion

The future plans of the majority of the nurses in Malawi and the UK involved educational attainment. This was particularly important for the nurses in Malawi, in order to allow them to progress in their careers. Whilst those who left for the UK came with educational goals, many were unable to achieve them in the timeframe expected, which has implications on how long they would stay. As the possibility of home student fees as well as gaining security from a more permanent visa improved over time, nurses were tempted to stay in the UK. As their stay extended, the ties that they made strengthened, especially for those with children in the UK education system. The family equation is considered to be a key factor in the return migration decision. Although most still identified Malawi as their home, and one that they missed very much, the lure

of returning was weakened not only by the ties in the UK and the thought of losing their UK lifestyle and work advantages, but also by the expectations of those back home. Whilst the pull of Malawi was strong for a number of nurses, including Sarah and Silvia, most felt that there would be limited opportunities for them back home. The main return pull came from retirement prospects in Malawi. Yet, if only retirees return, their economic contribution to their home country may not be optimal (Kingma 2006). In addition to this, a number of factors make the strategy of return migration as a way to improve the HRH situation in Malawi unviable. The barriers and stigma that nurses face upon return make it difficult to encourage them back into the government service where they are most needed. This is further exacerbated by the decision that they have made not to return to nursing in the government service even if they do return to Malawi.

Chapter 9

Conclusions and recommendations

9.1 Chapter overview

In this final chapter I summarise key research findings from the thesis and present my conclusions. I draw on the shift in motivations to become a nurse and changing patterns of migration, and explain how the findings contribute to the literature and to the theoretical understanding of nurse migration by presenting a revised push and pull model. I conclude with recommendations and reflections on the research.

9.2 Summary of research findings

Historical events have played a vital role in determining nurses' experiences and the decisions they have made about their lives. During the Banda years decisions were based on the limited availability of career options for women and the respect for nurses in society. Nurses were seen as personifying Banda's four cornerstone values, especially the attribute of discipline. As employment options were limited, there was little international migration (with the exception of some nurses overstaying their study periods overseas), and nurses were keen to enter the government service because of adequate working conditions and study opportunities. The peak migration years coincided with a decline in the economy and the healthcare system. A timely combination of poor working conditions, improved communications and the open door to the UK led to the departure of a significant proportion of the country's registered nurses who were keen to benefit from UK life. As one key informant at the MoH said, "the temptation was there, and they couldn't resist". Whilst educational and financial opportunities were important in motivating nurses to leave, many spoke about the 'trend' to migrate. An unexpected finding was that all the RN respondents who had stayed in Malawi had intended to leave and most had even begun the process to find work in the UK, suggesting that the push to migrate was very strong.

The fall-out of the migration years was a higher workload for the remaining nurses, especially enrolled nurses who continue to form the backbone of nursing in Malawi. Yet most who stayed did not resent those who left. On the contrary, many were able to benefit from improved promotion and educational opportunities in light of the staff shortages. The legacy of such promotions was felt by recent male nursing graduates, who experienced stigma and discrimination. Male nurses believed that the ENs who were promoted were nervous about losing their positions to them because they had higher qualifications, leading them to act inappropriately towards them. Nurses who stayed were also able to benefit from government initiatives to improve the HRH situation, most importantly the EHRP. Although respondents acknowledged these efforts, and were pleased with some EHRP initiatives like the locum system, in general the response was lukewarm. Most believed that there was still a long way to go to improve the situation and retain nurses within government. This has contributed to a continued outflow of nurses to higher paying NGOs in an attempt to regain the lifestyle they were accustomed to in the Banda years, when they could afford houses and holidays.

Nurses in the UK also perceived that little had changed within nursing in Malawi. Many felt that it would be difficult to return to work as nurses because of the higher standards of practice and working environments they were now used to. Such considerations meant that no respondent wanted to return to work in government, but as all the respondents still considered Malawi their home they planned to return eventually. Expectations that all migrants would become successful in their destination country made nurses hesitant about returning straightaway. In the UK, the high cost of living and studying (especially with international fees), as well as obligations to send money home, meant that nurses often took longer to achieve their goals. Concerns about returning to Malawi empty-handed contributed to the delay in returning. The stigma associated with UK care home work acted as another disincentive, as migrant nurses felt that they would not be able to demonstrate any professional improvements from their time in the UK. Their extended stays led to greater assimilation into UK society, despite the integration challenges they faced. Such challenges included adapting to new social norms and gaining recognition and respect in their workplace in light of the stigma they faced as African nurses. They also had to adapt to changes in family circumstances, particularly their role and that of their partner in childcare. In addition, their children often picked up behaviours which nurses felt conflicted with traditional Malawian values. Despite these challenges, most nurses were pleased with their lifestyle improvements, especially in terms of educational opportunities and readily

available and affordable commodities. Many had also been able to achieve significant financial success, reflected in home building and business developments back in Malawi. Nurses remaining in Malawi hoped to emulate such successes in their future plans, and many saw educational attainment as a way to do so.

9.3 Key conclusions

I have attempted to build a picture of nursing in Malawi by exploring the choice of nursing as profession, migration patterns, working experiences, and finally thoughts about the future. At each stage of the timeline all the nurses faced significant challenges and barriers inherent in Malawi's status as a low-income country. Limited opportunities, especially for higher education, forced them to make decisions about their career development. For most respondents this meant pursuing a degree in nursing even though it was not their intention or choice. In addition, the enduring high respect and perceived financial advantages of migration contributed to maintaining a strong desire to migrate.

The stories of the nurses and the accounts of key informants often revealed patterns within the data. Although the findings cannot be generalised to all nurses within Malawi, the consistency of the stories and reports suggests that Malawian nurses share a key set of factors that influence their experiences and decisions. These include family considerations and the country and political context. The former can be seen in the strong culture of extended family and the important role families play in the nurses' decisions. The importance of political context is seen in the marked similarities of responses between nurses who graduated during the same presidential era.

9.4 Relationship with and contribution to the literature

Many of the findings, especially regarding the nurses' experiences in the UK, are consistent with previous literature on nurse migration. Consistencies include the important role that families play in migration decisions, particularly return migration decisions in which migrants commonly take into account their children's education and integration in the destination country. Nurses in this study also faced a number of challenges regularly featuring in the literature, including deskilling, non-recognition of

qualifications and discrimination. However, they did not face as many challenges with promotions as is generally discussed in the literature. Similarities in findings were strong for those nurses who were working in care homes. Parallels were drawn in the literature, notably the research work of McGregor (2007, 2008) on decisions about care home employment and subsequent experiences.

In terms of the experiences of nurses in Malawi, my findings support studies which suggest that working conditions remain tough for nurses. However, literature is limited regarding the situation for nurses' post-EHRP, making comparisons challenging. What this study has been able to add is that nurses perceive that recent initiatives to improve the situation in Malawi have only been partially successful. Some even believe that they have made things worse. Specifically, the increase in student output has affected the quality of teaching, caused congestion in Malawi's hospitals, and negatively affected the working standards of new nursing graduates. Many criticised the initiatives for distorting nurses' salary expectations, so that even though nurses have higher salaries than other civil servants, they still perceive that they are far too low. Whilst research and media attention has no doubt helped to raise awareness of Malawi's nursing shortages and spur on initiatives, the negative media representation of nurse migration has served to anger and frustrate migrant nurses.

To accurately assess the current nursing landscape in Malawi, the study calls for the consideration of its strong cultural emphasis on family values and historical, political and demographic changes. These changes have played a key role in influencing career choice, workplace decisions, migration patterns and working life experiences. The high status attached to educational gain also has important implications for career choice, employment and migration decisions. The findings have contributed to a revised push and pull model of nurse migration decisions, although there is also agreement between the findings and the literature about key push and pull factors.

9.5 Theoretical contribution

9.5.1 The push and pull model of Malawian nurse migration

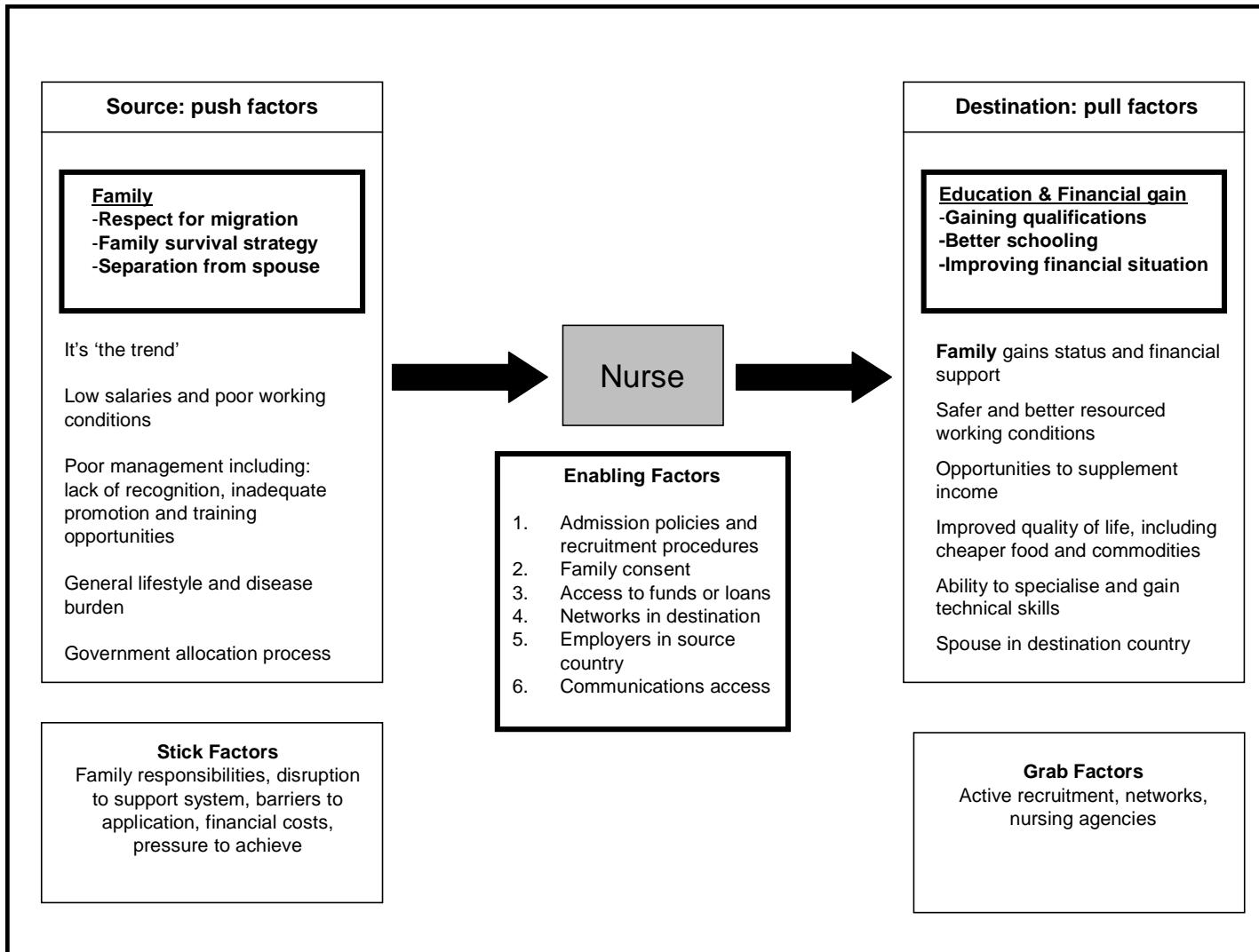
A push and pull model of migration based on existing literature was presented in Chapter Two. Although it is considered a solid framework to describe migration decisions, the model has been criticised for its simplicity and inability to capture the complexity of migration. Its simplicity partly stems from its failure to show the important influences of individual circumstances. By ignoring these, the model can potentially present only a limited interpretation of migration decisions. However, it is difficult for any model to fully and accurately represent the complexity of human decision making, and many consider the push and pull framework a useful tool to organise the most important factors in migration decisions. The simplicity of the model also makes it accessible and useful in providing a framework on which to build country and context specific models. An additional strength is that, although there may be differences in push and pull factors between contexts, there is often significant overlap. For example, many of the original factors presented in the previous model (based on global nurse migration data) were also applicable to Malawi.

However, the model is unable to capture individual characteristics, which play an important role in determining an individual's response to push and pull factors. Even when individuals' circumstances are similar, their responses may not be. This also extends to how outside factors influenced nurses. For example, since Malawians have a strong and culturally ingrained sense of family responsibility, many nurses aimed to support their families. Whereas some families wished this support to be financial, leading them to encourage nurses to migrate, other families wished for it to be available at home. Although I acknowledge that the model does not capture all the factors and influences, I have attempted to identify the priority areas in the respondents' decision-making processes in an amended framework. Figure 9.1 presents nurses' migration decisions specific to the Malawian context.

By presenting the factors most relevant to nurses in Malawi, I demonstrate how context can affect the composition of the model. I have made a number of amendments to the original framework, including removing factors like travel opportunities which were not applicable, and adding new factors. I also identified new 'stick' factors which included

the home security and support system and pressure to achieve (in particular the need to show that you have been successful in the UK which could act as a deterrent to potential migrants). To emphasise the relative importance of each factor from the point of view of the nurses, I created a hierarchy highlighting the factors that most influenced their decisions. These were family in the 'push' and educational and financial gain in the 'pull'. These factors were often linked. One such link was between financial and educational gains, which is why they are listed together. The motivation to gain qualifications was as much about economic survival as obtaining knowledge. With more people gaining degrees in Malawi, overseas Masters qualifications have become a way to improve one's opportunities and financial situation at home. Although the hierarchy is primarily based on the movements of nurses in the migration years, I have attempted to represent the current migration climate by highlighting the importance of enabling factors. In Chapter Two I discussed how enabling factors could override push and pull factors, particularly when migration restrictions were strong. The findings suggest that this is currently the case in Malawi: the decline in migration is not merely a result of diminishing push and pull factors, but is closely linked to increased restrictions. Many respondents believed that key push and pull factors were as applicable today as they were in previous years (for example, salaries remained low), and that it was mainly the role of enabling factors that had changed. I have also included responses more relevant to the Banda years, such as the pull of joining a spouse. By including the nurses' responses from all the periods, I attempt to present both a historical and a current picture of nurses' migration decisions.

Figure 9.1 Push and pull model of Malawian nurse migration



9.6 Recommendations

How do we create the conditions that make nurses' professional journeys a choice rather than an obligation or a forced escape?

Kingma 2006: 206

How could my recommendations help improve the nursing situation given that government HRH initiatives have met with mitigated success, both from the point of view of nurses and in terms of outcomes (the 77 percent nursing vacancy rate persists)? Firstly, government initiatives have focused on increasing output and improving retention, but there has been little consideration of the reasons that people enter nursing and the implications of these. Secondly, the focus on increasing output has occurred at the expense of ensuring that graduates are motivated and trained to high standards. Students were often left unsupervised in the wards because of a shortage of tutors, and many believed that this had implications for the quality of nursing care. In this section I make a number of recommendations (summarised in Box 9.1), in particular on how nursing output can be improved without compromising quality and how to improve the working experiences of nurses in both Malawi and the UK. The recommendations are based on the research findings as well as on the suggestions from respondents.

Box 9.1 Key recommendations

- Improve access to education and focus on improving quality of teaching, particularly in the sciences.
- Implement a strong system of careers advice in schools.
- Improve the image and status of nurses, particularly male nurses.
- Re-focus incentives away from financial to non-financial ones; this includes introducing strategies to improve the social lives of nurses and improve career development pathways.
- Introduce a system whereby nurses can work simultaneously in both government and higher paying NGOs.
- Incorporate retired returnee nurses back into the health system through mentoring programmes.
- Facilitate return migration through assistance with study fees and permit issues.

9.6.1 Improving the quality and quantity of nursing students

Malawi still has a shortage of nurses, but many in the system are dissatisfied with the quality and motivation of new graduates. Firstly, the pool of eligible candidates is limited by the fact that many Malawians face significant barriers to accessing education. Poor MSCE grades limit the pool further. Secondly, those who are selected into nursing (especially at degree level) may not be motivated by the prospect of a nursing career and may plan to go into alternative employment upon graduation.

To deal with the first two issues and to make nursing careers accessible to more Malawians, there is a need to improve access to education. Many respondents argued for increased educational investment, but this is challenging considering the economic difficulties Malawi faces³⁸. Improving access would require investment and effort from both the Ministry of Health and the Ministry of Education³⁹. The Ministry of Education could assist with improving motivation and retention levels of teachers in particular. Whilst nurses' salaries have been raised in recent years, teachers' salaries remain low. A key DFID informant believed that it made no sense to pay health workers more than teachers as they had more opportunities to supplement their income through locums. Improving the salaries of teachers (in addition to implementing other equally important non-financial incentive programmes) may help to motivate them and improve the quality of teaching, especially if combined with measures to reduce class sizes through improved recruitment and retention. Secondly, improving science teaching in both urban and rural areas could potentially help students to improve their science grades and therefore their eligibility for nursing. Tanner (2005) also supports the link between improved science teaching in schools and improved health worker training output.

To deal with the third issue of motivations to enter nursing, KCN recently took steps to ensure that it only selected applicants whose first choice was nursing. Such a measure can be helped by improving careers advice in schools to help students make informed and appropriate decisions. Tailored careers advice using dedicated advisors or teachers could also help to ensure that students are educated about the profession, as

³⁸ As we saw, the introduction of free primary school education had significant negative consequences for the quality of education.

³⁹ The importance of inter-ministry cooperation was recognised by the recent government Road Map for Maternal and Neonatal Health, which brought together a number of ministries to address the challenges of improving maternal health (MoH Malawi 2007c).

my research findings suggest that few respondents knew what the nursing profession entailed before they entered the course.

One key informant recommended introducing a system whereby students with inadequate grades but a strong dedication to nursing would be able to enter the profession (see Table 9.1). This may serve to not only improve nursing numbers, but also to ensure that more students are motivated by a desire to be a nurse; which may help to rebuild the image of nurses as professional and dedicated, and may in turn attract more applicants. Good publicity and education regarding nursing would also be useful in communities to help dispel the notions associated with the nursing profession such as that it is a dirty, lowly job. In the Banda years, nurses felt motivated to enter the profession because of the pride and respect associated with nursing. In recent years, this respect has faded and by association many students may not see the value of being a nurse. Whilst economic considerations make it difficult to entice and retain students through financial incentives such as the prospect of higher salaries, strategies that focus on raising the status of nurses in society may contribute to recruitment and retention.

Specific measures to achieve this include special awards ceremonies and rewards for good practice within the nurses' communities or national ceremonies involving high-profile leaders. These could be combined with improvements in the media representation of nurses, which currently tends to be negative. Silvia argued that the MoH needs to be seen as supporting and promoting nurses in the hospital and community. Leaders outside the MoH can also support nurses by attending Malawi's own health facilities. Currently, most politicians use private facilities or fly out to South Africa to access healthcare. Emma believed that this showed that "they don't care" what actually happens in facilities, and that it made nurses feel their services were not good enough to warrant high-profile patients. By attending government health facilities politicians may become more aware of the conditions and may have more of an incentive to improve them. A selection of additional recommendations is briefly presented in Table 9.1.

Table 9.1 Recommendations to improve student quality and output

Findings	Potential Application	Recommendations
Many students are excluded from nursing, even if they have a strong desire to become a nurse	Improving nurse numbers and increasing rural uptake	Introduce a system whereby aspiring nurses with lower grades can begin at a lower level, for example as a health care assistant level or patient attendant (which are in existence in Malawi), but strengthen appropriate promotion and training opportunities for those who want to move on to become qualified nurses. This could provide a way into the profession for those with lower grades
Issues with male retention, potentially because of discriminatory behaviour	Retention and attraction of male nurses	Raise awareness and build a positive image around male nurses to nursing leaders, other health workers and the public. As a starting point, appoint a male nurse to a high profile position; for example, within the Ministry of Health Make the language of nursing gender neutral; for example, adapt the name 'sister-in-charge'
Students and their families perceive nursing to be risky	Attracting students	Take active and public steps to ensure that nurses are protected from occupational risk, for example by improving resource availability in all health facilities
Some nursing students found the course challenging because of language difficulties	Improving motivation and performance of nursing students	Introduce a support system for those who struggle with English; for example, extra language courses
There is little to correlate motivation to enter nursing with performance and behaviour of nurses	Quality of care provided	Conduct a longitudinal study following the career trajectories of nurses (along the lines of the study by Lagarde and Blaauw 2009) to assess whether motivations affect behaviour (for example, if nurses select nursing by default are they less likely to stay as nurses?)

9.6.2 Improving conditions for nurses in Malawi

During the course of my research I was interested in defining the changes that respondents would like to see in the field of nursing in Malawi. In this section I propose recommendations based on the suggestions of nurses and key informants, as well as on my own interpretations of the research findings. Respondents believed that working

conditions in health facilities were still inadequate, particularly with regard to resources and staff numbers. Many of their suggestions to improve service conditions were consistent with the literature and the measures that the Malawian government took in the EHRP. These included raising salaries, lowering patient to nurse ratios and improving resource availability. As most of these incentives depend on significant government investment, I have chosen to present those recommendations that have not already been proposed and do not necessarily involve significant investment. In addition, although respondents talked about the need to raise salaries, the EHRP salary top-ups did not appear to be successful in retaining and motivating nurses. As salary improvements were often accompanied by rising commodity prices, this makes it difficult to justify additional pay rises. Aubrey believed that higher salaries are never satisfying as people just get used to spending more money. He suggested focusing attention onto non-financial incentives. Such incentives are increasingly shown by the HRH literature to be effective in helping retention (in Malawi by Lungu, 2004). Examples could include improving transport links to hospitals, especially for those in cities, and putting in place clearer and more defined career development pathways. A study of field epidemiology graduates⁴⁰ in Africa attributed high levels of retention to well defined career paths, as well as training and research opportunities, amongst other factors (Mukanga et al 2010).

Introducing defined career paths could assist with retention as my findings show that career progression and personal development are important motivators for nurses, and the lack of opportunities for professional development contributed to migration. Other examples of non-financial incentives proposed by respondents included focusing on the social aspects of nurses' lives. A key informant from KCN explained that this aspect is often ignored by the government. He proposed re-introducing football and other team sports in which health workers form teams and compete with other facilities. He explained that the football pitch at KCH in Lilongwe, which he and his colleagues had previously enjoyed, had recently been replaced by a shopping mall. Many respondents called for staff rooms to be introduced into facilities to enable them to have time away from their patients, as currently many took breaks on the wards. Similarly, respondents recommended that nurses be provided with more pastoral support in the form of an outlet to discuss their problems and stresses. Many felt that nurses often had no one to talk to about their everyday problems.

⁴⁰ Graduates play a central role in public health surveillance, programme design, and disease control.

In terms of the recent shift in the healthcare system, the emphasis on guardian care in health facilities had a number of implications for nurses' roles and hospital logistics. I propose developing formal logistical arrangements for guardians, such as introducing a liaison officer to help with logistical issues and to formalise the guardians' presence in hospitals; for example, to ensure a recording system for guardians (to prevent non-guardian impersonation to get food). Other solutions which go beyond the improvement of salaries and resource availability include tackling the issue of significant internal migration of nurses to NGOs to gain higher salaries. A Malawian doctor key informant suggested introducing a system whereby nurses could work for NGOs but could also stay in the government service. Government nurses could, for example, be allocated time to work with NGOs during their working hours. He believed that if nurses were able to supplement their incomes with NGO work but still remain in the government, "the high standards of NGOs can also filter down to the wards, and will result in an enhancement of care." At a meeting of Malawian nurse leaders in June 2010, many argued that when nurses left an NGO for government they were obliged to re-enter at lower levels, making it difficult to entice them back. Taking into account their NGO experience could help to attract nurses back to the government service.

The findings also highlighted issues with nurse retention and recruitment into rural health facilities. The WHO (2009b) has identified a number of interventions to improve the retention of health workers in remote and rural areas. These include general improvements in rural infrastructure, early and increased exposure to rural practice during undergraduate studies and special awards or social recognition for rural placements. Research has suggested that students from rural backgrounds are more likely to choose to practice there than those who were brought up in urban areas (WHO 2009b, Lungu 2004). This suggests that attracting rural students into the nursing profession may help to retain nurses in rural areas. However, my findings do not support this. Respondents from rural areas reported that once they had come to urban areas to train and had become used to amenities such as electricity, running water and the internet, it became hard for them to return to rural life. Recommendations on rural retention often have pitfalls. For example, the effectiveness of compulsory placement has been questioned. It appears to address short-term maldistribution, but has been criticised for alienating people from the profession (WHO 2009b). According to WHO (2009b), there is very little evidence about what works to improve retention in rural areas. Therefore, I have focused the recommendations regarding rural retention on improving educational opportunities for rural students as opposed to focusing on what

could retain nurses in rural areas beyond the suggestion that conditions, transport links and opportunities for nurses' children and spouses could be significantly improved.

9.6.3 Improving working conditions for nurses in the UK

Many of the studies on overseas nurses in the UK have made important recommendations about ways to improve integration and adaptation into the nursing workforce. Key recommendations included:

- Better pre-recruitment information for overseas nurses, including information on culture and local dialects and the type of work in the NHS and care homes (Allan and Larsen 2003).
- Proper orientation, mentoring and supervision, as informal or formal orientation sessions have been shown to facilitate the settling-in process (Kingma 2006).
- Induction programmes for UK staff working with overseas nurses, including information on behaviour norms in the source countries, and tackling racism amongst staff and at institutional level (Allan and Larsen 2003).
- Regulation of recruitment agencies, because they are often held responsible for much of the abuse against migrant nurses (Kingma 2006).
- Ethical nurse recruitment, including:
 - Equal pay for work of equal value.
 - Access to grievance procedures.
 - Employment trial periods (ICN Position Statement, cited in Anderson and Isaacs 2007).

As many of the findings of my research are similar to previous studies, I believe that the recommendations are applicable to improving the lives of Malawian nurses in the UK. I propose a number of additional recommendations which can be implemented in the workplace. Firstly, to deal with the issue of patient acceptance, a system could be introduced to educate patients (especially those in long-term care) that the qualifications of overseas nurses are equivalent to those of UK nurses. Secondly to help nurses who experience promotion difficulties, measures could be taken to prepare nurses with information about promotion procedures, including support for CV writing. Finally, many nurses spoke about having difficult relationships with their colleagues and managers. Measures to improve understanding in the workplace include having a

presentation session to staff by nurses about their lives overseas. This could potentially help colleagues to understand their country's nursing practices as well as its cultural practices (for example, explaining differences in the use of eye contact). In addition, measures could be taken to tackle the negative media about the 'brain drain' of nurses from countries like Malawi and the perception that nurses have 'abandoned their countries to make money'. Specific measures could include raising awareness through the media about the positive work of Diaspora organisations, such as MIND.

9.6.4 Implications of return migration decisions

Although few migrant nurses planned to return to work as nurses in Malawi and it was difficult to integrate returnees back into the system, return migration strategies still have a number of potential positive features. I present some recommendations that take into account the realities of nurses' lives and choices, namely that most only want to return when they retire. One recommendation is to incorporate the retired nurses back into the health system as they will have potentially built up a strong financial base and may not be as strongly motivated by economic factors. One possibility might be to use their experience and skills to help train nursing students. This could be done on a part-time (or flexi-time) basis in nursing colleges or on the wards, where they could help to fill the gaps in the supervision of students. In return, there could be a number of non-financial incentives such as special recognition or award ceremonies to increase their status and recognise their contributions.

Other recommendations relate to younger nurses who are put off returning to Malawi. Whilst the data suggest that improving salaries in the home country can help to encourage return migration (for example Chikanda 2004), the EHRP salary top-ups did not encourage nurses to return. Strategies need to focus on making conditions more appealing in Malawi, in other words to maximise the pull back to Malawi and into the government service. Such strategies could include accentuating the positive features of life in Malawi, such as the potential for bigger homes and domestic help, as well as the possibility of a more 'fun' rewarding career with promotion prospects and opportunities for further study support. Recognising qualifications could also be a helpful step in encouraging nurses back to the government service. A system of recognition of their experiences overseas could be introduced, even if they do not achieve an extra qualification. This could also help to combat the stigma that 'unsuccessful migrants' feel. As Sarah was able to fit back into the government system more easily because

she took a leave of absence, declaring an amnesty whereby all the nurses who left without giving notice are welcomed back and recognised by the government system may help to encourage nurses to feel that they would be welcomed with 'open-arms' by the government if they returned. Strategies to encourage return could also focus less on what keeps nurses from wanting to go back to Malawi, and more on what is keeping them in the UK. Many nurses stayed because they had not been able to gain Masters. It might be useful to develop ways to assist nurses with fees and permit issues so that they were not obliged to stay in the UK until they were eligible for permanent residency and home fees. Of course, the UK may not want to lose the nurses it has gained, and it is important to harmonise an approach that benefits the source and destination countries as well as individual nurses. Although approaches such as temporary placements in Malawi as part of the MIND initiative have their pitfalls, such programmes may increasingly help to ease the HRH situation in the short term whilst the Malawian government improves the situation to minimise the push that caused nurses to leave in the first place.

9.7 Reflections

I began this research process armed with data showing extreme and debilitating rates of nurse migration from Malawi. Although many nurses were lost to the migration years, I found that the image of persisting brain drain portrayed by the media and researchers was not consistent with current patterns of migration. What I discovered was that nurses, especially in the UK, were tired of the media presenting them as deserters of their country, whilst those in Malawi were tired of being asked their thoughts on nursing there without seeing any concrete improvements. As most respondents and key informants felt that the migration of nurses from Malawi was no longer the issue it previously was, this led me to examine issues that respondents and key informants felt were more pressing. These included the shift in motivations to pursue nursing, which many felt was much more dangerous to the profession than poor retention. They were concerned that the older generation of 'dedicated and disciplined' nurses was being replaced by a generation of nurses who had been hastily promoted in the migration years or who had been hastily trained in response to the HRH crisis. I felt that examining the reasons for this shift was timelier in terms of the current situation in Malawi and future initiatives. It has also been equally important to identify the underlying motivations for nurses to migrate. These have important implications for the future of nursing in Malawi, and I predict that, if the doors of a country like the UK once

again open to welcome nurses with relative ease, many of Malawi's nurses who continue to be dissatisfied and demotivated will leave, mirroring the migration wave of 2000-2005.

Afterword:

The nurses' lives, two years on

The last part of the timeline focused on nurses' future plans. As many of their plans addressed the imminent future, I was able to visit some of them again to see whether they had been successful in implementing them. Nearly two years after our interviews, all of the migrant nurses remained in the UK. Florence had been unsuccessful in her Masters scholarship applications, but was persisting with her search for funding.

Emmanuel returned to Malawi after he had successfully completed his Masters study in the UK, but was planning to return to the UK to complete his PhD. However, he was unsuccessful in his applications for PhD scholarships and currently remains working in Malawi.

Of the nurses in Malawi, Aubrey was awarded a PhD scholarship and left his high-level position to begin a three-year PhD in the UK. The other four returnee nurses remained in Malawi pursuing their careers in government (Sarah), in her NGO (Abigail), or were enjoying their retirement (Silvia and Julia). Amongst the home nurses, Christina, who had been working with an NGO at the time of our interview, revealed that since our interview she had been making steps to find work in the UK, even though she was against migration at the time of the interview. She eventually found her way into the UK with a scholarship for a Masters programme, and was living in Scotland. The week after our interview in 2009, Monica (a high level RN), left the government service to work for an international NGO.

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Appendix 1

Supplementary statistics

Table of key health indicators: comparison of UK and Malawi

Indicator	Malawi	Date	UK	Date
Population	13.5 million	2008	61.8 million	2009*
Total fertility rate (per woman)	5.6	2008	1.8	2008
Hospital beds (per 10,000 population)	11	2007	39	2004
Number of nursing and midwifery personnel	3,896	2008	399,810	2010**
Nursing and midwifery personnel density (per 10,000)	2.8	2008	6.3	2003
Adult mortality rate	481	2008	78	2008
Deaths due to HIV/AIDS (per 10,000 per year)	488	2007	<10	2007
Life expectancy (years)	53	2008	80	2008
Maternal mortality rate (per 100,000 live births)	1140***	2008	12	2008
Neonatal mortality rate (per 1000 live births)	29	2008	3	2008

Notes:

Adult mortality rate refers to the probability of dying between 15 and 60 years per 1000 population.

Sources:

NSO Malawi (2005), *Office for National Statistics UK (2010), WHO Global Health Observatory (2009), **NHS Information Centre (2010), ***Hogan et al (2010)

Table of the number of Malawian nurses registered by the UK NMC

Year end	Numbers registered by UK NMC
2000	15
2001	45
2002	74
2003	57
2004	64
2005	52
2006	41
2007	No data
2008	3
Total	351

Source: UK NMC (2009)

Appendix 2

Map of Malawi



Source: Mangham (2007)

Appendix 3

Audit trail for methodology

The following audit trail is based on the audit trail of Bong (2002) and is used here to detail the process of data collection and analysis.

Data collection:

- Reading and reviewing the literature on biographical methods and comparing it to other qualitative methods
- Learning how to use NVivo software
- Gaining ethical approval from University College London and local Malawian ethics committee
- Developing contacts and networks for recruitment
- Recruitment of respondents
- Arranging and conducting interviews

Preparing data for analysis:

- Data collection through semi-structured interviews, key informant interviews, focus group discussion and document analysis
- Verifying findings with key informants throughout data collection process
- Preliminary analysis of interviews
- Transcription of recorded interviews (and removal of identifiers)
- Familiarisation with transcripts through multiple readings
- Formatting and importing each transcript to NVivo software

Data analysis:

- Summary is written about each respondent
- Themes are identified and coded in the text using NVivo
- Common themes are identified and placed on a mind map, to which new themes and issues are repeatedly added
- Selection of key themes
- Reflection on key themes and discussion with supervisors and respondents
- Important quotes highlighting the themes are selected
- Themes are related to the literature

Appendix 4

Information sheet for respondents: UK

Experiences of Malawian nurses working in the United Kingdom and Malawi

This study has been approved by the UCL Research Ethics Committee: Project ID Number 1533/001.

Researcher

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Introduction

I would like you to be part of my PhD research. The purpose of my research is to describe the experiences of Malawian nurses during their nursing careers and to understand about the decisions that nurses make about their careers.

In particular, I would like to hear about:

- Why you became a nurse?
- What you did after nursing college?
- What it is like for you to work in the UK?

Your stories and experiences will become an important part of my PhD research, and your contribution will help to educate others on what life is like for Malawian nurses working in the UK.

Who am I asking for help?

I would like to interview Malawian born nurses who are now working in the UK.

- If you are happy to take part in this study, I would meet with you once to discuss your experiences.
- I would conduct our interviews in a location and at a time that suits you. This would take about an hour.
- The interviews will be tape recorded; these recordings will be securely stored in a locked computer (to which I have sole access).

What will happen to the results of the research study?

The results of the research will form my PhD thesis which will be completed in 2010, and may be presented at international research conferences and published in research journals. You will not be identified in any publication.

I shall keep you updated on the progress of the research prior to my thesis completion and I shall offer you a copy of the report to acknowledge your help with my research.

Other details

- You will have access to the written copy of the interview at anytime, and will have the opportunity to edit and approve the transcript prior to it being completed.

- The information you give me will be strictly confidential and you will remain anonymous. All personal identifiers (such as the name of your workplace) will be removed from the transcript, so that no one will be able to identify you.
- All data will be collected and stored in accordance with the Data Protection Act 1998. All recordings will be securely stored in a password protected computer and/or locked drawer and held only for as long as necessary for the completion of my PhD thesis in 2010.
- If you decide to take part you will be given this information sheet to keep and will be asked to give your verbal consent before the interview.
- Please be reassured that there are no foreseeable risks for you to take part.
- You are under no obligation to participate; choosing not to take part will not disadvantage you in anyway.
- If you do decide to take part you are still free to withdraw at any time and without giving a reason.

Please ask me if there is anything that is not clear or if you would like more information

**Thank you for reading this information sheet and I hope that you
will take part**

Appendix 5

Verbal informed consent sheet

The Experiences of Malawian Nurses Working in the UK and Malawi

The purpose of this discussion with the respondent is to:

- Gain consent for a recorded interview.
- Describe conditions regarding the use of the recordings and the transcripts resulting from these recordings.
- Permanently transfer the interviewee's copyright to the recordings, interviews and transcripts to the researcher.

Before the start of the formal interview, consent will be discussed as below:

- Do you consent to participate in a recorded interview?
- Are you aware what will happen during the interview, and do you understand that you may withdraw from the process at any time?
- Would you mind if I took ownership of the recording, interview and transcript for copyright purposes? (This means that I will then be able to use some of what you have said for my thesis and for publications).
- Do you have any questions arising from the Information Sheet or explanation given to you?

As the interviewer I will ensure that:

- Your interview remains anonymous and that any information that could identify you personally will be removed from the transcript.
- The transcripts will be securely stored on a computer to which I have sole access, and in a securely locked drawer.
- The data will be kept for no longer than necessary for the completion of my PhD thesis in 2010.
- You have access to transcript at anytime and have the opportunity to edit and approve the transcript prior to it being completed.
- Any information you give will be treated as strictly confidential and in accordance with the Data Protection Act 1998.

I shall be taking verbal consent for the following reasons:

- As migration is a sensitive issue, I shall take all the appropriate steps to ensure that the respondents feel at ease, and that their privacy is not threatened and therefore not ask for written consent.
- To ensure that all the interviews remain anonymous and that there is no official record (i.e. a signed consent form) on file that would link the respondent to this research study.
- There are also cultural issues of sensitivity. There are elements of Malawian culture that suggest that gaining written consent during interviews is inappropriate.

Appendix 6

Topic guide for interview with nurses (UK)

- **Introductions and informal conversation**
- **Go through information sheet:**
 - Reminder of purpose of research
 - Their rights as interviewee regarding withdrawal from the interview
 - Confidentiality, use of data, data storage
- **Go through verbal consent form:**
 - Gain consent for a recorded interview

Questions to cover

Topics:

- Background - general
- Nursing Background - why?
- Nursing college - opportunities, obligations?
- Migration - decisions, journey, arrival
- Current life - experiences in UK, living conditions
- The future - thoughts

Starter question

- Please tell me about what you are doing at the moment

Background

- Please tell me a bit about yourself and your background

Probe:

- Current job and location
- Where are you from? Rural/urban
- Education
- Family – Family background, married? Children?

Nursing Background

- Please tell me about why you became a nurse?

Probe:

- Expectations of family, community, school
- Your role in decision making

- What support did you receive?

- Support you received (family)
- Incentives (Government)

- If you were not a nurse what else would you have been?

Nursing college

- Please tell me about your nursing college

Probe:

- Which nursing college did you attend?
- Did you have any choice regarding which college to attend?

- What were your thoughts for the future during college?

- Please tell me about the opportunities available to you after college?

Probe:

- Employment opportunities
- Further education

- Please tell me about any obligations you may have had after college?

-Government

-Family (parents, marital family)

-Financial

Career progression

- Please tell me about what you did after graduation

Probe:

-First job (Where? What role? For how long? How was it?)

-Further qualifications

-Further employment: please tell me about this

Migration decisions

- Please tell me about when you first decided to migrate

Probe:

-Why did you migrate?

-Who else was involved in your decision to migrate?

-How long did you consider migrating?

-How did you find out about the opportunities available to you?

- Did you know of any other nurses who had migrated? Can you please describe what you knew of their experiences?

- What were your expectations regarding migration?

- How did you feel about leaving Malawi?

- Please tell me about the process of migration from Malawi, and how did you find it?

Probe:

-Official process in Malawi (length of time, level of ease, level of support)

-Personal preparations for migration

-Professional preparations for migration

-Family situation (would they join you? and if so when?)

Experiences in the UK

How long have you been in the UK?

- Please tell me about how you came to the UK and found a job there
- Please tell me about your journey to the UK

Probe:

Employment in other countries before the UK

Entry process to the UK

- Please tell me about your job

Probe:

Role (area of work)

Responsibilities

Workload

Working hours

- Please tell me about your workplace

Probe:

Entry (welcome, orientation, integration)

Relationships with colleagues

Management

Career opportunities

- What has it been like to work in the United Kingdom?

- How do your experiences compare to what you experienced in Malawi?

- Please can you tell me about any cultural barriers that exist for you?

Probe:

Language, communication issues

Living conditions

- Please tell me about your home

Probe:

What are your living arrangements?

Who do you live with?

What options were available to you regarding living arrangements?

How far do you travel to work?

- How do you feel about your living conditions?

- Can you please tell me about the community that you live in?

Probe:

What support do you have (family/friends)?

What spare time activities are you involved in?

- Please tell me about the contact you have with family, community back in Malawi

Probe:

How often do you travel home?

Do you send any gifts or money home?

- How do you feel your life has changed since you migrated?

Probe:

Changes in lifestyle e.g. diet?

Changes in health since migration?

Thoughts for the future

- Where do you see yourself in the next 5 years?
- What are your thoughts about remaining in the UK?
- What are your thoughts about returning to Malawi?
- What would need to be different in Malawi in order for you to return?
 - Probe (Do you think the situation has worsened/improved for nurses in Malawi since you left?)
- What do you think your life would have been like if you stayed?

End

-Is there anything else you would like to say that you consider to be important?

-Do you have any questions?

To follow up:

- Rearrange a further interview (if topic guide is not completed in first interview)
- Ask them who must I also interview to get a good understanding of this area?
And what should I ask them?
- Remind them about:
 - What will happen to data (transcript, storage issues, PhD thesis)
 - Their rights to access the transcript at any time, and their right to knock out any details that they do not like
 - That they can contact me at any time for further information

Appendix 7

Topic guide for interview with nurses (Malawi)

Introductions, information shared and verbal consent as for Appendix 6

Questions to cover

Topics:

- Background - general
- Nursing Background - why?
- Nursing college - opportunities, obligations?
- Current life
- The future
- Thoughts on migration - others, and theirs

Starter question

- Please tell me about what you are doing at the moment

Background

- Please tell me a bit about yourself and your background

Probe:

- Current job and location
- Where are you from? Rural/urban
- Education
- Family: Family background, married? Children?

Nursing Background

- Please tell me about why you became a nurse?

Probe:

- Expectations of family, community, school
- Your role in decision making

- What support did you receive?
- Support you received (family)
- Incentives (Government)

Nursing college

- Please tell me about your nursing college.

Probe:

- Which nursing college did you attend?
- Did you have any choice regarding which college to attend?

- What were your thoughts for your future during college?
- Please tell me about any obligations you may have had after college?

-Government

- Family (parents, marital family)
- Financial

Career progression

- Please tell me about the opportunities available to you after college?

Probe:

- Employment opportunities
- Further education

- Please tell me about what you did after graduation.

Probe:

- First job (Where? What role? For how long? How was it?)
- Further qualifications
- Further employment: please tell me about this

Current life

- Please tell me about your current job
- What is like working as a?
- How do you find your working conditions?

The future

- Where do you see yourself in the next 5 years?
- What are the factors that impact on this?

I would now like to ask you a bit about what other nurses choose to do in Malawi:

Thoughts on migration – others, theirs...

- Can you tell me about any nurses known to you who have migrated?
- What have you heard?
- What do you think life is like generally for those nurses who have migrated?
- Can you tell me about any nurses who have returned from working abroad?
How has life been for them since they returned?
- Do you think that there are any advantages of migration?
- Have you ever considered migrating?
 - Why did you not migrate?
 - What factors were involved in your decision?
- How has nurse migration impacted on you?
- How has the government's Emergency Human Resources Plan affected you?
 - Probe (salary top up, more responsibility due to task shifting)
 - Do you think it will improve working conditions for nurses in the future?

End as for Appendix 6

Appendix 8

Example of transcript (key informant in Malawi)

The first transcript I have chosen to present is from an interview with a Malawian doctor running a CHAM hospital in Malawi. He is active in the NGO and research community but has always worked within CHAM and the government health service.

Transcript: Doctor, Malawi 2009

What you think of Malawi human resource situation now?

One of the things that everybody more or less accepts is that there isn't enough of human resource for health in Malawi, and it has been identified as a problem for sometime, and now there has been a big concerted effort to actually improve that and there is some degree of improvement but it's quite slow. Partly because you can only push so much into a system that is, even with training there is a limit to the number of people you can train per year. There is also a limit to the number the government can absorb in a year into the system even though if we had all the numbers now and tried to push them into the system the wage bill will increase for more than what it's planned to be. It has to be done slowly to make any sense. At the moment people will talk to you that we have the money to employ more but that is because we haven't reached that level at which extra people, even though we need more, that money has been exhausted, we can still absorb a bit more. The other thing is there is an understanding if the human resource issue was actually met then the quality of care, the output would be better, that's an assumption, whether that is true? One of the problems of the human resource planning is that actually we do not know how to correlate the numbers that are going out and the improved outcomes, so we are always short staffed and therefore we need 20 nurses, all I have is 10, what is the kind of care I should be able to provide with 10? If I am able to provide 25% of the care, with half the number of nurses, if that number goes to 15 is it 40%? It is not a science you will find that certain cadres have increased considerably but it hasn't been associated with any improvement in the system itself.

Why?

I think partly it's the way the system has been allowed to develop. Originally any health system has outcomes but at some point we stopped looking at outcomes, we only looked at if we can provide it: the care. And because we stopped we haven't been able

to go back. So what happens is whatever health figures you are getting they are snapshots on the issues, so it becomes difficult to interpret them against what we are doing. So if you look at maternal mortality you see 900 something but if you look at the country and the health infrastructure on the ground, we shouldn't be that way. Why is there discordance? If we are able to improve on this it will get better.

While I have been doing my interviews the theme of quality of care has been coming up...what do you think about the current quality of care?

I think it's hard to say whether the increase in the number of people that you have trained does impede the quality, because you are looking at numbers, and punching into a cash register, you are not working on the quality of those people. I think most of the training is based on an assumption that there are already people out there that these people are going to join, but there are no people out there, so probably there is not the experience at that end already that people can rely on. Probably it is possible that the quality of care may not have gone down, but it may not have improved in line with improved numbers.

You just mentioned the situation had been happening for a while, in your experience what is 'a while'?

Actually the human resource problem in the country: we made it. We created this... The first place to go is the World Bank, IMF. In the 70s when the health system was being put down and designed, it's beautiful probably one of the best in sub-Saharan Africa, in terms of infrastructure the way it has been set, the contact between the people and the formal healthcare system, in this country you are no more than 20km for a health centre and most of the them are 10 km. So in terms of setting it up, it has been well set-up and in the 70s it ran very very well. And I think sometime towards the end of 70s early 80s, the big funders said the civil service is too big, you need to reduce it, who did we cut out? The nurses, teachers, and we cut those people out, so you cut off training, so you couldn't teach people anymore, we cut nurses we didn't have to have the number of nurses that we needed, so we stopped recruiting and we even got rid of some. As late as early 90s we were asking nurses to retire. It was a structural adjustment. The system has to run on a commercial basis it was a stupid thing to do, they thought that they should force these countries to go private, private health care if they put pressure enough on the public the private will come out, a theory in New York, absolutely wrong not even UK you take it. So we did this, we created this, and then now we say we are in trouble, you helped us get into trouble. If we were told stop employing nurses as soon as you say, they you stop training them. If you train

them where are they going to go? So we actually did that, of course it has a disastrous effect, all of a sudden the civil service shrank, less teachers and nurses. It was also in terms of bureaucrats, so the ministry became skeletons as well they couldn't plan. So we watched this thing more or less fall apart. The IMF they thought: 'the government is incapable of handling what we were planning, so we stop going directly to government and go directly to the people. Around 1996 to 2000, we are going to directly to people, funding NGOs, we don't fund government', and then they realised it actually didn't work, and then early end of 90s, there was realisation we need to talk to the government, we can only improve things straight from the government, so the idea, adopting SWAp started being planned, 2000, 2001. All of a sudden the international donors, it was in their interests to fund the government. The first cry was that there are not enough people in the government to work with. Yes. We are not enough because you didn't want them there, we now have certain level. If you go to any ministry there is so much expat Technical Assistants (TAs), these people are sitting in places, where previously people should have been sitting but they are getting 8 times more. For us to pay 8 Technical Assistants a year it's the same as paying all the nurses per year. If we took that money and said we are going to employ nurses we wouldn't need TAs. It is not in the interest of the TAs to be phased out. No you wouldn't, I wouldn't. 'TAs' is a big touchy subject, if you took out these 8 TAs out of the ministry you would have enough money, we are talking about 3000 nurses, or another 200 doctors, but you are giving it to someone so that they can count numbers for you. So it doesn't make any sense. So that is the overview.

That's really interesting...

The overarching policy was not set by us. If we are able to achieve 40% of SWAp we would see things much better. We have a good plan; the problem is running it because we don't have the planners at that level. For every good TA we have about 6 that are bad.

Do you think that money is the answer for the nurses?

I don't think that money is the answer. Money does help. It bothers me that I need it. It is an interesting thing that you have to remember in this situation when things are not ok; you aim for the most understandable aspect of solving that problem. And the most understandable aspect of solving the problem would be to throw money at it; we are seeing the economic crisis at the moment. But I think that the issue is not money, even if they were paid very very well, you would have satisfied one aspect of their motivation, there are more things that motivate them. So in terms people will always go

back to money, if you give us money, we will do better, but that is just a single aspect of motivation that allows someone to do good work. If your work is terrible, it doesn't matter how much money you give someone you will still feel miserable. At the same time, even if you love your work so much, if they are giving you miserable wages, you are not going to very much. So you need to be able to balance that, I think that there has been some improvement in salaries for nurses, not major. That could go along way to improve it but you have to improve the working conditions, a lot of what is happening now, we have seen the reduction in the exodus of nurses from government to private to mission hospitals, within the country, external is not as extreme. I think at the moment, migration to the UK is not the issue, partly because the cadre that we have the majority of the cadre that we have are not eligible to go (NMTs). So we don't lose them, we lose them here, because either they go to a different unit or they go to do something else other than nursing. We have seen a big movement into the institutions [NGOs] at the moment. Government people they think, less people are trying to get out because there has some improvement in what government has been paying. In terms of money then now just for salaries, having money to run the specific institutions, to make sure we have drugs, that does make a difference with SWAP there has been a lot of improvement.

Why is there less internal movement?

Government conditions are better than in CHAM. In government you get your pension, you get to go to workshops, if you are in CHAM you don't have as much of that, they are reasonably well managed and therefore there is a reasonable amount of control. The nurses here (CHAM), their workshop days are no more than 20 but if you go to a government institution you ask how many workshop days you have used up, they will probably for the total number of days that they are meant to work in that institution, probably half of those have been used for workshops. So if you use half of your year doing other things, how do you get the system to work? It's understandable.

Do you support the idea of workshops?

It doesn't make any sense, the reason they are so ubiquitous, because they are supplementing peoples' salaries. In reality if you calculate how much money people get from workshops and see what they do with it, most them, it doesn't help them very much. It makes you feel better but it doesn't improve what you have. Because it's not considered an income, it's considered as you have picked it up, easy come easy go. So in the long run it makes you feel better but it doesn't make you buy another pair of jeans. Very few people who are really in very high places, they will use their workshops

to build a house, they have access to it, so they manage to go to a workshop every week and accumulate. If you go to a workshop every 3 months, in terms of individual people, if you go to any hotel now in this country, in this city, today you will probably see a Ministry of Health meeting today. It will be the same tomorrow.

Is it from the NGOs?

It is because NGOs don't have any other way to spend their money. Most things that have to be delivered are long term things and NGOs are not designed to do long term things. They are designed to do things for 3 years, in terms of long term stuff they don't do very much. It's recognisable. If you think about it, in this country we have enough food more or less. Thank God the Ministry of Agriculture doesn't take farmers to workshops that much, the same way as Ministry of Health does. Then they would know very much about how to plant and take care of the crops, and how to harvest and how to market it, but there would just be no crops to market, because they would have spent most of their times in hotels learning it, and not doing it. They know it matters if they don't go to the garden that particular day. So if you take people that are working there, and put them in a hotel half the year... nobody was working...As money became difficult in the structural adjustment period, we haven't been able to weed it out (workshops). [Text removed].

NGOs also came up in another context... I was meeting KCN students and felt that their underlying aspirations were to go to NGOs, do you think that's...

I think for nurses at KCN that's a good thing, because that is what they are taught. Their teachers are not there, they are doing surveys and research for NGOs, so they are not taught nursing. So why should they go and do nursing anyway. That's what their teachers are doing. Your teachers are not doing any nursing. I go and train as a surgeon and paediatrician. My teacher is working as this, so that is what I will go and do: that is how you teach. The nursing college here, you don't find a tutor in a hospital doing medicine. The 2km square at KCH has the highest number of nurses probably in the country but the UNC project [research project], Baylor [research project], KCN, the hospital itself, small projects, so they have the biggest concentration of nurses in the country. But that's where the most type of nursing takes place, there are no nurses to take care of the patients, if you count the number of nurses, and the nurses of patients, each patient will have 2 nurses. I don't think it will get worse, we won't let it, the people of this country, you have to hit a point when people start saying this is not on. With the economic crisis around, a lot of NGOs will shut down. That's why SWAP is such a good thing. NGOs are not exactly powerless and they have the money.

Do you think other nurses would admire those who go to NGOs or abroad?

I think in terms of NGOs there are a certain group of nurses who feel that their lot will be better if they go and work for an NGO. NGOs pay very well for doing very little. There is a group of people who know that NGOs are not the future, as nurses. Some of the nurses we have employed here, maybe a quarter to a half came from NGOs, so they willingly gave up a much higher salary to come back to the system because 'I want to do nursing'. Nurses are not as particularly bad as we think they are. They come back and do some nursing. But they thought they had enough, some of them came from private hospitals which are paying much better. They were motivated by altruism... In terms of NGOs, it's not just a straightforward thing that nurses will always go for the NGO. But you have to remember that in NGOs the nursing jobs are not very secure. So if they employ you to draw blood for a vaccine trial which will run for a year, after that they find you another employment or they chuck you out. The NGOs themselves will try and find another project for them to do.

In terms of the UK, is that a respectable thing to do as well?

There will always be people that will go abroad, but I think that there have been enough people coming back to work here; it's much more fun working here, as a nurse too. If you really want to do that kind of work this is much better. You have to have a good reason for doing it (going to the UK) even if they open it up you won't find...I think people are less... they are getting less and less comfortable in foreign countries. Because foreign countries are not exactly as welcoming as they used to be (like South Africa). Even the UK people feel that you don't belong; even if you are not ill treated you don't belong. People push you around.

Is there anything else you would like to add?

It is important to realise that most of the documents were written with a conclusion in mind, we know what we want to say, it is important to be reasonably critical when looking at previous studies. If you find something that doesn't fit it with everything else, don't throw it away, it might just be true...that's important.

Appendix 9

Example of transcript (nurse in the UK)

The second transcript I have chosen to present is from the first interview I conducted in the UK with a Malawian nurse. I was introduced to Emma, a registered nurse, through the RCN. The interview was conducted in a shopping centre outside London.

Transcript: Emma, UK 2008

I wanted to ask what you were doing at the moment.

At the moment I work as a Sister on a respiratory ward, since 2001. Before I was working on labour, D grade nurse. I was a D grade nurse and then an E grade so I became a Sister. Prior to that I worked at X hospital, at the moment I work in X.

You came in 1994?

I came in 1994 but I didn't get the NMC registration [until] 1997, because I had to do adaptation so when I first came I wasn't coming to work as a nurse, I just came to help my aunt and check here and then someone said you can work as a nurse as well here, if I can do that. Then I started to find out how I could get registered with the NMC.

It took me a long time because I didn't have any information, because there was not much computer use then, so making phone calls and then eventually getting the phone number for NMC. And when getting the documents I had to send them to Malawi to the NMC in Malawi to confirm that I am a RN there, and send to the college where I went to university to confirm I trained as a nurse there, so it takes about 3 months. To do all the forms and then I had to send the forms, and then they had to send the forms back. And after that the NMC wrote to me and gave me a list of hospitals where I could do the adaptation.

And what was the adaptation?

The adaptation is usually for overseas nurses so they don't have to do their training all over again but you just need to learn about different things, the policies, how the NHS and things are done, so you become like a student for 6 months, they give you 3-6 months I was given 3 months to do that.

You just work. When I did it I worked as a student without being paid, but these days you get paid as well. People that do adaptation in our hospital they get paid but as a lower grade, not as a qualified grade until they get their registration. They start on a D grade.

How did you find the course?

It was actually an eye-opener, I didn't know about social workers, occupational therapists, those things referring to social workers are things that I never did in my training so it was an eye-opener, and some of the medical terminology here is different to what we use at home, so it was just learning even the doctors: different level of doctors, house officers, consultants whereas at home we have clinical officers, medical assistants and doctors, knowing who is who.

After the adaptation course then you could...

After I had taken the course, you send the documents back to NMC, someone has to say you have done the adaption and they are happy for you to practice. Once they have done that, they send the documents to the NMC and that is when they give you a pin number. So after that I applied for this job, at the X hospital I worked on gastrointestinal ward. The only difference was in Malawi I did general nursing so I could work on any ward, but here its speciality based, it's very in-depth, you become specialised in one field and you don't have any knowledge on other fields. Whereas in Malawi you work in one area, you can do 6 months, 1 year, they make you move, they used to rotate us.

So you wouldn't specialise after you graduated?

No.

After 6 months you get moved to another area throughout the hospital just rotating.

Once you work for a long time you might end up being in one area. Whereas here it is different you, when I went...<I hope you will be able to hear...>

When I went to do my work, with the gastro ward, I just realised if I stayed there for a very long time I was going to be very specialised and then you can't move to other fields, you are working in that area. So I didn't like it that's why I ended up in X I wanted more avenues to go down.

Did you choose gastro?

Initially no, wherever I get a job, I was very excited when I got my pin number, and that was my first interview and I got the job and I took it.

Did you choose London because your aunt is here?

I chose London because I did adaptation here, I did adaptation in X, so I ended up knowing London more, and so after I qualified I looked for a job in London.

And in London is there a big Malawian community here?

There is a big Malawian community but just spread out, they are all over. But that wasn't the reason at that time there wasn't many Malawian nurses that I know. I didn't know that many Malawian nurses; I don't think I knew anybody.

I wanted to go back a bit and ask you why you became a nurse, what decisions were behind becoming a nurse?

The reason I became a nurse, in Malawi the way at that time I was studying, the way the system was, when you do your GSCE here (we call them MSCE, form 4) when you do your exams you are given, you have to write three choices depending on your points, here you call them grades, depending on how you pass you have to chose what you want to do. So I chose, my first choice was social sciences but I didn't get the choice, business studies and my third choice was nursing.

Those are like to go the university in Malawi. So depending on how you pass they might select you based on your first choice, if you have the points in the right subject. The university will chose. So it came to me the difference.

So I didn't select nursing for my first choice or second. And I told my mum I wasn't going to go, I said I couldn't just bear the blood and I didn't want it. My mum was a nurse, 'I don't want to go' and then my mum said 'if you don't go what are you going to do?' And she said she couldn't afford for me to pay private university so I had to go to my third choice university.

If you are going to private university you can chose what you want to do?

If you go to the state they chose?

Yes and my friends told me if you go and do the first year, its similar everywhere, it's similar in the first year. So they said hmmm you can do that and then maybe transfer to another university after the first year. So I tried to transfer but it was a long process and very difficult and in the end I gave up and then I just thought ok, I will just do the nursing and finish. So I ended up in nursing. So initially it wasn't, I hadn't planned to be a nurse. I started liking it after I qualified and that was the one reason why I ended up working in a private hospital. Because I didn't want to go to the government hospital so when I qualified I went to work in a private hospital which was nice.

Why did you not want to go?

When you finish your training the government again send you, they decide where to send you. They pay for your training, you just pay for some kind of contribution which is not much but I think that they pay for everything, that's why with people leaving the country it is not good as they pay for you, for your training and then you end up leaving.

Do you think that it encourages more people to become a nurse because the government pays for it?

...at that time yes, but now I don't think, now they have to pay for the nursing, we never used to have to pay; now they have to pay.

Will that put people off?

No actually most people are doing nursing because they just want to leave the country.

When you were training?

Yes.

Is that what your colleagues were saying?

Yes, most of my classmates are not in Malawi. We were 40 in our class, maybe 20 are here and then I have got friends in America and Australia as well.

Was that the feeling at the time: that people would leave?

No when we trained, we didn't even think that we would be coming to the UK. At that time it was people never used to come here. I think it was soon after the government changed. In 1994 we had got a new president so it was all these movements started after. Before that people didn't used to leave, the conditions were different, under Banda, it was different. Not many people used to leave the country and go and work outside, they would go and train, go to South Africa come here [to the UK] and then go back to work in Malawi. It was after 94, the government changed.

Did people still after 94 still go to South Africa to train?

They trained in Malawi but if you want to specialise like intensive care, if you want to be highly specialised you go to South Africa.

Is that the case now?

Because South Africa is well equipped, that's why the government sends us to South Africa. It's the government, they pay for the training for one year.

Did you consider doing that?

I had but I think because my mum came and did paediatric nursing but did it here in the UK. So my mum said that maybe I would come here to the UK or America to specialise. I thought to UK or America.

Why the UK?

UK because my mum had talked about the UK that is why. America because I had a friend in America and it was easy to go there.

Did your mum work in Malawi after she trained in the UK?

She worked in Malawi, and still works there, lecturing in the school of nursing. She used to work in X deputy registrar. So she worked as a paediatric nurse for one year. She wasn't a bedside nurse.

Which part of Malawi are you from?

I am from the north of Malawi but I haven't lived there. My parents come from the northern part but I grew up in Lilongwe.

And where did you go to your training?

KCN in Lilongwe.

When you were training were you thinking a lot about your future?

I didn't really think about the future I was just thinking I want to do the training and work I thought I would work in Lilongwe. But when I finished the government sent me to one of the northern districts, and I said I wasn't going because I went to school in the northern region although I grew up in Lilongwe for myself I went boarding school. Most people go to boarding school, secondary education is boarding school, we are all boarders there are not many day schools. So I went to a boarding school in the northern part it was difficult to travel up and down to Lilongwe. And then when I qualified they sent me to work in the north again and I said I wasn't going because my mum wasn't living there, and I thought no, it was too far away from everybody, and I was young, I was 21. And 21, I was going to be stuck in some village somewhere, so I wasn't going to go.

Did you get a choice where you would go?

You are told to write choices of where you want to go, but in Malawi the colleges; we call it tribalism because our surnames you can tell where the person is from, so I have got one of those surnames people will know that I am from the north, because it is a popular name in the northern part of Malawi. It's more politics than anything, they look at these things and they want to separate people, so they are sending you it can be to the north part of Malawi, they look at the surname and say you come from there, even though I grew up in Lilongwe, so I wasn't happy there. And then allocated me the northern part, I didn't want to go.

Was that OK? Could you say you didn't want to go?

I did go to the ministry of health spoke to the chief nursing officer and my mum also knew the CNO and said 'she doesn't want to go', 'my daughter is saying she is not going'. My mum was encouraging me to go, she said 'just go, you will only be there for one year for the experience' but every time I thought about going I just said no...I said ok I will go there in a months time, 2 months and then close to the deadline I just said no I can't go and then I made up my mind I am not going. So I stayed in Lilongwe I worked part-time I did, I worked in a pharmacy sometimes and then I got a job to do research for the X on malaria and then I got another job, a small job to do another

research on HIV. I was interested in orphans in different districts so I travelled Malawi and we were getting paid in US Dollars, it was a lot of money it was good for me. Towards the end of the second research, and that is when I got a job with you know, X hospital, a private hospital. The biggest private hospital in X at that time, I got a job there because I am an Adventist, I ended up applying for a job there.

Were there lots of opportunities after you left nursing college? You said about the X thing?

No after you leave you get more choices if you have done at least two years, everybody wanted you to have at least two years, NGOs or wherever, even to go for further studies they want you to have 2 years nursing experience so you have to practice for 2 years. I was just lucky, I think I just knew the right people because my mum has got that nursing background, and she had people who know my mum and then when they were looking for people to do that research they would ask: 'your daughter is a nurse, what is she doing?' That's how I ended up in those jobs, through word of mouth. And the principal at the nursing college knew me personally so when people would go to the nursing school to ask for students to carry out research, and she said I know Emma, that's how I got it. And I had to find friends as well who were around Lilongwe at the time who wanted to get paid.

Were people happy to get involved?

Yeah, we got a lot of money for doing nothing.

Do you think a lot of people would like to do that ideally?

That is why, even most of my colleagues, I don't think that they are practicing in hospitals at the moment. Most of them are in NGOS, and I don't think any of my classmates are working in the hospitals right now. Most of them are working with NGOs.

Did you think some people would chose to work in a public hospital?

Yes, I have got a good friend of mine, the person who came to do the adaptation here she is a nurse, she is brilliant and loves her job, but her parents were very rich she ended up going to X to do her Masters. But she finished in X and has gone back to Malawi. She just got back...So she went back and started at the lowest point, went back into hospital even after X [text removed]. She moved on now, she works for [an NGO].

When you are in Malawi and when you were training did you hear about nurses who had migrated?

I had but not many, maybe. But I wasn't interested. I know some family member who had come, she is in X but I wasn't really interested in it.

So people didn't talk about it, what was happening?

No. The only thing we were interested was to go to South Africa and specialise and come back and work as maybe an ICU nurse, or work maybe dialysis. That is why we wanted to go to South Africa to specialise and come back and work with a different speciality.

So what changed? Why did people start thinking about the UK?

It was the government change, the conditions changed after 94, the new government the conditions went down, hospitals, everything went down. The other government was very corrupt. Corruption, they just wanted to get rich quick and didn't really care about poor people. If you ended you working in the civil service, after 94 you didn't get much, people were struggling. My mum trained as a nurse like me, but she had a house, she could afford the basic things. I grew up with a single parent [text removed], but she could afford everything. I wasn't poor. I wasn't rich but we were comfortable we had everything, we could afford to go outside the country for holidays, we could afford... but when I qualified I could not afford those things, the salaries were down. You know I couldn't afford things that me and my mum, I could not afford them, things started going down. When I came here, I came in 94, I came here and then my friend, who was my roommate when I was training, was posted to go to [a northern town] and she went with the same impression I will just be there for 2 years and move. She did her two years and then started asking to move, they wouldn't move her, she wasn't married so they couldn't move her, so she was there and I think did another 4 years until she resigned and went to work in the private hospital the same one in X, and then started writing me that she wanted to come here. So she came here, I did the NMC for her, paid for her, did her documents, by that time I knew the process, so it was easy. I did everything for her, paid for her here, I would give money to my mum in Malawi and then she got the pin number and she came here. Pin number registration, once you register with the NMC you can get a job.

Do you think a lot of people go through friends?

That's how we do it. I did it for her, I did it for another friend she did it for four friends. So that's how, everybody was just calling, you talk to your friends, what are you doing? How is it over there? And they talk about their experiences there, and that's how they end up coming here. Friends...

And do you think people generally have good experiences here in the UK? Would they tell about the positive things in the UK?

Yeah, there are positive things, the working environment, just the job and environment are positive but there is still racism so if you still end up going to a place where there are not many black people, outside London you still experience and then it's very difficult, it's hard for them and so the working conditions are not that good. I think it's different in the NHS; there is a mixture of different nationalities so it's not so bad. But people that work in rural areas where there are not that many, people working in nursing homes and they are the ones who have a bad time. They are isolated.

In your experience do they go into the NHS or nursing homes?

A lot of them work with nursing homes, because nursing homes were using agencies to get their work permits to come and they were using the agencies to get the work permits in Malawi. And then they would get people over here and so you come here and try for about 2 years, after 2 years, you can look for a job, so they give you a 2 year work permit. Work for them for 2 years and after that you apply for a job in the NHS and then they move to the NHS. So that is how, most people did it that way.

Is that because the NHS is the best place to be?

The NHS is better.

Nursing homes um, it's very hard. Because you work with mostly carers and the only thing you do there is give medication and maybe write a care plan whereas in the NHS you are a bedside nurse, hands on and there are more opportunities for you to move. A lot of my friends, some of them are E grade now they have moved on. I have friends that have been working, some of them as midwives. And then I have got friends working in X.

And in your experience, you mentioned that there were positive things in your working environment. But what about living conditions?

Living conditions, I think initially is tough, when you come and start from scratch it is very difficult but after 2 years you become sort of comfortable that's how I see it. When you know your way around, how to get certain things, it becomes a little bit easier, but the first year is very hard. It's hard because you know how we call each other, you come and visit your friends, so you might be sharing a bedroom with a friend, two friends in the UK, you would be sharing with someone until you are able to be independent and pay your own rent, buy your own house. But the first stage is hard, but you end up sharing a living room and you don't have a lot of money because you have just left there and you can't change the Malawi kwacha to the pound, the rate, you may as well leave your money over there. Just to settle it's quite difficult and you are not entitled to anything anyway because when you are on a work permit you are not

allowed to have any benefits, it's only when you get the indefinite that's when you get help. (Indefinite with the home office). So when you first come you are on a work permit, you are not entitled to anything, so if you have children you end up struggling with them, transport, food things. But after 2 years most people feel that they have it better.

How was it for you? Did you find it a shock coming over?

The biggest shock was taking the autonomy away from me. Because in Malawi the way of the training, you are trained to be a manager, the problem solver, the decision maker, all those things because you have to be on top of things, and when you come here you have to start in the lowest [grade], it doesn't matter if you have worked for 20 years in Malawi as a matron, it doesn't matter. When you come here you start at a D grade. So everyone starts here at the beginning, they don't count the experience you have had. That was very difficult for me to take. So you end up starting with people who are newly qualified nurses, and then you have got my experience you know what you are doing, you are more skilled, knowledgeable than them, but you all start at the same level and you have to work your way up. It's very difficult. Another one was when we did our training [in Malawi] we were trained in a lot of skills as a student nurse so by the time you qualify you are able to do those things you have practiced a lot as a student. But the training here is different once you qualify they still want you to go, to do something after, you have go for one day study day, they give you a certificate to say, yes you can do this. And a simple thing like putting a canula in Malawi you start doing that as a student. So the four years you are doing that, you come here, if you don't have, if you haven't been for the canula study day, for three hours you cannot do that, so you become deskilled here. You can put in a urinary catheter, you have to catheterise so many times, if you come here and you don't have the certificate you cannot do that, you have to go for a study day. If you are working in an area, the managers will say you don't need that, because the doctor or junior doctor comes to do that.

Even though you know?

Even though you know. Sometimes you end up waiting for a very long time, maybe it is good because you have doctors on different levels and they need to do something as well so it's good. It's different to learn that this is how you have to be. You could wait for four hours for a doctor to do a canula. So we all have got a lot more skills than nurses here, but because we don't have it on paper. Because it's incorporated in our studies, by the time you qualify you are competent in those things, here is it different because

you qualify and then you go for further study and then you are allowed to do it. It's still that way up to now and I don't get it.

When you were in Malawi what were your expectations about working in the UK?

I thought you would be more autonomous, you were allowed to do a lot more things. I thought of having high standards but I feel that I have more experience than the nurses who are the same here. I still feel that way that I do have a lot more experience; it's the type of nursing training that they have got. But maybe the training in London that I have been exposed to, in London, because I end up working with nurses, and they tell you I have never done this, never given this injection and you are thinking – 'you have done three years of your training, and you have never given an injection what were you doing your three years?' Me, I was thinking that nursing was giving injections...so things like that, so the training it's really different. I don't like the way they train their nurses. They have got more theory, they do have a lot of theory they have got the knowledge but the practical side is lacking, they don't like practising.

It seems like there are lots of rules as well, is that right?

It is like that. Things like medication you cannot give because the policy said you can't give, it must be given by a doctor. So sometimes you end up saying to a doctor please write a note saying that you are happy for me to do this. I have been working in X ward for 8 years and I have seen [doctors] come for 6 months and then go, junior doctors and the registrars they come for one year and go and you tell me that I don't have experience in that area, where I have worked there 8 years, and these are people who just come 6 months, and leave. And you expect them to be giving that kind of medication when I have got, I will be telling them what to do, how it is done. There are some things that don't make sense. It's frustrating. But then it only comes with experience, once you are very experienced... that's when you start looking at things and thinking it's so frustrating but if you don't have the confidence you are so happy for the doctor to do it even though 90% of the time the doctors don't know what they are doing.

From a technology point of view did it feel very different working in Malawi than the UK?

Yes, oh yes. I was lucky with the computer whilst I was with my aunt, because I came in 94 but I didn't start working as a nurse till 98. When I was with my aunt she bought a computer, she is a secretary and then she was practicing and she would tell me come and practice so I started doing Word Windows. So when I went to work and they started introducing the computers, I felt comfortable but other people even up to now

it's really frightening to just, you are expected to write care plans on your computer. In X that was 98, we would write care plans on the computer and you are doing everything. So if you had never done that you would be frightened.

Does it put some people off coming to the UK, that kind of level?

Yes but I think it would be only those people that trained a while ago but if it's people that just qualified now, they should, because even now they have to type their essays and things like that so they are computer literate but the ones who trained a long time ago aren't.

You mentioned that you did the adaptation programme; may I ask what were you doing in the years before you started that?

[Text removed] and then after one year, I sort of worked, my adaptation I paid £1000 to do my adaptation, you had to pay up front. So I needed some money to pay for that, so what I did was care work, I did care work and raised some money for my fees and for my upkeep so when I got the money, I got about 3000 and then I paid for rent and I have money for transport and the adaptation. That's why it took me a long time.

You didn't have your children at this stage?

I was single.

Did that make it easier?

It was easier, I didn't have any commitments. I was able go and do the adaptation because at that time the NMC said that we should do adaptation but after 98 people from Malawi don't do adaptation they were just sending them pin numbers to Malawi. So they didn't have to because of training, maybe they were happy with the type of training we did in Malawi, so they didn't have to do adaptation. My friend the last one who did adaptation was in 98, the person I said was my roommate didn't do adaptation, they just sent the pin number to her, and then I have since registered about 3 people after that they just send the pin number. They have changed it again, the adaptation thing again, they changed two years ago (2006), but I don't know how it is, I haven't registered anyone.

Did you think that it made it more attractive to come to the UK because you didn't have to do adaptation?

Yeah. The period when you didn't have to do adaptation, once you get your pin number find out through agencies, because it was being advertised in the newspapers in Malawi, different agencies in Malawi, so you just pick up the phone and they pay for your ticket and accommodation. That's why they came to nursing homes for one year, two years and then moved.

With the agencies did people like going through them?

They liked, because they paid for, you didn't have to pay for anything you pay them back by working, it's the nursing homes that pay the agent.

Were people happy with them? Or did people have bad experiences?

I am not sure about that. I have never heard any complaints. I am sure that things have happened with them.

Are people quite open – Malawian nurses – about talking about their experiences or is it quite a private thing?

No we are, we talk amongst ourselves. People we call each other and ask for advice and different things happen even at work, people will call you: this has happened at work what do I do? We give each other advice. But it's just that people are scattered all over so, people are in Manchester, they do things differently from down here, so some things are different. But I do have a few friends, 3 friends that I usually call for advice, if I am going for an interview or something like that.

Does that make things easier?

Yes it does but at the moment I am one of the 'experienced ones' now so people call me asking me for all sorts of things. Work things.

You mentioned that you came as a single person – do a lot of people who come leave their families in Malawi?

Yes. Most people have left their families, they came first maybe worked for a year, settled, and then they call their families.

Their children and their husband/wife?

That's how most people do it. I don't think that there is anyone that has moved with their whole family, no. They usually come work a bit and then get a place to live and then call their family.

And is your husband Malawian?

Yes [text removed]

Do a lot of Malawian nurses here get married to Malawian men?

The ones I know some of them were already married when they came here so they had their Malawian husbands some of my friends are single, going out with UK nationality not just Malawians. But the ones I know who are married most of them are married to Malawian men before they came here. A big culture difference and things like that.

[Text removed].

With wages, would you send money back to Malawi?

I send her sometimes, I send her but my mum is still working so I do send her here and there but it's not like I have to. But I know most of my friends send money, they support their parents at home. Yeah, some people who have got their parents who are not working or lots of brothers and sisters who are still going through the education, they are sending money to put them in education. [Text removed].

Your friends, people who you know send money back; do you think they are under pressure to go to the UK to send back money?

Yeah I think that is one of the reasons why people would come here just to help their families.

Do you think that the families put on pressure?

Yeah, because they end up relying on you and they expect money from you all the time so you are sort of the breadwinner for your family here, you have to pay your bills here and then you have to do back home as well. It is difficult. And it's difficult because that is why most people they have got their full time jobs but they do agency work as well or overtime bank. They end up doing extra every week to pay for, or to send money home.

And what do you think about the future? How do you see yourself?

As for me at the moment I have just registered with the X I have started doing a nursing degree because I have got a diploma. [Text removed], and then go on and do a Masters.

Is it easier if you have a nursing degree?

Yeah and maybe in the future go home back to Malawi.

Do you think you'd go back for work?

I would go back to work but not in the hospital. I would like to work for maybe an NGO, maybe do teaching that kind of thing. Nursing. Because I have done the respiratory specialisation so I can do TB, the HIV bit. I have got an interest in HIV, although I haven't really worked in an HIV ward. Because there are a lot of people dying from HIV in Malawi.

You wouldn't go back and be a nurse?

No, I couldn't be when I was there. But I do feel sorry, I do feel guilty sometimes working here thinking you have been trained by the government, they have invested in you and then you end up leaving and working here. But then it is also the government to blame, the conditions they don't really care about the people on the floor, so it's also they have to play a part in the blame for the brain drain. I have got lots of friends who

are doctors they end up doing... with lots of experience but they also end up working here, so it's the government.

Do you think that if you did go back to Malawi, if the conditions changed would you want to work as a nurse?

Not at this stage [text removed]. At this stage I would only want to do management, I don't think I could do bedside. I would become management type of job.

What do you think really needs to change for nurses in Malawi?

What needs to change is I think the nurses need to be valued. They don't value the nurses, they do have a lot of experience because for us to train in a third world country, and for us to be able to come here and move. I have got friends who are matrons who have jobs here, for us to come and compete in this market and get a good job that means that there is something to the training that we get over there. But we feel that we are not valued over there. They don't value the nurses. Its only maybe now after so much press. They have started to see that they also contribute. Maybe if the hospitals stopped running. So it's... they have to value the nurse but I don't know what kind of incentives they have to give. They need to invest a lot, money-wise in the nurses. Salaries, and maybe give people opportunities mostly in the government hospitals, because what people do when they get to a certain level you go to NGOs, even though people are still in Malawi they still don't stay in the hospitals, they go to NGOs. So it's something that they need to do in the hospitals. Have to invest in hospital and the money is there for people to stay. Another thing was I was just thinking, whether it's practical, even when people work for NGOs they should be told that they should still have experience in the hospital. So maybe they can work in the NGO and then at some point come back and work in the hospital. Even if just 6 months and go back maybe that would make more people I don't know.

As more and more NGOS coming to Malawi, do you think more and more nurses will leave?

Yes that is what is happening. The training I think is good, the nurse training but its keeping, retention of nurses that's where it's lacking. It will be good, but I don't think that people really want a lot of money; people just want a comfortable life. I don't think it's the money, I think it's just being comfortable, you can't be expected to go to a labour ward with HIV and then be expected to deliver with no gloves, basic things like gloves. So how do you do your job, you might as well stand back and say why should I die for other people? You know you stand back; you are not in the army. The army is

the one place you die, but you are a nurse. There are no gloves so it's basic things like that.

Do you think that if they do these things, more nurses will want to stay in Malawi?

What they also need to do, the government, the politicians, they usually when they are not well or their families, you know that they fly them to South Africa. So if they have money, they go to South Africa. Why? They should make those hospitals for everybody including them, because if they start going to the hospital for treatment, they will improve the conditions there but for now, they don't care, they don't really look at it, they know they will go to South Africa or UK for treatment that's why we have got the problem. Yes, it's moral as well. When they don't come to the hospital what does that tell you? That the conditions are so bad that they don't, can't come to that hospital. So they should be investing and going for the treatment. They only go to private hospital, never government. I used to work in a private hospital, when president Banda was coming for treatment we had all the equipment, all private rooms. We used to call it one to one nursing. And we get paid per hour by the rich people who were doing that. You could also go to their homes and nurse them at home and they pay you per hour. So when I was working in the private hospital that's how I did it. If the hospital is full then they can say, ok I want a nurse to come to my house and I will be paying 100 kwacha per hour. And that was until a bed comes available. I have also escorted a patient in a helicopter to South Africa. When I was working in the private hospital, the patient had no bed, the injuries they have got they need to go to South Africa. They say have you got your passport ready? And you go to South Africa escort them and come back.

It's mostly the poor people that suffer. There are no resources, you can't improvise it for everything. Even when we were training in the college we had everything all the equipment, things that we see in the books and when you go to the wards, we don't have this but this is how we do it because we don't have this and that. And you are thinking ok. Some of the things I saw them in the book, it makes sense that when I came here (to the UK), I said ok this is what this thing looks like because I read about it and didn't really know what it looked like because we never had it. The nursing colleges are well equipped, they get lots of donations people who go and study in places in America, they will take lots of things back, or people being lecturers they will come and teach for a few months and when they go back they will send a few things. In nursing university we have got good equipment. And when you leave you go to the hospital and you are shocked and I couldn't cope and that's why I ended up in a private

hospital, I just felt like oh no I can't cope with this. The private hospital they had everything because they charge for everything, they have got money, making money. If you use a canula, you will charge for that. Everything has got a price, so you just write an inventory and then they replace it.

Is there anything that you think is important that I have missed out or anything else you'd like to say?

No. I hope that you have all the answers but if you want more, once you listen maybe we can go somewhere else.

Appendix 10

Characteristics of the nurses when they migrated

Nurse migrant	Workplace	Approximate age	Family status
Mercy	Retired from government service, then KCN lecturer	Over 50s	Married with children
Silvia	Lecturer at KCN	Over 50s	Married with children
Julia	Lecturer at KCN	Over 50s	Married with children
Emma	NGO	Early 20s	Single no children
Florence	NGO	Middle 20s	Married with children
Sarah	Nursing college tutor	Middle 20s	Married with children
Dinah	Nursing college tutor	Middle 20s	Married with children
Emmanuel	CHAM	Early 20s	Single no children
Martha	Government nurse (EN)	Early 20s	Engaged no children
Aubrey	Government nurse (RN)	Early 20s	Single no children
Lindiwe	Government nurse (RN)	Middle 20s	Married with children
James	Post KCN graduation	Early 20s	Married with children
Anna	Post KCN graduation	Early 20s	Married with children