

**MIGRATION OF NURSES AND THE PERCEIVED IMPACT ON THE PUBLIC  
HEALTH CARE SYSTEM IN ZAMBIA**

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## **DEDICATION**

**My prayer is that this work manifests the glory of the God Almighty to whom I dedicate  
this thesis**

**I further dedicate the work to the following:**

**My late father, James Ralph Patwayo Daka**

**My late mother Esina Joyce Jere Daka**

**For the wisdom of parenting and seeing our future that they never lived to experience  
with us as their children**

**My loving husband and friend, Michael Mpofu Msidi for his unfailing support and  
encouragement**

**Each of our children for their love and encouragement, which I so greatly appreciate**

**My sisters and brothers and all the children**

**The nurses and midwives of Zambia represented by the appealing voices of those who  
participated in this study**

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I pray that each of these individually receive my heart felt and sincere gratitude and God's blessings



## ABSTRACT

The subject of international migration has become an important social issue and feature of globalized labour market in health care. International migration of nurses has increasingly become a concern and the volumes are reported to be increasing particularly from the developing world where, in some countries, is a leading cause of attrition and subsequent shortage of nurses as a human resource. This has implications on the capacity of health systems to respond to the challenge of health care delivery to populations considering that nurses form the largest health workforce in most countries.

In Zambia, nurse migration has equally been a concern including the absence of relevant studies with evidence to inform policy direction, planning and management of nursing human resource. The purpose of this study was to determine the extent of nurse migration, the reasons why nurses resign their employment positions and leave the country, why other nurses do not migrate and to further determine the perceived nurse migration impact on the public health care system. The study was a non-experimental descriptive survey design that used both quantitative and qualitative approaches to data collection and data analysis. A triangulation approach was used in data collection involving various methods; multistage, stratified and systematic sampling; purposive and snowball with a range of data collection instruments; semi-structured for focused interviews of nurse migrants, nurses seeking verifications and policy makers; self-administered questionnaire that enlisted data from clinical nurses and nurse educators on the perceived impact of nurse migration on the public health care system and topic guides for focus group discussions. Computer software were used to code and analyze data;

SPSS version 11.0 for quantitative data and NVivo7 for qualitative data. A total of 309 clinical nurses and 23 nurse educators responded to the self administered questionnaire. Thirty three key informants participated in focus group discussions conducted in four health facilities situated in four districts. There were five directors at provincial, district and national levels and 13 nurse migrants interviewed. Data on nurses with verification of qualifications sent to countries were collected from a total of 1,142 records; 931 for RNs and 211 for ENs.

The study was guided by a conceptual framework developed from two migration theories namely the World Systems Theory and the Push and Pull Theory. The World Systems Theory structured the world into three zones of Periphery (poor countries), Semi-Periphery (Transitional economies) and the Core (industrialized wealthy countries). Push factors caused people to leave the Periphery to the Semi-periphery and to the Core where the Pull factors attracted those from the Periphery and Semi-periphery.

Major findings of the study showed dissatisfaction with work conditions, poor living conditions, lack of professional recognition and autonomy and lack of access to professional development as being among the push factors while the pull factors included attractive work conditions, conducive work environment and access to professional development, among others. The perceived impact included nurse shortage, excessive workload, long working hours and poor quality of patient care.

Findings on issues for policy on managing nurses leaving for greener pastures were in the form of interventions that would address the push factors and formed the basis for recommendations from the study.

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## **LIST OF ABBREVIATIONS**

**AIDS: Acquired Immuno-Deficiency Syndrome**

**ANA: American Nurses Association**

**CDEs: Casual Daily Employees**

**CRHCS: Commonwealth Regional Health Community Secretariat**

**DIFID: Department for International Development**

**ECSA-HC: East, Central and Southern Africa Health Community**

**EN: Enrolled Nurse**

**EM: Enrolled Midwife**

**GNC: General Nursing Council of Zambia**

**HIV: Human Immune Virus**

**ILO: International Labor organization**

**ICN: International Council of Nurses**

**IGO: International Governmental Organization**

**INGO: International Non-Governmental Organizations**

**IOM: International Organization on Migration**

**MOH: Ministry of Health**

**MTR: Mid Term Review**

**NHS: National Health Service**

**NMC: Nurses and Midwives Council**

**NNF: Norwegian Nurses Association**

**OECD: Organization for Economic Co-operation and Development**

PAHO: Pan American Health Organization

RCN: Royal College of Nursing

RN: Registered Nurse

RM: Registered Midwife

WHO: World Health Organization

UK: United Kingdom

UN: United Nations

UTH: University Teaching Hospital

USA: United States of America

WHA: World Health Assembly

ZUNO: Zambia Union of Nurses Organization

# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND TO THE PROBLEM

The subject of the international migration of professionals has attracted the interest of many different analysts including labour, economics, human geographers and human resource specialists (Martineau et al, 2002). A report by the World Health Organization (WHO) and the World Bank states that the migration and brain drain of health professionals has reached serious proportions and refer to it as the likely single most important source of attrition from the health workforce in many countries in the African region (WHO, World Bank, and Rockefeller Foundation, 2004).

This view is also supported by Bach who indicates that migration has become a more prominent and controversial feature of health sector analysis in recent years (Bach, 2003). Health is a labour intensive service employing an estimated 35 million people worldwide (ILO, 1999). Because the nature of the service is population and client-oriented, it cannot, in general be moved to the sources of labour (Martineau et al, 2002). The international movement of labour is greatest among those with a high level of skill. Health professionals form the biggest group of skilled migrants, as shown by data by Mehmet (2002) in his report on the emerging global market which indicate that current demands include information technology (IT) skills, teachers, and social workers. Results of a

study on recruitment of health workers to the UK showed that between 2000 and 2001 alone, Barbados lost 10% of its nursing workforce from the health sector. The majority of these left the country for employment elsewhere (Buchan & Dovlo, 2004).

A report from a meeting on Africa's brain drain reveals that there are more Ethiopian doctors in the United States than there are in Ethiopia. The International Organization for Migration (IOM) states that according to available data, Africa has the most mobile population in the world and estimates that 23,000 African health professionals leave home every year "leaving their own stretched health services in dire straights" (Kramer, 2005). According to their calculations, the IOM indicates that poor nations are spending U.S. \$500 million a year training medical workers who migrate to richer nations. According to this report, the cost to the industrialized world of training the estimated three million health professionals who were educated in poor countries but are now working in Europe, North America and South Asia, would have been a 'staggering' U.S. \$552 billion, at an average of U.S.184, 999 for each of those professionals.

According to United nations data, the number of international migrants is increasing and in terms of actual figures, the number of migrating persons has more than doubled from 75 million in 1965 to an estimated 175 million in 2003 (IOM, 2003). Bhagwati (1976) argues in his survey of the issues in international brain drain and taxation, that empirical evidence on the size of the brain drain was at best patchy. Available data referred to flows rather than stocks and captured only gross flows with no information on reverse migration. Much of the evidence came from sources that were not typically comparable

and in return, lack of systematic evidence hampered empirical investigation in this field. Despite this argument, this data further indicate that the size of the brain drain has been largely undisputed as shown by reports which point out that the Sub-Saharan Africa lost 30 per cent of its skilled personnel between 1960 and 1987. However, Adams and Kinnon (1998) allude to the degree to which Sub-Saharan African countries are significant importers of migrant labour from other African countries and beyond, pointing out that this is an important dimension in migration, which is usually overlooked. The researchers cite Cuban doctors in Ghana, as an example of such migration.

The Caribbean **region** is also hard hit. For example, Jamaica had to train five doctors in order to keep one. A study by Carrington and Detragiache (1998) shows that migration rates are proportionately large among educated people. For example, more than 15 per cent of the home country population with a tertiary education has migrated to the US.

Regarding the general direction of migration of skilled workers globally, literature shows that the total volume of south to north migration has grown during the last three decades. The flows to the north have come from a larger number of increasingly diverse countries in the south (OECD, 2003a). According to UNFPA (1993), 93 million people were added to the world population in 1992 alone and the world population was estimated to reach 8.5 billion by 2005. As much as 93 per cent of this population growth takes place in countries in the south. While countries in the north have a stagnant or decreasing level of reproduction, the average fertility rate in Africa was 6.0 children per woman. The population increase in the south has not been paired with a growth in employment opportunities (UNFPA, 1993). Hammar and Tamas (1997) predict that the present level

of unemployment and under-employment will continue and probably grow and thereby give new incentives to a future increase in the south to north migration. However, they point out that the causes for staying may be even more powerful and that intra-south or south-to-south migration may be important alternative strategies for those people who will face unemployment. They refer to the countries in the north as Europe, North America, Australia and Japan and the south as those which include countries in Asia, Africa and Latin America. The two researchers state that the south to north difference is not only the geographic position, indicated by the labels, but primarily the economic gap between the poorer south and the richer north.

According to Steffen (2004), Germany is losing its best qualified professionals to better paid positions elsewhere in a country where 4.6 m people are jobless and nearly 118,000 people of various levels and qualifications left the country in 2002 for jobs abroad. Those with good career opportunities outside Germany included hoteliers, chefs, managers and mechanical engineers. Steffen (2004) cites science as another area that is losing people with expertise and states that every seventh person with a doctorate in science leaves Germany for the United States and that three of the four German Nobel Prize winners work in the United States. A report from the United Kingdom (Tikki et al, 2002) estimates that 31% of its doctors and 13% of its nurses are born overseas. In London, the figures are 23% and 47% respectively (Glover et al., 2001). In India, it is estimated that 40% of the doctors who work in the private sector migrate outside the country (Nandray, 1992).

The United Nations Population Division (2003) describes international migrants as those who reside in countries other than those of their birth for more than one year. Most of the world's migrants live in Europe (56 million), Asia (50 million), and North America (41 million) and 60-65 million of this total are described as economically active. Between 1970 and 1990, the number of countries that qualified as major receivers of migrant workers rose from 39 to 67 and those that qualified as major senders rose from 29 to 55 (United Nations Population Division, 2003).

Experience from Zambia indicates that health worker migration is a problem and that of nurses in particular. Although literature indicates health worker migration from the developing to the developed countries, which includes countries in Africa among them Zambia, the Zambian situation shows that there have been no studies on nurse migration and therefore, there are no data to inform policy. Concerns have been raised, however, about the extent and impact of nurse and other health worker migration by the Health Ministry in Zambia and the need for data that would inform planning and management (MOH, 2004b), but still without action to generate the required data to facilitate evidence based decision making and planning.

## **1.2 PROBLEM STATEMENT**

Although there is no available documented data on the actual percentage of nurses in Zambia, they are estimated to comprise 75% of the health workforce and are the most widely distributed. From the researcher's experience, this percentage has been quoted in various forums. Records at the General Nursing Council of Zambia (GNC), the organization responsible for regulation of the nursing and midwifery profession show a

total output of 5,619 registered nurses and 11,916 enrolled nurses from the nursing and midwifery education and training programmes during the period 1965 to 2002. The records date back to the country's first registered nurse graduates from Kitwe Central Hospital in 1968 to end of 2002. These numbers are inclusive of all nurses, registered and enrolled, irrespective of their post basic or other qualifications. Out of these numbers, 2,642 and 4,680 nurses have undergone one year training in registered and enrolled midwifery respectively. However, records show that only 9,536 (54.4%) of the nurses renewed their practicing licenses in 2002 out of the 17,535 (GNC, 2002).

The reasons for this disparity in these numbers have not been indicated or documented anywhere and are thus not known. What exists are speculations that indicate that some nurses may have left the country while others could have died and there could be others still who may be available in or outside the country but may just not have renewed their practicing licenses and are therefore not counted in this manner during this period. The numbers attributed to any of these possibilities are not known, as there is currently no system of tracking down nurses who have died, retired or left the country for whatever period or purpose.

Meanwhile, several documents in the ministry of health give a gloomy picture of the health workforce and describe the human resource situation in the country as "a crisis" that required urgent attention (MOH, 2004a; MOH, 2004b; MOH, 2004c; MOH, 2004d; MOH, 2004e). The magnitude of this crisis was not defined in terms of numbers and types of health professionals affected or the extent of the problem.

In its paper on the human resource crisis in the country, the health ministry (MOH, 2004b) bemoaned the migration of health personnel from Zambia and stated that this was

a major concern to the country. There were no indications, despite this concern, to investigate where the health care professionals were going or to find out from them as to why they were leaving, as there were no data available. The ministry conceded to the lack of information that was essential for effective and efficient decision-making and in the absence of data, attributed this situation to lack of necessary systems and processes that would support generation and maintenance of relevant information.

There was an expressed desire, however, to know the extent of the attrition of health personnel in order to make informed decisions about the output required from the education and training institutions, and the importance of data based on evidence as any inaccuracies in such data would be very misleading (MOH, 2004a p.18). Despite this desire for data, there were no efforts, from the experience of the researcher, to conduct any studies to generate such data in order to show the extent of the human resource problem. This and other papers did not indicate any plans to conduct studies on the migration of nurses and the magnitude of the problem, including finding out why they were leaving. The researcher was interested in establishing the extent of the involvement of nurses in this human resource crisis by conducting a study to facilitate the generation of data on nurse migration to guide management and policy decisions related to the demand and supply of nurses in the country.

According to available information, professional staff were referred to as precious in the circumstances and there was further concern that the loss of even a few could have disproportionate effects on the delivery of services. According to the ministry of health (2004c p.6), the trend in migration of trained health staff appeared to be accelerating

despite an increase in the salaries for health sector staff in the preceding two years and placed the blame for this trend on the lack of comprehensive and clear strategies and policies, resulting in wastage of both skilled human and financial resources (MOH, 2004f). From the information available, it was clear in the view of the researcher that the magnitude of nurse migration was not known and that there were no indications as to where the nurses were going although experience continued to show that nurses were continuing to leave the public health sector. Although nurses appeared to be leaving, others appeared to stay behind and the reasons for this behavior were not found in any of the documents on human resource issues.

Despite fears regarding the implications of the human resource crisis, there were no studies to establish how nurse migration had been perceived to impact on the public health care system, including on the nurses themselves and the work that they did. This knowledge gap on nurse migration was not peculiar to Zambia alone. For example, Buchan (2003) and his colleagues lamented the many publications on the subject that have relied on anecdotal information or media reports, and point out that this could lead to misleading or fragmented assessment of trends and implications in nurse migration. This knowledge gap appeared to be supported by other researchers. For example, Pang (2002) referred to the need for better evidence on the extent of the problem of migration and its impact in poorer countries; both countries of origin and destination, and the effectiveness of measures to deal with it.

The major problem in this study therefore was that the extent of the problem of nurses who were migrating was not known, neither were the reasons for their leaving and the

countries where the nurses were going including why some nurses did not migrate while others did and what would make nurses with intentions to leave stay and work in Zambia. Furthermore, there were no studies that did show the impact of nurse migration on the public health system. From the available documents, the ministry of health had the desire to make informed decisions on the supply, demand and recruitment but there were no data to guide such policy decisions.

### **1.3 PURPOSE OF THE STUDY**

The purpose of this study was to describe the extent of nurse migration in Zambia, the reasons why nurses in Zambia resigned their nursing positions and left to work outside the country, the countries where nurses went and the intended duration of their stay in those countries. The study further sought to describe why other nurses decided to stay when others were leaving and the perception of nurses and policy makers on the impact of nurse migration on the public health care system including what would guide policy development on nurse migration as it affected both the nurses and the country.

### **1.4 OBJECTIVES OF THE STUDY**

- Determine the extent of nurse migration in Zambia.
- Establish why some nurses resign their nursing positions in Zambia and leave for other countries.
- Determine why some nurses decide to stay and work in the country.

- Describe the perceived impact of nurse migration on the public health care system.
- Outline measures that would guide policy formulation on management of nurse migration as it affects both the nurses and the country.

## 1.5 RESEARCH QUESTIONS

- What is the extent of nurse migration in Zambia?
- Why do nurses resign their nursing positions in Zambia and where do they go?
- How long do nurses who leave Zambia for jobs in other countries intend to stay outside the country and what are their reasons for staying for that period?
- What would make nurses who intend to leave, stay and work in the country?
- What is the perceived impact of nurse migration on the public health care system?
- What measures are appropriate for the development of policy on management of nurse migration as it affects both the nurses and the country?

## 1.6 SIGNIFICANCE OF THE STUDY

WHO reports that during the 107<sup>th</sup> session of the WHO Executive Board, members “expressed alarm” at the trend of nurse migration and its consequences and stated that

**“unless effective action is taken to halt the growing migration of skilled nursing and midwifery personnel, they feared that the quality of services and the health of the population would suffer” (WHA, 2001, In: WHO, 2002 p.1).**

WHO (2002) has placed nurse migration as an important agenda item and has expressed fears about the effect of globalization on the movement of health personnel. The

International Council of Nurses (ICN) states that migration and international recruitment of nurses have become more prominent features in the last few years (ICN, 2004 p.6.). The ICN (2004) has also expressed concern about the potential impact of nurse migration on some developing countries and further ‘expressed interest in ascertaining the destinations of migrating nurses’ (ICN Workforce Forum Report, 2003 p.10.). At regional level, the Commonwealth Regional Health Community Secretariat (CRHCS) reported that “although a long existing phenomenon, nurse migration has recently become more important as the numbers have increased significantly” (Munjanja et al., 2005 p.35.).

The motivation for this study was to fill up the knowledge gap on nurse migration, because from the experience of the researcher, such a study had never been conducted before in Zambia. The study is therefore the first that has addressed the migration of nurses in the country. Literature shows that existing studies on nurse migration refer to data in other countries and in the researcher’s view, these were not focusing on the areas that this study has addressed. According to the researcher, what was required was a study with results relevant to the public health care system for responsive policy formulation and decision making on managing nurse migration. The relevance and appropriateness of this study include meaningful data on how nurse migration has been perceived to impact on the nurses who remain in the country.

The study has responded to the various concerns about nurse migration in Zambia as this issue had been and still is high on the agenda of issues related to human resources in the health sector and will therefore provide the needed data on nurses who have left the

country and where they have gone, why other nurses have stayed and how migration has impacted the public health care system. The results from this study will be useful in targeting specific countries for signing of international agreement or memorandum of understanding for better management of nurse migration.

Results from this study will further assist with planning for the supply and demand of nurses. The results will provide policy options aimed at facilitating management of nurse migration and mitigating its impact on the public health care system. The study will also create further potential for stimulation of interest in giving attention to nurses and their welfare and initiate improvements in what it would take to retain them in the country.

## **1.7 OPERATIONAL DEFINITIONS**

*Migration* – In this study, migration means the movement of nurses from their nursing position in the public health sector in Zambia in preference for another job in any field, either within or outside the country.

*International migration* – means movement of nurses from one country to another in search of better rewarding jobs. In Zambia, movement of health professionals from one country to other countries is commonly referred to as “leaving for greener pastures”; greener pastures in this context means health workers leaving their jobs in order to seek employment in other countries with prospects for a better quality of life.

*Country of origin* - is also referred to as source country or sending or home country from where nurses are recruited by the richer or industrialized countries.

*Country of destination* – also referred to as host or receiving or recruiting country which recruits nurses to fill up job vacancies.

*Emigration* – the act or process of leaving one's country to another.

*Migrant* – a person who has left one's country and resides in another which is not her or his country of birth.

*Returnee migrants* – are nurses who had migrated to other countries and have decided to come back to settle in Zambia. They may or may not have intentions of further migration.

*Visiting nurse migrants* – are nurses who migrated and working or residing outside the country and were visiting Zambia at the time of data collection.

*Nurse* – means any person with the title of nurse; including registered nurse, enrolled nurse, registered midwife, enrolled midwife, psychiatric nurse, operating theatre nurse, public health nurse and nurse tutor/lecturer.

*Health workers* – means all individuals working in the health care facilities or institutions at all levels of the health care system.

*Impact* – means the effect of the nurse migration on the public health care system, specifically what has changed due to migration in terms of workload for nurses, job satisfaction, provider attitude towards work, vacancy levels, levels of nurse qualifications and experience available, distribution of nurses and skills mix, utilization of staff, adequacy of supervision by nurse leaders, stress or potential for stress, motivation for patient care, quality of care including adequacy of coverage of health needs of patients or clients, working shifts and nurses' scope of practice. In this study, the impact studied was from the perception of nurses, managers or key informants and policy makers.

*Extent of migration* – means the magnitude of the movements of nurses or other persons in relation to their migration.

*Public sector* - refers to the health care facilities and services and other areas under the auspices of the government.

*Health care professionals* – refers to all skilled health service providers who include nurses, doctors, pharmacists and others.

*Health care system* – in this study, health system is defined as the nurses, managers, educators, policy makers, student nurses and the community (clients who access health care services). It also means workload for nurses, vacancy levels, levels of nurse qualifications and experience, nurse turn over rates, distribution of nurses and skills mix, staffing, and information flow to nurses and from nurses, management, leadership and supervision, motivation for patient care. The term ‘health care system’ is used interchangeably with ‘health system’.

## **1.8 CONCLUSION**

Health worker migration has increasingly become an important agenda item at every level of policy direction. Migration of nurses in particular has raised concern considering that nurses comprise the majority of the health care professionals in most countries. The fear of the potential effect of their loss to other countries, particularly from the poor to industrialized countries, is of concern considering the health challenges confronting governments, their health systems and populations in the region. This justifies the importance of this study as exemplified in the study questions and objectives.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter gives an overview of international migration in general and the trends at global, regional and country levels and the involvement of multilateral and professional organizations in determining its magnitude and potential effects. Attempts are made to focus on nurse migration in Africa although from the researcher's observation, the information is scanty and where it is available, it is part of bigger studies on migration in general or that of other health care professionals, particularly physicians. The literature also describes the magnitude of the trend as it relates to the health systems in the region. The chapter further addresses the possible contributing factors to international migration both in the sending and receiving countries generally and reviews the theories that describe what are considered to be the causes of international migration.

#### **2.2 HISTORICAL PERSPECTIVES ON INTERNATIONAL HEALTH WORKER MIGRATION**

From the available literature, it appears health worker migration has had a long history going back to the 1950s. According to Mejia and other researchers (Mejia et al., 1979), many countries in the 1950s and 1960s expanded their welfare states rapidly and accompanied this by recruiting health workers from abroad. In the post-colonial period, many developing countries started to expand their health facilities and services and to train their nationals to staff them. Although initially countries appeared to have been

training for their local needs, there were already concerns, from the 1960s, that some of these professionals were being lost to richer countries which were expanding their own health services and lacked sufficient home grown professionals, thus widening the gap between developed and developing countries. Because of fear of a brain drain, WHO was prompted to conduct a study on the flows and stocks of physicians and nurses in 40 countries (Mejia and Pizurki, 1976), the only study of this kind, hereafter referred to as the Mejia study (Martineau et al., 2002). They concluded that in 1972, about 6 per cent of the world's physicians (140,000) were located in countries other than those of which they were nationals. Also significant about the findings was that 86 per cent of all migrant physicians were working in five countries (Australia, Canada, the Federal Republic of Germany, the United Kingdom and the United States).

In the 1970s, 35 per cent of all hospital physicians in the UK were trained overseas, 60 per cent of them in developing countries. Abel-Smith (1986) reports that these physicians generally filled positions unpopular among British physicians (only 19% in teaching hospitals compared to 39% in all other hospitals). Mejia (1978) reports from his study that past colonial language and cultural ties were very important in determining migration patterns and directions. To further elaborate this trend, he cites the high proportion of UK immigrants from Commonwealth countries, especially from India and the Caribbean and acknowledges that these ties extended to the nursing profession, and were evident in the nursing education structure, the textbooks, the curriculum etc. A report by Studlar (1979) shows that Britain treated people in colonies that became independent as citizens of the

mother country and they could automatically enter the United Kingdom with full citizenship rights.

The stock of nurses working overseas was estimated to be lower, at about 5 per cent, but the main recipient countries were the same as for physicians with the exception of Australia (Mejia et al. 1979). Even at that time, there was already concern about the impact of health worker migration in the poorer countries. This concern was also expressed at the Commonwealth Medical Conference in 1965 (Martineau et al., 2002).

The physician flows represented about 16 per cent of the global stock of physicians on the move and were mainly from Canada, Germany, Ireland, UK, India, Iran, Pakistan, Sri Lanka, the Philippines, Korea and Latin America to the USA and the UK. In the 1970s, it was estimated that about 135,000 nurses (or 4% of the world total) were outside their country of birth or training, 92 per cent of these were in Europe, North America and the developed countries of the West Pacific (Mejia and Pizurki 1976). During the mid-1970s, a total of 13,480 physicians were working in the Philippines compared to 10,410 Philippines-trained physicians who were employed in the United States (Goldfarb et al., 1984)

The migration of nurses was more multidirectional than that of physicians. Major sending countries were Canada, Egypt, New Zealand, the Philippines and the UK. The major destination countries were Canada, USA, UK, Germany and Australia. The Philippines appear to have a long history of large migration flows. For example, Mejia (1978) reports that the majority of the nurses newly registered in the USA in 1972 were from the

Philippines (over 49%), followed by Canada and the UK together (over 21%) and 14 per cent from India, Korea, Thailand and the West Indies together. Abel- Smith (1986) suggests that migration of nurses was at times like a 'carousel' because when nurses emigrated from the UK for example, replacements were recruited from Ireland, the West Indies and Mauritius (Abel-Smith, 1986).

In the 1960s and 1970s, there was an energetic movement to stem what was referred to as 'brain drain' from developing countries, which included calls for compensation for the investment in education and training by developing countries (Gish and Godfrey, 1979). However, Mejjia (1976) argues that this concern about the level of international migration gradually seemed to evaporate possibly due to the assumption that demand in developed countries would ease off and the positive economic forecast for developing countries would attract health professionals to stay. He points out that other views implied the apparent loss of concern was due to the influence of the more powerful stakeholders who stood to lose out. Mejjia laments the shelving of a more detailed follow-up study planned by WHO as a result of this, and the little information, even recently, that has been gathered on international migration of health workers.

However, it appears that despite this long history of health worker migration, not much effort has been made to conduct studies in this area. Hoffman and Lawrence (1996) and the OECD (2003) bemoan the absence of comparably detailed studies of health worker migration since the 1970s, reflecting the limitations of the existing data sources and refer to this situation as 'a difficulty that is generic to migration studies'. They cite the variety

of sources used by countries to record migrants (for example work permits, population registers), and the absence of data linked to occupation that makes it difficult to analyze health migration. The establishment of accurate data on stocks and flows of health workers remains a major challenge that continues to inhibit effective migration management (Bach, 2003).

Another source of data is that from verifications, that is when an examination is made to confirm that an individual's name is on the professional register. This data provides an indication that an individual has intentions to register and work overseas. Similarly, registration data records the number of nurses or doctors registered to practice in a particular recipient country. According to Buchan (2002a), this does not eliminate all difficulties and cites Australia and the United States among the federal countries where registration is at state and not national level and that this may lead to double counting if nurses registered in more than one state. He however advocates for registration data as being reliable because it has been compiled on a consistent basis over time, and would thus provide a valuable source of trend data, despite the fact that such data indicate the intent to work rather than actual employment status.

### **2.3 INTERNATIONAL MIGRATION: AN OVERVIEW**

A report from the United Kingdom (Tikki et al, 2002) estimated that 31% of its doctors and 13% of its nurses are born overseas. In London, the figures are 23% and 47% respectively (Glover, 2001). In India, it is estimated that 40% of the doctors who work in the private sector migrate outside the country (Nandray, 1992). Internationally, the number of persons migrating has more than doubled, from 75 million in 1965 to an

estimated 150 million in 2000 (IOM, 2000) and 175 million people (2.9 per cent of the world population), of which 48 percent are women. Most of the world's migrants live in Europe (56 million), Asia (50 million), and North America (41 million) and 60-65 million of this total are described as economically active (United Nations Population Division, 2003).

## **2.4 INTERNATIONAL MIGRATION OF NURSES**

### **2.4.1 Trends and dimensions**

Surveys have shown that morale among National Health Service (NHS) nurses in the UK is at “rock-bottom” and that in the previous year, three quarters of the nurses had considered leaving. According to Brown (2001), data from these surveys also show that 3,400 nurses emigrated in 1997 amidst disillusionment about lack of apparent government efforts to improve working conditions.

From the available information, migration of nurses appears to be mainly from the poor to richer countries and is aimed at solving the nurse shortage in the recruiting country. In the Caribbean, the emigration of nurses, which is partly in response to international recruitment efforts, is exacerbating the Caribbean's own home grown nursing shortage. The USA, which has 97.2 nurses per 10,000 people, is recruiting nurses from such countries as Jamaica and Guyana, where the ratios are far lower, at 11.3 nurses per 10,000 people and 8.6 nurses per 10,000 people respectively. The USA has 100,000 vacant nursing posts (Quan, 2005) and one million more nurses will be required to meet

the needs of an aging population by 2010 (Howell, 2003). Canada predicts a shortfall of 78,000 nurses by 2011 and Australia 40,000 by 2010 (Buchan & Calman, 2005).

In Britain, the National Health Service (NHS) appears to be facing an unprecedented crisis. Britain is recruiting from the world's poorest countries, which include India, Pakistan and the Philippines. Brown further asserts that a total of 8,500 nurses were imported in 2000 with growing numbers coming from Zambia, Botswana, Zimbabwe and Malawi where "medical services are collapsing under the burden of the Aids pandemic." In the Philippines, overseas employment of nursing staff started later but has markedly increased, stimulated by the expanding supply.

In the 1970s, there were 63 schools of nursing. This number had increased to 198 by 1998. As a result, in 1970, there were almost 40,000 nurses in the Philippines. This number increased to 306,000 by the end of 1998 (Corcega et al., 2002). This has enabled a massive increase in overseas employment. Over 70 per cent of the 7,000 nurses who graduate each year leave the country, and this contributes to the annual estimated outflow of 15,000 nurses bound for more than 30 countries (Adversario, 2003). It has even been suggested that doctors are retraining as nurses because of the greater opportunities available for employment abroad (Sison, 2003).

Britain's recruitment levels from the developed nations such as Australia and Canada are shrinking because of unattractive NHS pay and conditions. Britain is reported to be recruiting more nurses from abroad than are trained each year. From the available survey

results, Britain is seen to be addressing its crippling nurse shortage through its aggressive recruitment from the world's poor countries. Britain's recruitment of nurses is estimated at 15,000 per annum with a loss of 8,000 nurses to emigration. The main destinations are Australia, United States of America, Canada, Ireland and New Zealand (UKCC, 2005).

## **2.5 FORCES BEHIND MIGRATION OF NURSES**

### **2.5.1 Influence of colonial powers**

In Africa, international migration movements have continued to be influenced by the continent's history of colonization. The colonial powers imposed arbitrary borders that often divided people belonging to the same ethnic tribal or ethnic group. The need for labor to exploit agricultural and mineral deposits of the colonies forced workers to move from one corner of a colony to another or even outside their colonies. The migrant worker recruitment practices were as a result of formal agreements developed between newly independent countries following the end of the colonial rule (Zlotkin 2004). Zlotkin also states that as time elapsed and when the economic situation of labor receiving countries deteriorated or as the prices of commodities they produced fluctuated in the world markets, the labor-receiving countries have often resorted to expulsion measures to reduce their foreign labor force in times of economic constraints. However, the fast moving population growth that most African countries had experienced, together with the stagnation that had characterized most of the African economies, had left few countries in need of labor (Zlotnik 2004).

### **2.5.2 Influence according to types and reasons for migrating**

Buchan (2002c) states that it is possible to develop a typology of different groups of overseas nurses in the UK as outlined below but argues that it is not currently possible to identify how many overseas nurses conform to each type. In this regard, he notes that the significant recent increase in active recruitment of nurses from abroad who require work permits to enter the UK points to a relative growth in the numbers of contract workers, and potential economic migrants in recent years. He points out that among the permanent movers in migration are the economic migrants, who are attracted by the standard of living, the career move, whose attraction is enhanced career opportunities and the migrant partner, which is as a result of a spouse or partner moving. The temporal movers on the other hand, are those on working holiday, study tour, students and contract workers.

According to Kingma (2006), nurses are now a very profitable market niche and represent a principal wave of migrant workers. Regarding migrating for economic gain, she points out that for professional workers, the discrepancy between overseas wages and local salaries is usually greater than for unskilled workers. Omeri and Atkins (2002) explain that professionals have a greater potential for economic gain from migrating and are more interested in employment opportunities abroad. Professionals have more options for overseas employment than an unskilled worker and are more likely to be better informed of opportunities abroad and have greater access to financial resources needed to migrate.

### **2.5.3 Forces according to other categories of migration**

Fischer and his colleagues (1997) categorize migration into 'voluntary' and 'involuntary'. Involuntary migration, depending on the situation, could also be defined as flight, expulsion or refugee movement. Causes can, for example, be wars, political terror or ecological disasters. In such situations, the urge of the individual to move to a different country or region is likely to be extremely strong, especially in the case of concrete dangers for life or safety. The researchers perceive the situation in involuntary migration as extreme and so the decision to go is self-evident and the need to decide when and where to move remains in principle the same as for voluntary migration.

### **2.5.4 Work related influences**

A number of studies point to the need to recognize that many health workers in many health systems work in situations where they are underpaid, have inadequate resources to perform their functions, are struggling with heavy workloads, and, in some cases have to cope with the threat of violence. This may particularly be the case in developing countries where health systems are under-resourced (Mutizwa-Mangiza, 1998). In such situations, some workers will leave to go to other sectors or to other parts of the country or abroad, and thus create a bigger challenge for those who remain.

## **2.6 MIGRATION TRENDS IN AFRICA: AN OVERVIEW**

The migration of highly skilled professionals from poor to rich countries is not a new phenomenon. The losses attributed to this global migration, commonly referred to as the 'brain drain' have been recognized internationally since the 1960s (Carrington and Dettrachiage, 1998). According to Adepoju (2004), the migration of skilled Africans has

precedents in the 1960s, when developing countries engaged in an unprecedented expansion of access to education. In later years, the brain drain of the newly educated generation was influenced by a combination of economic, social and political factors, and that in the 1970s, highly qualified, experienced workers in trades and professions, drawn by higher wages, migrated from Zambia, Zimbabwe, Senegal, Ghana and Uganda to South Africa and even destinations outside of Africa. Since the 1980s, this emigration to Europe, North America and the oil-rich nations of the Middle East has increased uniformly for similar reasons. African men, along with women, increasingly participate in migration as a family survival strategy (Adepoju, 2004).

In the health sector, migration of health professionals appears to affect mostly doctors and nurses. In Ghana, a study that examined migration of locally trained doctors showed that 60.9 per cent of doctors produced between 1985 and 1994 had already left the country, mainly to the United Kingdom and USA (Dovlo and Nyonator, 1999). The World Health Organization has acknowledged nurse migration as a global problem.

### **2.6.1 Migration trends in the Sub-Saharan Africa**

Statistics from the British Medical Journal (Nawaal and Hobbs, 2004) show that 2,114 nurses left South Africa for Britain, Zambia 183, and Kenya 155 during the period 2001/2002. In the Sub-Saharan Africa, many doctors work overseas and the numbers of nurses are higher. The loss of nurses has been extreme in some countries. For example, 18,000 Zimbabwean nurses work abroad (Mangwende, cited in Pang et al., 2002).

The South African medical school information suggests that a third to a half of its graduates emigrate to the developed world (Weiner et al, 1998) and 17 per cent of all South African Medical Practitioners and 4.5 per cent of the country's nurses are working abroad (Woodcock, 2004). Recent attention has focused on South Africa. Martineau and other researchers (2002) report that almost 80 per cent of rural doctors were non-South African in 1999. At the same time, Alberta in Canada has recruited South African doctors to work in rural areas that are equally unattractive to its own citizens (Bundred and Levitt, 2000). However, Jinks (2000) and his fellow researchers argue that many African doctors migrate within the continent. They cite South Africa as the country of destination for most of them because of higher salaries.

South Africa has become an important source country for nurses. This is indicated by the fact that the number of nurses seeking verification for their qualifications before applying for overseas employment increased from 511 in 1995 to 2,543 in 2000 (Xaba and Phillips, 2001). The flow of nurses from South Africa has increased eight times since 1991 and well over half of these leave for the United Kingdom (The Economist, 2003). However, an even greater number of nurses from Sub-Saharan Africa are moving to the developed countries (Tata, 2002).

A study conducted in Ghana by Dovlo and Nyonator (1999) showed that 61 per cent of the graduates of the Ghana Medical School for the decade 1985-1994 had left the country with the majority to the UK. Evidence also shows that some health professionals do not return when sent abroad for studies. For example, data on Lesotho (WHO, 1994) shows

that only 30 per cent of persons awarded WHO scholarships returned home after their studies. Figures on nurses migrating from the developing countries have continued to rise. For example, more than 500 nurses left Ghana in 2000 alone to work in other industrialized countries. This was twice the number that graduated from the training institutions in the country that year (Zachary, 2001). Between 1999 and 2001, over 60% of the entire staff of registered nurses in a single tertiary hospital in Malawi (114 nurses) left for jobs in other countries. Data available also show an increase in the number of countries that are sending nurses to industrialized countries. For example, in 1990, nurses came from 71 countries, but by 2001, they came from 95 countries (Sochalski & Ross, 2003).

## **2.7 INTERNAL AND RURAL TO URBAN HEALTH WORKER MIGRATION**

Stilwell and other researchers (unpublished) argue that international migration should not divert attention from internal migration from rural to urban areas, between states within a country, or from public to private sectors. The researchers give an example of large countries such as Nigeria and India, with large differences in health status and health care provision, where migration form an important component of migration process. They observe that internal migration to urban areas and the impetus to recruit internationally are often interrelated because the authorities in many countries seek migrant labour to work in rural and remote geographic regions where shortages are most acute; in addition internal migration may be a precursor to international migration. Matineau and his research colleagues (2002) cite the case of nurses moving from rural parts of Eastern

Cape in South Africa to more highly skilled jobs in KwaZulu-Natal to improve their prospects of gaining employment overseas.

## **2.8 GENDER AND HEALTH WORKER MIGRATION**

There is an increased awareness of the important role that gender plays in international migration. This reflects the increased proportion of migrant women alongside increased recognition that the experience of migration differs for men and women (Taran and Geronimi, 2003).

According to Zlotnik (2004), males have tended to outnumber females among international migrants in Africa. The proportion of females among international migrants in Africa has generally been lower than the average for the world as a whole. Bjerer (1997) argues that the notion that men are still seen as the most significant migrants is a misconception based on a time lag combined with a 'majority bias'. Zlotnik (2004) further states that the proportion of females among international migrants in Africa has been increasing steadily and faster than at the world level and that the gender aspect of migration has been ignored to the extent that available statistics still make it difficult to distinguish the balance between men and women in individual migration streams (Zlotnik 1995). This author asserts that the participation of women in the international migration directed to developed nations is of major importance. In several migration streams, women outnumber men, and where they do not, the dominant trend is towards more balanced sex ratios. Zlotnik (1995:252) points out that international migration from South to North cannot be understood unless women become visible both in terms of statistics and as major actors in the migration process.

It was estimated that by 2000, 46.7 percent of the 16 million international migrants in Africa were female, up from 42 percent in 1960 when the number of international migrants in the continent stood at nine million. Adepoju (2004) refers to this trend as 'feminization of migration'. He reports that the traditional pattern of migration within and from Africa has been male dominated, and that both long-term and long-distance migration is increasingly becoming feminized. Adepoju (2004) further reports that evidence reveals a striking increase in migration by women, who had remained at home while men moved around in search of work, and that a significant share of these women is made up of migrants who move independently to fulfill their own economic needs and that "they are not simply joining a husband or other family members".

Zlotnik (2004) gives an account of the proportion of female international migrants from the 1960s. He notes that in 1960, Africa had the lowest proportion of females among international migrants in comparison to other major areas. For example, in 1960, 45 percent of all international migrants in Latin America and the Caribbean and 46 percent in Asia were female. By 2000, the proportion of females among international migrants in Asia (43 percent) was lower than that in Africa (47 percent) but in all other major areas, female migrants constituted more than 50 percent of the international migrant population.

At the regional level, Southern Africa has traditionally had the lowest proportion of females among the international migrant stock (42 per cent in 2000, up from 30 percent in 1960). Zlotnik (2004) attributes the strong predominance of men among international migrants in Southern Africa to the reliance of the coal and gold mines of the Republic of

South Africa on male migrant workers. The country began to reduce the dependence of the mining sector on foreign labor in the 1970s. This resulted in the steady decline of the number of temporary migrant workers and the increase in the female proportion of the overall international migrant stock.

### **2.8.1 Implications of female migration**

Adepoju (2004) asserts that national borders do not confine the increase in independent female migration; professional women from Nigeria and Ghana now engage in international migration, often leaving their spouses at home to care for the children. He points out that female nurses and doctors have been recruited from Nigeria to work in Saudi Arabia, while their counterparts in Ghana are taking advantage of the better pay packages in the UK and the United States to accumulate enough savings to survive harsh economic hardships at home.

According to this researcher, the relatively new phenomenon of female migration constitutes an important change of gender roles for Africa, creating new challenges for public policy. He gives an example of the time before the outbreak of civil war in Cote d'Ivoire during which an ongoing economic crisis did not prevent female migration from Burkina Faso. His argument about what made this possible was that women gradually clustered in the informal commercial sector, which is less affected by economic crises than the wage sector, where most male migrants work. This emergence of migrant females as breadwinners puts pressure on traditional gender roles within the African family context. He laments the gendered division of family labor that has been upset by

the loss of male employment through urban job retrenchment and structural adjustment, as this has resulted in forcing women to seek additional income-generating activities to support the family.

## **2.9 HEALTH WORKFORCE SHORTAGES**

The World Health Report (2006) acknowledges the shortage of health worker supply and indicates that it is among the most significant constraints to achieving the three health related Millennium Development Goal (MDGs). WHO (2005) indicate that nurses make up the largest group of health care providers in virtually all countries and their services are essential to the provision of safe and effective care and are a vital resource for meeting the MDG targets. According to the ICN (2004), the nursing shortage occurring in health systems around the world is resulting in a serious crisis in terms of adverse in terms of impacts on the health on the health and well-being of populations. A report from the sub-Saharan Africa where there is a shortfall of more than 600,000 nurses in relation to the estimated numbers needed to scale up priority interventions (ICN, 204).

## **2.10 OTHER CAUSES OF HEALTH WORKFORCE ATTRITION**

### **2.10.1 HIV/AIDS and the health workforce in Africa**

A report of the Africa Working Group of the Joint Learning Initiative on Human Resources (JLI, 2004) has described the HIV/AIDS epidemic as having “swamped” health services with patients and has begun to push the existing health conditions such as malaria (that are very severe in their own right), into a lowered priority status; and that evidence beginning to show point to the fact that this epidemic has started crowding

outpatients with the usual endemic conditions, while at the same time, increasing demand for a wider range of services and skills than the health sector has offered. The report further indicates the challenge of HIV/AIDS to the workforce as going beyond the rising workload and new skill needs, also pointing out that evidence from some of the worst affected countries show increased attrition from the health workforce.

According to Consten (1995), sero-conversion rates among surgeons in Africa may be 16 times higher than in developed countries. Projections suggested by Kinoti (2003) in his review of UNAIDS and World Bank data show that health systems in Africa are likely to lose a fifth of their employees to HIV/AIDS over the next few years and asserts from his calculations that given 15% adult sero-positive in a country, the health services could lose between 1.6 and 3.3% of its workers annually. Kinoti (2003) also reports that there was a six-fold increase of mortality of Malawi health workers between 1985 (0.5%) and 1997 (3%) with similar trends appearing in the region. According to the Joint Learning Initiative (2004), the Human Sciences Research Council of South Africa reported that up to 13% of deaths among health workers were HIV/AIDS related between 1997 and 2001.

According to Kinoti, (2003), the epidemic has impacted human resources for health in two ways: 1) direct costs—labor loss, disability and death benefits, and increasing medical aid costs; and 2) indirect costs in form of increased absenteeism, reduced productivity, and stressed workforce from additional staff recruitment and training of personnel. With a generalized epidemic of HIV/AIDS in many African countries, workers in the health care system are being infected, as they are part of the adult, sexually

active population. The impact of HIV/AIDS is serious and is estimated to be the cause of between 19-53% of all deaths of government health employees in African countries, today (Tawfik & Kinoti, 2003). This results in attrition due to deaths and absenteeism due to sickness. For example, by some estimates a person living with AIDS may be away from work for up to half the time of their final year of life (Tawfik & Kinoti, 2003). Caring for ill family members or dependents and attending funerals also contributes to worker absenteeism.

## **2.11 THE ZAMBIAN CONTEXT**

### **2.11.1 National Health Reforms**

The Zambian government introduced health sector reforms in 1991. The main aim of the reforms was to restructure the health services through improved structure, leadership, accountability and partnerships (MOH, 1991). In 1996, the National Health Services Act made the Ministry of Health responsible for the legal and policy framework for health institutions and boards and for regulatory mechanisms. The Central Board of Health (CBOH) became responsible for health delivery and policy implementation. Administrative functions such as procurement of drugs were assigned to the Central Board of Health (DFID, 2003). among the resulting achievements were more decentralized authority to manage district health services, participatory structures, increased resource flows to the districts, a basic health care package and a purchaser (MOH) – provider (CBOH) split (Cohen et al., 2003). However, Cohen and his colleagues argue that a number of challenges remained which included an adverse economic environment, limited improvement in service delivery, limited access for poor

and disadvantaged groups including the youth, women and terminally ill patients, low quality care, and reliance on external funding among, others. The reforms introduced community participation in the management and delivery of health care services through the creation of hospital and district health boards, neighborhood health committees at district and health center levels (MOH, 1991).

The vision of the Ministry of Health in Zambia is “to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible” (MOH, 1991). To achieve this vision and national health priorities, the MOH developed a Basic Health Care Package (BHCP) as a means of fulfilling the intention of providing the people in Zambia with access to basic health care as close to the family as possible. However, a decision was taken to in 2004 to dissolve the Central Board of health and repeal the National Services Act of 1995 due to what was perceived as lack of role clarity between the Central Board of Health (CBOH) and health ministry with “service delivery not drastically improving and health indicators declining” despite high health sector expenditures (MOH, 2006 p. 1).

#### **2.11.2 The human resource situation**

Although no comprehensive studies have been conducted on migration of health care professionals in Zambia, anecdotal information on the human resource crisis in the country indicate what is referred to as *economic migration* which is reported to have led to the departure of qualified staff. It is assumed that this has led to deterioration in working conditions, pointing out that this in turn, has lead to further migration as it serves

as an incentive for others to leave (MOH, 2004a). An earlier World Bank Review Mission on the Zambian Health Sector (December, 1999) estimated staff turnover rates of between 12-20 per cent. However, this figure included rates for CDEs who are a less stable component of the health workforce.

Another major contributing factor to attrition is loss of health workers through deaths attributed to HIV/AIDS, which is reported to affect health care workers in equal proportions to the population at large, leading to other consequences. The paper (MOH, 2004c) cited some of these consequences as absenteeism of staff due to caring for dependents who include the sick and orphans, attending to funerals and sick leave by staff themselves some of whom may be infected. The paper further gave a total of 225 HIV/AIDS related deaths among health workers recorded in the first half of 2004.

*Voluntary separation* from the public sector also contributed to staff attrition from the health sector. A voluntary separation package (VSP) was offered to employees in the public sector as part of efforts to reduce the size of the civil service (government workers). This affected health workers in the public sector who responded like any other government employees. Although it became clear that major shortages of staff had began to occur in some of the health care facilities, no action was taken to suspend the scheme and revisit its implications on the staffing needs of the health sector. Although no data is available on the overall impact of this scheme, anecdotal evidence showed that departure of staff made it difficult to maintain acceptable standards in the provision of health care

(MOH, 2004a). The report cited the national tertiary hospital, the University Teaching Hospital (UTH) where over 75% of the nurses had left.

A paper on an analysis of the human resources situation in the health sector in Zambia describes what is currently obtaining as:

*“a human resources crisis in the Zambian Health Service, which, like a creeping paralysis, is inexorably undermining the ability of the Ministry of Health (MOH) to deliver vital health services”*

The MOH conceded in this analysis stating that the problem was not new and that numerous reports had been written drawing attention to what was referred to as the ‘*looming catastrophe*’ (MOH, 2004a).

Globally, nursing and midwifery personnel comprise more than 50 per cent of the labour force in many developing countries (O’Brien-Pallas et al., 1997). Nursing and midwifery services comprise a large component of health service provision and account for the majority of health care personnel (WHO, 2002 p.28). Nurses and midwives are responsible for preventive, curative and rehabilitative care and in turn, improved health systems performance (ICN, 2004 p.5). The situation in Zambia is not different. nurses comprise the majority of the health workforce. From experience, they function at every level of the health care system and provide a wide range of services within their broad scope of practice as provided by the Nurses and Midwives Act. Records at the General Nursing Council of Zambia show that the country has trained a total of 5,619 registered

nurses and 11,916 enrolled nurses from 1968 to end of 2002. Out of these numbers, 2,642 and 4,680 nurses have undergone one year training in registered and enrolled midwifery respectively. However, only a total of 9,536 (54.4%) renewed their practicing licenses in 2002 out of the trained total of 17,535 (GNC, 2002).

The assumptions for this state of affairs are that some nurses have left the country while others have died and may be others did not just renew their practicing licenses. The numbers attributed to any of these possibilities are not known, as there is currently no system of tracking down nurses who have died, retired or left the country for whatever period or purpose.

From the experience of the researcher, the General Nursing Council of Zambia (GNC), as the regulatory body for the nursing profession, issues verification statements to nurses wishing to register outside the country. Nurses request for verification of their professional status most commonly for employment purposes. Records of those who seek verification of their qualifications and registration with the GNC show an upward trend, indicating an increase in the number of nurses intending to register with foreign Nursing Councils or other nursing regulatory bodies. South Africa and the United Kingdom appear to have been the most sought after countries during the years 1997-2002. The records show a sharp decline for South Africa application for registrations in the last two years. The trend towards the UK almost doubled with numbers applying to register in the USA also increasing. The number of applicants to Botswana appears to be consistent.

## **2.12 FACTORS CONTRIBUTING TO INTERNATIONAL MIGRATION**

### **2.12.1 Globalization and health**

According to Woodward and his research colleagues (2001), globalization is one of the characteristics that define the beginning of the 21<sup>st</sup> century. These researchers explain that although there is no single definition of globalization, it is clear that it is a multidimensional process encompassing economic, social, cultural, political and technological components, and that it defines much of the environment within which health is determined. Economic globalization is a dynamic, evolving process and can be seen through growth in goods and services of 8.6 per cent per year between 1991 and 1999, 3 per cent faster than output growth (IMF, 2000). Economic globalization has resulted in differences between economies, showing faster growth in the richest and slower growth in the poorest. Globalization has also been blamed for increasing inequality within countries and slower poverty reduction in low-income countries (UNCTAD, 1997; Woodward, 1998). The World Trade Organization, established to promote “freer trade”, has assisted and supported the increase of global economic integration. Among the multilateral trade agreements that have particularly important implications for public health is the General Agreement on Trade and in Services (GATS) which covers the movement of providers and consumers across borders to receive and supply health care, and the emerging areas of e-commerce and telehealth. GATS provide WTO members with substantial flexibility to decide which service sectors to liberalize (Woodward, et al., 2001).

The health sector is among the most rapidly growing sectors in the world economy. It is estimated to generate US\$ 3 trillion per year in countries in the Organization for Economic Co-operation and Development alone and is expected to rise to US\$ 4 trillion by this year, 2005 (Zarilli & Kinnon, 1998; UNCTAD, 1997). The globalization of health services is reflected in the growing cross-border delivery of health services, through movement of personnel and consumers (by electronic and other means), and in an increasing number of joint ventures and collaborative arrangements (Chanda, 2002).

One of the modes through which health services are traded is via the movement of health personnel, who include physicians, specialists, nurses, paramedics, midwives, technicians, consultants, trainers, health management personnel and other professionals. The movement of health care professional includes both temporal and permanent flows, each having legal, social and economic implications for both source and host countries. According to Chanda (2002), short-term flows of health professionals have been mainly driven by conscious strategies to promote health services exports, in order to earn foreign exchange and foster cooperation between governments. He gives examples of China and Cuba who send their health personnel abroad on short term remunerated contracts to countries in Africa, under government supervision.

Short-term flows of health care professionals exist from Ghana to Jamaica and from India to the Eastern Mediterranean. The later is an important host market for physicians, nurses, X-ray technicians, laboratory technicians, dental hygienists, physiotherapists, and medical rehabilitation workers from many developing countries. Chanda (2002) points

out that permanent migration of health care providers on the other hand occurs mainly from the developing to the industrialized countries and is driven by wage differences between countries and a search for better working conditions and living standards, better training possibilities and demand-supply imbalances in the health sector between the sending and receiving countries.

A 1998 United Nations Conference on Trade and Development/WHO study estimated that 56 per cent of all migrating physicians flow from developing countries to industrialized countries, while only 11 per cent migrate in the opposite direction; the imbalance was even greater for nurses. The most prominent source countries for health personnel were India, the Philippines and South Africa, whose nurses, physicians and technicians emigrate to Australia, the Eastern Mediterranean, the United Kingdom and the USA (US Government, 1997).

Studies (Kaplan et al., 2000; Cohen, 2003) show that the bulk of cross-border flows of health care professionals do take the form of permanent migration. For example, an estimated 10,000 health professionals emigrated between 1989 and 1997, and between one third to one half of the health profession graduates emigrate each year, mainly to the United Kingdom and the USA. Similarly, it has been estimated that over 10,000 medical and biotechnology experts from Egypt have emigrated from that country (Khalil, 1999) and out of 1200 physicians trained in Zimbabwe during the 1990s, only 360 were practicing in the country in 2001. A large number of nurses also emigrated from Zimbabwe to Australia, New Zealand and the United Kingdom prompted by low wages,

poor working conditions and political instability in their home country (Nyati, 2000). Some 60 per cent of Ghanaian physicians trained locally during the 1980s have also left the country. In Sudan, an estimated 17 per cent of physicians and dentists left the country between 1985 and 1990.

Recent decades have coincided with the rapid globalization of the nursing profession. During the period 1995/6-1999/2000, Australia saw an additional 11,757 permanent or long-term overseas-qualified nurse arrivals. Nursing in that country is ranked as third target profession in Australia's skill migration programme, in the context of continuing attrition among local nurses. Globalization of nursing is not only reflecting western demand but the growing agency and participation of women in skilled migration, their desire for improved quality of life, enhanced professional opportunity and remuneration, family reunion and adventure (Hawthorne L, 2002).

### **2.12.2 Factors contributing to globalization**

Giddens (2004) states that some important advances in technology and the world's telecommunications infrastructure have facilitated the explosion in global communication. Although the telecommunication infrastructure is not evenly developed around the world, a growing number of nations can now access international communication networks in a way which was previously impossible. This development has resulted in a reorientation in people's thinking from the country to global levels.

Giddens (2004) explains that individuals are now more aware of their interconnectedness with others and more likely to identify with global issues and processes than was the case in the past. He indicates that one dimension of people shifting to global outlook is that as members of a global community, people increasingly perceive that social responsibility does not stop at national borders, but extends beyond them. The other dimension is that people are increasingly looking to sources other than the nation-state in formulating their own sense of identity, and that this is a phenomenon that is both produced by and further accelerates processes of globalization. In addition, local culture identities in various parts of the world are experiencing powerful revivals at a time when the traditional hold of the nation-state is undergoing profound transformation. Held and his colleagues (Held et al., 1999) assert that transnational corporations are at the heart of economic globalization; they account for two thirds of all world trade and are instrumental in the diffusion of new technology around the globe, and they are major actors in international financial matters.

Political changes have also contributed towards the intensification of globalization. An example is the formation of the international and regional growth of government. The United Nations and European Union are the two most prominent examples of international organizations that bring together nation-states into a political forum. Others with the driving force are international governmental organizations (IGOs) and the international non-governmental organizations (INGOs) (Held et al., 1999).

### **2.12.3 International migration and immobility**

Hammar and Tamas (1997) argue however that the majority of the people do not migrate although in studies of international migration, all attention is given to those who actually

migrate, and according to these researchers, the behavior of these migrants under most circumstances is not the normal one, but a deviant case. They maintain that all disciplines, within their framework, focused on the explanation on “why do people migrate”, neglecting the twin question “why do they not migrate”. They explain that the distinction between international and internal migration may be regarded as formal and legalistic but it has an impact of great significance on the relations between individual migrants and the countries on both sides of the boarder, as well as between these countries. They point out that international migration is more or less regulated by the destination countries and to some extent also by the countries of origin. Furthermore, they point out that when migrants leave the country where they are citizens and enter another country where they are aliens (as well as vice-versa when they return), this implies a major change in their legal status, their right to take up residence and work, their social, economic and political rights.

## **2.13 MIGRATION THEORIES**

According to Hammar and Tamas (1997) international migration is studied within most social science disciplines. These include anthropology, demography, economy, education, geography, history, political science, psychology and sociology. Contributions are also made within many other fields such as law (international law and legislation about aliens and citizenship) and social medicine. International migration, in other words, is not the domain of any one discipline. The two researchers explain that international migration is a field of study where multidisciplinary research is needed but highly lacking and that research is frequently undertaken without consideration or consultation of related work in other disciplines.

There are several theories of international migration that attempt to explain movements of people. Massey (1993) points out that scholars of international migration agree, "there is no single, coherent theory of international migration, only a fragmented set of theories that have developed largely in isolation from one another". Sulaimanova (2004) concedes that there is a vast body of literature on international migration, especially to the United States but argues that many of the studies lack theoretical grounding and the majority of literature is not empirical.

### **2.13.1 Neoclassical Economic Theory**

According to Harris and Todaro (1970), macro theory of neoclassical economics is the oldest and best-known theory that argues that international migration is caused by differences in the supply of and demand for labour in sending and receiving countries.

However, Massey (1993) argues that this theory assumes that differences in wages cause international migration and that the “elimination of wage differentials will end the movement of labour, and migration will not occur in the absence of such differentials” According to this theory, countries, with a large endowment of labour relative to capital tend to have low equilibrium market wages, whereas countries with a limited labour endowment relative to capital are characterised by high market wages. The resulting wage differences entice workers from low-wage countries to move to high-wage countries. As a result of this movement, the supply of labour decreases and wages rise in the countries of origin and the supply of labour increases and wages fall in the countries of destination (Maresova, 1999). This leads to a new equilibrium in which wage differences reflect only the cost of migration. Maresova (1999) argues pointing out that the neoclassical theory of international migration has some limitations that include its failure to take into account the international political and economic environment, as well as the effects of political decisions, which influence individual decisions regarding migration. This researcher argues further indicating that the theory assumes there is homogeneity of skills between the regions of origin and destination, implying that labour is completely interchangeable, and that full employment is maintained in both areas during the migration process.

Macro-theory of neoclassical economics states that individuals are rational actors and decide to migrate after a cost- benefit analysis that projects a positive net return from migration (Todaro & Maruszko, 1987). The argument from the microeconomic model of individual choice is that “individual human capital characteristics that increase the like

rate of remuneration or the probability of employment in the destination relative to the sending country (e.g. education, experience, training, language skills) will increase the likelihood of international movement, other thing being equal” (Massey et al., 1993).

### **2.13.2 Push and Pull Theory**

The traditional push and pull model base on the assumptions of neo-classical economics has remained an influential perspective within geography (e.g. Dorigo and Tobler 1983). The basic ideas about this perspective are that migrants respond primarily to economic conditions in the places of origin and destination, that migrants have adequate information about living conditions in the place of destination, that the migration decision is based on rational economic calculation and that migration is therefore the response to the actual economic conditions in the places of origin and destination (Hammar and Tamas, 1997). However, Hefti (1997) argues that contemporary views on migration depart from the earlier premise of the push-pull theory of migration.

According to this theory, people moved either because social and economic forces in the place of destination impelled them to do so, or because they were attracted to the places of destination by one or more social and economic factors there. He points out that observers of migration have long seen the vast changing nature of migration. What used to be purely economic reasons for migrating no longer hold in many places.

Hefti (1997) points out that globalisation of communication technology has affected extensively the original impetus of the individuals to migration. He also explains that

linkages between receiving and sending countries are readily established and that these networks connect migrants and non-migrants, where news and information are shared. Job opportunities are readily shared and earlier migrants assist subsequent migrants with accommodation, jobs and contacts. He further explains that information on these successes reaches home, thus encouraging further migration and this migration may continue even after the initial impetus for migration no longer exists. In addition, to this argument, the model fails to deal with the influences on migration of information flows, personal contacts, and social networks in migration systems. In addition, the model does not pay attention to the varying opportunities and inclinations of people in different situations (with different sex, age, class or cultural backgrounds) to make rational migration decisions, and to substitute the advantages of one place for those of another.

### **2.13.3 World Systems Theory**

According to Wallerstein (1974b) a world system is any historical social system of interdependent parts that form a bounded structure and operate according to distinct rules, or “a unit with a single division of labour and multiple culture systems”. The modern world-system is a world economy and is larger than any defined political unit and the basic linkage between its parts is economic (Wallerstein, 1974c). He further explains that the world system is a capitalist world-economy because the accumulation of private capital, through exploitation in production and sale for profit in a market, is its driving force; it is a system that operates on the primacy of the endless accumulation of capital (Wallerstein, 1998).

The key feature is that the capitalist world-economy has no single political centre. It has been able to flourish precisely because it has had within its bounds not one but a multiplicity of political systems which has given capitalists a freedom of manoeuvre that is structurally based and has made possible the constant expansion of the world-system (Wallerstein, 1974c). The system consists of a single division of labour within one world market but contains many states and cultures. Labour is divided among functionally defined and geographically distinct parts in a hierarchy of occupational tasks (Wallerstein, 1974c).

Wallerstein (1974c) developed a theoretical framework to understand the historical changes involved in the rise of the modern world. The modern world system, essentially capitalist in nature, followed the crisis of the feudal system and helps explain the rise of Western Europe to world supremacy between 1450 and 1670. Wallerstein's theory makes possible a comprehensive understanding of the internal and external modernisation process during this period and makes possible analytically sound comparisons between different parts of the world. The new capitalist world system was based on an international division of labour that determined relationships between different regions as well as the type of labour conditions within each region. In this model, the type of political system was also directly related to each region's placement within the world economy. As a basis for comparison, Wallerstein proposed four different categories; core, semi-periphery, periphery and external, into which all regions of the world can be placed.

However, other researchers, for example Maresova (1999) mention only three of these zones; core, semi-periphery and periphery, and describes them as 'geographically distinct zones'. The core regions benefited the most from capitalist world economy. Politically, the states within this part of Europe developed strong central governments, extensive bureaucracies and large mercenary armies. Impoverished peasants often moved to the cities to provide cheap labour essential for growth in urban manufacturing. In Lechner's analysis (2001), superior military strength and means of transportation enabled them to establish economic ties with other regions that favoured the accumulation of wealth in the European core.

Maresova (1999) points out that in core countries, the demand for migrant labour is not uniform since it usually reflects the relative scarcity of persons who are prepared to work for low wages. In sectors that cannot rely on productivity increases to maintain profit levels, the demand for cheap labour rises. The theory presupposes that core states concentrate on higher skill, capital-intensive production and appropriate much of the surplus of whole world economy (Wallerstein, 1974b).

The periphery areas on the hand lacked strong governments or were controlled by other states, exported raw materials to the core and relied on coercive labour practices. The core amassed much of the capital surplus generated by the periphery through unequal trade relationships. According to Wallerstein (1974a), the entering of Asia and Africa to the periphery zones in the nineteenth century increased the available surplus, allowing other areas such as the US and Germany to enhance the core status.

Maresova (1999) points out that periphery areas focus on low skill, labour intensive production and extraction of raw materials and asserts that the coexistence of such developments with the permanent demand for low-cost labour in core countries results in international migration of workers from the periphery to the core countries. According to this theory, migration is more likely to occur between past colonial countries and their former colonies because it is facilitated by the cultural, linguistic, administrative, transportation and communication links existing between them.

The semi-periphery areas said to be less dependent of the core than periphery ones and have more diversified economies and stronger states. They function as a “necessary structural element in the system because they partially deflect the political pressures which groups primarily located in periphery areas might otherwise direct against core states (Wallerstein, 1974c) thus preventing unified opposition (Lechner, 2001). The external areas, according to this theory, maintained their own economic systems, for the most part and managed to remain outside the modern world economy.

In a summary of a book written by Wallerstein, an unknown author states that the capitalist world economy, as envisioned by Wallerstein, is a dynamic system which changes over time and that Wallerstein himself the development of he capitalist world economy as detrimental to a large proportion of the world’s population. He further explains that although the functioning of the world economy appears to create increasingly larger disparities between the various types of the world’s economies, the

relationship between the core and its periphery and semi-periphery remains relative, not constant. Technological advances, for example, could result in an expansion of the world economy overall, and precipitate changes in some periphery and semi-periphery areas. However, Wallerstein asserts that an analysis of the history of the capitalist world system shows that it has brought about a skewed development in which economic and social disparities between sections of the world economy have increased rather than provided prosperity for all.

#### **2.13.4 Dependency Theory**

According to Ahmed (1997), the Marxist conception of international migration has influenced dependency theory, which presumes that a single capitalist economy pervades the whole world, that it has a centre (or core) where all power is concentrated, and a periphery which is dependent and vulnerable to the will and interest of the centre. The North is the centre, while the South is the periphery. Frank (1970) put forth the argument, theorising that the structure of the world economy was such that surplus produced in the periphery was appropriated by the centre. The ties of dependency vis-à-vis the centre did not allow genuine self-perpetuating development in the periphery. Instead, it allowed an inverse relationship between development in the centre and underdevelopment in the periphery. The more the periphery was integrated into the centre, the more the underdevelopment in the periphery. The argument by Frank (1970) was that dependency theory did not explain the phenomenon of non-migration but maintained that labour migration was a result of the dictates of the centre. According to this theory, the flow, extent and direction of migration were determined by structural changes in the global economy. Dependency theorists point out that brain drain from South to North adversely

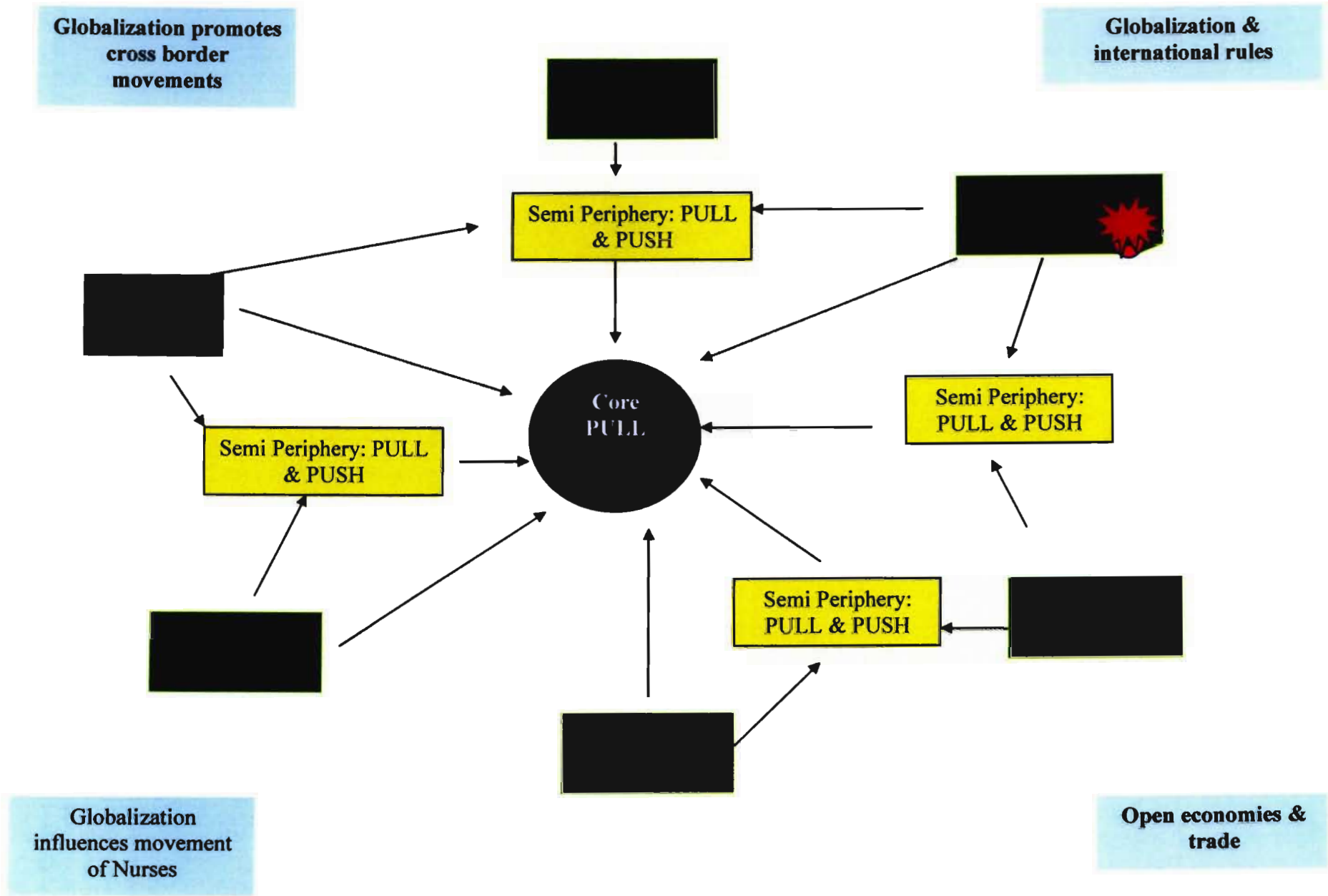
affects the development of the former. For example, well educated and skilled elite, which might be most valuable to the periphery, is lost to the center (Frank, 1970).

This theory presupposes that the labour force that is exported to the core or centre is surplus and that there are economic benefits that accrue from this labour force as they are expected to bring in remittances from their earnings as policy. Ahmed (1997) argues that such remittances sent to the periphery by those who migrate are rarely invested in production.

Other available options in theoretical terms which Hammar and Tamas (1997) describe are staying and not migrating or full immobility or some form of internal migration to another spatial unit (another area) within the country, as for example, in rural to urban migration, commuting, or internal refugee migration. The two explain that even in the case of forced or reactive migration, various factors may hinder people from crossing borders. An example that they cite is refugees who may have to remain as displaced people within their country of residence because they are given no opportunity to leave. Hammar and Tamas (1997) argue that most people of the world remain within the borders of their country or even at their very place of birth.

## **2.14 THEORETICAL FRAMEWORKS AND THEIR APPLICATION TO THE STUDY**

A combination of two theories was adapted for application in this study. These theories are the World Systems Theory and the Push and Pull Theory. The description of the conceptual framework is diagrammatically represented on the next page.



A Conceptual Framework on Migration of Nurses from Poor (Periphery) and Transition (Semi-Periphery) and to Wealthy (Core) Countries facilitated by the Push-Pull Factors and the resulting impact on the Health System of the poor countries

### **2.14.1 World Systems Theory**

In the definition of international migration, the world is described as being divided into territories of sovereign states and that some migration goes across the national borders (Hammar & Tamas, 1997). Wallerstein and other proponents of the World Systems Theory see the world in a similar manner but divide it into zones. For the purpose of this study, the researcher has opted to select three zones namely the Core, Semi-Periphery and Periphery in accordance with Maresova (1999) instead of four zones (Wallerstein, 1974a) into which all regions of the world can be placed.

### **2.14.2 Assumptions from the conceptual framework as applied to the study**

In international migration of nurses and other health care professionals, the assumptions according to this theory are as follows:

- 1) The Periphery countries are in the developing world and are the poorest with the greatest health care needs and demands with poorly managed economies. Africa has the highest disease burden of any continent (per population) but has the lowest numbers and ratios of health workers per population. In addition, despite higher maternal and child mortality than found anywhere else, Africa produces the lowest numbers of health workers (WHO, World Bank, and Rockefeller Foundation, 2004).
- 2) International migration thus, with reference to the above, is depleting the developing world of its meagre human resource for health, in this context the nurses.
- 3) Examples of Semi-Periphery countries are South Africa and Botswana with transitional economies which are described as 'relatively well off' (Dovlo & Martineau,

2004). These are less rich than the Core countries, but attract nurses and other health care professionals from the poorer Periphery countries.

4) Core countries are the rich economies of the world. The remuneration gap between Africa and the countries that recruit its health workers is wide and cannot be readily met by government pay increases (Consten et al., 1995)

5) All migratory movements lead towards one direction; to the Semi- Periphery, or through the Semi-Periphery (transitional or relatively rich economies) to the Core or wealthy countries. There are no migratory movements towards the Periphery or poor countries, according to this theory.

6) The Core countries are strong and supreme (Lechner, 2001) and are able to penetrate the rest of the countries in the world; thus the Periphery and Semi-Periphery countries, and influence 'their life styles and desires' for better quality of life.

7) Migration, after all, is a natural outgrowth of disruptions and dislocations in the process of capitalist development (Massey et al., 1993). This is an acknowledgement of the impact of migration on the poor (periphery) and less poor (relatively rich or transitional economies) countries.

8) The Core countries are strong and may control the Periphery and Semi-Periphery. Bond and Dor (2003) appear to support this and argue that the era of structural

adjustment and free market approaches to health care (imposed by the core countries) resulted in reduced public sector involvement in health including the loss of health workers through retrenchments and recruitment embargoes that may have deprived poorer and rural communities access to health services.

9) The large bulk of Africa's health professionals leave to work in just a few industrialised countries (WHO, World Bank, and Rockefeller Foundation, 2004).

10) Factors within the World Systems and the Push and Pull conceptual framework result in migration of nurses to the relatively rich and rich countries.

11) Movements of nurses may be directed to the relatively rich countries only, like South Africa and Botswana or migrating nurses may go directly to the developed countries.

12) Nurses and others who migrate to the relatively rich countries may in due course, make further moves and migrate to the developed world.

#### ***2.14.2.1 Push and Pull Theory***

The push and pull theory assumes that *push* factors within countries of origin force potential migrants, and in this study nurses, to leave their countries and that there are *pull* factors that attract nurses in the intended destination countries. Various studies on health worker migration in the Sub-Saharan Africa show the following push and pull factors:

### *Push factors*

Nurses and other health care professionals are affected by push factors based on various studies within the Sub-Saharan Africa. These are economic difficulties, poor working conditions, low remuneration, poor leadership in health services, poor motivation, slow career prospects, perceptions of a high occupational risk from HIV/AIDS, among others.

### *Pull factors*

These include active recruitment by recipient countries, more job vacancies, lack of recipient country efforts to mitigate their own health worker needs, vast remuneration gap between Sub-Saharan countries and the industrialized ones (Vujicic et al., 2004), rich recipient countries making it easier for nurses and doctors from Africa to work in their countries for affluent life, attractive working conditions including remuneration, better working environment, better quality of life, and respect for nurses.

#### ***2.14.2.2 Impact of nurse migration on the health care system: assumptions***

The assumption is that migration impacts on the health care system.

#### ***2.14.2.3 Assumptions about globalization***

Globalization is a catalyst for migration of nurses through open economies, promotion of their free movements across borders, assisted by technological advances, particularly in communication.

## 2.15 TRANSNATIONAL MIGRATION

Literature shows that there are mechanisms by which people who migrate still maintain links with their countries of origin. Transnational migration has been defined as ‘the process by which immigrants build social fields that link together their country of origin and their country of destination’ (Glick Schiller, Basch, and Blanc-Szanton, 1992, p. 1). According to these researchers, transnational migration should be viewed as a specific area within the broad field of transnationalism, one that focuses on ‘the social process in which migrants establish social fields that cross geographic, cultural and political borders.’ However, Mahler (1999) bemoans the overwhelming focus on adult migrants with little regard paid to children and the youth. While acknowledging the availability of abundant literature on migrant children who are viewed as resettled in a second country, Mahler (1999) advocates for the same to be applied to children whose lives are transnational.

### 2.15.1 Concepts linked to transnationalism

Faist (1997) describes these concepts as follows:

- 1) *Transnational social space* - a concept in which the issues of social, political and cultural change in international migration converge. ‘Transnational social spaces’ are defined as relatively permanent flows or movements of people, goods and services across international borders that tie slayers and movers in both areas. Both regions are sending and receiving at the same time.
- 2) *Transnational social spaces* suggest that even more permanent settlement in the receiving country does not necessarily imply a complete rupture or break of social ties.

The existence of transnational social spaces attests to the ability of movers to creatively pattern their occupation and personal experience ties and other forms of linkages.

3) There is also the *global elite* (Beaverstork 1996) whose movement is often shaped by employment in sectors such as financial services; and also the movement and temporal migration of individuals and families from the 'developing' world to the industrialized west, such as the Mexicans who work in California and the Filipino nurses who work in Britain (Smith and Guarnizo, 1998)

4) *Transnational Migrants* - It is thus appropriate to talk about transnational migrants instead of emigrants and immigrants to facilitate development of concepts that cannot only be applied in either the sending or receiving regions but can also refer to emerging transnational social linkages. Examples are those between Algeria and France, India and the United States, Turkey and Germany, Mexico and the Caribbean and the United States.

5) *Transnational networks* - Exchange relationships partly account for network formation. Migrant and refugee networks and organizations facilitate social and individual action in reducing information and transport costs as well as costs in the country of destination. Migrants may, for example, get information about prospective employment through various means of communication. These exchange relations decrease the risk of not finding a job and income in the country of destination (Faist 1997). The value of networks for international movers and stayers differ. For example, a study on young New Zealander migrants in London showed that what was more central

to them a sense of connection, shared values and times together, a sense of personal worth, etc

6) There are also *transnational entrepreneurs* who are actually brokers and facilitate international migration. These can be pioneer migrants or refugees who capitalize on their experience, professionals in organizations concerned with labor recruitment or respectable individuals in the sending or receiving communities. Exchange relationships can also be applied for sending community strategy chosen. For example, inhabitants in some Mexican villages can best expect to reap results from international migration if they all agree to sponsor individuals for graduate studies in the United States (Pries 1996).

7) While this concept helps to explain immobility (first time decision making), migration (once the process is underway), return migration and decline of migration flows seem to depend on the sending and receiving countries.

## **2.16 CONCLUSION**

This chapter analyzed the concept of health workforce migration and nurse migration in particular. Migration trends with statistics at global, regional and country levels were critically addressed including the potential of the nurse and health worker migration on poor countries. A critical analysis of the migration theories was given showing how the conceptual framework for this study was arrived at and adapted, with a detailed account of the theoretical assumptions as they relate to both the conceptual framework used and

the study. Generally, both the literature and conceptual framework formed the basis for the development of study objectives and research questions described in the next chapter.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This section of the study describes its design, the study population and sample and the sampling strategy. The instruments for collecting data for the study and the procedure for data collection are described in detail. Ethical consideration including the information availed to respondents in all data sources to seek their informed consent is indicated. Furthermore, the data collection process is described according to phases explaining both the quantitative and qualitative sources of data and the arguments for triangulation approaches used to source data. The sampling procedure for quantitative data is presented diagrammatically while that for qualitative data is given in narrative

#### **3.2 RESEARCH DESIGN**

This research was a non-experimental descriptive survey that used both quantitative and qualitative study approaches. Babbie and Mouton (2002) define a research design as a plan or structured framework on how the researcher intends to conduct the research process in order to solve the research problem; thus, the research design addresses the planning of scientific inquiry; designing a strategy for finding out something. The research design for this study aimed at determining the migration of nurses and its perceived impact on the public health care system in Zambia.

The purpose of descriptive studies, according to Polit and Hungler (1997), is to observe, describe and document aspects of a situation as it naturally occurs. This study has

described and documented the extent of nurse migration in Zambia from the perspectives of the respondents, the reasons why some nurses resign their nursing positions and leave to work outside the country and why others remain. Descriptive surveys depend only on observations (Williams, 2003:89). In this study, the researcher observed respondents' characteristics and their perceptions on nurse migration and its impact on the public health care system, through questions and further described what would guide policy formulation on management of nurse migration as it relates to both nurses and the country. A survey, on the other hand, is the collection of information on a wide range of cases, each case being investigated only on the particular aspect under consideration (Bless & Higson-Smith, 1995). The survey design was used in this study to facilitate collection of data on nurse migration and its perceived impact on the public health care system from a wide range of sources or cases.

Quantitative research is defined as the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design (Polit & Hungler, 1997). The quantitative approach was used in order to generate and quantify data on the extent of nurse migration and its perceived impact on the public health care system in numerical terms that were generalized in numerical representation (Babbie and Mouton, 2002) while the qualitative approach facilitated the understanding of the phenomenon from the participants' perspective, not the researcher's (Hardon 1995). In addition, the researcher followed the steps outlined in the research plan.

The qualitative approach, in accordance with Hancock (2002), was concerned with finding the opinions, experiences and feelings of individual respondents producing subjective data. This approach was used in the study to describe the social phenomenon of migration as it occurred and its understanding was gained through a holistic

perspective (Hancock, 2002 p.2). Hardon (1995) and other researchers recommend a combination of the two approaches and argue that a quantitative study has the advantage that if performed correctly, may generate conclusions that may be generalized while the qualitative approach may produce more insight and in-depth information. In this study, a combination of both facilitated approaching the problem both in depth and in general.

### **3.3 STUDY POPULATION**

Polit and Hungler (1997) refer to the target population as the entire population in which the researcher is interested and the accessible population as those cases that conform to the researcher's eligibility criteria and are accessible to the researcher as a pool of subjects for the study. The target population comprised the 12,934 nurses who were on the register of the General Nursing Council of Zambia (GNC) at the time of data collection. Of this number, 4,379 were registered nurses (RNs). Among the RNs, 2,014 had registered midwifery (RM) qualifications and 64 were qualified nurse educators (NE) or tutors. There were 8,278 enrolled nurses (EN) on the GNC register out of whom 3,038 were enrolled midwives (EMs). Other registered nurses with post basic qualifications were public health nurses (62), operating theatre nurses (392), pediatric nurses (9) and 94 and 183 registered and enrolled mental health nurses respectively.

The eligible cases in this study included nurses and policy makers working in public health care institutions and those seeking verification of their qualifications from the GNC with the intention of registering outside the country. Williams (2003) describes the population as a term that does not necessarily have to apply to the human population of a given geographical location, but as a statistical term that refers to a collection of persons,

groups, events or things about which the researcher wishes to generalize. In this study, nurses who had migrated to other countries and were in Zambia at the time of data collection were also included in the study population. According to the GNC (2005) records, there were 4,850 nurses who had been issued with verification of their qualifications during the period 1995-2005.

Nurses of all levels were included in the study because they went through the day-to-day experiences of providing patient or client care. Nurse managers or supervisors were included as they provided leadership through management of nursing and midwifery services and were generally accountable for the overall quality of care provided in the respective health care facilities. In addition, they worked closely with the nurses who provided direct care to patients and shared nurses' experiences in their work environment and public health system.

According to records at the GNC (2005), all nine provinces in Zambia have a school or schools of nursing and or midwifery where nurse educators are responsible for facilitating the education and training of nursing and midwifery students. There were 10 EN, 5 EM, 8 RN, 3 RM and 1 Operating Theatre Schools in the country. Nurse educators were included in the study in order to establish their perception of nurse migration impact. Registered and enrolled nurses differ by way of their training and professional career progression. Registered and enrolled nurses obtain their qualification after undergoing three year and two year educational programmes respectively. Both enter nurse education and training after twelve years primary and successful secondary school education (grade 12) although the entry qualifications for the RN candidates are higher.

Registered nurses serve as a pool for post basic nursing education candidates. Among the post-basic nursing education programmes in the country are midwifery, registered mental health nursing, operating theatre nursing and university degree in nursing. Some of these become nurse educators as lecturers or tutors. They also progress to management and other nursing leadership positions in a variety of settings. From experience, registered nurses also progress along promotional ladders with or without university preparation particularly in clinical settings. The health facilities where nurses work are distributed in the nine provinces of the country. The provinces have a total of 73 districts.

### **3.4 SAMPLE AND SAMPLING PROCEDURE**

#### **3.4.1 Sample**

The following were the study sample for *primary data*:

- *Health workers*

These were nurses, policy makers at ministry of health, directors and nurse managers at provincial and district levels of the public health care system.

- Nurses seeking verification of their qualifications for purposes of registering and working outside the country
- Nurse migrants visiting Zambia at the time of data collection

The following were the study sample for *secondary data*:

- Nurses whose names were on the GNC records as having verification of their qualifications sent outside the country in the last 10 years; January 1995 December 2005.

For *quantitative* data, the study sample was obtained through multistage sampling in order to narrow down the nine provinces to two, the districts in the two provinces to four and the health facilities to four with one per district, until the level where there were clusters of nurses was reached (see figure 1). At this level, samples per each stratum were 50% nurses and 50% nurse educators. Polit and Beck (2004:300) argue that there are no simple formulas that can indicate how large a sample is needed in a quantitative study. The two maintain that the larger the sample, the more representative of the population it is likely to be, and that smaller samples tend to produce less accurate estimates than larger ones; thus the larger the sample, the smaller the sampling error.

For the *qualitative* data, there were 33 participants in the four focus groups discussions; one per district with eight in the first, nine in the second, ten in the third and six in the fourth groups respectively. The key informants interviewed comprised one policy maker at national and 4 directors at district levels (1 per district).

### **3.4.2 Sampling Procedure**

Williams (2003) refers to sampling as a more formal process of selection and a search for typicality; and further refers to selection as implying the most suitable choice, for whatever purpose.

### *Quantitative data*

A *multistage sampling* approach was adopted for this study. According to Bless and Higson-Smith, (1995), the principle underlying multi-stage sampling is to start by sampling a population which is much more general than the final one. These authors explain that in the second stage, on the basis of the first sample, a new population is considered, one that is less general than the first one, and a new sample is subsequently determined. The procedure is continued until the population to be investigated is reached and a final sample is drawn. At each stage, sampling is done in a random way (p.93). In this study, the approach that was used first selected the provinces, then the districts from the selected provinces, followed by the health facilities in the districts that participated in the study.

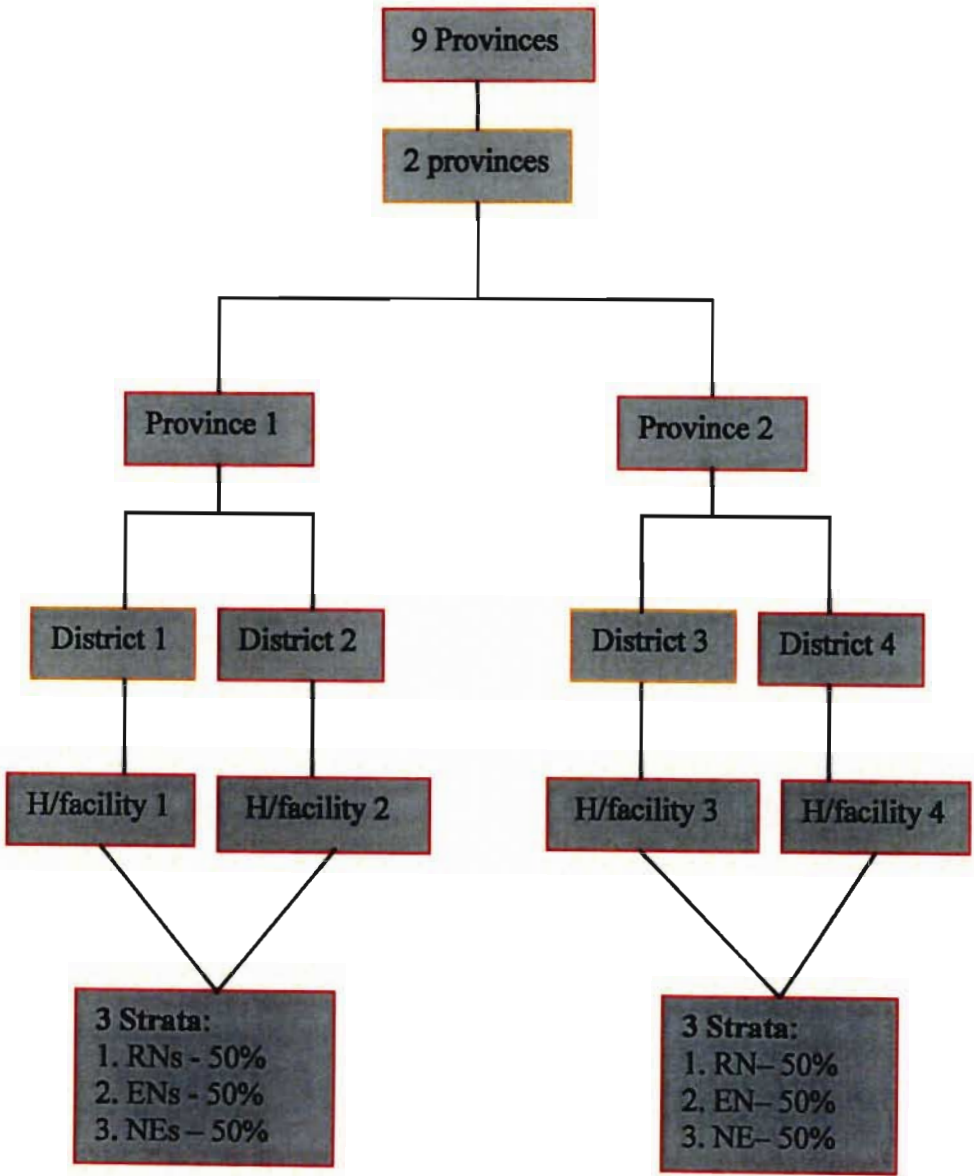
The first stage in the multistage sampling in this study involved random sampling of 2 provinces from the country's total of 9. In the second stage, 2 districts were randomly sampled from each of the 2 provinces. The total number of participating districts was thus 4. In the third stage, a total of four health facilities were *purposively* selected, thus one health facility per district. The multistage sampling approach was used only up to the health facility level where there were clusters of nurses within the health care facilities. At this stage, *stratified sampling* method was used to select study participants (Figure 1).

According to Bless & Higson-Smith (1995), the principle of stratified random sampling is to divide a population into different groups called strata, so that each element of the population belongs to one, and only one stratum. Then, within each stratum, random

sampling is performed using either the simple or the interval sampling method. According to these researchers, simple random sampling, or even systematic random sampling in its purest form is seldom used in social sciences research because it is cumbersome for large populations, but it becomes a useful tool when used as part of other random sampling techniques, such as stratified sampling methods.

In this study, each of the populations of nurses in the four districts that were selected was divided into three strata of registered nurses, enrolled nurses and nurse educators. Nurse educators comprised tutors or lecturers and clinical teachers working as school staff and nurses attached to schools to assist either with classroom or clinical teaching on part time basis. This method was used in order to enhance representation of the nurses in the study. A list of nurses at each respective health facility and school saved as a sampling frame. There were three lists; one for registered nurses, the second for enrolled nurses and the third for nurse educators. Within each stratum, a random sampling method was used to select participants for the study (Bless & Higson-Smith, 1995).

**Figure 3.1: Summary of the Sampling Strategy for Quantitative data: Multistage Sampling Method**



**KEY**

- H/Facility - Health Facility
- RNs - Registered Nurses
- ENs - Enrolled Nurses
- NEs - Nurse Educators

Records of nurses with verification of their qualifications sent to other countries during 1995-2005 were stratified into two strata of registered and enrolled nurses. *Systematic random sampling* was used to select records of nurses whose verification of their qualification were sent outside the country in the last 10 years from each stratum of nurses. These records were kept by the General Nursing Council of Zambia (GNC), the professional regulatory organization for nurses responsible for the setting of standards in nursing education and practice and for the registration of nurses trained both outside and within the country. The GNC full mandate is embodied in the Nurses and Midwives Act No 31 of 1997. One of its roles in maintaining standards for nurses wishing to register with other nursing councils or regulatory institutions is to verify the qualifications of individual nurses upon request, through written statements or completion of verification forms (Nurses & Midwives Act, 1997). Apart from registers for nurses, according to this Act, the GNC is expected to maintain a record of its transactions among which are records on verifications which are sent to respective nursing councils or countries. Nurses normally apply for such verifications and pay a fee to support the processing and postage of the verification statements.

#### *Qualitative data*

*Purposive sampling* was used to select between six to ten informants per each of the four respective focus group discussions (1 per district) that were conducted in the four selected districts.

*Purposive sampling* method was used to select a total of five directors, one per each of the four districts, and one at national level for focused interviews, because, according to experience, individuals at provincial and district director's level were responsible for the

management of their respective districts and provinces respectively and had experience with issues associated with recruitment and deployment of nurses in their areas. The same applied to the director's national level role of policy and deployment of nurses. According to Silverman (2002), purposive sampling allows the researcher to choose a case because it illustrates some feature or process in which the researcher is interested. Silverman (2002) also argues that provided the researcher has thought through the options, it is unlikely that the selection will be criticized, and states that sampling in qualitative research is neither statistical nor purely personal, but that it is, or should be theoretically grounded. The purposively selected sample of participants provided data on nurse migration and its perceived impact, a phenomenon that was grounded in the conceptual framework developed and adapted for this study.

*Snowball* method was used for sampling of 13 nurses who had migrated to other countries and were in Zambia at the time of data collection. Each of these was asked to identify others who had worked outside the country and were in Zambia at the time. These nurses were interviewed until data saturation was reached. According to Fink (1995), snowball sampling is a method where previously identified members identify other members of the population. The method is used in a situation where it is not practical to obtain a list of members of a population. In this study, it was not possible to obtain a list of the nurses who had migrated and had come to Zambia for visiting or other reasons.

### **3.4.3 Quantitative Data**

#### *Multistage sampling*

The following were the stages followed in multistage cluster sampling of clinical nurses and nurse educators who participated in the study:

*Stage 1:* Two provinces were randomly selected from a total of nine.

*Stage 2:* Two districts per each selected province were randomly selected to obtain a total of 4 districts

*Stage 3:* One health facility per each selected district was purposively selected for the study (a total of 4 health facilities).

*Stage 4:* Nurses in each of the four selected health facilities were stratified into three strata of nurses. The first stratum comprised registered nurses, the second enrolled nurses and the third nurse educators comprising lecturers or tutors and clinical teachers.

#### *Systematic random sampling*

Systematic random sampling was used to select nurses and nurse educators who participated in the study.

Records on all nurses issued with verification of their qualifications in the last ten years (from General Nursing Council of Zambia) were stratified into two strata of registered and enrolled nurses respectively. Systematic random sampling was used to select 50% of records for enrolled and 50% for registered nurses for the study.

### **3.4.4 Qualitative data**

- *Snowball Sampling* – 13 Nurses who had earlier left the country were identified at time of data collection.
- *Purposive sampling* – Nurses seeking verification of their qualifications between January and December, 2006.
- *Purposive sampling* – participants for each of the four focus groups
- *Purposive Sampling* – five directors: one provincial, three district, one director at national level

## **3.5 DATA COLLECTION PROCESS AND INSTRUMENTS**

### **3.5.1 Data collection instruments**

This part describes the data collection instruments. These were developed for this study by the researcher and had therefore never been used before.

#### *Checklists for capturing data from GNC records - Annex 1*

A checklist was used for capturing data from records of nurses with verifications sent outside the country. Polit and Hungler (1997) refer to checklists as tools for recording the appearance, frequency or duration of pre-specified behaviors, events or characteristics and are based on the development of 'category systems' for encoding the observed phenomena. The checklists in this study were for capturing the characteristics of nurses whose names appeared on the records of nurses issued with verification of their qualifications by the GNC. The checklists included biographic and professional data. Other information included the recorded country where the verification was sent.

*Interview guide: for nurses seeking verifications of their qualifications from the GNC with intentions to register and work outside the country– Annex 2.*

This instrument had parts on the respondents' demographic data, family responsibilities with regard to number of children and dependants to demonstrate respondent centeredness of the data collection. Bless and Higson-Smith (1995) argue that researchers should always take into account the needs, interests and problems of respondents in the design of questionnaires or interview as these are more important than the academic factors. This was even more important to nurses who were intending to leave the country and this facilitated enhancing the researcher's understanding of the respondents and their desire to migrate.

In addition, the tool had sections on professional data as well as qualitative data on nurse migration with broad questions on why the nurses wished to leave their jobs and the country, where they intended to go, why they had chosen the country of their intended destination and what would make them change their minds and stay to work in Zambia.

*Interview guide for interviewing nurses who had migrated and were in Zambia during data collection - Annex 3.*

The tool had parts which sought demographic data and professional qualifications of respondents. The second part was on qualitative data, with a broad topic guide that was used to collect data on nurse migration with broad questions on why nurses resigned from their employment, why they left the country and why they chose the country of their destination and how long they intended to stay in the destination countries. According to

Polit and Hungler (1997), a broad topic guide and broad questions facilitate covering all questions. Many scholars (for example Krueger, 1994; Lincoln & Guba, 1985; Mason, 1996) in qualitative research recommend that qualitative researchers should be conscious of the need to develop research questions which can generate meaningful and useful data. The interview guide used in this study was comprehensive with open-ended questions that enabled nurses to conceptualize their perceptions and opinions in using their own words. Open-ended questions minimized the occurrence of leading or directing respondents to answer questions in a particular manner (Brenner et al., 1985; Rubin & Rubin, 1995).

*Topic guide for focus group discussions with clinical nurses and nurse educators - Annex 4.*

The topic guide was broad facilitating questions on why the nurses had stayed while others had migrated. The questions were also on how the nurses perceived nurse migration impact on the public health care system, which included their work, workload, quality of care and attitude and on the teaching and learning of students. Polit and Hungler (1997) state that a topic guide or written format set of questions guides focus group discussions. These questions were used to guide the discussions and obtain qualitative data from the focus group participants.

*Two self-administered questionnaires completed by clinical nurses and nurse educators respectively – Annex 5.*

These instruments were almost similar except that one targeted the nurses in the clinical settings and the other the nurse educators. They both had questions on demographic data, professional data, workload data and respondents' level of responsibilities. Respondents

were requested to complete the instruments themselves respectively in a paper-and-pencil format. Polit & Hungler (1997) point out that in a structured or standardized instrument, the respondents are asked to respond to exactly the same questions in exactly the same order and are given the same set of responses for their responses. These authors further assert that the purpose of using questions with such a high degree of structure is to ensure comparability of responses and to facilitate analysis. The instruments in this study consisted of closed and open-ended questions. Although, according to these authors, closed-ended questions are more difficult to construct, they are easier to analyze than open-ended questions that, on the other hand, are easier to construct. Closed ended questions are easier to complete in a questionnaire and are less time consuming on the part of the respondent although on the other hand, open-ended questions allow for a richer and fuller perspective on the topic particularly if the respondents are verbally expressive and cooperative (Polit & Hungler, 1997). Such structured closed and open-ended questions were included in this instrument which allowed the respondents to respond to the same questions in their own words in written. This enabled the researcher to compare the respondents' characteristics and professional data.

*A semi-structured questionnaire for interviewing policy makers - Annex 6.*

This instrument was an interview schedule. The instrument is known as the interview schedule when the questions are asked orally in face-to-face or telephone format (Polit & Hungler, 1997). The instrument had questions on the participants' demographic data, their perceptions on the impact of nurse migration on the public health care system and policy issues on management of nurse migration. The instrument had closed and broad

open-ended questions. The broad open-ended questions allowed participants to express themselves in responding to the questions on their perceived impact of nurse migration.

### **3.5.2 Pilot study**

According to Polit and Beck (2004), the purpose of a pilot study is to test protocols, data collection instruments and other aspects of the study in preparation for a larger study. In this study, each of the data collection tools was pre-tested before finalization. For the checklists, the first 10 GNC records of nurses with verifications sent to other countries for the year 1994 were used to test the instrument. These records were selected because they were not included in the study as the study focused on the 1995-2005 records. There were no problems observed with the instrument and no adjustments were thus made.

For the structured questionnaires, four clinical nurses from a health center and two nurse educators responded to the self-administered instruments respectively. The interview guide for both focused interviews and focus group discussions were tested with two and four nurses from a second health center respectively before finalizing the tool. For each of the tools, it was found necessary to indicate the word 'migration' in brackets wherever 'nurses leaving for greener pastures' appeared as two of the questionnaire respondents sought clarification on whether 'migration' was the same as 'nurses leaving for greener pastures'. This was done before finalizing the tool. The instrument targeting migrant nurses who were in Zambia at time of data collection was tested on the first two visiting respondents. These were not included in the study. It was found necessary from the

preliminary themes that had begun to emerge to add two questions directed at returnee nurses. These were:

- Their experiences while outside the country.
- Advice, if any, to other nurses who had not yet migrated.

### **3.6 DATA COLLECTION PROCEDURE**

Data were collected in four phases in accordance with the objectives of the study as follows:

#### **3.6.1 Phase 1: Objective 1**

This phase was implemented from February to July 2006 and had three activities.

i) The first phase involved training of two data collectors that were identified to collect data from the GNC records. For purposes of safeguarding information on records, the two young school leavers were identified because they had worked for the GNC before on short term contracts and their work had been related to handling of nurses' information including their applications for registration and other formalities. This meant they had prior knowledge on the need for confidentiality of nurses' personal and organizational information and other requirements. However, the two were still trained on the techniques of data collection and the need for confidentiality of the research data. This part took longer because the GNC had just completed a re-registration exercise for nurses aimed at streamlining management of their information system. The old records, which were of interest to the researcher, had not been re-organized for appropriate storage.

ii) The second part involved a process of rearranging all the registered and enrolled nurses' paper files, according to dates of the nurses' first registration and going through them to select those with records on sent verifications dating between 1995 and 2005.

iii) Since the paper files for registered and enrolled nurses were identified by their color, the arrangement was convenient for conducting a systematic random selection of 50% files for the study from the enrolled nurses' files and 50% from registered nurses' files respectively. Data collection began after this process. This formed the third activity of this phase.

The study thus used the record method of collecting data on nurses who had verifications sent outside Zambia. According to Bless & Higson-Smith (1995), the record method is a non-reactive research method in which information about the respondent is gathered without direct interaction by use of public documents. In this method, respondents were not aware that they were the subjects of a study and this eliminated some biases. However, according to these two authors, use of this method is endangered by other sources of error. For example, records used may contain institutional biases. Other sources of error are erratic record collecting and keeping, the secrecy of certain data and lack of information on the actual way in which the recorded data was collected and the bias introduced by the person who collected the data. The researcher had knowledge about the manner in which information on nurses seeking verification was recorded by a person trained in recording and record keeping. All processed verifications were sent to countries of nurses' choice unless in situations where the applicants specified the collection of their verifications. Method of postage or collection of verifications was

specified in the personal records of respective nurses. The meticulous recording of details on verifications minimized errors and biases. Although the participants were not aware about their participation in the study, the researcher ensured confidentiality of all data that was collected through coding of selected files which made it possible for reference in cases where further clarity of information became necessary.

### **3.6.2 Phase 2: Objectives 2**

This phase had two activities that were carried out simultaneously from November 2005 to May 2006. The period included the festive season during which some migrant nurses were expected to visit Zambia:

*i) Data from nurses seeking verifications* – Data were collected from nurses who were seeking verification of their qualifications from January to May 2006 to find out why they intended to leave the country, where they intended to go and why, and what would make them change their minds and stay to work in Zambia. From experience, nurses seeking verification of their qualifications apply for such verification from the GNC and make follow ups for the result either in person or through their relation. Verifications statements are either posted to countries of the nurses' choice by GNC or are collected for postage by the applicants. It was during the visits to the GNC that nurses seeking verifications were identified and permission sought from them for interviews at a time that was convenient to them. These interviews were conducted in one of the GNC offices because the arrangement was convenient to the participants and the researcher. The researcher interviewed the respondents after obtaining their consent. The researcher took

notes and tape recorded the interviews, ensuring that the tapes were labeled for ease of reference, using codes.

*ii) Data from visiting nurses* - Collection of data from migrant nurses who were in Zambia was conducted through focused interviews from November 2005 to February 2006. Polit and Hungler (1997) point out that focused interviews are used when a researcher has a list of topics that must be covered in an interview and that the questions are of the type that encourage conversation rather than yes and no responses. In this study, a semi-structured instrument was used to guide the interviews. A list of broad question areas in the instrument ensured that all questions were covered. The researcher's role was to encourage participants to talk freely about all the topics listed in the instrument (Polit and Hungler, 1997 p.255). The interviews were tape recorded and notes were taken during interviews.

### **3.6.3 Phase 3: Objectives 3, 4, 5**

There were two activities conducted from June to September 2006; distribution and collection of the completed questionnaires and focus group discussions.

*i) Distribution and completion of self-administered questionnaires* - The researcher travelled to all the four study sites. At the first site, the researcher distributed the questionnaires and collected them after their completion. A research assistant at each of the three study sites was trained and took responsibility for the distribution of the self-administered questionnaires to the clinical nurses and nurse educators and ensured their completion and safe return. Data collected was on the perceived impact of nurse

migration on the public health care system and why some nurses had stayed while others had migrated.

ii) Four focus group discussions with 8, 9, 10 and 6 members per group were conducted in the four study sites respectively. Focus group discussions are groups of about 5 to 15 people (Polit and Hungler, 1997). The groups comprised nurses working in the clinical areas and nurse educators. These discussions enlisted information on the perceived impact of nurse migration on the public health care system that could not be obtained through the self-administered questionnaire. The discussions offered participants free expression of their feelings and perceptions on nurse migration and its impact. A set of questions guided the group discussions. The questions included how nurse migration had affected their work in terms of workload, quality of patient care and teaching and learning of students, and how nurse migration could be managed in the interest of both the nurses and the country, and why some nurses had not migrated.

The researcher moderated and guided the discussions using a topic guide. The advantage of this method was that it was efficient and generated a lot of dialogue (Polit and Hungler, 1997). The researcher encouraged participants to express themselves during the discussions in order to obtain data that could not be obtained through the questionnaire.

### **3.7 DATA ANALYSIS**

There were two sets of data collected for the study; quantitative and qualitative.

#### *Quantitative data analysis*

The researcher used descriptive statistics to describe and synthesize quantitative data (Polit & Beck, 2004). Quantitative data comprised demographic, professional and data from closed questions in the semi-structured instruments as well as data from the self-administered questionnaires for clinical nurses and nurse educators. Data were analyzed using Statistical Package for Social Sciences (SPSS) version 11.0 using percentages, frequencies and averages. According to Polit and Beck (2004) statistical procedures enable researchers to summarize, organize, evaluate, interpret and communicate numeric information. Quantitative data from this study were presented in tables, figures and graphs.

#### *Qualitative data*

Data from focus group discussions and focused interviews were analyzed by putting them into themes, patterns and codes using Nvivo7 qualitative soft ware. This package was used because it has more flexibility within it when compared to other packages and offers advanced modeling facilities (Lacey & Luff, 2001).

### **3.7.1 Validity and Reliability for quantitative data**

Reliability for quantitative data:

Williams (2003) suggests that reliability can be improved through training of interviewers and matching them to the appropriate populations, through consistent check of data entry, and mostly through testing of the questionnaire and items in it. In order improve reliability in this study, the data collection instruments were piloted on members of the target populations; in this case clinical nurses, nurse educators and directors and thus were pre-tested and refined before use in the survey. Furthermore, data collectors were trained to ensure that they understood and were able to interpret the questionnaire

content and meanings of words and concepts. This was supported by continuous data entry checks during the data management process to enhance reliability of the data.

### **3.7.2 Validity for quantitative data**

Validity is an important criterion by which the quality of a quantitative instrument is evaluated and is referred to as the degree to which the instrument measures what it is supposed to be measuring (Polit and Hungler, 1997). According to Bless and Higson-Smith (1995), it is important that a measurement technique is closely linked with known theory in the area of study and with other related concepts, and that where such close links could be demonstrated, the data collection instrument could be said to have high construct validity as the opposite is the case when the links between the instrument and the related theory are very weak (Bless & Higson-Smith, 1995). To enhance validity in this study, the data collection instruments were constructed in relation to the conceptual framework developed from two migration theories that guided the study. The questions in the instruments targeted to enlist data from respondents in accordance with the theories-based conceptual framework regarding what had attracted nurses to their respective destination countries, why they had left or wished to leave their employment positions, why they had left or intended to leave their country and how these factors could contribute to nurse migration policies.

### **3.7.3 Truthfulness in qualitative data**

Silverman (2002) refers to validity as another word for truth while Hammersley (1990) defines validity as the extent to which an account accurately represents the social phenomena to which it refers. Lincoln and Guba (1985) refer to trustworthiness as

another way of clarifying the notion of objectivity as it manifests in qualitative research and for these researchers, trustworthiness is the key principle of good qualitative research which they clarify as meaning neutrality of its findings or decisions.

This study undertook *triangulation* to demonstrate academic rigor and to enhance truthfulness of the data. Triangulation means gathering and analyzing data from more than one source to gain a fuller understanding of the phenomenon under investigation (Lacey & Luff, 2001). Silverman (2002) refers to triangulation as an attempt to get a true fix on a situation by combining different ways of looking at it or different findings. The researcher used multiple methods of data collection as a way of gaining different insights into the same phenomenon of nurse migration. The data collection methods included self-administered questionnaires, focused interviews using semi-structured questionnaires and focus group discussions. Miles and Huberman (1984) also recommend use of multiple sources of information to triangulate the qualitative data.

The researcher also undertook measures to enhance trustworthiness. Babbie and Mouton (2002) refer to credibility, transferability, dependability and conformability as ways of operationalizing trustworthiness. According to these two researchers, credibility is achieved through *prolonged engagement*, meaning staying in the field until data saturation occurs. To enhance reliability in qualitative data, the researcher spent sufficient time with the participants to check for discrepancies in the responses, and verified the accuracy of participants' responses (*member checking*) and explored each participant's responses meticulously (Lincoln & Guba, 1985). To maximize validity in qualitative research, Scott (1995) recommends accurate reporting and representation of participants'

responses while Babbie and Mouton refer to *referential adequacy*; referring to what materials are available to document findings.

During data collection, the researcher stayed in the field until there were no more new themes in the data being collected or until *data saturation*. In addition, interviews and focus group discussions were tape-recorded and detailed notes were taken throughout to ensure availability of materials for documenting findings. Information and the interpreted data were checked with selected informants to correct any obvious errors. Regarding transferability, that is, the extent to which the findings could be applied to other contexts or with other respondents, Guba and Lincoln (1994) suggest purposive sampling as another way of achieving this because this sampling method involves purposively selecting informants and locations that differ from one another. Their argument is that this method maximizes the range of information that can be obtained. This fitted well in this study as the key informants for focused interviews and the participants in the focus group discussions were purposively selected and in different provinces and districts.

On the question of *dependability* of the data from this study, Guba and Lincoln (1994) argue that since there can be no validity without reliability (and thus no credibility without dependability); a demonstration of the former is sufficient to establish the existence of the latter. The other argument by Babbie and Mouton (2002) is that if it is possible using the technique outlined in relation to *credibility* to show that a study has that quality, it ought not to be necessary to demonstrate dependability separately. This study therefore demonstrated credibility in view of its methodological arguments that have been advanced.

## **3.8 ETHICAL CONSIDERATION**

### **3.8.1 Ethical clearance**

In order to conduct this study, the researcher first sought the written permission of the University of KwaZulu-Natal Research Ethics Committee, Durban, South Africa and the University of Zambia Research Committee, Lusaka, Zambia. Other permission sought were the Ministry of Health, who are responsible for the overall public health services and health institutions and to whom the provincial and district health care facilities are accountable for health delivery to the respective populations and the health facilities and General Nursing Council of Zambia. Informed consent was obtained from all the nurses and policy makers who participated in the study. To enhance confidentiality, as recommended by Babbie and Mouton (2002), data collectors were given training in their ethical responsibilities and emphasis was placed on the importance of being clear in differentiating confidentiality from anonymity, as the two are not the same as recommended by Babbie and Mouton (2002).

### **3.8.2 Informed consent**

The researcher ensured that respondents were not coerced into participating in the study. Information about the visits to the study sites was given in advance. At each selected health facility, the researcher met with key individuals in management to provide information on the study, its purpose and the process of selection of study participants and data collection. These discussions also provided opportunities to clarify questions and issues pertaining to the study. Management at each health facility requested evidence of authority from the Ministry of Health to conduct the study and ethical clearance. Copies of an authority letter from the Permanent Secretary, Ministry of Health and the

ethical clearance letter from the University of Zambia were submitted. In view of this, the purpose, merits and de-merits of the study were explained to individual participants and groups, making it clear that each had a right to refuse to participate or to even withdraw in the process of their participation. The researcher further explained to each selected participant that in cases where they would decide to withdraw from the study, they would not be penalized but would continue to be respected in every way. The researcher also mentioned that the same would apply to individuals who would refuse to participate in the study. The researcher indicated that the participants had such rights which, if exercised, would be upheld and respected. Respondents were informed that the information they were giving would be tape recorded and also recorded in notes form and that their privacy and sensitivity would be protected including what was going to happen to their information after being recorded (Henning, 2004). Upon giving all the explanations and assurance of confidentiality, the researcher ensured that each participant gave written informed consent only when they were willing to do so.

Bless and Higson-Smith (1995) advocate that people should agree before they are subjected to research and consent must be obtained to indicate their willingness to participate in the study. Clarifying the importance of informed consent, Williams (2003) explains that those being researched not only know that they are being researched, but also that they should be able to comprehend why. In this study, the information given to participants included the purpose of the study and its potential merits for health care and the country. The relevant information on consent is attached. In addition, the consent form signed by respondents was attached to each data collection tool.

### **3.8.3 Anonymity**

Names of respondents were not recorded to ensure their anonymity and avoidance of biased responses. Instead, use of numbers as codes was considered adequate for identification of respondents. Respondents, according to Bless and Higson-Smith (1995), regard anonymity as essential, and that to avoid biased responses from participants; they must be convinced that anonymity would be respected. Participants were selected and treated in a way that minimized risks of their being identified as having given information which might be sensitive but valuable to the study goals. For example, provinces, districts and health facilities selected for the study are identified by numbers as province 1 and 2; districts 1,2,3,4, and health facilities 1,2,3,4, respectively for anonymity because they were few and the key study participants are were known and are likely to be identified.

### **3.8.4 Confidentiality**

With regard to situations where anonymity could not be maintained, like in the case of data from interviews where the researcher had to re-check the information with key informants for clarity, the respondents were assured that information that they gave would be kept in strict confidence, and that the data would be used for the given purpose.

According to Bless and Higson-Smith (1995), when the respondents are assured of these conditions, they feel free to give honest and complete information. To enhance confidentiality, as recommended by Babbie and Mouton (2002), data collectors were trained in their ethical responsibilities. These authors also emphasize the importance of being clear in differentiating confidentiality from anonymity, as the two are not the same.

To enhance confidentiality, addresses and names were not recorded on the questionnaires and identification numbers were used instead with a master identification file that was created to link the numbers to names to allow correction of missing or contradictory information and this information was kept in confidence (Babbie and Mouton, 2002).

### **3.9 LIMITATIONS OF THE STUDY**

There were two major limitations in this study. The first was that it was the researcher's part of the research plan to collect data on nurses issued with visas to travel to their destination countries and work permits that allowed them to work in the respective countries. These data were meant to measure the extent of nurse migration in Zambia and were expected to provide figures on actual numbers of nurses leaving for greener pastures. The data were to be collected from records of embassies or high commissions of the respective countries as these, from experience, are responsible for visa issuance to individuals or groups traveling to or recruited for employment in their respective countries. Permission letters with copies of the research proposal were sent to the various embassies, namely, Australia, Botswana, South Africa, Swaziland, United Kingdom, and the USA. However, none of the embassies gave permission for collection of such data from their records. Responses from the embassies of Botswana, South Africa, the United Kingdom and the United States of American are appended to this study. There were no responses received from the other embassies or country high commissions.

The second limitation of this study is that data on nurse migration were collected from within the county, that is, from nurses who were visiting Zambia or had come back as returnees at the time of the study. It would have been preferable to obtain the data from

the nurse migrants while in their host countries. However, despite this limitation, the information that was collected was not of less value. The study was based on the assumption that nurse migrants who were visiting the country or had come back without intentions of going back to their destination countries would still provide the same information regarding their migration in terms of why they had left their employment and left the country and what had attracted them to the destination countries.

### **3.10 CONCLUSION**

This chapter described the study design with the various methodological approaches to the collection of data. Denzin (1989) advocates for triangulation which this study used. He states that by combining methods in the same study, researchers can partially overcome the deficiencies that flow from one method. The data collection tools and the various phases of the data collection process were described in detail.

## **CHAPTER FOUR**

### **FINDINGS**

#### **4.1 INTRODUCTION**

This chapter focuses on the results which are described based on the four main study objectives namely the extent of nurse migration in Zambia, why some nurses leave the country and why others stay, the impact of nurse migration on the public health care system as perceived by respondents and measures that would inform policy on management of nurse migration.

The quantitative and qualitative results are presented in accordance with the responses obtained from the various data sources in the study. The data sources for this study included a check list that captured recorded information for each nurse that applied for verification of their training and had the verification information sent to countries of their choice by the General Nursing Council of Zambia and two self administered questionnaires for clinical nurses and nurse educators respectively. Other sources were focused interviews of nurses who had migrated and were in the country during data collection, nurses seeking verifications of their qualifications at the time and focus group interviews of both clinical nurses and nurse educators.

Both quantitative and qualitative results are presented. Joint Learning Initiative (2004) attests the use of both quantitative and qualitative data in migration studies particularly

from the African continent and argues that quantitative data alone do not tell the complete story of Africa's migration crisis as the qualitative effects are even more severe. The first part of the results focuses on findings from quantitative data followed by results from the qualitative data analysis. The presentation of findings is made in the format of tables and graphs each with preceding descriptions. In the main results from the qualitative data analysis, data are presented in narratives, elaborating the themes and sub-themes from the findings and supported by relevant illustrative quotes and excerpts to enhance clarity and understanding of the findings, where available.

## **4.2 PRESENTATION OF RESULTS**

### **4.2.1 Quantitative data**

Quantitative data were from the following sources:

- General Nursing Council (GNC) records of nurses who had applied for verification of their qualifications and had the verifications sent to countries of their choice
- Nurses who were applying for verification of their qualifications and visiting the Council following up on outcome of their applications. Nurses who participated completed the first part of a semi structured questionnaire and were interviewed using a question guide in the second part.
- Nurses who had migrated to other countries and were visiting Zambia at time of data collection and were interviewed
- Nurses who had migrated to other countries and had come back to settle in Zambia and were interviewed

- Nurses working in the public health facilities in Zambia completed a self administered questionnaire on the impact of migration on the public health care system
- Nurse educators working in government institutions on the impact of nurse migration on education and training of nurses.

#### ***4.2.1.1 Data from verifications records***

##### *Characteristics of nurses with verifications sent to countries outside Zambia*

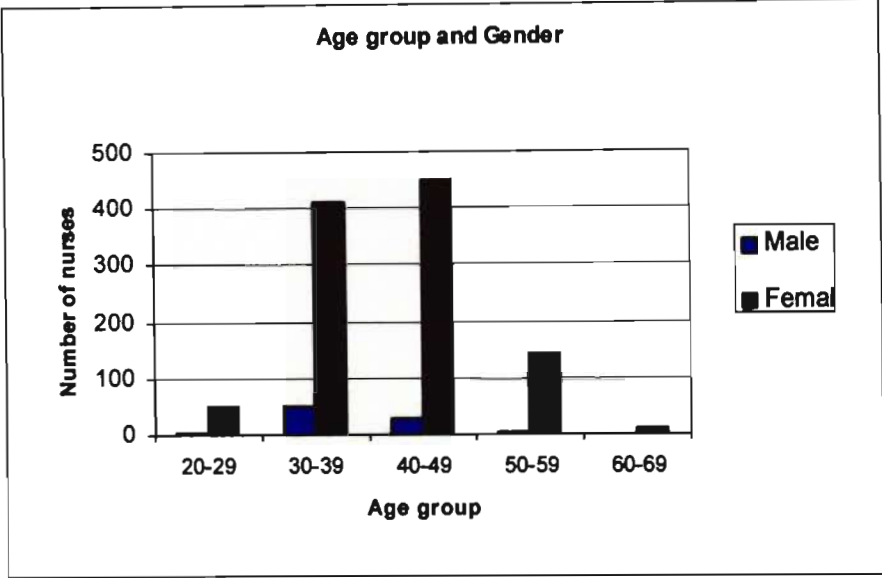
Of the 1142 records of nurses in the sample who had their verification of qualifications sent to countries of their choice by the Nursing Council of Zambia between 1995 and 2005, 1059 (93%) were females while 83 (7%) were males (Figure 4.1).



**Figure 4.1 Gender of Nurses with verifications sent outside Zambia (n=1142)**

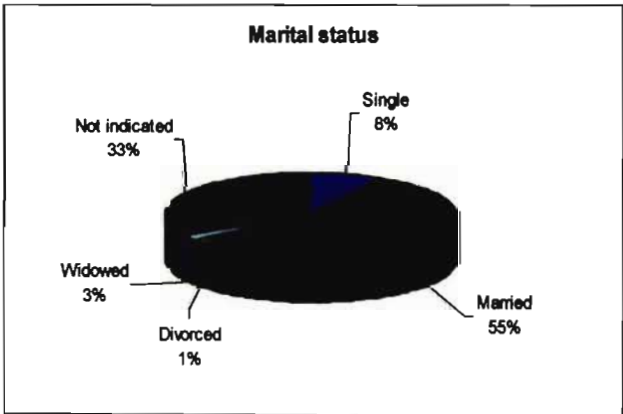
Regarding the ages of the nurses in the sample, results in Figure 4.2 indicated that these ranged from 20-69 years with the majority of 477 (42%) being in the 40-49 age category followed by a total of 458 (40%) of those aged 30-39 years. The older nurses aged 50-59 years and 60-69 years were 144 (13%) and 11 (1%) respectively. Nurses in the 20-29 age group who had their verifications sent outside the country were fewer (52). The 60-69 years group comprised 11 (1%) of the sample, the least among the age groups.

The data in Figure 4.2 show gender and age of the nurses in the sample of records. Of the 1142 nurses, 83 (7%) were males and 1059 (93%) females. The number of both male and female nurses combined was highest (477) in the 40-49 age group, comprising 28 males and 449 females. These figures indicated 34% and 42% of the males and females in the sample respectively. The next highest number of nurses was 458 (40%) and this was in the 30-39 age category. Of these, 48 (58%) of the male nurses in the sample were in this age group while 410, showing 39% of the females were in this category. The 50-59 group showed 144 (13%) of the total number of nurses with 3 (4%) males and 141 (13%) females. The younger age group of 20-29 totaled 52 (5%) nurses with an equal percentage of 5% of the males and of the females respectively. The least number was among the older 60-69 group comprising female nurses only indicating 1% of the sample.



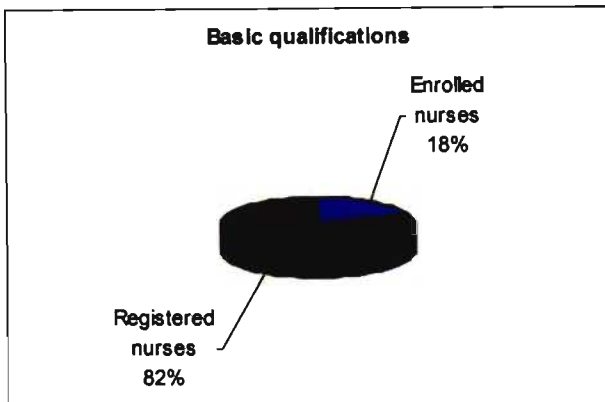
**Figure 4.2 Age group and gender of nurses who had verifications sent outside Zambia (n= 1142)**

According to the data in Figure 4.3 on marital status of the nurses in the sample, the results indicated that there were more married than single nurses. These comprised 55% and 8% respectively. Widowed and divorced nurses comprised 3% and 1% of the sample respectively. Results also showed that data on marital status of the nurses was not indicated in 33% of the sampled records.



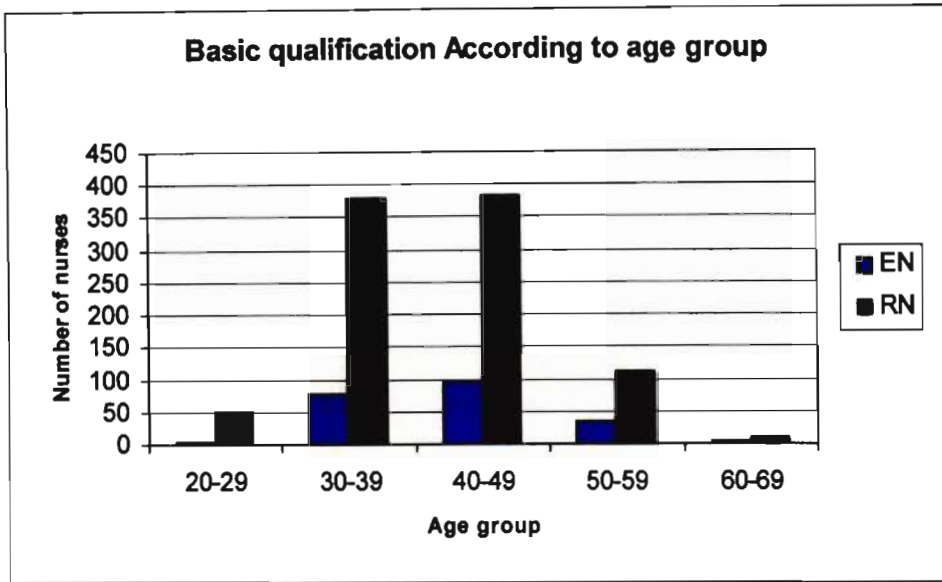
**Figure 4.3 Nurses' marital status (n= 1142)**

Figure 4.4 indicates that there were more nurses with basic qualifications of registered than enrolled nurses, each comprising 82% and 18% of the sample respectively.



**Figure 4.4 Nurses' Basic Qualifications (n= 1142)**

The findings in Figure 4.5 show that there were more registered nurses in all the age groups who had their verifications sent outside the country by the General Nursing Zambia. Out of the 1142 registered and enrolled nurses, the highest numbers were in the 40-49 age group for both groups with 382 (33%) and 95 (8%) enrolled and registered nurses respectively.



**Figure 4.5 Basic qualifications according to age group (n= 1142)**

Figure 4.6 represents results from further analysis of the qualifications which showed that out of 931 registered nurses with verifications sent outside the country, 482 were registered midwives with 113 operating theatre nurses and 26 registered mental health nurses. Nurses with degree qualifications comprised 42 Bachelor's and 4 Masters out of which 11 were tutors or lecturers. Of the 211 enrolled nurses, 133 comprised of enrolled midwives and 4 enrolled psychiatric nurses. Nurses with qualifications other than these were 239.

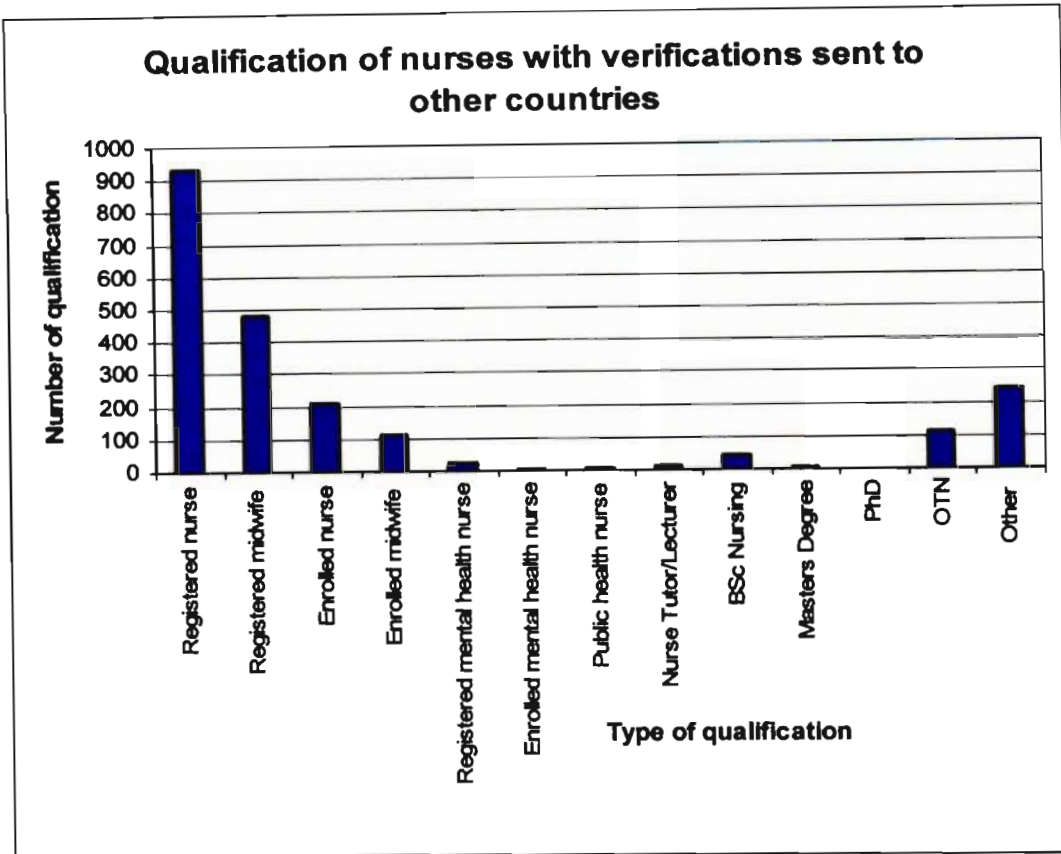
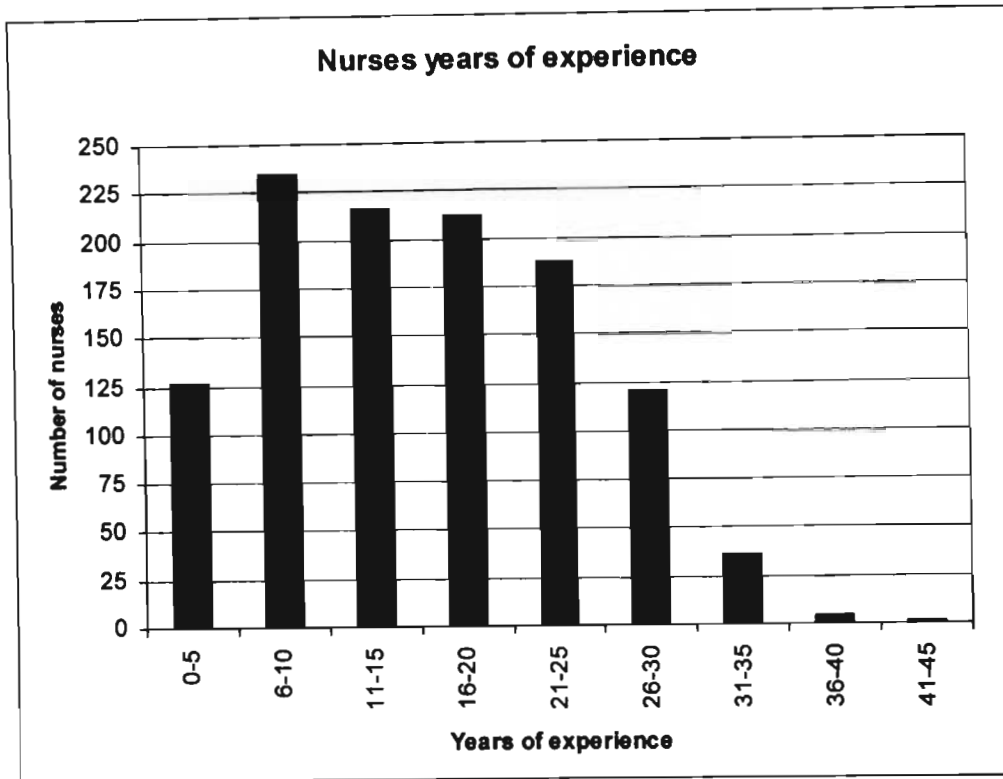


Figure 4.6 Qualifications of nurses with verifications sent outside Zambia (n= 1142)

**Nurses’ period of work experience**

With regards to work experience, most of the nurses (235) who constituted 21% had had 6-10 years work experience. According to findings displayed in Figure 4.7, nurses in the 11-15 and 16-20 years category of work experience were 216 and 212 respectively, each constituting an almost equal percentage of 19% of the sample. Thirty eight percent of the nurses had had 11-20 years work experience before their first verification was sent outside the country. Those who had worked between 21-25 years were 16%.



**Figure 4.7 Nurses' years of experience (n= 1142)**

The years of experience were further analyzed in relation to the basic qualifications of the nurses in the sample of records. As indicated in Table 4.1, 123 (13%) of the registered compared to only 4(2%) of the enrolled nurses had verifications sent to countries outside Zambia by the time they had worked for only 5 years or less. The highest number (235) of nurses with sent verifications was among those who had had 6-10 years experience, comprising 197(21%) and 38 (18%) of the registered and enrolled nurses respectively. This indicates 21% of the total number of nurses in the sampled records. However, as can be seen in Table 4.1, the number of nurses with sent verifications seemed to decrease with increase in years of experience.

**Table 4.1 Nurses' Experience in years by basic qualification (n= 1142)**

Experience in years	Basic qualifications		Total
	EN	RN	
0-5	4 1.9%	123 13.3%	127 11.2%
6 -10	38 18.1%	197 21.2%	235 20.7%
11 -15	45 21.4%	171 18.4%	216 19.0%
16-20	38 18.1%	174 18.8%	212 18.6%
21-25	37 17.6%	150 16.2%	187 16.4%
26-30	32 15.2%	88 9.5%	120 10.5%
31-35	13 6.2%	23 2.5%	36 3.2%
36-40	3 1.4%	1 0.1%	4 0.4%
41-45	- .-	1 0.1%	1 0.1%
Total	210 100.0%	928 100.0%	1138 100.0%

Table 4.2 summarizes the findings regarding the total number of verifications and the countries where they were sent. Of the 1944 total number of verifications sent to countries, 708 (36%), comprising the majority, were sent to the United Kingdom. Those sent to South Africa and Botswana were 328 (17%) and 300 (16%) respectively followed by 185 (10%) to New Zealand. Other verifications were sent to the United States (109) and Australia (94). Among the countries with the least verifications sent to them were Ghana, Malawi, Mexico and Uganda where data shows an equal number of one verification to each of these countries.

An important note to make in this table is that 1142 nurses sent 1944 verifications. This is because some of the nurses requested to have repeat verifications sent, particularly in situations of delayed responses from the respective countries.

**Table 4.2 Number of verifications and countries to which they were sent (n= 1142)**

Country	Total Number of verifications	Percent
United Kingdom	708	36.41
South Africa	328	16.87
Botswana	300	15.43
New Zealand	185	9.52
United States of America	109	5.60
Australia	94	4.83
Namibia	56	2.88
Swaziland	51	2.62
Canada	46	2.36
Ireland	29	1.49
Zimbabwe	14	0.72
Hong Kong	7	0.36
Kenya	6	0.30
Lesotho	3	0.15
Mexico	2	0.10
Ghana	1	0.05
Malawi	1	0.05
Republic of Maldives	1	0.05
Seychelles	1	0.05
Uganda	1	0.05
Not indicated	1	0.05
<b>Total</b>	<b>1944</b>	<b>100</b>

Results further revealed a tendency among the nurses to repeat applications for verification to the same countries. Table 4.3 shows the number of times that nurses

applied for verifications and had them sent to countries of their choice. All the nurses in the sample (1142) applied for and had their first verification sent.

On the question of where nurses chose to send their first verification, the United Kingdom appeared to have attracted most of the nurses with the intention of registering in that country. The United Kingdom had the majority of 431 (38%) followed by South Africa with 218 (19%), Botswana 172 (15%) and New Zealand 185 (16%). Australia, the USA and Canada had 52 (5%), 42(4% and 12(1%) verifications sent to them respectively. Looking at other countries in Africa, Namibia was in third place after South Africa and Botswana with 35 (3%) nurses whose first verifications were sent to that country. The least in terms of attracting nurses to their countries were Ghana, Lesotho, Malawi and Uganda with one verification sent to each one of them.

Repeated applications for verifications to same countries appeared to decrease with subsequent verifications as shown in the Table 5.3. Nurses who repeated applications to the same countries for the second time and had them sent were 503. Third and fourth time verifications to same countries were 195 and 64 respectively. As indicated in the table, the United Kingdom continued to attract the highest number of applicants in each repeat of verifications.

South Africa and Botswana attracted repeat applications with 30 and 22 verifications sent to these countries the third and fourth time verifications respectively. There were no

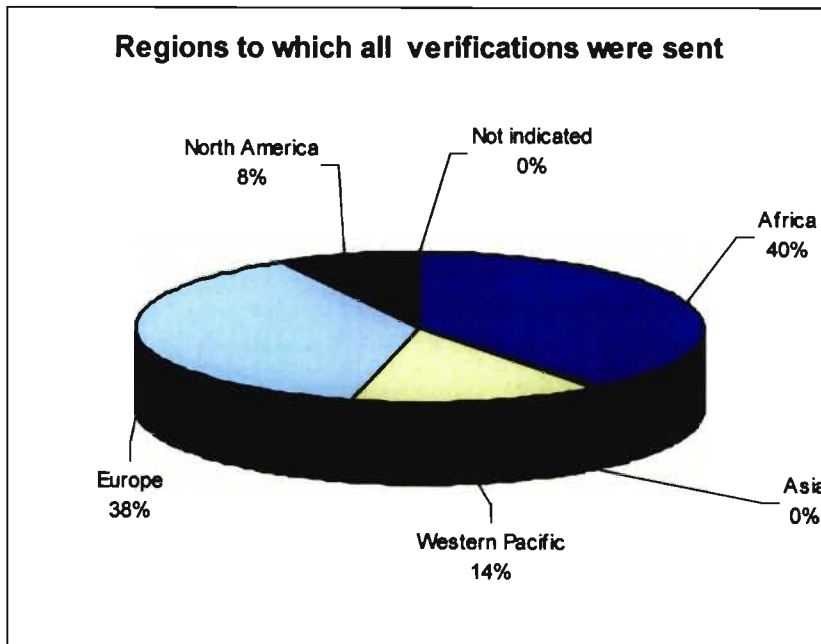
details regarding the country where the verification was sent for one application as indicated in the table.

**Table 4.3 Number of times verifications were sent per country (n= 1944)**

Country	1st Verification	2nd Verification	3rd Verification	4th Verification	5th Verification	6th Verification	7th Verification	8th Verification	Total
United Kingdom	431	171	72	20	10	1	3	0	708
South Africa	218	72	30	8	0	0	0	0	328
Botswana	172	93	22	10	2	0	0	1	300
New Zealand	100	58	20	2	2	3	0	0	185
Australia	52	23	11	6	1	1	0	0	94
United States of America	42	34	16	8	7	1	1	0	109
Namibia	35	12	5	1	2	1	0	0	56
Swaziland	31	15	2	1	2	0	0	0	51
Canada	23	12	6	3	0	2	0	0	46
Ireland	12	8	6	3	0	0	0	0	29
Zimbabwe	10	2	1	1	0	0	0	0	14
Kenya	5	0	1	0	0	0	0	0	6
Hong Kong	4	1	2	0	0	0	0	0	7
Lesotho	1	1	1	0	0	0	0	0	3
Malawi	1	0	0	0	0	0	0	0	1
Republic of Maldives	1	0	0	0	0	0	0	0	1
Seychelles	1	0	0	0	0	0	0	0	1
Uganda	1	0	0	0	0	0	0	0	1
Ghana	1	0	0	0	0	0	0	0	1
Not indicated	1	0	0	0	0	0	0	0	1
Mexico Mexico	0	1	0	1	0	0	0	0	
<b>Total</b>	<b>1142</b>	<b>503</b>	<b>195</b>	<b>64</b>	<b>26</b>	<b>9</b>	<b>4</b>	<b>1</b>	<b>1944</b>

### Where verifications were sent by region

Data on where all the nurses' verifications were sent in accordance with their country preferences were further analyzed according to regions. A total of 1944 verifications were sent to countries within the various regions. The findings are as shown in Figure 4.8. These indicate that more verifications (40%) were sent to countries within the African region. The European region attracted 38% of the total, Western Pacific 14% and North America 8%.



**Figure 4.8 Verifications sent by region (n=1944)**

Additionally, the findings, as shown in Table 4.4 indicate more (476) nurses chose to have their first verifications sent to countries within the African region. Those sent to countries in Europe were 444 (39%), Australia 152 (13%) and North America 65 (6%). This implied that more nurses wanted to register in countries within these regions. As shown in the table below, Asia had the least number (4) of verifications; thus fewer

nurses who chose to have verifications sent to that region. Details of the country for one verification sent were not indicated in one of the files included in the study.

**Table 4.4 Regions to which the first verifications were sent (n= 1142)**

Region	Frequency	Percent
Africa	476	41.7
Europe	444	38.9
Western Pacific	152	13.3
North America	65	5.7
Asia	4	0.4
Not indicated	1	0.1
<b>Total</b>	<b>1142</b>	<b>100.0</b>

**Qualifications of nurses whose verifications were sent to regions**

Table 4.5 presents findings on verifications sent to countries in the various regions. The data in this table shows more registered (429) than enrolled (14) nurses had preferred to have their first verifications sent to countries in Europe.

With regards to other verifications, 365 registered and 112 enrolled nurses chose to have their verifications sent to countries in Africa. Seventy-seven (8.3%) of the registered and 75 (36%) of the enrolled nurses had their first verifications sent to Australia with 57 (6%) and 8 (4%) registered and enrolled nurses respectively who had theirs sent to North America. An equal number of two registered and enrolled nurses chose Asia.

**Table 4.5 RN and EN qualifications by region to which first verifications were sent (n=1142)**

Qualification	Australia	Africa	Europe	North		Not indicated	Total
				America	Asia		
RN	77	365	429	57	2	1	931
%	8.3	39.2	46.1	6.1	0.2	0.1	100.0
EN	75	112	14	8	2		211
%	35.5	53.1	6.6	3.8	0.9		100.0

#### **Other qualifications of nurses with sent verifications**

Table 4.6 shows nurses in the sample with scarce qualifications of operating theatre nursing, registered mental health nursing and tutors or nurse educators. According to the data in this table, 113 operating theatre nurses applied for verifications to register in countries outside Zambia. Of these, 35 (31%), being the majority, chose to have their verifications sent to the United Kingdom, 24 (21%) to Botswana and 23 (20%) to South Africa. Other countries of choice for this level of nurses included the United States of America with 6 (5%), New Zealand 5 (4%), Australia 4 (3.7%) and Swaziland 3 (2.7%). Hong Kong and Namibia had two applicants (2%) each from this group.

A total of 26 registered mental health nurses chose to have their verifications outside Zambia. The countries of choice for these nurses were Botswana with the majority of 10 (39%), South Africa with 6 (23%) and the United Kingdom with 4 (15%). The figures show only few of these nurses preferred to have their verifications sent to Australia (2) and Ireland (2). Namibia and New Zealand had the lowest number of one (4%) each.

For the nurse educators, South Africa and the United Kingdom had an equal number of 27% (3) of the total number of 11 nurse educators' verifications while New Zealand had 2(18%). Botswana, Namibia and Ireland had on (9%) each.

**Table 4.6 Other qualifications by country to which first verifications were sent (n= 150)**

Country	Percent	OTN	RMHN	Nurse Educators/Tutors	Total
Australia		4	2	0	6
	% of Total	3.5	7.7	0.0	11.2
New Zealand		5	1	2	8
	% of Total	4.4	3.8	18.2	26.4
Botswana		24	10	1	35
	% of Total	21.2	38.5	9.1	68.8
South Africa		23	6	3	32
	% of Total	20.4	23.1	27.3	70.8
Swaziland		3	0	0	3
	% of Total	2.7	0.0	0.0	2.7
United Kingdom		35	4	3	42
	% of Total	31.0	15.4	27.3	45.8
Canada		2	0	0	2
	% of Total	1.8	0.0	0.0	1.8
Namibia		2	1	1	4
	% of Total	1.8	3.8	9.1	14.7
United States of America		6	0	0	6
	% of Total	5.3	0.0	0.0	5.3
Ireland		3	2	1	6
	% of Total	2.7	7.7	9.1	19.5
Zimbabwe		1	0	0	1
	% of Total	0.9	0.0	0.0	0.9
Malawi		1	0	0	1
	% of Total	0.9	0.0	0.0	0.9
Hong Kong		2	0	0	2
	% of Total	1.8	0.0	0.0	1.8
Kenya		1	0	0	1
	% of Total	0.9	0.0	0.0	0.9
Seychelles		1	0	0	1
	% of Total	0.9	0.0	0.0	0.9
<b>Total</b>	<b>Count</b>	<b>113</b>	<b>26</b>	<b>11</b>	<b>150</b>
	<b>% of Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Table 4.7 shows data in terms of regional distribution of the additional and scarce qualifications that nurses in the sample had. There were more nurses with the additional qualifications who had their first verification sent to countries within Africa. Nurses with Operating theatre qualification and had verifications sent to countries in Africa were 56 (50%), registered mental health nurses 17 (65%) and nurse educators 5 (45%). The next highest numbers of nurses with these qualifications were those with verifications sent to the European countries showing 38 (34%) of the operating theater nurses, 6 (23%) of the registered mental health nurses and 4 (36%) of nurse educators. Verifications sent to North America and Asia had 8 (7%) and 2 (2%) nurses with operating theatre nurses qualification respectively. The operating theatre qualification appeared to be more widely distributed (113) than registered mental health nurse (26) and nurse educators (11).

**Table 4.7 Other qualifications by region to which verifications were sent (n= 1142)**

	Australia	Africa	Europe	North America	Asia	Total
OTN	9	56	38	8	2	113
%	8.0	49.6	33.6	7.1	1.8	100.0
RMHN	3	17	6	0	0	26
%	11.5	65.4	23.1	0.0	0.0	100.0
Nurse Educators	2	5	4	0	0	11
%	18.2	45.5	36.4	0.0	0.0	100.0

**Experience of registered nurses with sent verifications**

Table 4.8 shows the distribution of the registered nurses’ experience in years and the regions to which their first verifications were sent. The figures indicate the years of nurses’ experience from 0 to over 41 years. Of the 928 first verifications of nurses with

various levels of experience in years, there were more (415) who had chosen to send their verifications to European countries than Africa (377). The Western Pacific had the next highest with 79 and North America 54.

These figures reveal that the majority, 345 (37 %) of the nurses in the sampled records had had 11-20 years of work experience at the time of applying for verification of their qualifications. Of the nurses in this category, more 157 (17%) had their verifications sent to countries in Africa while 135 (15%) of the verifications went to countries in Europe and 30 (3%) to the Western Pacific. The next highest number of nurses with first verifications that were sent was 320 (35%) and these were in the 0-10 years category of work experience. In this category, there were 141 (15%) verifications sent to Europe with 128 (14%) that went to countries in Africa and 28 (3%) that were sent to the Western Pacific. The next highest number of verifications was 238 (26%) in the 21-30 and 24 (0.1%) in the 31-40 categories of experience in years. Of the 238, 126 (14%) were sent to countries in Europe and 83 (9%) went to Africa and 20 (2%) to Western Pacific.

The number of verifications sent appeared to reduce with increase in years of work experience. This is more significant in nurses with experience of 31 years and above with the least number being one for those with experience of 41 years and above.

**Table 4.8 RN Experience and region to which verification(s) were sent first - Cross tabulation (n= 931)**

RN experience in years	Western-Pacific	Africa	Europe	North America	Asia	Not indicated	Total
0-10	28	128	141	21	1	0	320
% of Total	3	13.8	15.2	2.3	0.1	0.0	34.5
11-20	30	157	135	22	1	0	345
% of Total	3.2	16.9	14.5	2.4	0.1	0.0	37.2
21-30	20	83	126	9	0	0	238
% of Total	2.2	8.9	13.6	0.9	0.0	0.0	25.7
31-40	1	8	13	2	0	0	24
% of Total	0.0	0.0	0.1	0.0	0.0	0.0	0.1
>41	0	1	0	0	0	0	1
% of Total	0.0	0.1	0.0	0.0	0.0	0.0	0.1
<b>Total</b>	<b>79</b>	<b>377</b>	<b>415</b>	<b>54</b>	<b>2</b>	<b>1</b>	<b>928</b>
<b>% of Total</b>	<b>8.5</b>	<b>40.6</b>	<b>44.7</b>	<b>5.8</b>	<b>0.2</b>	<b>0.1</b>	<b>100.0</b>

### Experience of enrolled nurses

Data were further analyzed for experience that enrolled nurses had in years when they had their first verification of their qualifications sent. Table 4.9 illustrates the distribution of their experience of 0-30 years and the regions to which their verifications were sent.

As reflected in the table, enrolled nurses in the 11-20 year category of experience constituted the majority (83) indicating 40% of the first verifications sent. Of this number, 50 (24%) had selected to have their verifications sent to countries in Africa, 25 (12%) to Western Pacific, 5 (2%) to North America and only 3 (2%) to Europe. The next highest number of 69 (33%) of enrolled nurses was those with 21-30 and 0-10 years of experience. Most (32) of those with 21-30 years experience chose to have their verifications sent to countries in Africa while 27 (13%) preferred Western Pacific, 8(4%) Europe and 1 (1%) North America and Asia respectively. In the category with 0-10 years

experience, there were 42 (20%) of the total number of enrolled nurses with sent verifications, 20 (10%) of whom had theirs sent to African countries, 16 (8%) to the Western Pacific, 3 (1%) to Europe and 2 (1) to North America.

The majority, 111 (53%) of the total number of enrolled nurses with sent verifications appear to have chosen countries in Africa for their first verifications. The Western Pacific was next with 75 (36%), followed by 14 (7%) for Europe, 8 (4%) North America and 2 (1%) Asia.

**Table 4.9 EN experience by region to which verifications were sent (n=210)**

EN experience in years	Western Pacific	Africa	Europe	North America	Asia	Total
0-10	16	20	3	2	1	42
% of Total	7.6	9.5	1.4	1.0	0.5	20
11-20	25	50	3	5	0	83
% of Total	11.9	23.8	1.5	2.4	0.5	39.5
21-30	27	32	8	1	1	69
% of Total	12.9	15.2	3.8	0.5	0.5	32.8
31-40	7	9	0	0	0	16
% of Total	3.3	4.3	0.0	0.0	0.0	7.6
>41	0	0	0	0	0	0
% of Total	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>75</b>	<b>111</b>	<b>14</b>	<b>8</b>	<b>2</b>	<b>210</b>
<b>% of Total</b>	<b>35.7</b>	<b>52.9</b>	<b>6.7</b>	<b>3.8</b>	<b>1.0</b>	<b>100.0</b>

#### ***4.2.1.2 Interviewed applicants seeking verification***

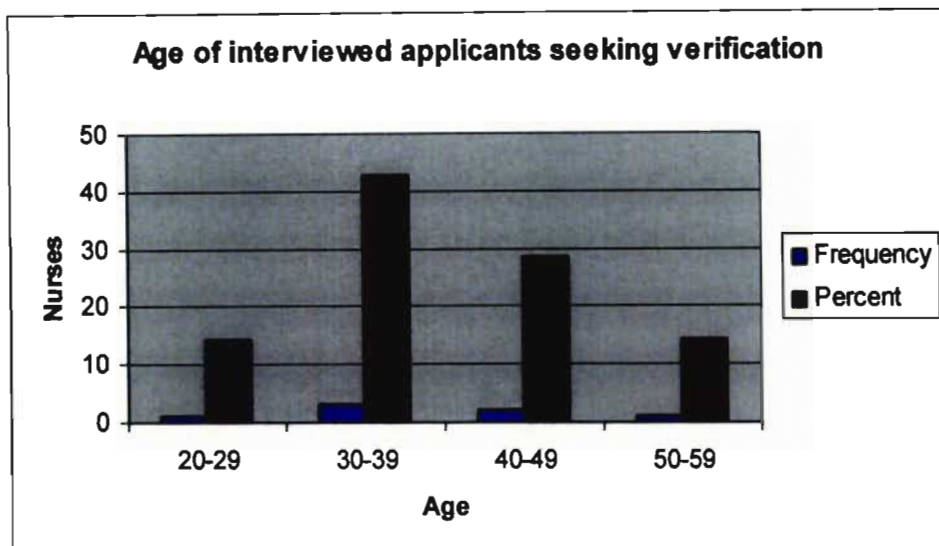
The findings in this part of the study are based on data from nurses who were still working in Zambia and were applying for verification of their qualifications or were making follow up visits to check for their application outcome at the time when data was

being collected. During these visits, nurses who participated in the study completed the first section of a semi structured questionnaire which sought for quantitative data and were interviewed by the researcher using an interview guide in the second part of the same instrument on qualitative data. A total of 7 nurses participated in this part of the study. Findings from the analysis of the quantitative data are presented in this section and those from the interviews are presented in a later part under qualitative data results.

### **Characteristics**

Regarding the gender of nurses who participated in this part of the study, 86% were females and 14% males. On the question of whether the respondents were married or not, the results revealed more single than married nurses who were seeking verification.

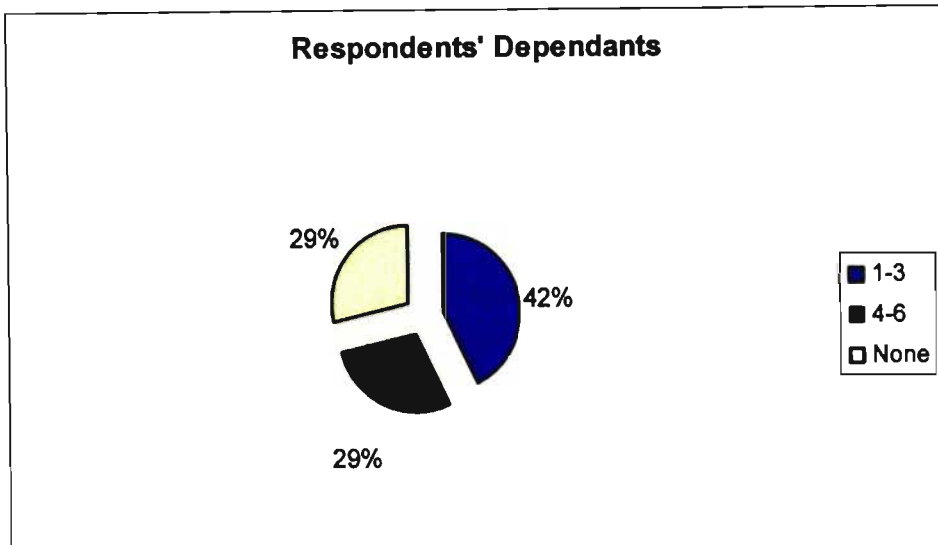
The results displayed in Figure 4.9 indicate the age of the respondents who were visiting the Council applying and following up on their verification. As indicated, there were more (43%) nurses in the age group of 30-39. twenty-nine percent of nurses aged 40-49 were next in majority. Those aged 20-29 and 50-59 years comprised 14% each respectively.



**Figure 4.9 Age of applicants interviewed while seeking verifications (n= 7)**

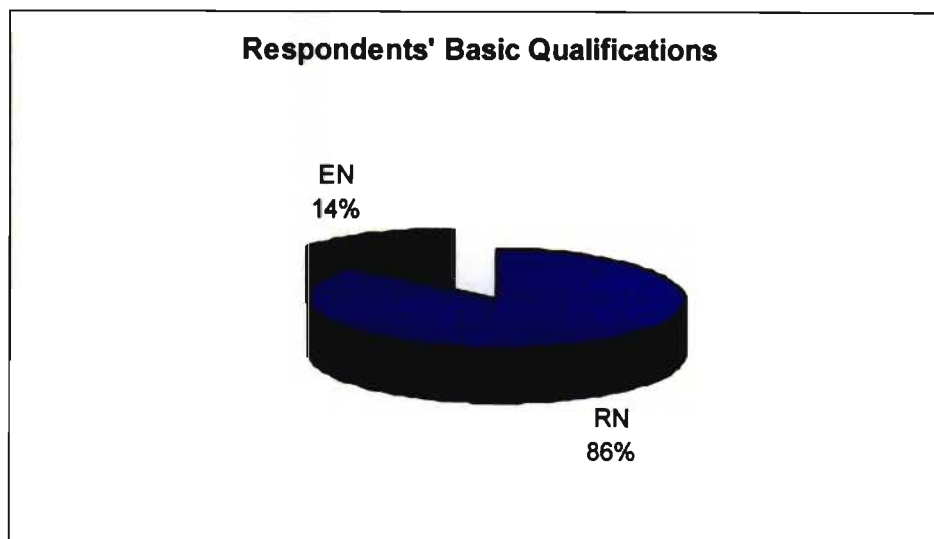
About the number of children that respondents had, results showed more nurses (86%) had between one to three children. The rest of the nurses who comprised 14% had 4 to 6 children. Figure 4.10 shows the ages of the respondents' children. More (43%) of the nurses had children aged 5 years and younger while children of 28% of the nurses were aged between 6 and 10 years. An equal number (14%) of nurses had children aged 11-15 and 21-24 years respectively.

On the question of the number of dependants living with the respondents, the results in Figure 12 reveal that 42% of the nurses had between 1 to 3 dependants living with them at the time they were applying for verification. While 29% of the nurses had no dependants, an equal percentage (29%) of the nurses had a larger number of 4 to 6 dependants under their custody or care at the time.



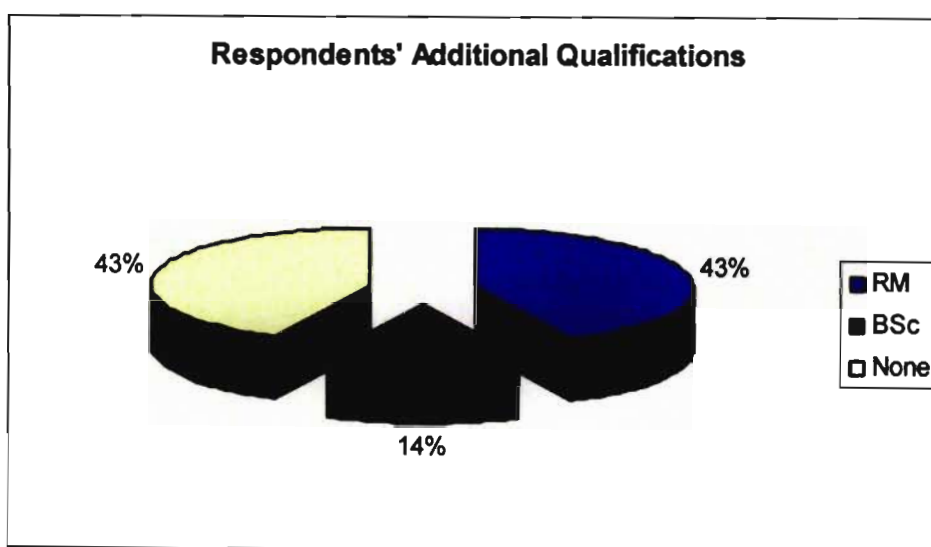
**Figure 4.10** Number of dependants living with respondents at time of applying for verification (n= 7)

Data was analyzed for professional qualifications that the respondents had at the time they were applying for verification. Results as displayed in Figure 4.11 showed the majority (86%) of the respondents were registered nurses. Enrolled nurses comprised 14% of the sample.



**Figure 4.11** Basic Qualifications of the Respondents applying for verification (n= 7)

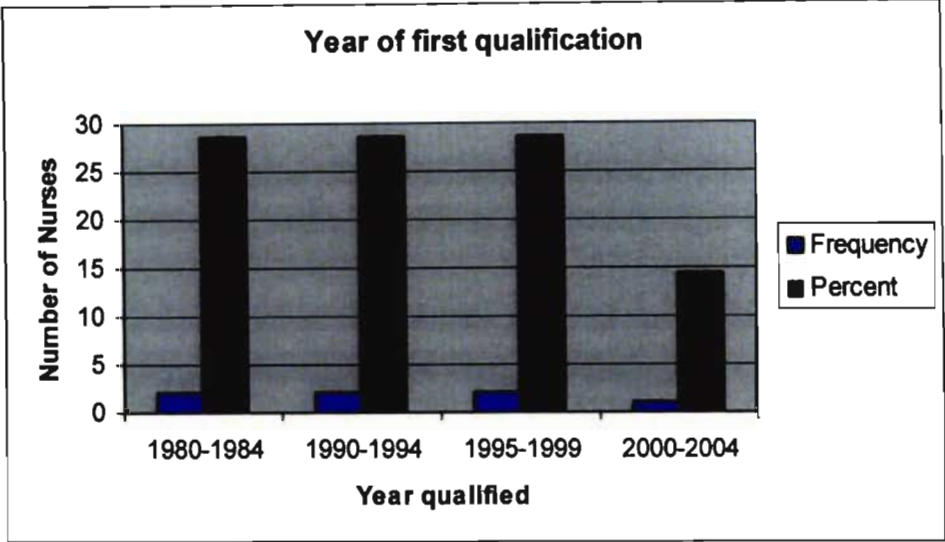
Other qualifications that respondents had are shown in Figure 4.12. Although 43% of the respondents did not have any other qualification other than the basic one, an equal number (43%), being the majority, had registered midwifery as their second qualification. Respondents with Bachelor's degree as a second qualification comprised 14%.



**Figure 4.12 Second qualifications that respondents had (n- 7)**

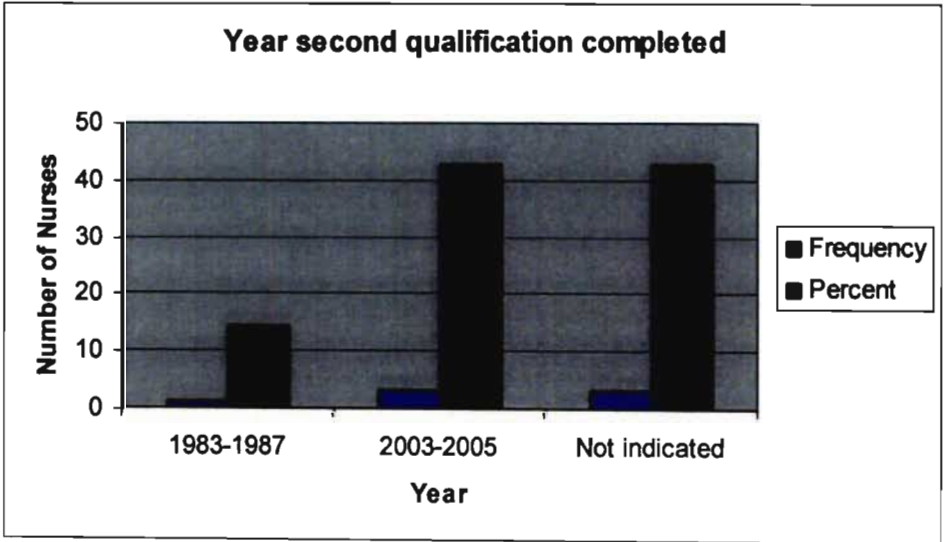
### **Respondents' years of experience**

Figure 4.13 displays results regarding when the respondents completed their basic, which was the first professional qualification as nurses. The figures indicate that most (29%) of the respondents had been nurses since the years 1990 to 1994 and 1995 to 1999 respectively, the periods when they completed their first professional qualification. Fewer (14%) had been in the profession since the years 2000 to 2004 when they obtained their first nursing qualification.



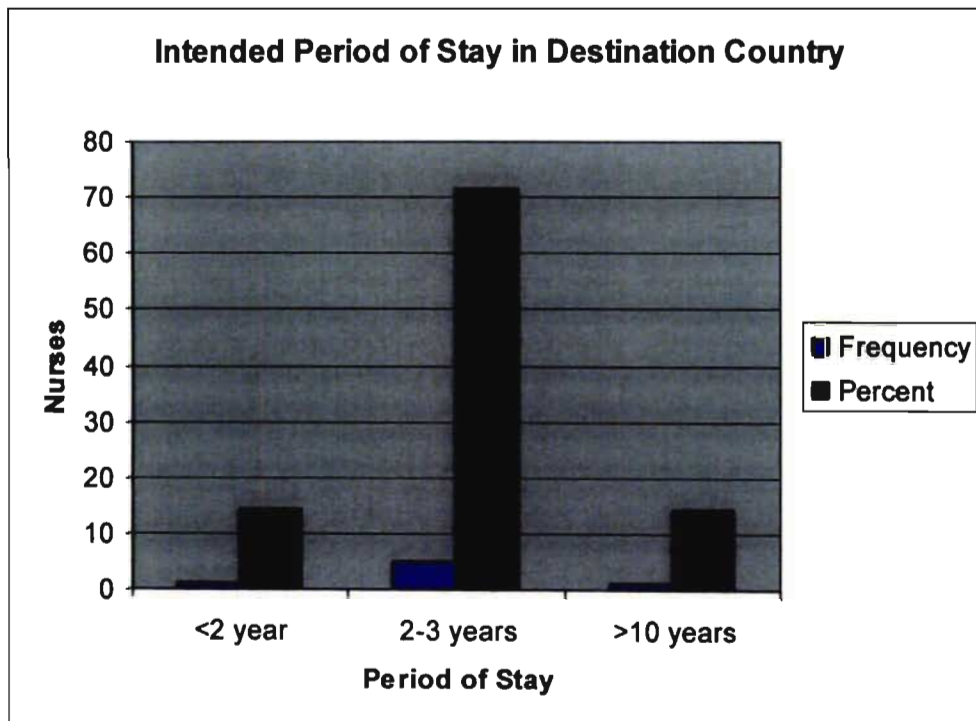
**Figure 4.13 Year respondents completed basic qualification (n= 7)**

Further analysis of the data revealed that 43% of the respondents obtained their second qualification between 2003 and 2005 while a similar number (43%) did not indicate having attained any other qualification other than the initial basic one. Fourteen percent had had a second qualification between 1983 and 1987 as shown in Figure 4.14.



**Figure 4.14 Year respondents completed second qualification (n= 7)**

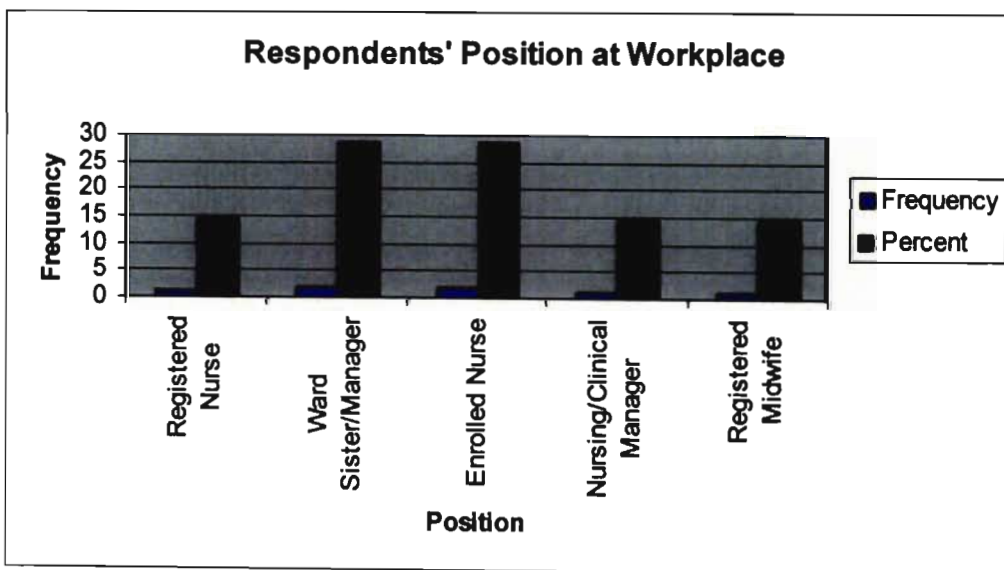
According to the data in Figure 4.15, more of the nurses (72%) that were applying or following up the outcome of their applications for verification were planning to be out of the country for 2 to 3 years. This meant this was the period they wished to stay in the country to which they had requested their verification to be sent. Only 14% had the intention of spending two years or less in their country of choice. The nurses who planned to spend ten years or more in those countries were also 14%.



**Figure 4.15** Number of years respondents wished to stay in preferred country to which verification was to be sent (n=7)

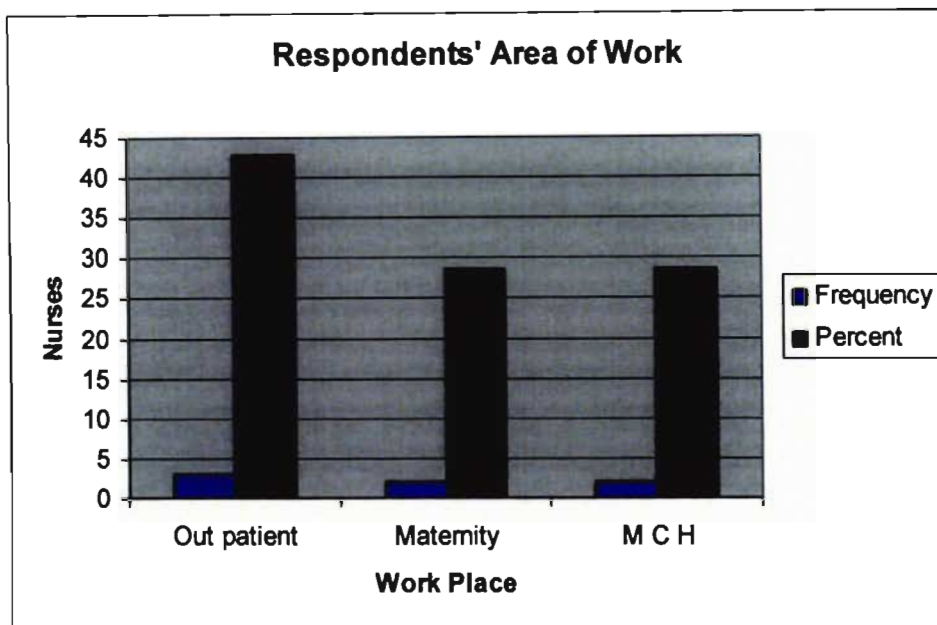
### Position of respondents at workplace

Data were further analyzed to establish the position held by respondents at their workplace at the time they were applying for verification of their qualifications; and thus their level of responsibility in health care delivery at the time. As shown in Figure 4.16, there were more nursing managers (equivalent of matrons) and enrolled nurses, each comprising 29% of the number of the respondents. The rest of the nurses were in positions of registered nurse, ward managers or sisters and registered midwives, each showing 14% of the total number of respondents.



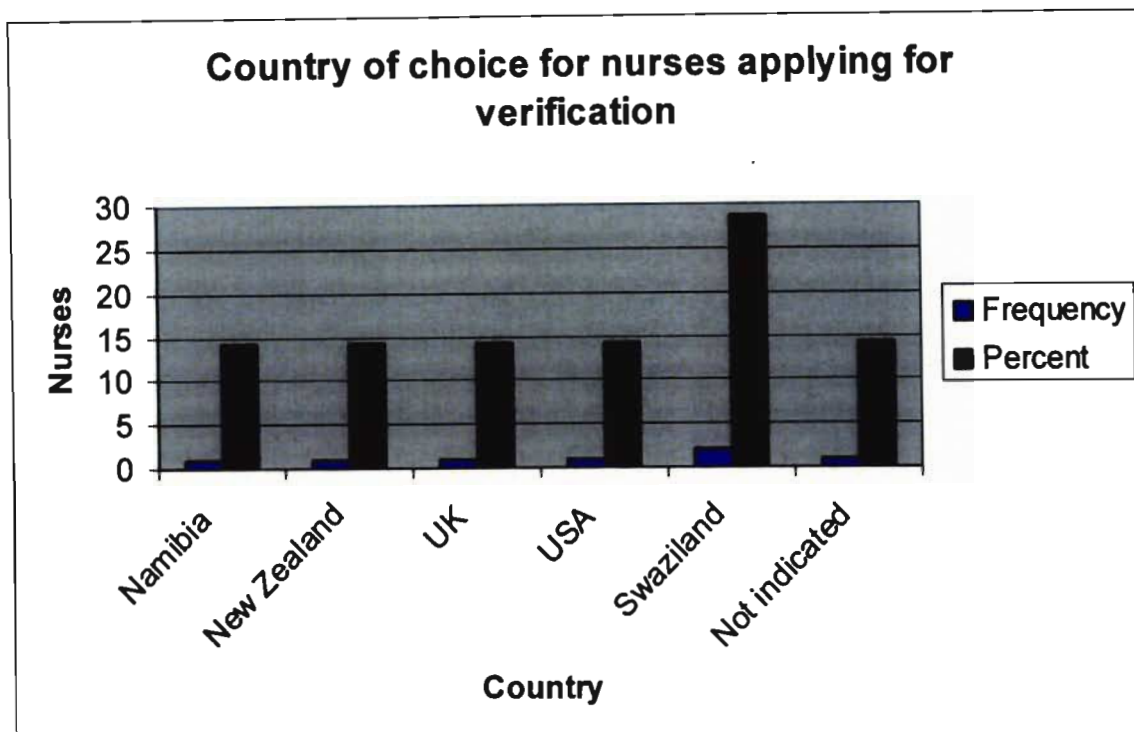
**Figure 4.16 Position held by respondent at their work place (n= 7)**

Regarding the area in which respondents were working at the time of seeking verification, the results shown in Figure 4.17 indicate that 43% of the nurses in the sample were working in out patient settings of the health care facilities where they were working. These were in the majority. The nurses working in maternity areas were 29% and so were those in maternal and child health.



**Figure 4.17 Where respondents were working at time of verification (n= 7)**

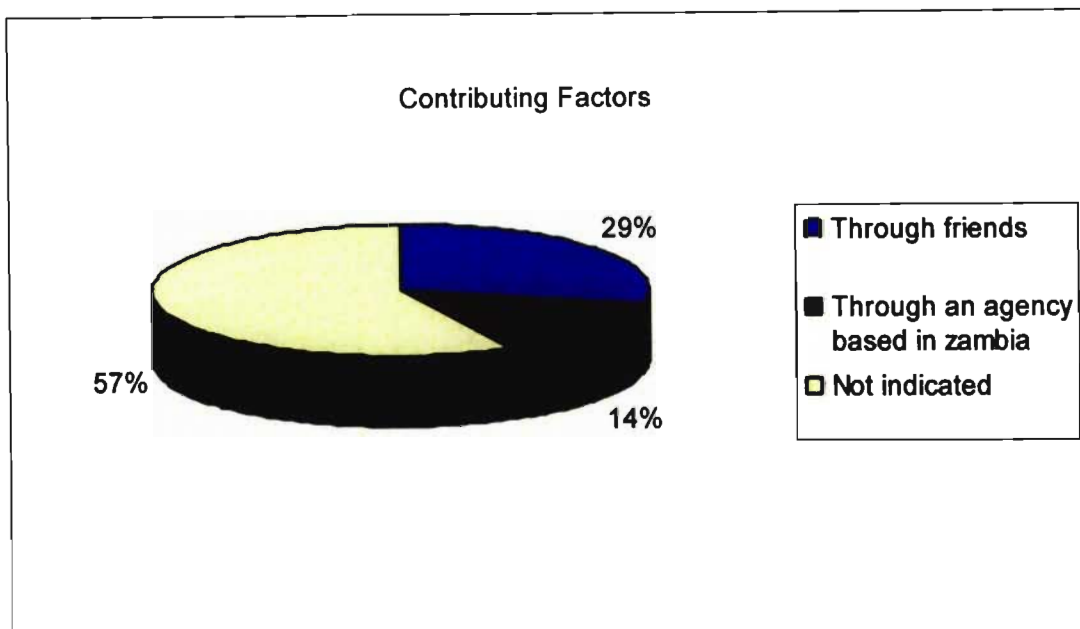
Data was also analyzed for the names of countries where respondents wished to have their verifications sent. Figure 4.18 shows the majority (29%) indicated they wished to have their verification sent to Swaziland once processed. The rest of the countries shown in this figure were preferred by 14% of the nurses in the sampled records.



**Figure 4.18 Countries of choice for respondents' verifications (n= 7)**

#### **Influence on decision to leave employment**

With regards to the factors that influenced the respondents to leave their employment and begin the process of verification in order to register outside Zambia, the findings in Figure 4.19 show that 57% did not give any factors. However, 29% indicated they were influenced by friends while 14% mentioned that a recruitment agency based in Zambia was influential in their decision making.



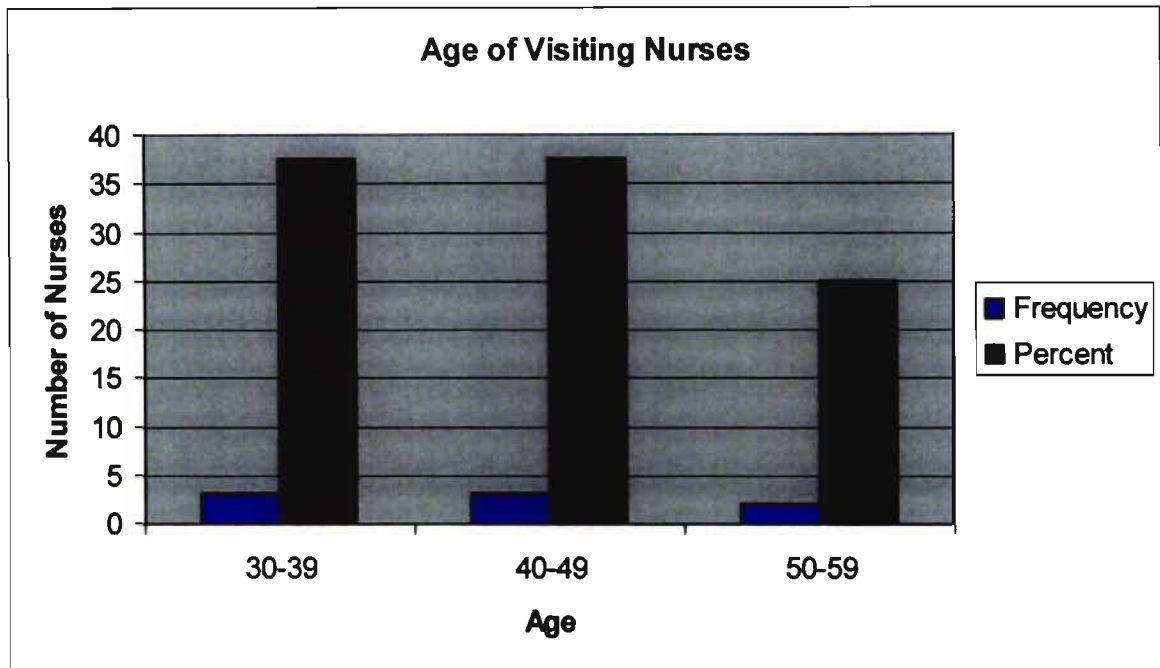
**Figure 4.19 Factors that influenced respondents to leave employment (n= 7)**

#### ***4.2.1.3. Data from nurses working outside Zambia***

Data from visiting nurses who had migrated and were working outside the country were included in the study. Nurses who participated completed the first part of a semi structured questionnaire seeking quantitative data before being interviewed by the part of the same tool which sought qualitative data. This section presents the quantitative part of the analyzed data.

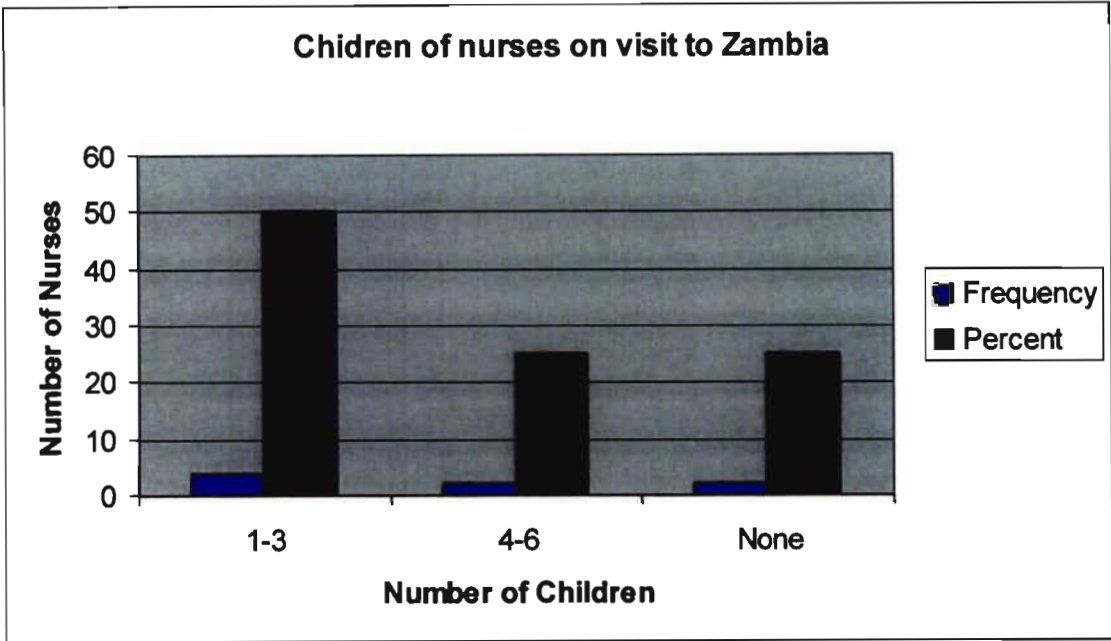
#### **Respondents' characteristics**

A total of eight nurses who were visiting Zambia participated in the study. Sixty two percent of these were female while 38% were male. Most (38%) of them were aged 40-49 years and 30-39 years (37%). The older group aged 50-59 years were fewer and (Figure 4.20) constituted 25%. Eighty seven percent of the nurses were married and 13% widowed.



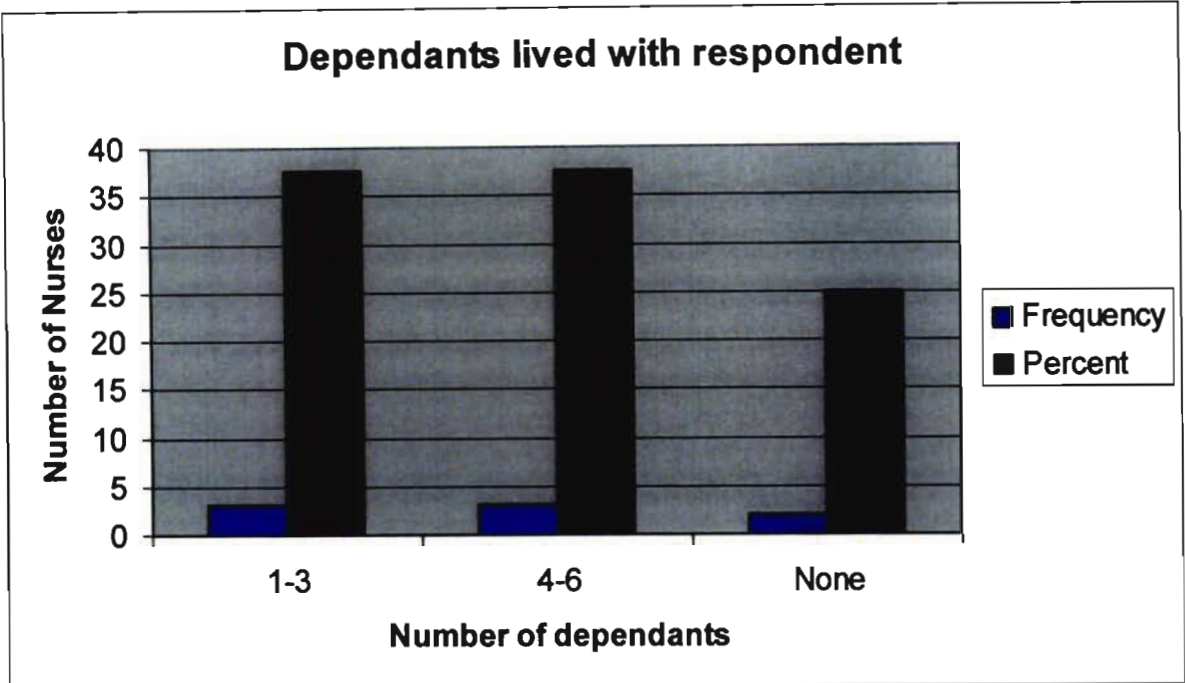
**Figure 4.20 Age of nurses working in other countries and on visit Zambia (n= 8)**

Data on visiting nurses were further analyzed for children that the nurses had. As indicated in Figure 4.21, nurses with children in the younger ages of 1-3 years were 50% of the total number that participated in the study. Twenty five percent had between 4-6 children and another 25% had no children at all.



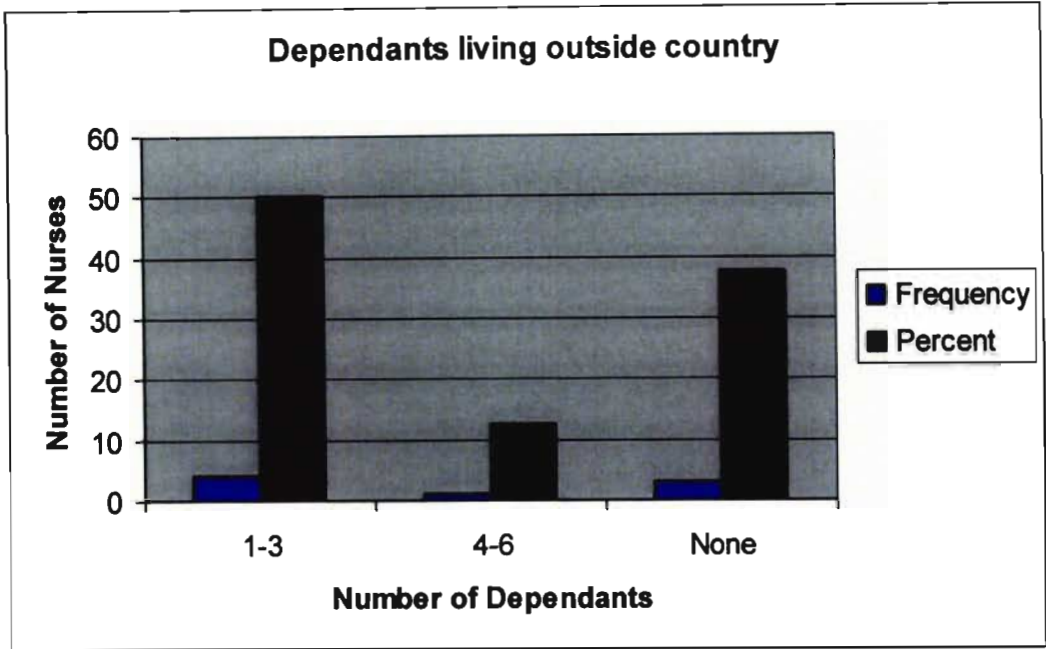
**Figure 4.21 Number of children of nurses working in other countries and on visit to Zambia (n= 8)**

Results on dependants who lived with respondents before they emigrated from Zambia are reflected in Figure 4.22. These show that 75% of the nurses who participated in the study had dependants who lived with them before they left the country for greener pastures. Of these nurses, 38% had the larger number of between 4-6 dependants who lived with them. Thirty-seven had between 1-3 dependants living with them before they left to work outside the country.



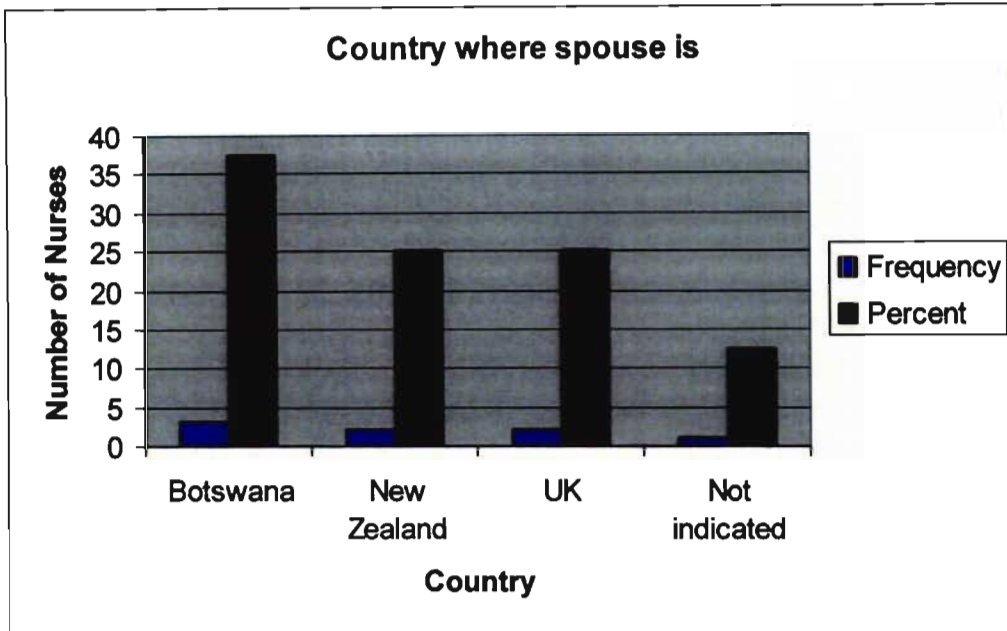
**Figure 4.22** Number of dependants who lived with respondent before they left for greener pastures (n= 8)

Regarding the number of dependants living with respondents outside the country, 38% indicated they did not have any dependants living with them in the respective countries outside Zambia. However, as indicated in Figure 4.23, 62% of the respondents had dependants under their custody while living outside the country. Of these, the number of dependants numbered 1-3 for 49% of the respondents and 4-6 for 13% of them.



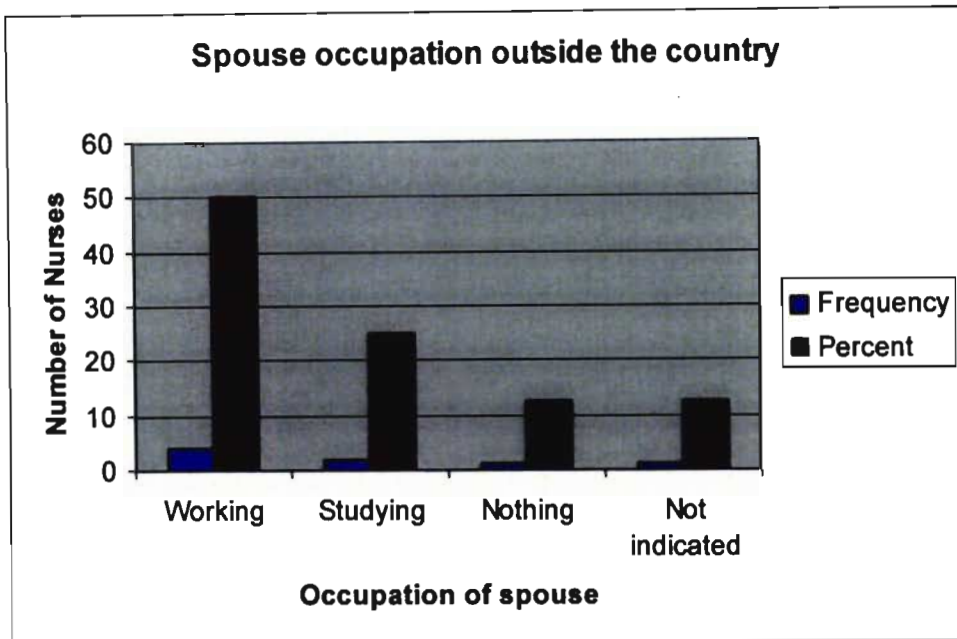
**Figure 4.23 Number of dependants living with respondents outside the country (n= 8)**

On the question of whether respondent’s spouse was living outside the country with respondent at the time of their visit to Zambia, 87% responded in the affirmative while only 13% did not have spouses living outside the country. Respondents were also asked to indicate the country where their spouses were living. Results indicated that 37% of the spouses lived Botswana, 25% in New Zealand and another 25% in the United Kingdom (Figure 4.24).



**Figure 4.24 Country where Respondents Spouses lived (n= 8)**

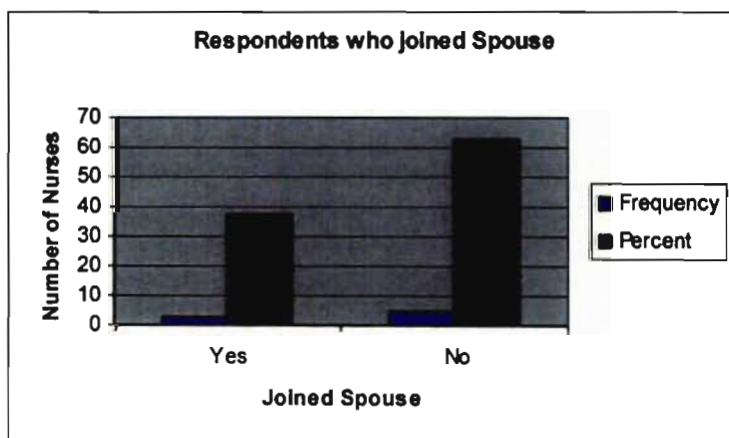
When data on what spouses of the respondents were doing outside the country were analyzed, the results indicated that there more (49%) respondents with working spouses. According to data in Figure 4.25, those whose spouses were studying comprised 25%. Thirteen percent of the respondents' spouses were doing nothing.



**Figure 4.25** What respondents' spouses were doing outside Zambia (n- 8)

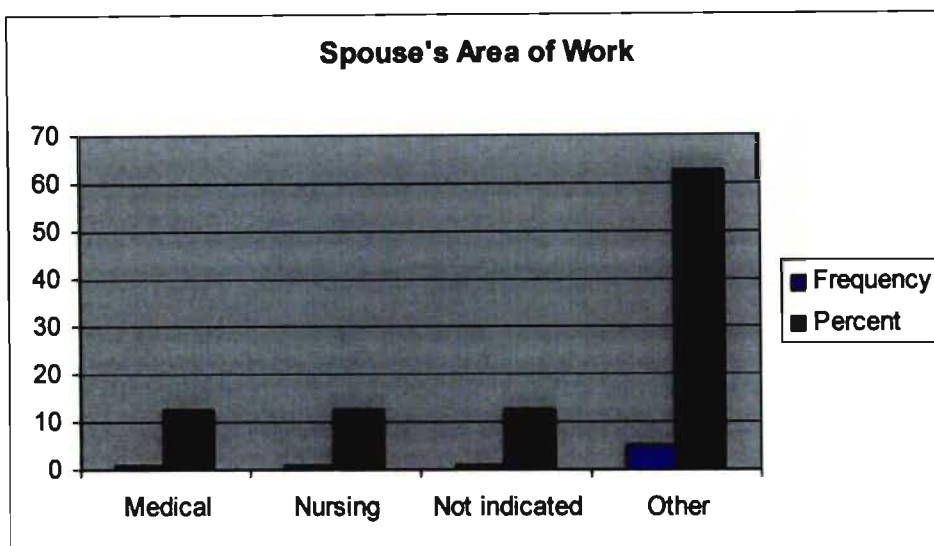
According to Figure 4.26, only 35% of the respondents left Zambia to join their spouses.

The majority (62%) did not have spouses in their destination countries.



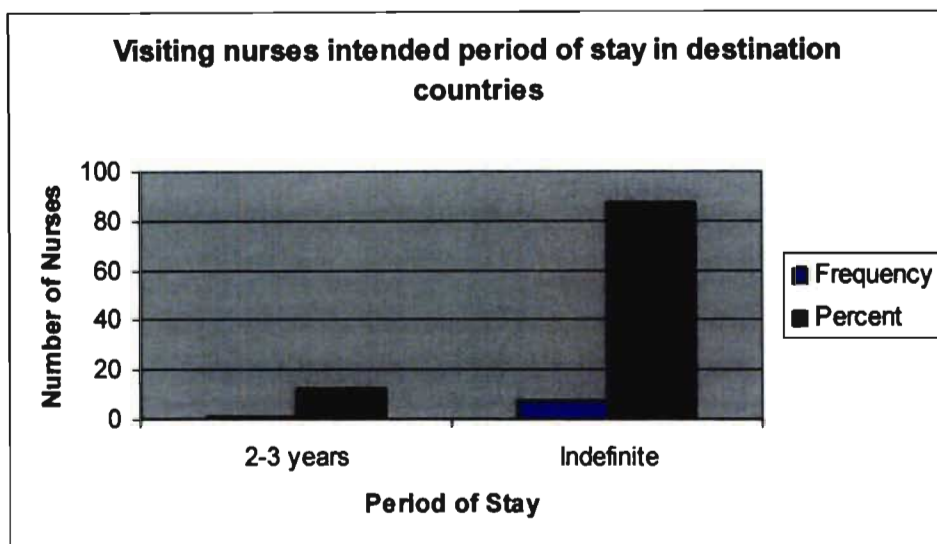
**Figure 4.26** Respondents who left Zambia to join their spouses (n=8)

Regarding the area of work or profession of the respondents' spouses who were working outside Zambia, results in Figure 4.27, reveal that 13% were in nursing while 12% were in the medical professions respectively. However, 62% did not indicate their spouses' professions or area of work.



**Figure.4 27 Profession of Respondent's Spouses (n= 8)**

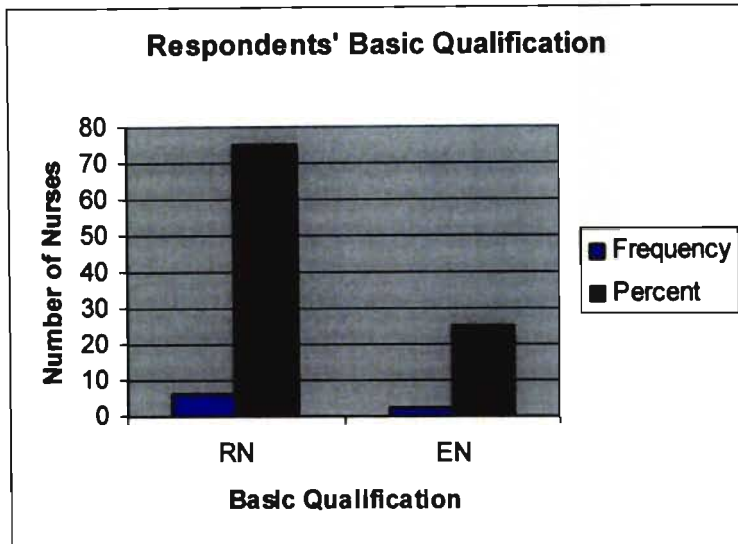
Data were further analyzed for the period that respondents intended to stay in the country where they were at the time before they came on a visit to Zambia. The findings displayed in Figure 4.28 showed that the majority (87%) intended to stay for an indefinite period in those countries with no specific plans on when to move back home or go to another county. A small number (13%) indicated they would stay for another 2-3 years in the countries in which they were at the time.



**Figure 4.28 Intended period of stay in destination countries by nurses on visit to Zambia (n= 8)**

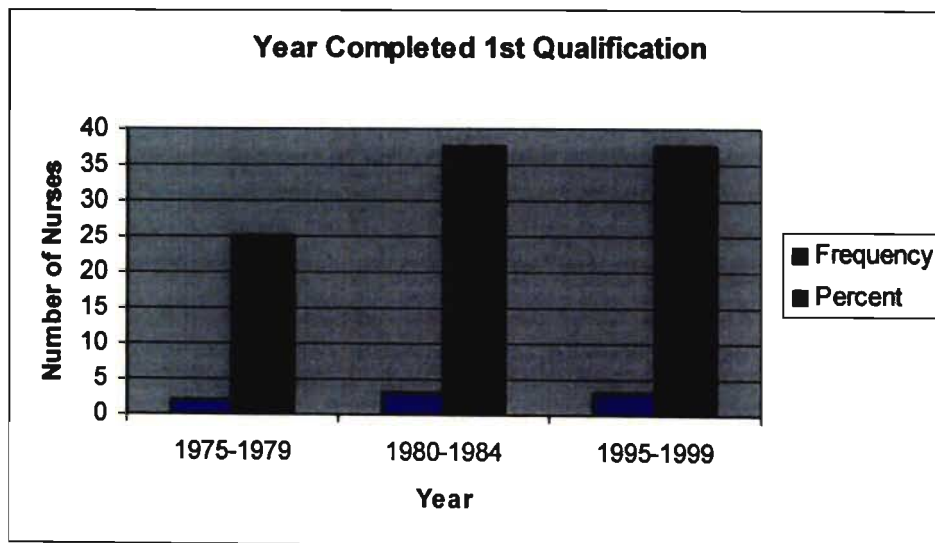
### **Professional qualifications and experience of respondents**

The basic qualifications of the respondents who had migrated and were visiting Zambia are as shown in Figure 4.29. As indicated, registered nurses were in the majority (75%) with fewer enrolled nurses (25).



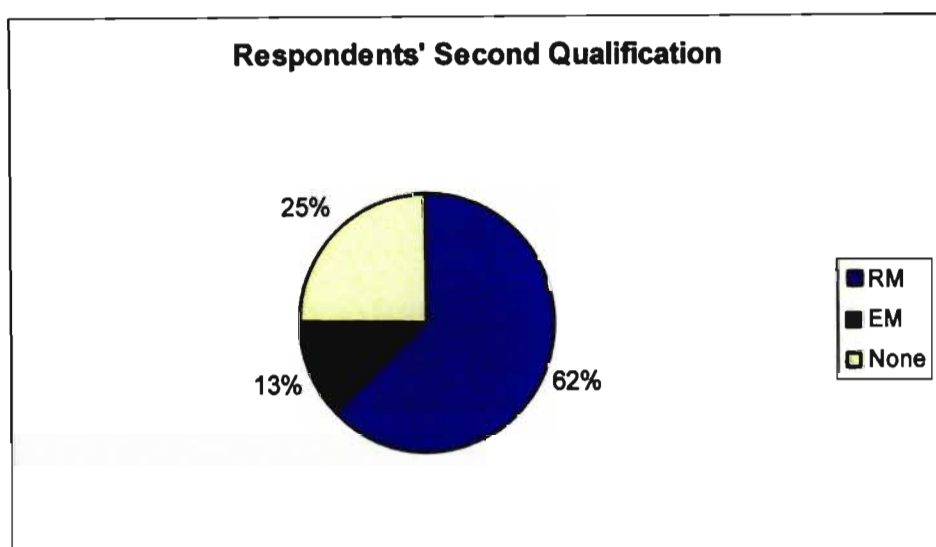
**Figure 4.29 Basic qualification of visiting nurses (n= 8)**

Regarding the respondents' work experience in years following their completion of training as registered and enrolled nurses, the findings in Figure 4.30 show that most (38%) of them had qualified between 1995 and 1999. thirty seven percent had completed their training between 1980 and 1984 while the rest (25%) had been qualified as nurses since the years 1975-1979.



**Figure 4.30 Year when respondent completed basic qualification (n= 8)**

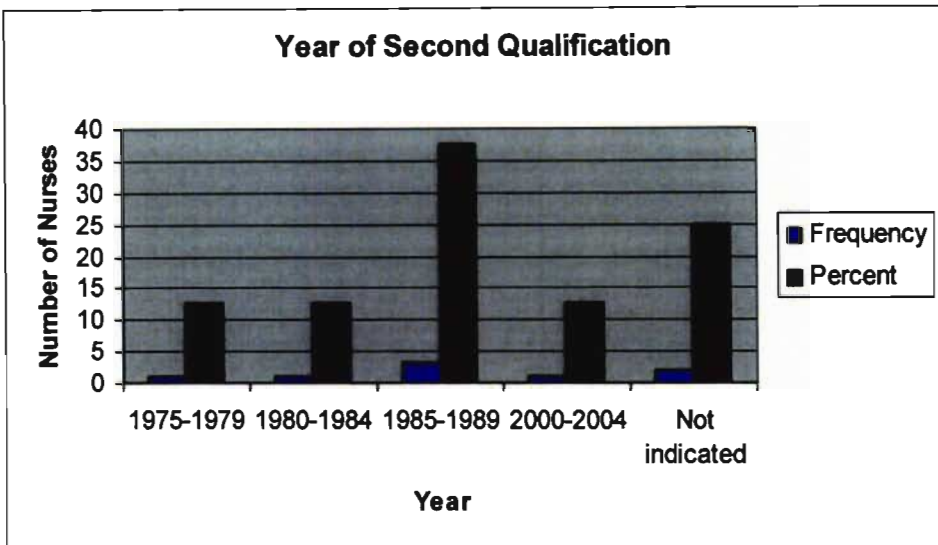
Data were also analyzed for respondents' second qualification. Figure 4.31 indicates that Most of the respondents had registered midwifery as their second qualification (62%) followed by enrolled midwifery qualification (13%).



**Figure 4.31 Second qualification of respondents who had migrated and were visiting Zambia (n= 8)**

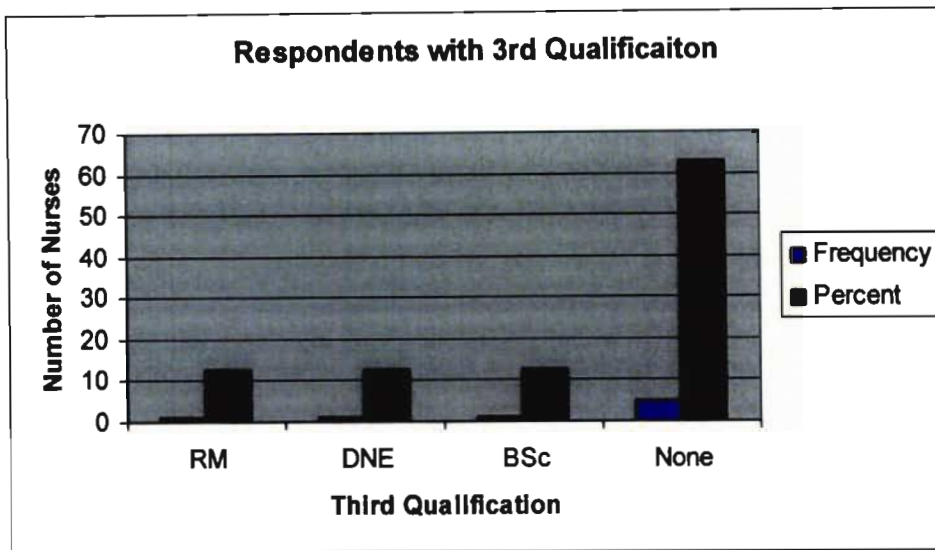
#### **Experience of respondents with second qualification**

According to data in Figure 4.32, most respondents (37%) had obtained the second qualification between 1985 and 1989. Thirteen percent of the respondents had had the second qualification since the years 1975-1984 and 2000-2004 respectively. Twenty four percent did not indicate having second qualification.



**Figure 4.32 Year in which respondent obtained second qualification (n= 8)**

Data were also analyzed for third qualification that respondents had. The findings as indicated in Figure 4.33 showed that most (62%) of them did not have a third qualification. However, findings showed respondents with Bachelor of Science degree in nursing (13%), Diploma in Nursing Education (13%) and registered midwifery qualifications (12%)



**Figure 4.33 Respondents who had obtained 3rd Qualification (n= 8)**

**Respondent’s last position held at workplace**

Further analysis of the data on visiting nurses who lived in other countries showed that most of them had worked as registered nurses (25%) and college lecturers (25%) before they left Zambia for other countries. According to Table 4.10, the rest of the respondents worked as enrolled nurses (13%), ward sister (13%), night supervisor (13%) and in-service education programme coordinator (13%).

**Table 4.10 Last position of respondent at workplace (n= 8)**

Position	Frequency	Percent
RN	2	25
Ward sister	1	12.5
Lecturer/Tutor	2	25
EN	1	12.5
Night Supervisor	1	12.5
In service Education Coordinator	1	12.5
Total	8	100

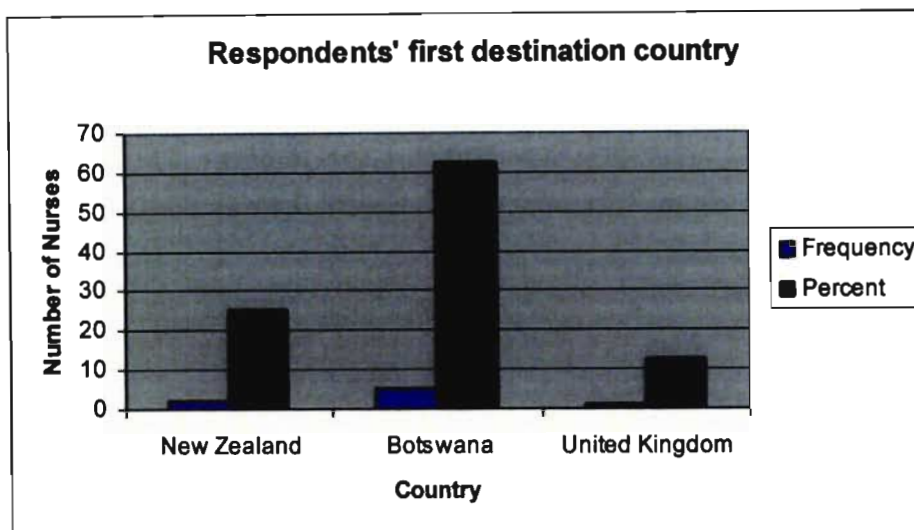
**Migratory movements of visiting nurses**

According to Figure 4.34, the majority of the respondents first left Zambia during the 2000-2004 period. The rest did leave the country for the first time in the years 1990-1994.



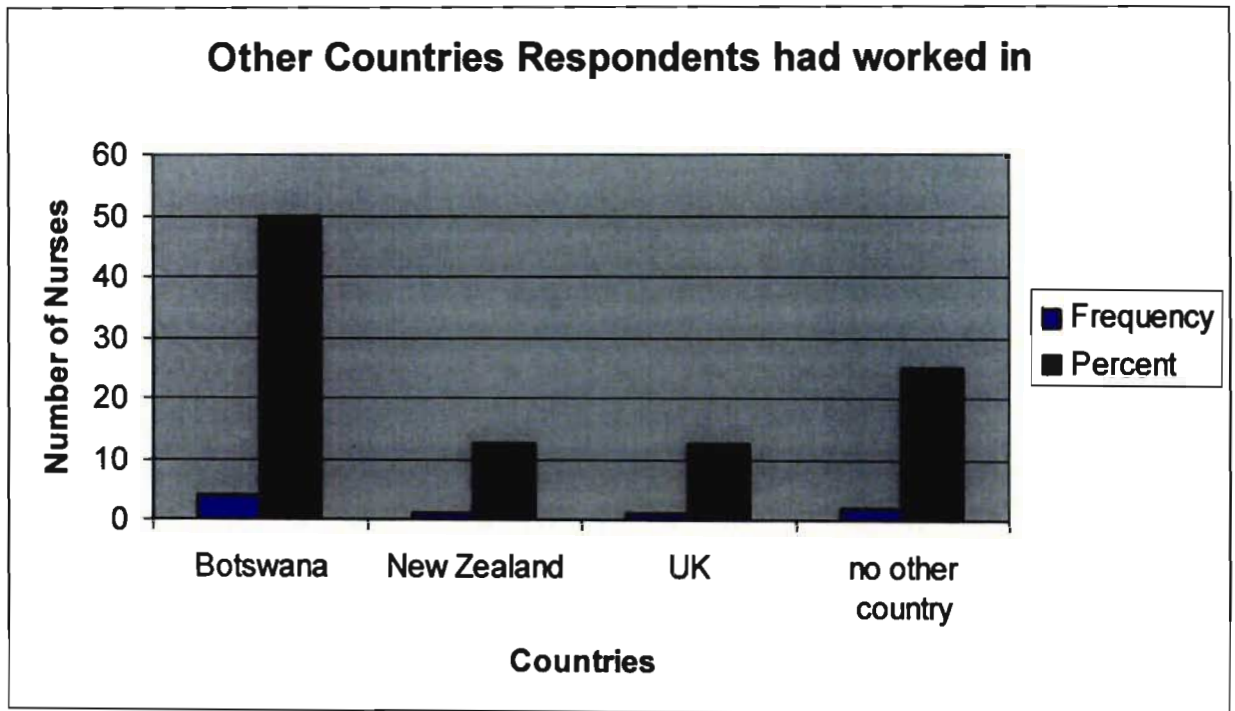
**Figure 4.34 Year when respondents visiting Zambia first left the country (n= 8)**

Figure 4.35 shows results on countries where respondents went when they first left Zambia for greener pastures. As indicated, most of them first went to Botswana (62%). Others went to New Zealand as their first destination country (25%) and the United Kingdom (13%).



**Figure 4.35 Country where Respondents first went upon leaving Zambia (n= 8)**

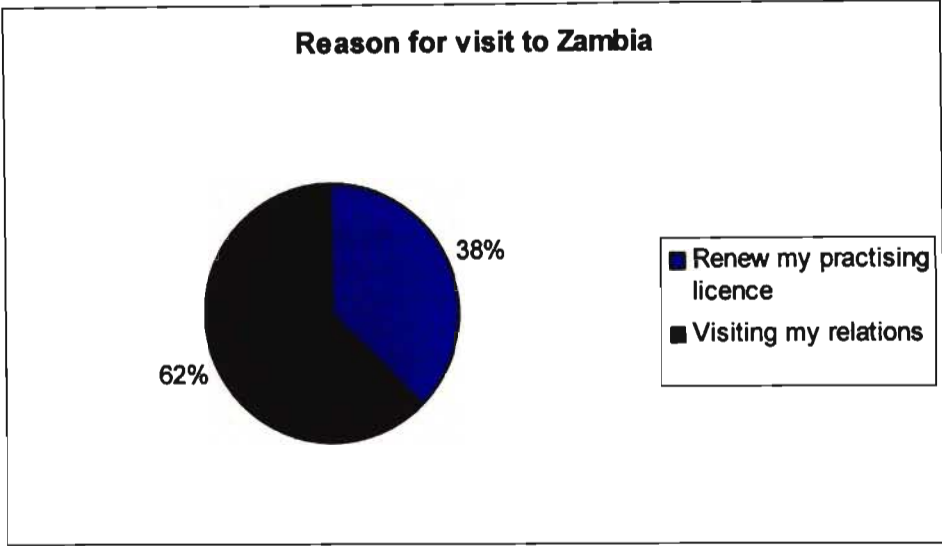
On the question of other countries that the respondents had worked in, the findings in Figure 4.36 show that more of them had worked in Botswana (49%), New Zealand (13%) and the United Kingdom (13%). However, 25% of the respondents had not worked in any other country other than the initial destination country.



**Figure 4.36 Other countries in which respondents had worked after leaving their first destination country (n= 8)**

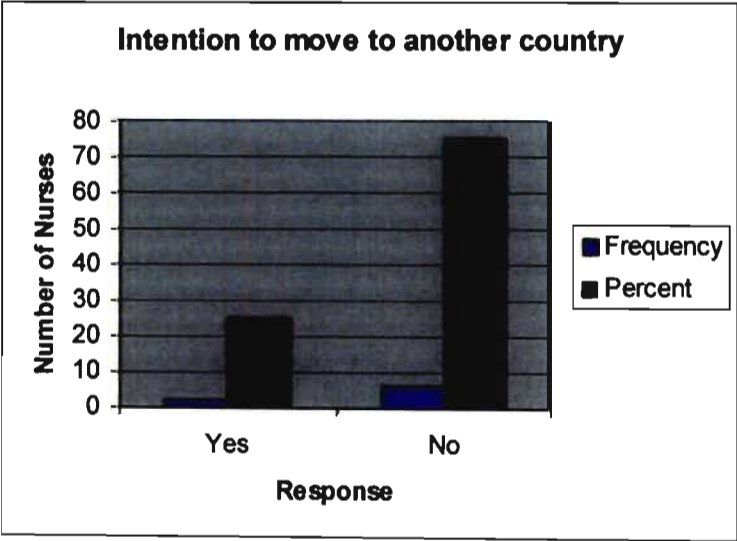
**Purpose of visit to Zambia**

Findings from analysis of data on why respondents had come to Zambia are shown in Figure 4.37. The figures show two reasons; 62% indicated coming to their home country was for the purpose of visiting their relations and 38% came to renew their practicing license at the Nursing Council.



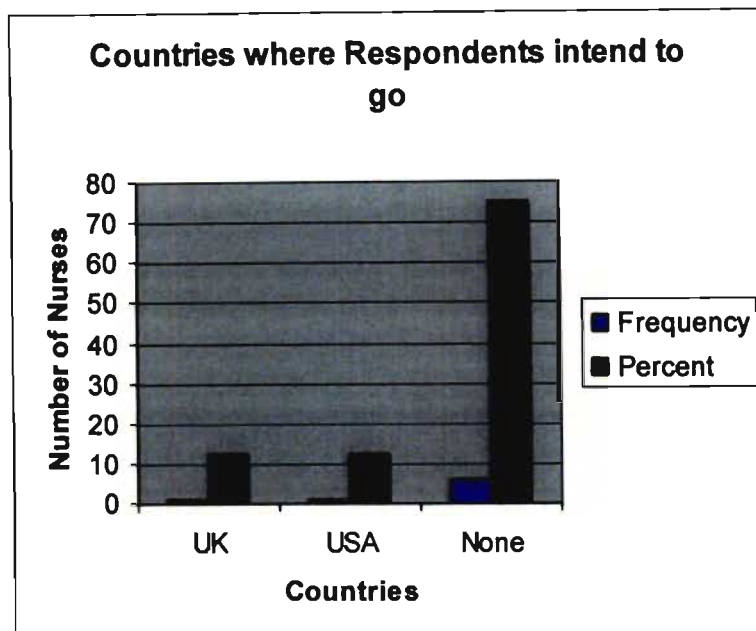
**Figure 4.37 Respondents’ purpose of visit to Zambia (n= 8)**

As to whether the respondents had intentions of moving to another country from where they were at the time, Figure 4.38 shows 75% had no intention of moving while 25% did intend to move to another country.



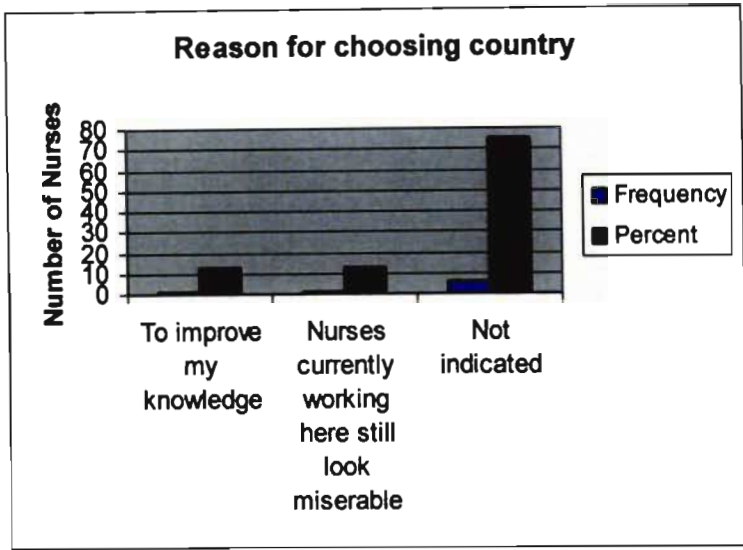
**Figure 4.38 Respondent’s response as to whether they intended to move to another country (n= 8)**

For those respondents who had the intention of moving from the countries where they were at the time to another country, data in Figure 4.39 shows an equal number of 13 % each intending to go to the United Kingdom and the USA respectively.



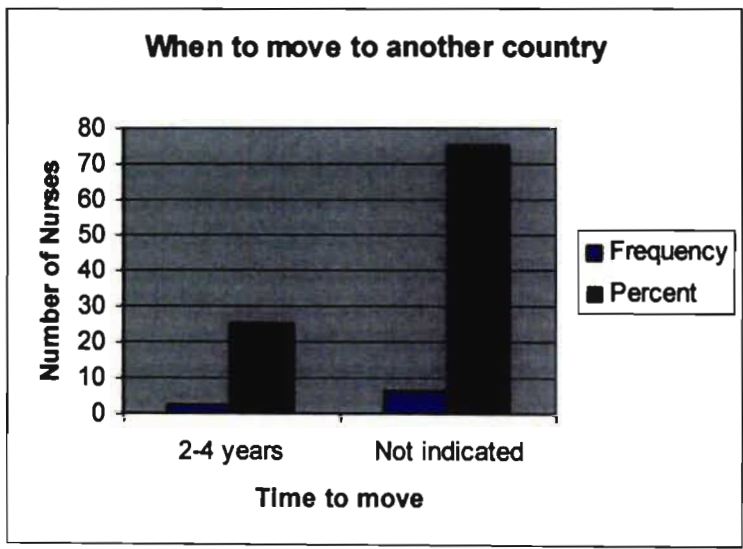
**Figure 4.39 Countries where respondents who wished to move from their destination country intended to go (n= 8)**

From results displayed in Figure 4.40, 13 % of the respondents who had the intention of moving to another country chose that country in order to go and improve their knowledge while another 13% indicated that nurses who were working in Zambia still looked miserable meaning that the respondents were not attracted to coming to their home country.



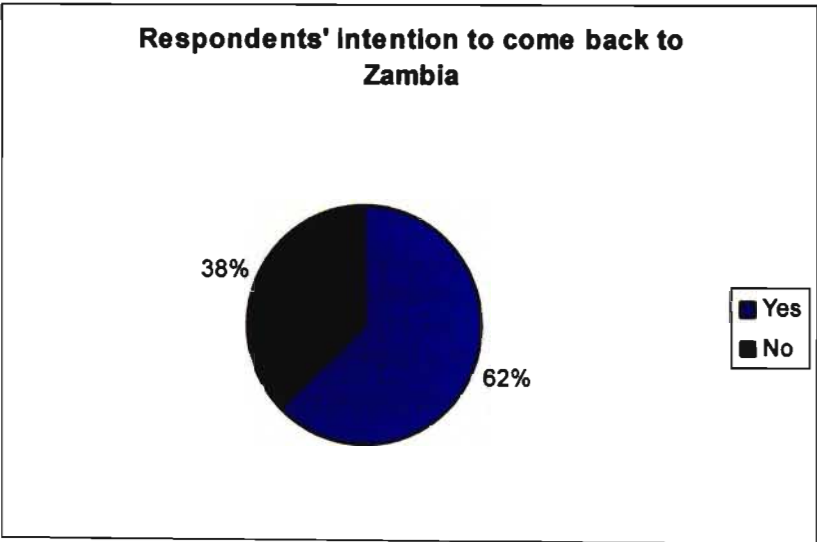
**Figure 4.40 Reason given by respondent for choosing the country where they intended to move (n= 8)**

Data was further analyzed regarding when those respondents who intended to move to another country would do so. According to Figure 4.41, all the 26% respondents who intended to move indicated they would do so in 2-4 years time.



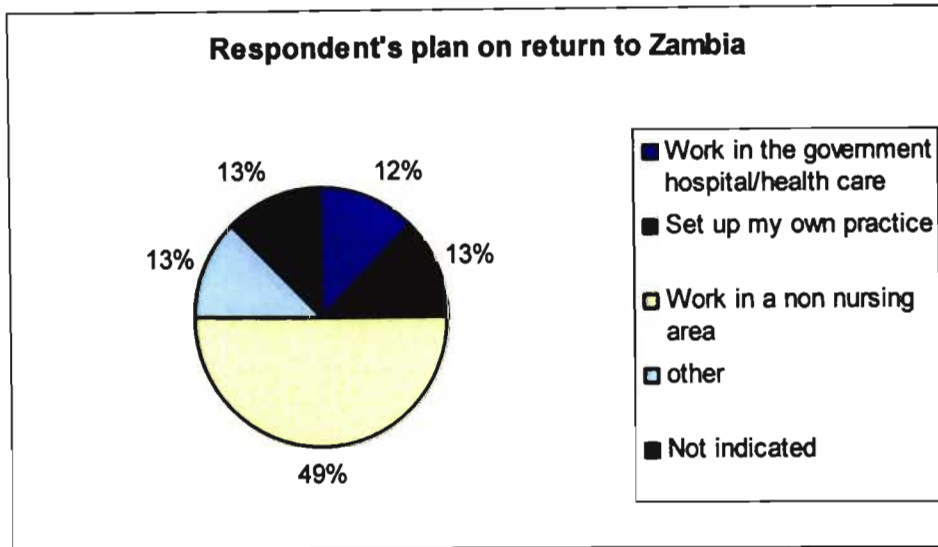
**Figure 4.41 When Respondent intends to move to another country (n= 8)**

Respondents were asked if they intended to come back and work in Zambia. Sixty two percent of them indicated they would come back and 38% would not (Figure 4.42). When asked when they would come back to their home country, only 25% specified the period and indicated they would do so in 5-7 years time. Thirty seven percent of the respondents could not specify when they intended to come back and 38% did not indicate any period at all.



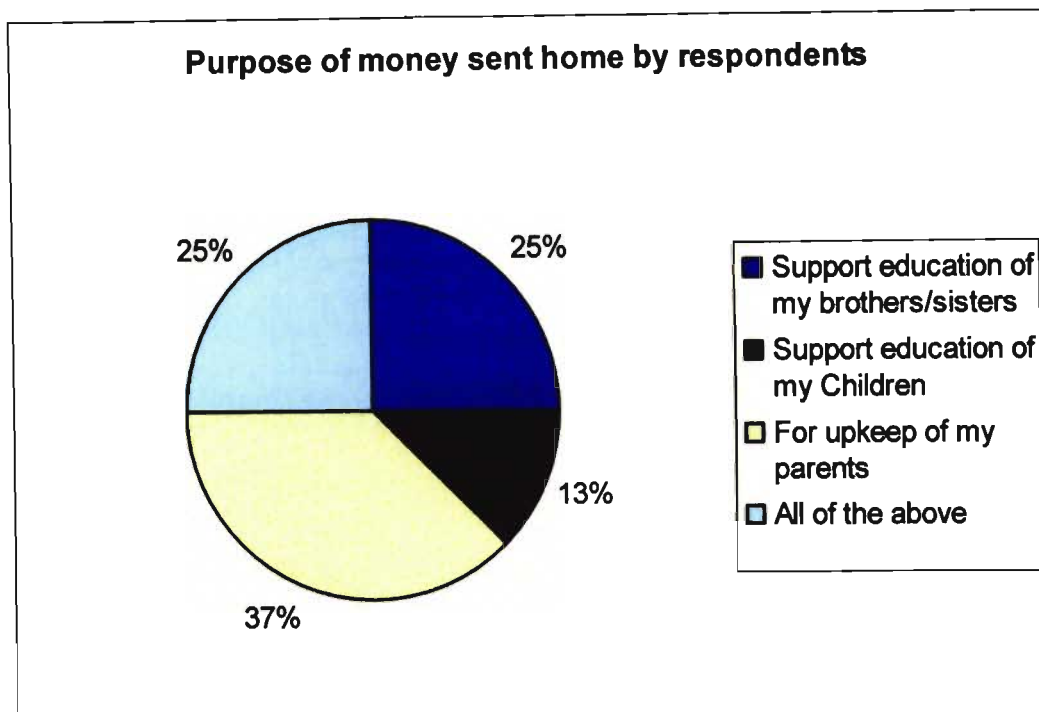
**Figure 4.42 Whether respondent had intention of coming back to Zambia (n=8)**

Respondents who intended to come back to work in Zambia were also asked on what they intended to do on return. As can be seen from Figure 4.43, 49% would work in a non-nursing area and 13% would set up their own practice. Those who expressed interest in working in a government health facility were only 12%.



**Figure 4.43 What returning respondents would do when they come back to Zambia (n=8)**

When asked whether they were sending any money home while working outside Zambia, all the respondents indicated they did so. In terms of intended purpose of the money sent home, results in Figure 4.44 show most (37%) respondents sent money home in order to support the upkeep of their parents, 13% did so to support the education of their children and 25% were supporting the educating of their brothers and sisters. Those who sent money for the purpose of all the mentioned support were 25%.



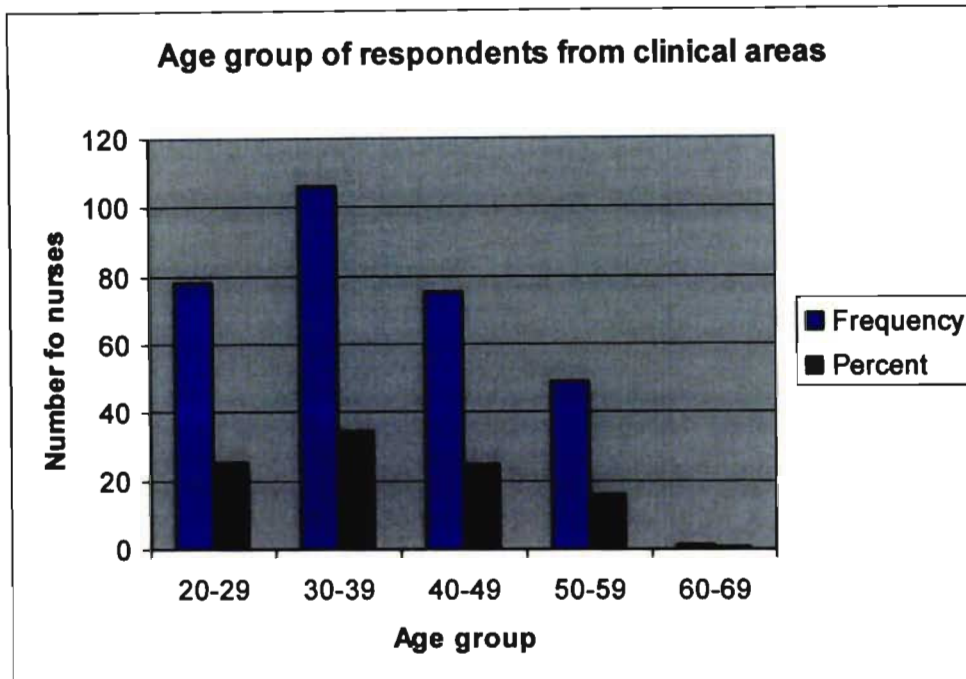
**Figure 4.44** How the money sent home by respondents was used (n= 8)

**4.2.1.4. Perceived impact of nurses leaving for greener pastures**

This part of the study deals with the perceived impact of nurses leaving for greener pastures on the public health care system. Findings presented are based on data collected from nurses working in health care settings using a self administered questionnaire. A total of 500 questionnaires were distributed to nurses working in clinical settings and 309 (61.8%) completed ones were collected back by the research assistants.

The respondents working in various care settings and were included in the sample comprised 295 (95%) females and 14 (5%) males. One hundred and forty one (46%) of these were married, 111 (36%) were single and 34 (11%) widowed. The rest comprised 17 (6%) divorced and 6 (2%) separated.

According to Figure 4.45, the categorized age groups of respondents showed 106 (34%) who were aged 30-39 years and 78 (25%) 20-29 years. Seventy five (24%) of the respondents were aged 40-49 years and 49 (16%) were in the 50-59 age group.



**Figure 4.45 Age group of respondents working in health care facilities in Zambia (n= 309)**

When data were analyzed according to age group and gender, results as per Table 4.11 showed that in the age group of 30-39 years, the percentage of male respondents was much higher (57%) than that of females (33%). However, the percentage of females was higher in the age groups of 20-29 (25%) and 40-49 (25%).

**Table 4.11 Age group and gender of nurses working in Zambia (n= 309)**

Age group	Sex		Total
	Male	Female	
20-29yrs	3 21.4%	75 25.4%	78 25.2%
30-39yrs	8 57.1%	98 33.2%	106 34.3%
40-49yrs	1 7.1%	74 25.1%	75 24.3%
50-59yrs	2 14.3%	47 15.9%	49 15.9%
60-69yrs	0 0.0%	1 0.3%	1 0.3%
Total	14 100.0%	295 100.0%	309 100.0%

Data on the basic qualifications of nurses revealed more enrolled (69%) than registered nurses (31%) in the sample. Table 4.12 displays data on basic qualifications and work experience. The figures show more nurses with less experience in the sample. Nurses with work experience of 0-5 years were 77 (27%) and the 6-10 years experience were 67 (23%). The total number of registered nurses was 85 and 34 (40%) of this number was in the 0-5 years category of experience while enrolled nurses in the same category of experience were 201 with 43 (21%) According to these figures, the number of nurses appeared to decrease with increase in years of work experience. For example, nurses with work experience of 31-35 years were 15 (5%) while those with 36-40 years experience were only 7 (2%).

**Table 4.12 Basic qualifications and work experience of nurses working in health facilities in Zambia (n= 309)**

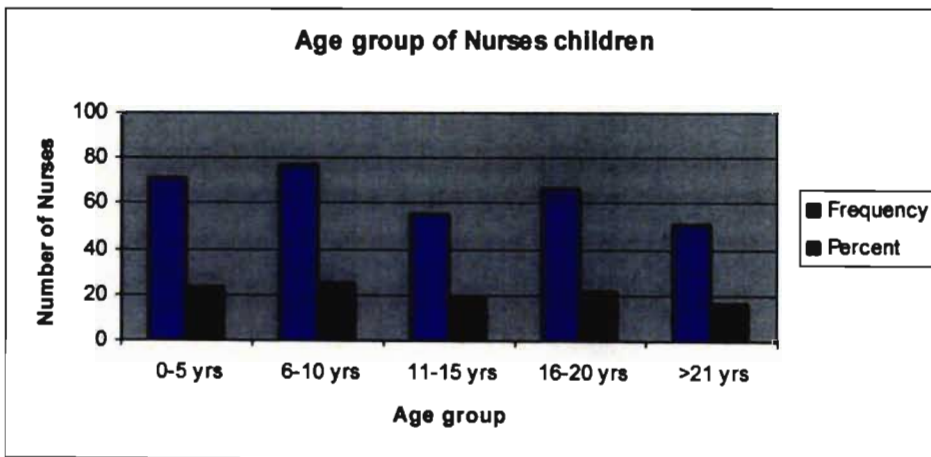
Experience in years	Basic qualifications		Total
	RN	EN	
0-5	34 40.0%	43 21.4%	77 26.9%
6-10	16 18.8%	51 25.4%	67 23.4%
11-15	7 8.2%	22 10.9%	29 10.1%
16-20	6 7.1%	23 11.4%	29 10.1%
21-25	9 10.6%	19 9.5%	28 9.8%
26-30	10 11.8%	24 11.9%	34 11.9%
31-35	3 3.5%	12 6.0%	15 5.2%
36-40	0 0.0%	7 3.5%	7 2.4%
Total	85 100.0 %	201 100.0 %	286 100.0 %

Respondents were asked to indicate the number of children that they had. According to figures in Table 4.13, 156 (50%) of the respondents had 1-3 children and 70 (23%) had 4-6 children. Those who had more children (7-9) were 9 (3%) in number and 6 (2%) had 10 children or more.

**Table 4.13 Number of children of nurses working in Zambia (n= 309)**

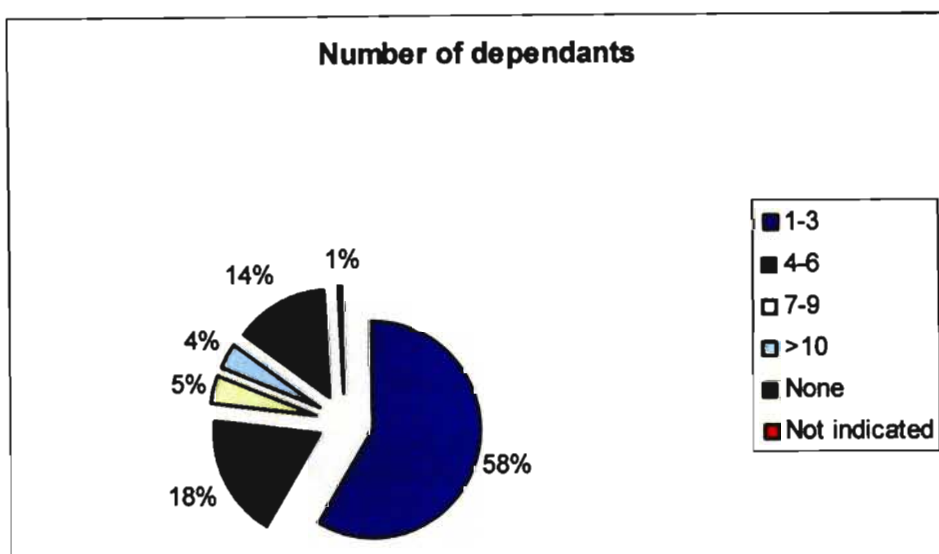
No of children	Frequency	Percent
1-3	156	50.485437
4-6	70	22.653722
7-9	9	2.9126214
10>	6	1.9417476
None	67	21.682848
Not indicated	1	0.3236246
<b>Total</b>	<b>309</b>	<b>100</b>

Regarding the age of children that respondents had, findings in Figure 4.46 show that 77 (24%) had children in the younger age group of 6-10 years and 71 (22%) had children aged 0-5 years. Only 16 (16%) had older children of 21 years and above.



**Figure 4.46 Age group of children of nurses working in Zambia (n= 309)**

For the nurses still working in Zambia, the number of dependants who were living with them is shown in Figure 4.47. Fifty eight percent of the nurses in the sample had 1-3 dependants living with them and 18% had 4-6 dependants under their care. Five percent lived with 7-9 dependants and 4% of them had over ten dependants. Only 14% of the nurses did not have any dependants at all.



**Figure 4.47 Number of dependants living with respondents who were working in Zambia (n= 309)**

#### **Respondents' position at workplace**

Respondents were asked to indicate the position that they held at their place of work in order to ascertain their level of responsibility and seniority. The results from the data analysis are shown in Table 4.14. As indicated, 184 (60%) of the respondents were enrolled nurses and these were in the majority. Enrolled midwives comprised 43 (14%) of the respondents. There were 39 (13%) registered nurses and 11 (4%) registered midwives. Respondents in senior positions were sisters in charge of wards or departments

5%, acting ward manager 1%, principal enrolled nurse 1% and nursing officer (matron) 1%.

**Table 4.14 Workplace position held by respondents working in Zambia (n=309)**

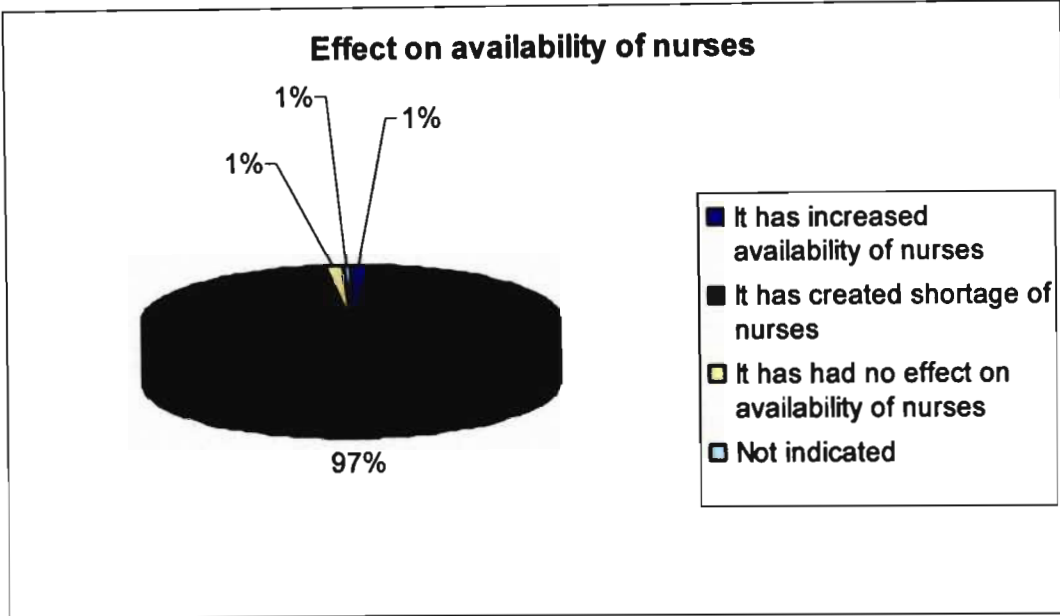
Position	Frequency	Percent
Enrolled Nurse	184	59.55
Enrolled Midwife	43	13.92
Registered Nurse	39	12.62
Sister in charge	16	5.178
Registered Midwife	11	3.56
Principal Enrolled Nurse	3	0.971
Acting Ward Manager	3	0.971
Nursing Officer	2	0.647
Not indicated	8	2.589
<b>Total</b>	<b>309</b>	<b>100</b>

**i) Perceived impact of migration on availability of nurses**

This part of the results addresses the issue of perceived impact of nurses leaving for greener pastures on the public health care system. Respondents were asked for their perceived impact on availability of nurses, utilization of staff, work implications and the quality of care.

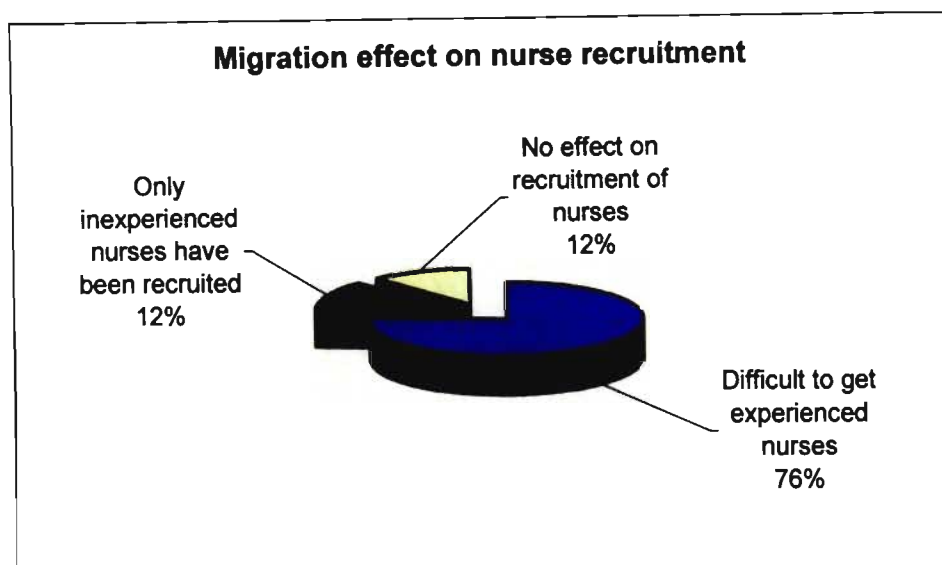
**Availability of nurses**

According to the results in Figure 4.48, 97% indicated that nurses leaving for greener pastures had decreased the availability of nurses in their work places. Only 2% had indicated the contrary and 1% did not indicate their response.



**Figure 4.48 How nurses leaving for greener pastures has affected availability of nurses in respondents' work place (n= 309)**

Regarding the question on recruitment of nurses, a large percentage (76%) responded indicated that it was difficult to get experienced nurses in their work place as a result of nurses leaving for greener pastures. As indicated in Figure 4.49, only 12% inexperienced nurses had been recruited in their workplaces. Only 12% responded that nurses leaving for greener pastures had had no effect on the recruitment of nurses in their work places.



**Figure 4.49 How nurses leaving for greener pastures affected recruitment of nurses (n= 309)**

#### **Utilization of staff**

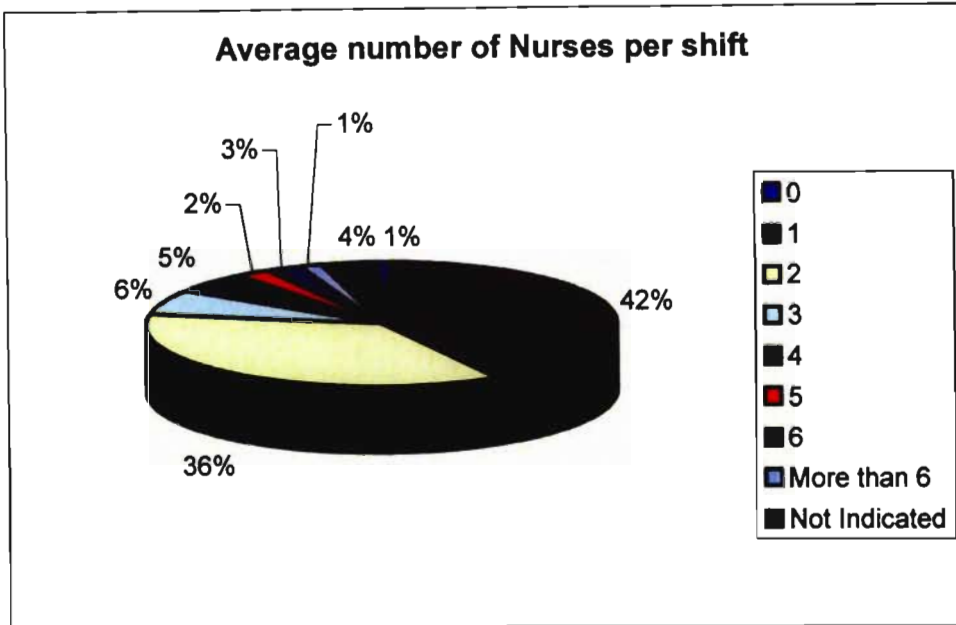
To establish the manner in which nurses were being utilized, respondents were asked questions on who took charge in the clinical settings of their work places, their working shifts and their scope of practice.

On the question of who was in charge most of the time where respondents worked, Table 4.15 shows that 229 (74%) indicated the registered nurse was in charge of the ward or clinic most of the time. Fifty four respondents (17%) gave the enrolled nurse as the person who was in charge in their workplace most of the time while 10 (3%) indicated anybody available at the time could take charge. Ward attendants were given as the other persons who took charge by 6 (2%) of the respondents. The registered midwife was indicated by only 4 (1%) of the respondents and the sister in charge was mentioned by only 1 (0.3%) respondents as the person in charge of their workplace most of the time.

**Table 4.15 Person in charge of respondent's workplace (n= 309)**

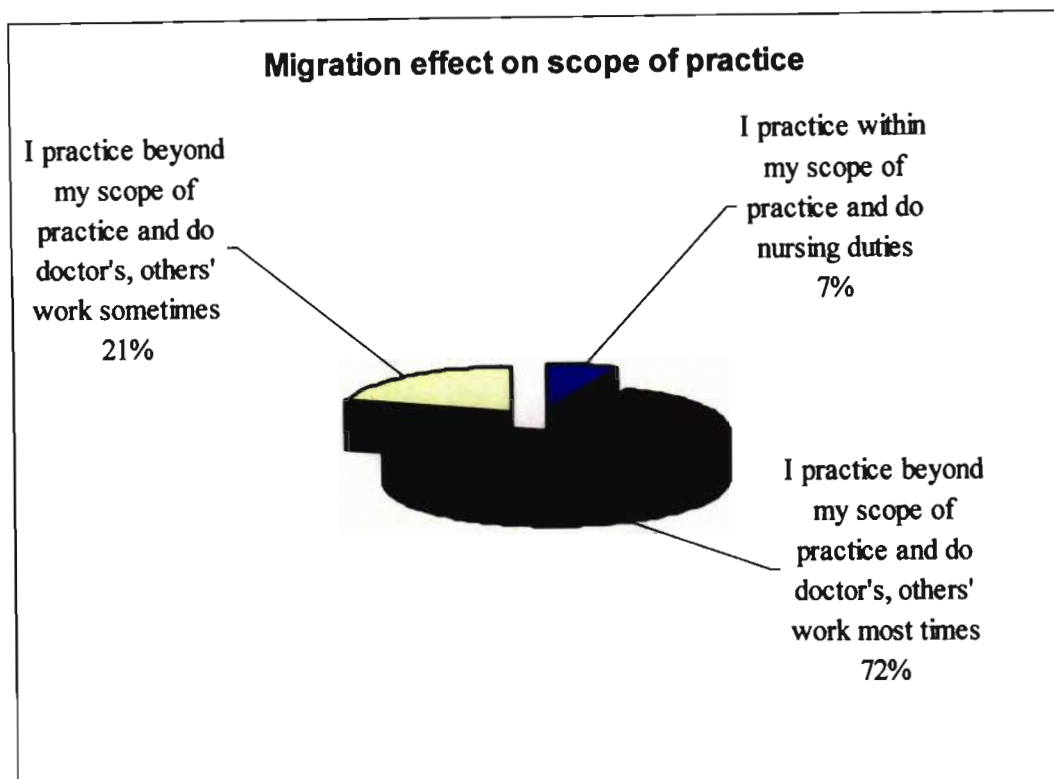
Person in charge	Frequency	Percent
Registered nurse	229	74.11003
Enrolled Nurse	54	17.47573
Anybody available at the time	10	3.236246
Ward Attendant/Manager	6	1.941748
Registered Midwife	4	1.294498
General Worker	1	0.323625
Registered Nurse & Enrolled Midwife	1	0.323625
Sister-In-Charge	1	0.323625
Not indicated	3	0.970874
Total	309	100

Data on the number of nurses during each shift was analyzed. According to Figure 4.50, most (42%) of the respondents indicated there was only one nurse per shift on average to care for an average of 40 patients. Thirty six percent indicated there were an average of two nurses per shift and 6% gave 3 for the same number patients . Five percent indicated 4 nurses per shift, 3% gave 6 nurses, 2% gave 5 as the average number and 1% more than 6 nurses. However, 1% of the respondents indicated a zero number of nurses per shift to care for the average number of 40 patients.



**Figure 4.50 Average number of nurses available and providing care to an average of 40 patients per shift (n= 309)**

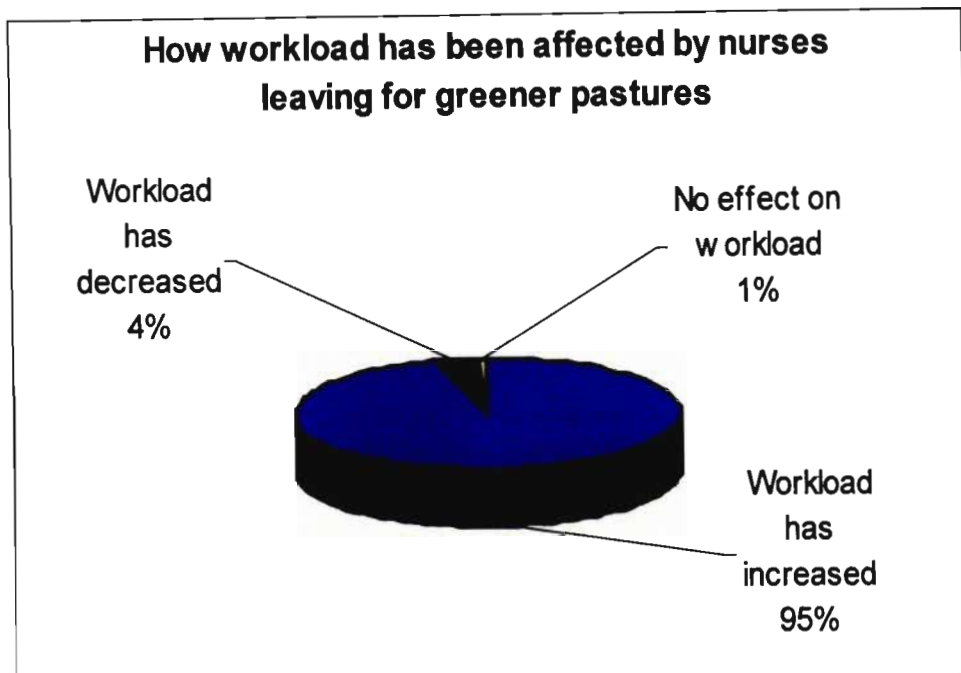
Data on how respondents' scope of practice had been affected by nurses leaving for greener pastures is shown in Figure 4.51. According to the findings, 72% of the respondents described their practice as beyond their scope and indicated that they did doctors' and other workers' work and 21% did the same but only sometimes. Only 7% indicated they did nursing duties and practiced within their scope of practice.



**Figure 4.51** How respondents' scope of practice had been affected by nurses leaving for greener pastures (n= 309)

**ii) Migration implications on respondents' workload**

Regarding how respondent's workload had been affected by nurses leaving for greener pastures, Figure 4.52 almost all the respondent (95%) indicated that their workload had increased as a result of nurses leaving for greener pastures. Only 4% perceived their workload as having decreased and 1% had had no effect on their workload.



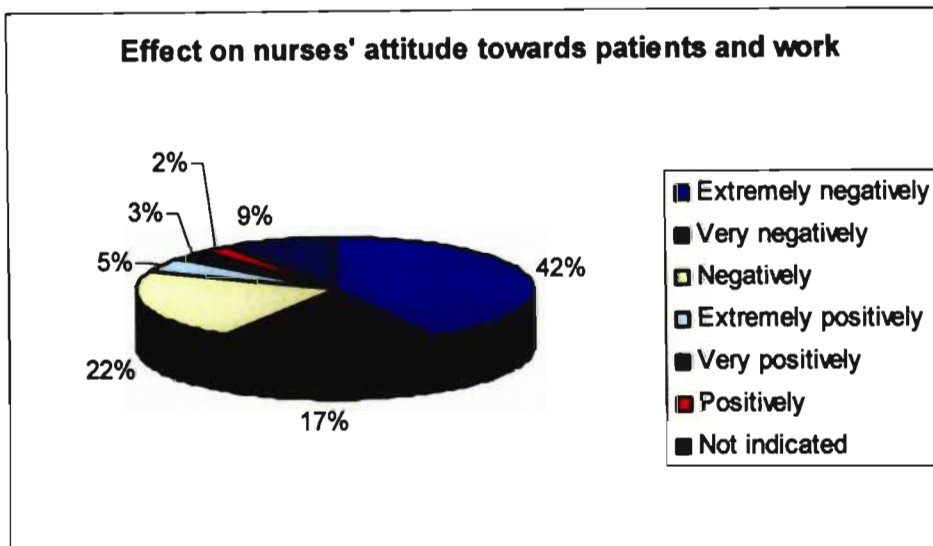
**Figure 4.52 How respondents' workload had been affected by nurses leaving for greener pastures (n= 309)**

On the question of whether the leaving of nurses for greener pastures had affected the respondent's job satisfaction, Figure 4.53 shows that there were more nurses (95%) who responded in the affirmative and only 5% did not indicate any response. the majority (58%) indicated they were frustrated in their job most of the time and (22%) felt frustrated always while 15% were occasionally frustrated in their job.



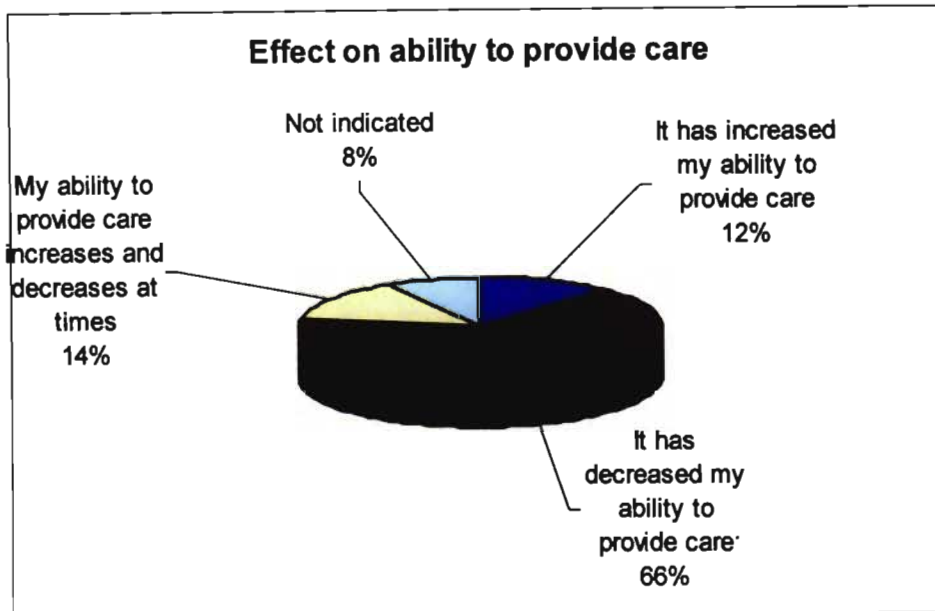
**Figure 4.53 Effect of nurses leaving for greener pastures on respondents' job satisfaction (n= 309)**

Regarding the attitude of nurses towards patients, 284 (92%) of respondents indicated that the attitude of nurses towards patients and their work had been affected by nurses leaving for greener pastures while 25% indicated nurses attitude had not been affected. According to Figure 4.54, most respondents rated the effect as extremely negatively (42%), very negatively (17%), negatively (22%), extremely positively (5%), very positively (3%) and positively (2%). Those who did not respond to this question were 9%.



**Figure 4.54 Effect of nurses leaving for greener pastures on nurses attitude towards patients and their work (n= 309)**

On the question of effect on ability to provide care as a result of nurses leaving for greener pastures, the figures in Figure 4.55 reveal that 66% of the respondents indicated their ability to provide care had decreased while that of 14% increased and decreased at times and the ability for 12% had increased. Eight percent of the respondents did not provide any response to the question.



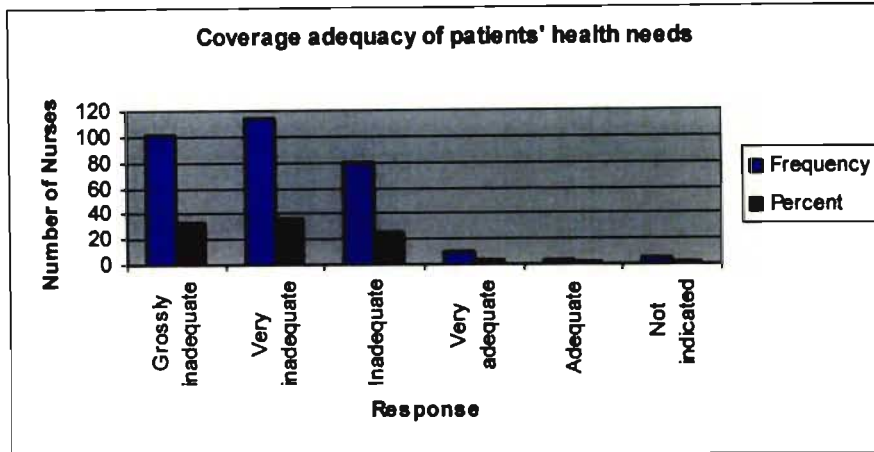
**Figure 4.55 Effect on respondents' ability to provide care by nurses leaving for greener pastures (n= 309)**

### iii) Impact on quality of care

This part of the data presentation focuses on the impact of nurse migration on the quality of care in relation to respondents' perception on adequacy of coverage of patients health needs, institutional management and leadership response to provision of supplies and the quality of management supervision. Also included is data on management of nurses leaving for greener pastures, whether respondents intend to leave the country and what has made them stay in Zambia.

On the question of adequacy of coverage of patients' health needs, 113 (37%) described it as very inadequate while 101 (33%) indicated it was grossly inadequate. Those who described it as inadequate were 79 (26%), very adequate 9 (3%) and adequate 3(1%).

Four (1.3%) did not provide responses to the question (Figure 4.56)



**Figure 4.56 Respondents' perception on adequacy of coverage of patients' health needs and quality of supervision (n=309)**

Respondents were also requested to respond to questions regarding the impact on management supervision in view of nurses leaving for greener pastures in relation to supplies that enable nurses to do their work. Table 4.16 displays the findings which show that the 183 (52%) who were in the majority of the respondents stated that management did nothing about the pre-requisites and supplies needed to do their work. Seventy eight (25%) of them indicated there had been a decrease in the supplies necessary for their work. Only 44 (14%) responded that there had been an increase in the provision of supplies that enabled them to do their work.

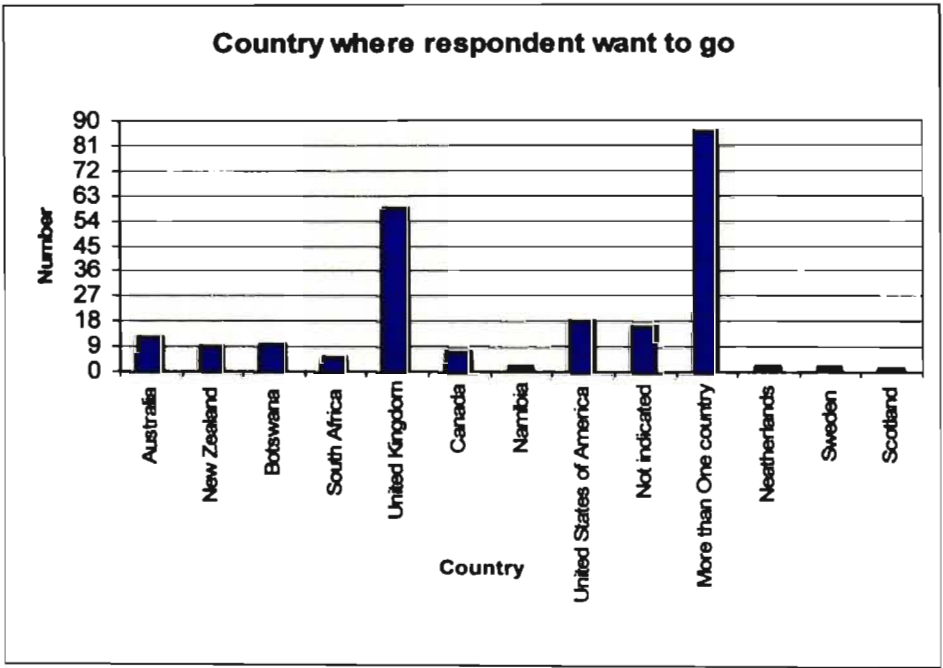
Regarding the response to the question on whether the quality of leadership and management support and supervision had improved in view of nurses leaving for greener pastures, more respondents, 139 (44%), strongly disagreed and 125 (40%) disagreed that the quality of supervision had improved. However, 13 (4%) strongly agreed that the quality of management supervision had improved and 28 (9%) agreed that it had.

**Table 4.16 Perceived impact on management support and quality of supervision (n= 309)**

In response to nurses leaving, management:	Frequency	Percent
Increased the pre-requisites and supplies needed to do my job	44	14.23948
Decreased the pre-requisites and supplies needed to do my job	78	25.24272
Did nothing about the pre-requisites and supplies needed to do my job	183	59.2233
Not indicated	4	1.294498
Total	309	100
Nurse leaders support and quality of supervision improved:		
Strongly agree	13	4.20712
Agree	28	9.061489
Strongly disagree	139	44.98382
Disagree	125	40.45307
Not indicated	4	1.294498
Total	309	100

With regards to the respondents' intention to leave and work outside Zambia, 225 (73%) had plans to leave. Only 79 (26%) had no intentions of leaving the country and 5 (2%) did not give any response to the question.

For those with the intention of leaving in order to work outside the country, data in Figure 4.57 shows the countries to which they wished to go and work. Fifty eight (18%) chose the United Kingdom as the county they wished to go and work and 18 (6%) intended to go to USA. However, 86 (28%) indicated they would wish to go to more than one country.



**Figure 4.57 Countries where respondents who wished to leave the country intended to go (n= 309)**

Findings on what would make respondents stay and work in Zambia are shown in Figure 4.58. The majority, 126 (41%) of the respondents were still working in Zambia because

they were hoping the conditions of work would be made better in the future. family responsibility was the reason for staying for 104 (34%) of the respondents. Other respondents, 17 (6%), were still processing their papers and also mobilizing resources specifically the money needed for the move which others were hoping to get from their retirement. Other reasons given were better education in Zambia (5%), patriotism (3%), satisfied with working conditions(1%), still working on qualifications and experience (1%) waiting for the right time (1%). Ten percent did not indicate reason for not leaving and staying in Zambia.

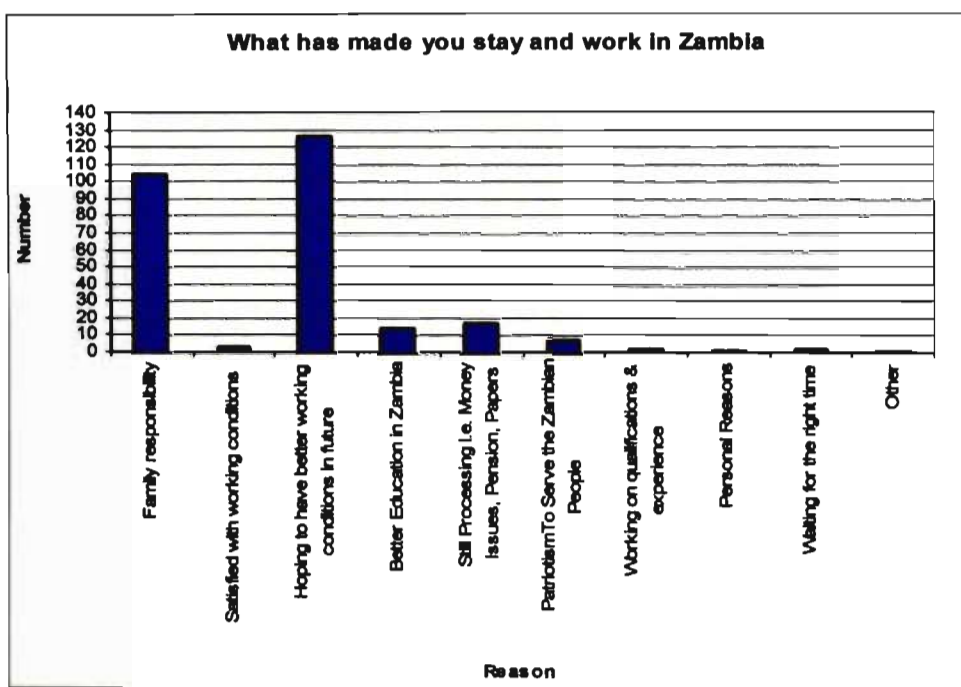


Figure 4.58 Respondents' reason for staying and working in Zambia (n= 309)

#### ***4.2.1.5 Issues for policy on managing nurses leaving for greener pastures***

Respondents were asked regarding guidelines that should be put in place in order to better manage nurses leaving for greener pastures. According to data analyzed and displayed in Table 4.17, there were more respondents 81 (26%) concerned with the need for transport, loans, improving work conditions and increasing the number of nurses in the country. Fifty two (17%) specifically mentioned that government should improve the nurses' salary scales and provide them with accommodation and 51% indicated the necessity for better work conditions. Thirty three (11%) indicated nurses should work for 2-5 years before being allowed to leave the country while 20 (6%) that there should be no rules at all regarding nurses leaving for greener pastures. Sixteen (5%) stated nurses going for greener pastures should be given specific time to work outside the country and that nurses should be free with management and government regarding making such arrangements.

Other results were 11 (4%) government to provide equipment, supplies and adequate staffing, 10 (3%) nurses to go for further studies and improve conditions, 6 (2%) government to sponsor nurses leaving the country and conditions of service, 2 (1%) for provision of easy rules for going and incentives for staying, introduction of minimum fee or payment by the receiving country, government should listen to people, good relationships, bonding nurses for a period and communication with management.

**Table 4.17 Policy issues on management of nurses leaving for greener pastures (n= 309)**

<b>Guidelines</b>	<b>Frequency</b>	<b>Percent</b>
Government to provide loans, transport allowance, increase nurses	81	26.2
Government to improve salary scale, accommodation, working condition	52	16.8
Government should provide better conditions of service	51	16.5
Nurse to service for at least 2-5yrs before leaving	33	10.6
No Rules	20	6.4
Give specific period of time to work & be free with management	16	5.1
Government to provide equipment, supplies & adequate staffing	11	3.5
Nurses to go for further studies & improve conditions	10	3.2
Government to sponsor those going & conditions of service	6	1.9
Not indicated	6	1.9
Other	3	0.9
Management to place easy rules for going out, incentives for staying	2	0.6
Introduce minimum payment or fee per country	2	0.6
Good relationship, bondage, communication	2	0.6
Improve supplies for work & conditions of service	1	0.3
Guidelines on how to work n express themselves, better environment	1	0.3
Nurses to upgrade themselves in fields they like - workshops	1	0.3
Get advice from neighboring countries about their nurses	1	0.3
Government to stop those who are sick from seeking treatment outside	1	0.3
Countries where nurses are going should pay Government	1	0.3
Government should listen to the people	1	0.3
Nurses to be appraised after long service	1	0.3
<b>Total</b>	<b>309</b>	<b>100</b>

#### ***4.2.1.6 Perceived impact of nurse migration on education and training of nurses***

The results in this part of the presentation are based on the data from nurse educators who completed a self-administered questionnaire in relation to their perception of the impact of nurses leaving for greener pastures, with a focus on the education and training of nurses. Forty (40) self administered questionnaires were distributed to nurse educators who included tutors, lecturers and nurses who assisted with the teaching of students in the

school and clinical settings. A total of 23 (57.5%) responded. The questions were on their demographic characteristics, professional qualifications and family responsibility in relation to their children and dependants. Impact questions in view of nurses leaving for greener pastures were on availability of nurse educators, utilization of educators as staff, work implications, and impact on the quality of teaching and learning of students.

### **Characteristics of respondents**

The findings showed that of the 23 nurse educators who completed the questionnaire, 3 (13%) were males and 20 (87%) were females. Twelve (53%) of them were aged 40-49 years and 8 (35%) were in the 30-39 age category. Only 2 (9%) were aged 50-59. the youngest was in the class interval of 20-29 years. There were more married (83%) than single (9%) and widowed (8%) nurse educators. All the respondents had children.

Fourteen (61%) had between 1-3 children and 9 (39%) had 4-6 children aged 6-10 years (13), 11-15 years (12), 0-5 years (5) and 16-20 (4) respectively.

Findings further showed that the majority (87%) of nurse educators had dependants who they were looking after and living with and the rest ((13%) had none. Of those with dependants, 14 (61%) had 1-3 and 6 (26%) had 4-6 dependants respectively.

Regarding their qualifications, results indicated all 23 (100%) nurse educators had registered nurse qualification with post basic qualifications such as midwifery, diploma in nursing education, Bachelor of Science and Masters Degrees. The distribution of these

qualifications was nine with registered midwifery, two diploma in nursing education, nine Bachelor of Science in Nursing degree and one Masters Degree holder.

Results also showed the positions that the respondents held at the institutions where they worked as nurse educators were as follows: 9 (39%) clinical teachers, 6 (26%) registered nurse tutors, 4 (17%) principal tutors, 2 (9%), 1 (4%) registered midwifery tutor and 1 (4%) lecturer.

#### **Availability of nurse educators**

Findings on how nurses leaving for greener pastures affected the availability and recruitment of nurse educators showed that all 23(100%) of the respondents indicated that nurses leaving for greener pastures had decreased availability of nurses and nurse educators in their institutions. Regarding the question on how recruitment had been affected in the last three years, the majority (71%) responded that it was difficult to get experienced nurses and nurse educators and 14% indicated only inexperienced nurses and nurse educators had been recruited and another 14% responded that there had been no effect on recruitment of nurse educators in their work places.

#### **Utilization of staff**

Results on the question on who was in charge of the school most of the times showed more (39%) respondents who indicated the principal tutor followed by 22% for nurses education manager, 17% for senior tutor and tutor respectively and 4% who indicated lecturer as person who was in charge most of the time.

### **Work implications**

Findings on the work effects of nurses leaving for greener pastures on nurse educators are shown in Table 4.18. Regarding the effect on workload, results showed 96% indicated their workload had increased and only 4% saw no effect. On the question of effect on job satisfaction, 87% indicated their job satisfaction had been affected; 53% were frustrated in their job most of the times and 32% only occasionally while 18% did not respond to the question.

Results from the question of effect on nurse educators' attitude showed 87% had been affected; 29% by an equal percentage of extremely negative effect, very negatively, and negatively respectively. Only 9% showed a positive effect and 4% extremely positive effect.

Analysis of data on the question of effect on nurse educators' ability to provide teaching of students shows only 9% of respondents were positive in terms of increase in their ability to teach. Fifty percent had their ability decreased, 40% had it increased and decreased at times and 4% did not indicate.

**Table 4.18 Work effects of nurses leaving for greener pastures on educators (n= 23)**

<b>How has your workload been affected</b>	<b>Frequency</b>	<b>Percent</b>
My workload has increased	21	95.5
No effect on my workload	1	4.5
Not indicated	1	4.5
<b>Total</b>	<b>23</b>	<b>100.0</b>
<b>How has your job satisfaction been affected</b>		
I am always frustrated in my job	3	15.8
I am frustrated in my job most of the times	10	52.6
I am occasionally frustrated in my job	6	31.6
Not indicated	4	18
<b>Total</b>	<b>23</b>	<b>100.0</b>
<b>How has your attitude been affected</b>		
	<b>Frequency</b>	<b>Percent</b>
Extremely negatively	6	28.6
Very negatively	6	28.6
Negatively	6	28.6
Extremely positively	1	4.8
Positively	2	9.5
<b>Total</b>	<b>23</b>	<b>100.0</b>
<b>How has your ability to provide teaching been affected</b>		
It has increased my ability to provide teaching	2	9.1
It has decreased my ability to provide teaching	11	50.0
My ability to provide teaching increases and decreases at times	9	40.9
Not indicated	1	4.5
<b>Total</b>	<b>23</b>	<b>100.0</b>

### **Quality of teaching and learning**

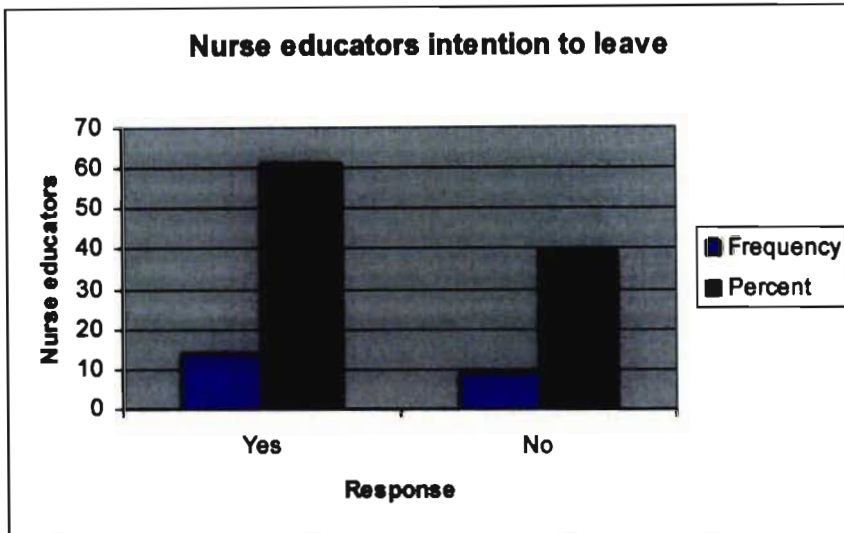
This part presents results on quality of teaching and learning based on questions on adequacy of coverage of learning needs of students, management's response with regards to providing the necessities for enhancing learning of students and their quality of supervision, whether respondents intended to leave Zambia, what had made them stay and what would inform policy on managing nurses leaving for greener pastures.

According to data in Table 4.18, respondents described the adequacy of coverage of students' learning needs as grossly inadequate (36%) very inadequate (27%) and inadequate (36%). In terms of management response to providing the necessities for learning and teaching of students, results showed they did nothing (64%), increased the pre-requisites needed to their job (23%) and decreased the pre-requisite needed (14%). In response to the statement that nurse leaders' quality of supervision had improved, 48% strongly disagreed with the statement, 44% disagreed and only 4% strongly agreed and disagreed respectively.

**Table 4.19 Adequacy of responding to teaching and learning needs (n= 23)**

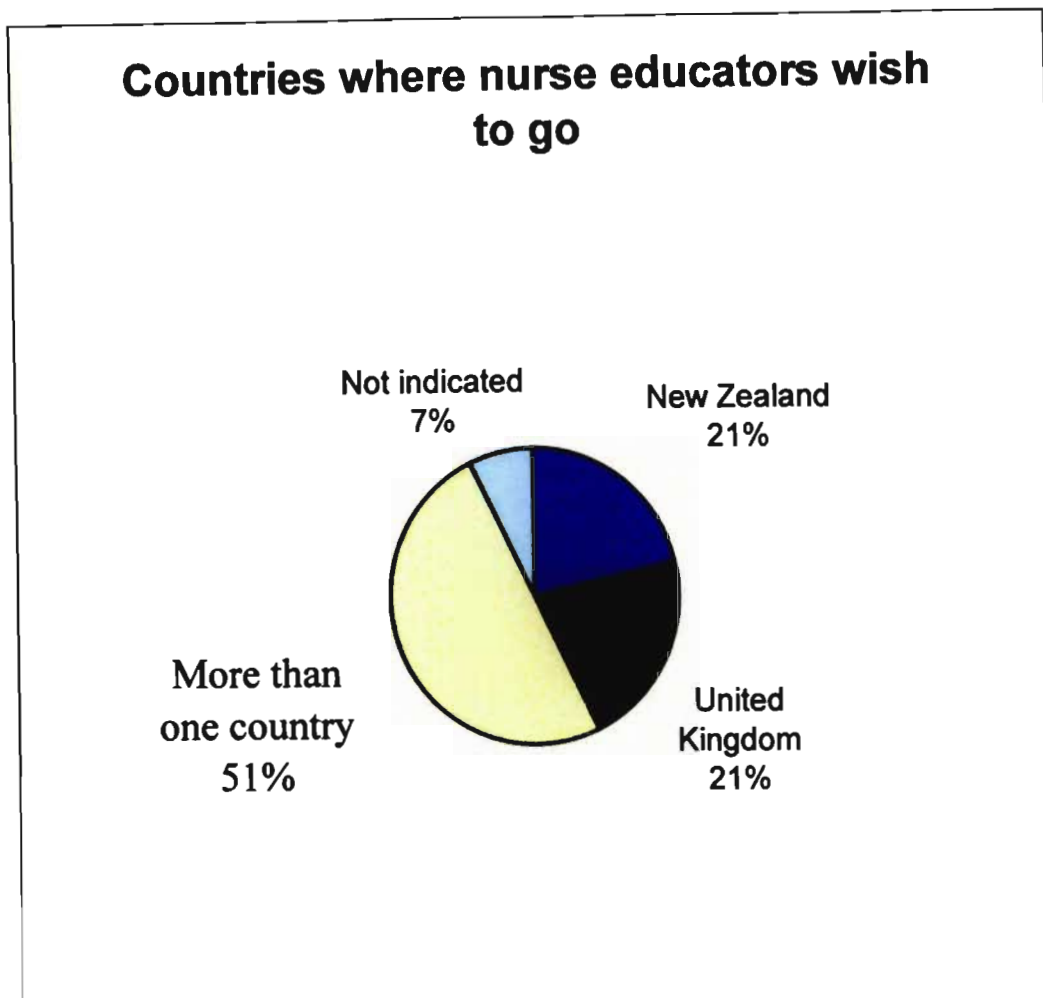
What is the adequacy of coverage of learners' needs	Frequency	Percent
Grossly inadequate	8	36.4
Very inadequate	6	27.3
Inadequate	8	36.4
Not indicated	1	4.3
<b>Total</b>	<b>23</b>	<b>100.0</b>
Nurses leaving for greener pastures encouraged management to:		
Increase the pre-requisites and teaching materials needed to do my job	5	22.7
Decrease the pre-requisites and teaching materials needed to do my job	3	13.6
Do nothing about the pre-requisites and teaching materials	14	63.6
Not indicated	1	4.3
<b>Total</b>	<b>23</b>	<b>100.0</b>
Nurse leaders' quality of supervision improved:		
strongly agree	1	4.3
Agree	1	4.3
Strongly disagree	11	47.8
Disagree	10	43.5
<b>Total</b>	<b>23</b>	<b>100.0</b>

Results in Figure 4.59 regarding whether respondents intended to leave and work outside the country showed a high percentage (61%) of those with such intentions. The rest (39%) had no intention of leaving.



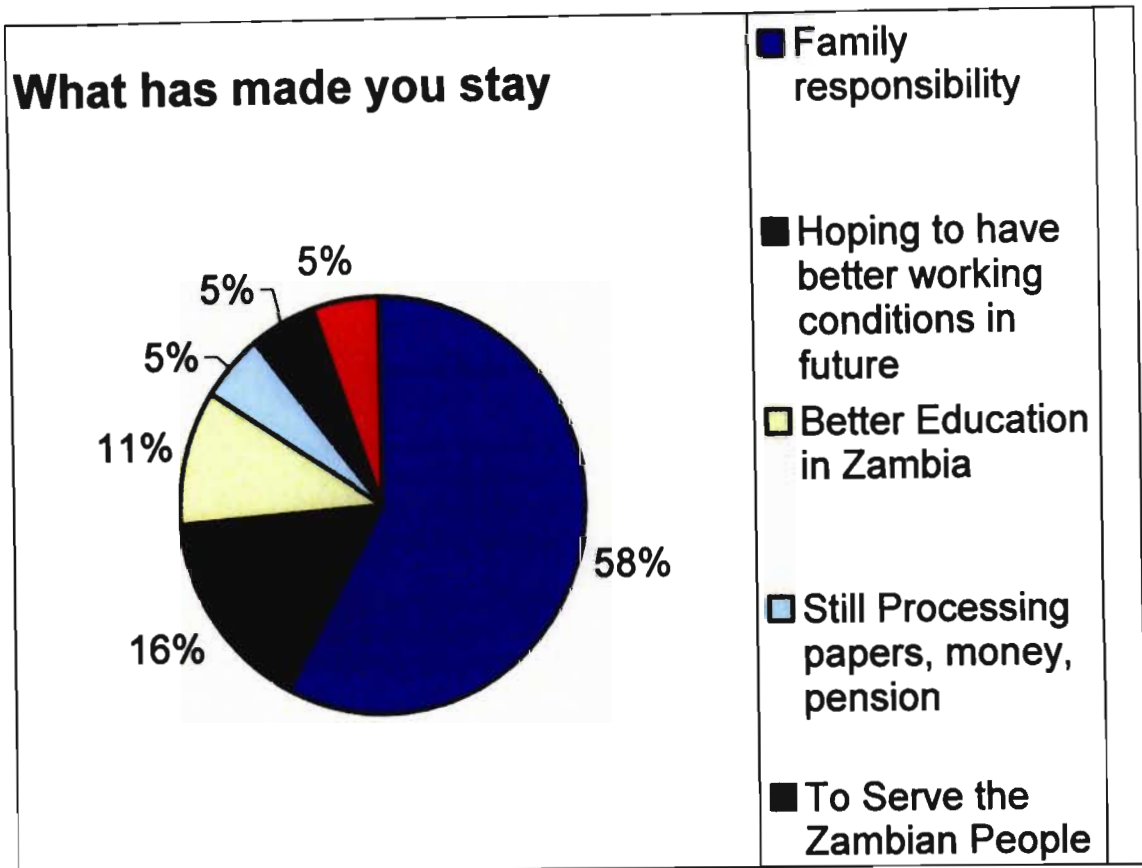
**Figure 4.59 Whether nurse educators intended to leave and work outside the country (n= 23)**

For the respondents who wished to leave the country, most (51%) of mentioned more than one country in response. New Zealand and the United Kingdom were countries of choice by an equal 21% respectively as indicated in Figure 4.60.



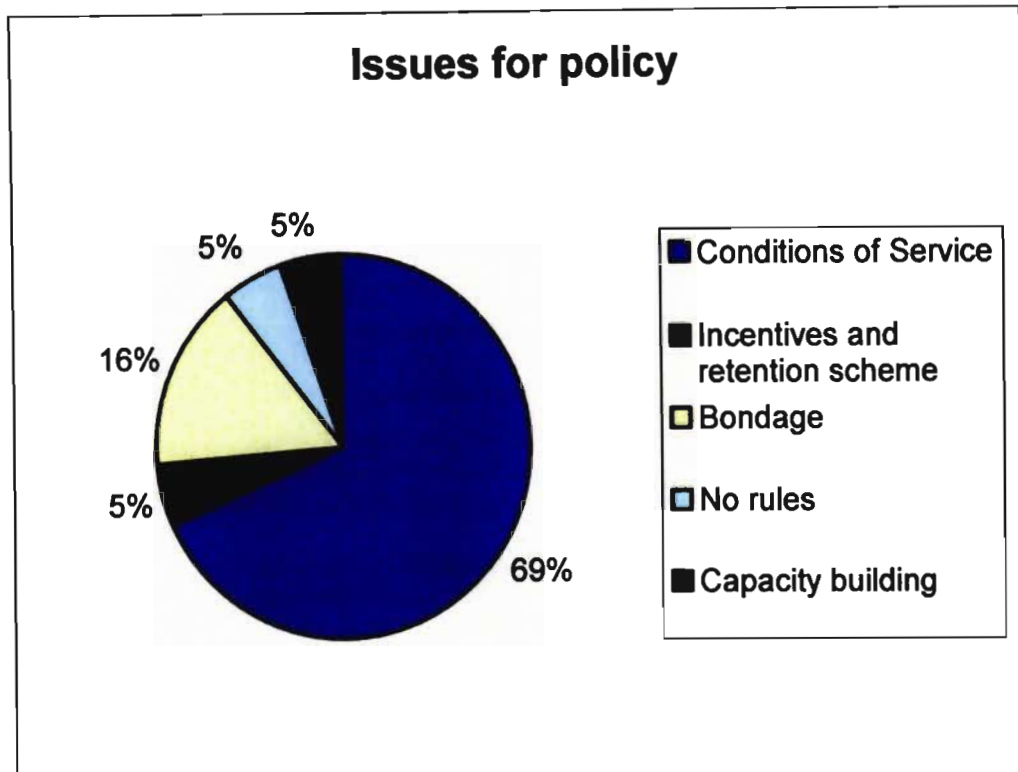
**Figure 4.60 Countries where nurse educators who wished to leave and work outside the country intended to go (n= 23)**

Findings on why the respondents had stayed to work in Zambia are shown in Figure 4.61. As indicated, more (58%) of the respondents stayed because of family responsibilities while 16% had hoped to see better working conditions in future. Reason given by 11% was that there was better education in Zambia. Others were still processing papers to facilitate their leaving (5%). Only 5% had stayed in order to serve the Zambian people.



**Figure 4.61 What made nurse educators stay and work in Zambia (n=23)**

Results on what would inform policy on how to manage nurses leaving for greener pastures show, in Figure 4.62, that most respondents' (69%) concerns were on the need for policy for nurses' work conditions and bonding of nurses (15%) to provide for conditions to be met before nurses could leave the country for work elsewhere. Other findings were the need for policies on incentives and a retention scheme for nurses (5%), capacity building that enhanced continuing education (5%) and respondents who indicated that there should be no rules at all regarding nurses leaving for greener pastures (5%).



**Figure 4.62 Issues to inform policy on managing nurses leaving for greener pastures (n= 23)**

#### **4.2.2 Qualitative data**

Qualitative data was from five sources. These were:

- Nurses who were applying for verification of their qualifications and visiting the Council following up on outcome of their applications.
- Nurses who had migrated to other countries and were visiting Zambia at time of data collection and were interviewed
- Nurses who had migrated to other countries and had come back to settle in Zambia and were interviewed

- Nurses who participated in four focus group discussions held in four selected districts.
- Policy makers at national, provincial and district levels

#### ***4.2.2.1 Nurses seeking verification***

A total of seven nurses who were applying for verification of their qualifications with the intention of registering outside Zambia were interviewed by the researcher after each completed the first part of the data collection tool. The questions in the second part of the instrument that guided the data collection from these nurses were:

- 1) What are the factors that have contributed to your decision to leave your employment?
- 2) Why do you want to leave Zambia?
- 3) What are the factors that have made you choose the country where you intend to go?
- 4) Have you already secured a job in that country? If yes, how did you get the job?
- 5) What would make you change your mind to stay and work in Zambia?
- 6) What do you suggest should be put in place to manage nurses leaving for greener pastures (nurse migration) considering the interests of both the nurses and the country?

The presentation of the findings is guided by these questions.

#### **Contributing factors towards intention to leave the country**

Study participants seeking verification of their qualifications at the General Nursing Council of Zambia with the intention of registering and working outside the country were

asked about factors that contributed to their intention to leave their jobs and the country Zambia. Five themes emerged from the analysis and these were:

- Discontent with employment conditions.
- Family responsibilities.
- Poor living conditions.
- Search for better quality of life.
- Lack of professional autonomy.

### **Discontent with employment conditions**

This was a dominant theme in the responses from the informants. What was described in relation to poor work conditions included poor remuneration, heavy workloads, poor work environments and poor career prospects.

#### ***Poor remuneration***

Informants' perception of poor remuneration was low salary, expressed by nearly all respondents as contributing to their intentions to emigrate for greener pastures. Low salaries made it difficult for them to sustain their needs, as revealed by informants below;

*The factor is the salary which is very low such that it can not sustain us. So we opt to leave.*

*The money I get is not enough to cater for everything I need.*

*Low salary which I am unable to sustain our families to the month end.*

In the above extracts, a sustaining salary is one that can last from pay day, which is commonly last day of the month, to the next pay day and the low salary referred to is not able to stretch over this period.

Some of the respondents' expectations of their salaries included to have some left over money for their personal use after attending to the basics and also to save for future eventualities. The low salaries made it difficult for them to save as stated in the excerpts below by some informants;

*Very little is left for me*

*No money is left in the bank for future use in case of emergencies.*

The inadequacy of the salary was seen not just from the respondents' needs as workers but from the perspective of their capacity to meet daily living obligations including those of their families as expressed by an informant;

*My basic salary is one million kwacha (about 238 US Dollars) and is not enough for my family, dependants, ZESCO (Zambia Electricity Supply Corporation), Water, Schools, and for my personal needs. Here in Zambia, we believe in extended families and all are supported from the same one million Kwacha.*

Most of the respondents expressed the desire for working conditions that would include more money. Leaving Zambia for a job with more money was perceived as an opening to solving the financial problems they were experiencing and being able to save for the future as indicated in these statements by informants;

*I want to leave due to financial problems which have forced me to want to leave Zambia for other countries.*

*My basic salary is seven hundred thousand Kwacha (about \$180.00 US Dollars) and it is not enough.*

*I want to have enough money in the bank for other things.*

One of the reasons cited for leaving employment in addition to poor salaries was lack of incentives which were not provided to nurses. Although incentives were not clearly defined, risk allowances and loans appeared to be part of the incentives referred to from the analysis of responses.

The need for risk allowance was perceived in relation to risks of diseases in the work environment according to excerpts expressed by informants;

*There are no incentives given to nurses*

*There is no risk allowance of diseases*

Access to loans was seen as empowering in the acquisition of family residential and transportation facilities and perceived as a means of security. An informant expressed this in the following statement:

*There are no loan facilities towards houses and cars to provide security and transport for our families.*

### **Family responsibilities**

Being able to meet family needs was described as one of the goals to be achieved through leaving the country, working hard once there and managing to provide for the family. The family in this context, referred to both the immediate and extended families. Ability to provide for the family included having adequate financial capacity to access decent accommodation and transportation through their acquisition and ownership, according to what was expressed by an informant in the statement below;

*I want to find a country where I will be able to work and achieve these goals;*

*build a good home for my family, buy a car and support both my immediate and extended families.*

From the analysis of the responses, the desire to give better education to their children was one of the dominant responses according to informants as expressed in the statements;

*My daughter has done well and all my children are always in the average but no better school to go to due to lack of money.*

*I want to raise money to educate my daughter and my brothers.*

*I want to send my children to better schools.*

*School children wait for month end to come.*

### **Poor living conditions**

Respondents perceived their way of life as within the poverty line and below that of a working person and expressed concern that this was affecting their capacity to provide basics like food for their families as expressed by the informants;

*I am living the poverty line or below the working standards of a working person.*

*Food also waits for month end to come and even then the money is not enough and not manageable.*

Poor accommodation facilities referred to as sub-standard life was seen as affecting the education and future of their children as expressed by informants in these statements;

*Here I have no decent accommodation. I share a house with three other families. We also share the toilet which is a pit latrine.*

*One of my children is at college but is not doing well due to my substandard life which also negatively affects her.*

### **Search for better quality of life**

Leaving for greener pastures was perceived as a gateway to a better quality of life. The excerpts below reveal the envisaged potential to improve their way of living as verbalized in the following excerpts by informants;

*I want to have a better life than the one I have in Zambia*

*I want to go to greener pastures so as to improve my life and way of living.*

*I also want to live decently.*

### **Professional identity and autonomy**

Lack of recognition of nurses was expressed as a concern and was seen in form of not being rewarded with a higher salary even when nurses made efforts to acquire higher university qualifications, whereas the opposite was the case with medical doctors. The low status of the nurse was perceived as not even comparable to helpers responsible for maintaining hygiene in work places. Informants had this to say;

*Even after attaining a degree, a nurse still has no incentive as a doctor.*

*The nurses are not well respected here. Even a maid is more respected.*

### **Attraction to destination countries**

Respondents who were seeking verification of their qualifications were asked regarding factors that contributed to their choice of the country where they intended to emigrate. Five themes emerged following the analysis of the responses: i) ease of communication ii) ) closeness to home country iii) prospects for better remuneration iv) better quality of life v) potential for integration vi) Peaceful environment vii) Availability of food viii) Access to professional development.

### **Ease of communication**

Being able to access information about a country contributed to informants' decision to choose the respective country. Ease of communication appeared to compliment the process of making the choice as stated by informants in the excerpts below;

*They were ready to put information on the desk for me*

*It was easy for me to communicate with them*

#### *Advantages of home country proximity*

According to the analysis results, closeness to the home country was a contributing factor to choosing a country where respondents wished to emigrate. This was considered to facilitate ease of movement between destination and home countries and providing family support including personal development through further education. The proximity of the home country also had the advantage of cost effective transportation as indicated in these statements by informants;

*I want to be close to my home country so that I can be able to attend to my family needs.*

*It is nearer to Zambia. One can just use a bus.*

*I have also intentions of coming back to Zambia to further my education.*

The last excerpt above indicates the confidence that some of the respondents had in the quality of the educational system in Zambia as they expressed their desire to come back for furthering their education. For these respondents, furthering their education may not have been one of their reasons for leaving their home country.

### **Prospects for better remuneration**

Some respondents were attracted by remuneration packages that appeared better than what they were getting back home. These were described in form of higher salaries as expressed by the informants in the following extracts;

*They pay the nurses good salaries*

*I have been attracted by the salary which is between Five to Six million Kwacha (about \$1282-\$1538)*

*Salaries are better there*

### **Better quality of life**

Respondents expected to have what they desired in the prospective destination countries through what was due to them. Inclusive was the fulfillment of what they envisioned as better quality of life in form of the type of accommodation and access to personal transportation as expressed by informants in the listed extracts below;

*I want to have a better life than the one I have in Zambia*

*This country I have chosen is able to provide what I want to have.*

*There, they even offer accommodation that is fully furnished. They even provide you with a car.*

### **Potential for integration**

From the results of the analysis, favorable racial policies and the possibility of not being segregated on the grounds of one's color was an attraction for a country. An informant explained the potential for one to work in such a country as expressed in the statement below;

*There is no segregation in terms of race as such I can work there*

### **Peaceful environment**

A good environment in a chosen country was perceived as a country which was quiet and peaceful as verbalized by an informant;

*The place is quiet and peaceful.*

*The environment is good*

### **Availability of food**

According to an informant, availability and affordability of food is important in the choice of a country as expressed in the extracts below by informants;

*.....country with plenty of food.*

*.....food is cheap.*

### *Access to professional development.*

Availability of opportunities for professional development influenced some respondents' choice of a country as expressed by an informant;

*I want to study from there in any Public Health Programme that is currently not available in Zambia.*

### **Job status**

As to whether respondents had secured jobs in advance in countries to which they intended to emigrate, only one indicated had done so as in the excerpt below;

*Yes, I have already secured a job.*

### **Factors that would make informants stay**

Three main themes emerged from findings on the question regarding what would make informants who were seeking verifications change their minds to stay and work in Zambia. These were (i) improving employment conditions (ii) addressing the nurse shortage/high workload and (iii) Professional identity and autonomy.

### **Improving employment conditions**

Employment conditions were commonly referred to as ‘conditions of service’ in the responses and referred to employment terms under which nurses were contracted or employed. This included their levels of remuneration and other entitlements that went with their jobs. According to the findings, respondents seeking verification of their qualifications expressed their willingness to change their minds from leaving the country if conditions of service were improved to a level that would enable them realize their dreams of improving their personal and family life. This improvement was associated with higher salaries, accommodation, access to loans and incentives as expressed by informants in the following statements;

*I would like the following to be put in place before I could change my mind about leaving - government should pay good salaries to nurses, a sustaining salary. They should provide loans, car, and houses.*

*When I can get enough money to provide the things that I need and save money for the future. At present building a house for myself is priority and a farm. I cannot save in Zambia. I have credits to top up on my salary thus I never have cash. Also if the government could increase salaries to K5 million Kwacha (\$1,282.00) per month for the nurse.*

An informant also referred to vocational leave for nurses, which, according to the statement below, implies that it had been suspended;

*They should also lift the suspension on vocational leave.*

*Addressing the nurse shortage*

The shortage of nurses was cited as one of the issues to be addressed in order for respondents to stay and work in Zambia. According to an informant, nurse shortage had implications of work overloading and stressing nurses. Government was perceived as the authority to address the issue as stated below by an informant;

*Government should also employ enough nurses to prevent work overload in our working places which lead to a lot of stress.*

### **Professional identity and autonomy**

Professional identity and autonomy was expressed in form of recognition of the nurse as a professional person and was stated by an informant as one of the factors that would encourage staying and working in Zambia as extracted below;

*Recognition of the nurse as a professional*

### **Policy issues**

The following themes emerged from analysis of the data on the question focusing on suggestions that would inform policy on management of nurse migration; (i) improving employment conditions (ii) improving work environment (iii) professional identity and autonomy of the nurse (iv) supportive interventions for migrant nurses.

### **Improving employment conditions**

Improvement of working conditions was recommended for inclusion in managing nurse migration policy. The issue pointed out by nearly all informants was better remuneration for nurses, with suggestion for minimum monthly wage. Additionally, access to loans was part of the conceived good work conditions. Comparatively, nurses in government were perceived more deserving than those in the private sector and this was considered motivating to nurses in the public sector. The following excerpts indicate what was expressed by informants:

*The government should pay nurses good salaries per month, at least between 6-8 million Kwacha (\$1538-\$2051 per month and provide loans to those who need the loans.*

*If the Government could increase salaries so that we could be able to sustain ourselves.*

*In Botswana for example, government nurses are paid more as compared to those in the private sector. This motivates nurses.*

### **Improving work environment**

A good working environment as policy was perceived as inclusion of modern equipment in practical settings to ease the work of nurses and employing more nurses as expressed by informants;

*There should be modern machines to make work easier for the nurses.*

*There should be equipment in the clinical areas such as other monitors like in other countries.*

Increasing the number of nurses for patient care reasons was also perceived as part of the strategy on improving the work environment as indicated by an informant in this statement;

*Government should employ more nurses to cater for the patients.*

### **Professional identity and autonomy**

The necessity for government recognition of nurses as professionals and essential workers and expansion of education and training facilities for the upgrading of enrolled nurses to the professional level were expressed by informants in the following excerpts;

*We should be recognized by the government as professionals and essential workers.*

*Some people think that a nurse is somebody who had been picked from the market, that a nurse is a helper but we are learned people.*

*Government should look at up-grading a nurse to the standard that she is recognized as a learned professional (registered nurse).*

The need for government to acknowledge the contribution of nurses in the health care system and monetary recognition of nurses with degree qualifications was expressed in the following statements by informants;

*Government should also consider nurse degree holders' salaries so that at least their salaries would be better considering the effort made on the nurse's part to improve herself in terms of education.*

*Here in Zambia, Enrolled nurses are never recognized by management no matter how much knowledgeable. Enrolled nurses are underutilized in management (Enrolled Nurse).*

A respondent perceived registered nurses as being recognized even when inexperienced as expressed in this extract;

*Registered Nurses are recognized even when they are inexperienced (Enrolled Nurse).*

### **Supportive interventions for migrant nurses**

Stories of difficult experiences of nurses who have migrated to other countries included not being able to find jobs commensurate with their professional qualifications and doing menial work. These were perceived as motivating factors for government's intervention to track down the movement of nurses and redeem the affected ones as expressed by an informant;

*For those who have gone abroad, government should follow them up and find means of protecting them there because I hear some are degraded abroad for example; in the UK nurses work in nursing homes. They cannot find jobs in hospitals but these stay because of the money involved and the government should look into that.*

The above excerpt also implies that not finding jobs commensurate with the level of one's professional preparation does not necessarily prevent other nurses from emigrating; the informant quoted in this case was seeking verification in order to emigrate despite the available information on difficulties faced by nurse migrants. It appears nurses who emigrate are prepared to endure the difficulties as their focus is the perceived benefits of emigrating.

#### **4.2.2.2 Migrated nurses**

A total of thirteen nurses who had migrated to countries outside Zambia participated in the study. Of this number, eight were visiting with the intention of going back to their countries of destination and five had returned to live in Zambia after working in other countries. During interviews, the researcher based the questions on the following five areas:

- Why respondents had left their employment in Zambia

- What had attracted respondents to their country of destination
- The purpose of their coming to Zambia
- Type of work they were doing and reasons for choice of the work and if not working, why
- Suggestions for policy on how nurse migration can be managed in Zambia

There were two additional questions specifically directed at the returnee nurses basing on the themes that were emerging during data collection. These were based on:

- Their experiences while outside the country
- Advice, if any, to other nurses who had not yet migrated.

### **Reasons for leaving employment in Zambia**

Four key themes emerged from results on why respondents had left their employment in Zambia to work outside the country; (i) discontent with working conditions (ii) search for international experience (iii) poor leadership in health services (iv) early retirements.

### **Discontent with working conditions**

Visiting migrated respondents already working outside the country attributed the economic hardships experienced prior to their leaving to low salaries which inhibited their ability to provide for their families. Low salaries were perceived as part of poor work conditions as expressed by visiting migrant informants in these statements;

*The nurses' conditions of service in Zambia were not good for me*

*I also left because of the lack of support to my extended family due to the low income I was receiving.*

A returnee informant referred to poor conditions of service in the country and compared the low salary she was getting in Zambia to what she had been receiving as a salary abroad in the following statement;

*My reasons for leaving the country were that our conditions of services are quite bad compared to there; the salaries were 2,700 Euros which is equivalent to K10 million Kwacha as compared to K1.5 million (about 400 US dollars) which we are getting here in Zambia after deductions.*

The statement above reveals the gap in remuneration between what had attracted the respondent before leaving the country and what she had come back to.

The desire for decent accommodation and the efforts made to get even the minimum was expressed through comparison and description of what was available and obtaining for nurses and their families at the time as recounted by one of the visiting migrant informants;

*I could not provide for my family adequately. I looked at my salary and this could not even afford decent accommodation. At the time I was staying in a one bed roomed house and this I only got after a struggle. The salary was too little to survive.*

*Also lack of support to my extended family due to low income I was receiving.*

The above statement also reveals expressed concern for the respondent's inadequacies related to supporting the family with emphasis on the salary as the basis for the financial difficulties.

### **Search for international experience**

Other than being attracted by more money, the desire for job opportunities abroad that would open possibilities for gaining insight into nursing in other countries and gaining exposure to international experience had motivated most returnee respondents to leave their employment and work outside the country as recounted by informants in the statements below;

*Another reason for my leaving was to acquire new skills and knowledge*

*I left mostly to gain international work experience. I was seeking a job opportunity in my relevant field.*

*I wanted to gain more proficiency and more money and to see how other nurses work and to see how to nurse different conditions in different parts of the world.*

The above reasons were also supported by two visiting informants, as expressed in the extracts below;

*I was also interested to go outside the country and see what other people were doing there.*

*I also wanted to learn what other countries could offer.*

### **Poor leadership in health services**

Lack of support and intimidating behavior by management and leadership towards nurses in the work environment was a contrast to that expected by the respondents and affected the organizational climate as seen by informants and expressed in the statements below;

*I was intimidated by my supervisors.*

*Lack of support, for example there was no counseling from my supervisor.*

### **Lack of access to professional development**

Absence of opportunities for individual professional development were attributed to poor leadership and management at work place level as indicated by a returnee informant in this statement;

*Lack of personal development and education at the individual level because there was no sponsorship for progression, were some of the reasons.*

The statement above also implies that respondents perceived themselves as having potential for further education and personal development but could not achieve this due to lack of financial support which was expected as policy from the health system resulting in inability to progress professionally, including access to promotions to more challenging positions.

Some activities in the health system were perceived as constituting corruption at national level by some respondents as indicated through their expressed perception. An informant had this to say;

*Worst of all was the corruption in Government and the health sector.*

### **Early retirements**

Some of the visiting migrant respondents had left the country because they were made to retire early before their statutory retirement age. These retirements, referred to as retrenchments or voluntary separation, were as a result of government policy which was applicable either in the mining industry or civil service public sector. Some of the informants had this to say;

*I was retrenched by the Zambia Consolidated Copper Mines*

*At that time there was voluntary separation. So I went on voluntary separation*

A further contributing factor was what the respondents were paid after being retrenched as recounted by a visiting migrant respondent in this extract;

*I felt belittled by being paid K150, 000.00 by the government after leaving.*

Respondents who were in the public sector were offered the housing units they were occupying for purchase at the time as stated by an informant in the extract below;

*I was in a pool house. I was given money and I paid for the house which I bought.*

For some respondents, it was their spouses who lost their jobs through this policy on retrenchments or voluntary separation. The perception of their inadequate capacity to sustain the livelihood of their families, including the education of their children, without their spouses' income had contributed to their decision to leave the country. This was expressed by two of the visiting migrant informants in the following statements;

*My husband lost his job in the mines and my job could not sustain the family. So we had to make a decision to leave and go where we could educate our children.*

*My husband was not working. I could not manage with six children, paying for accommodation and paying schools fees.*

### **Attraction to destination countries**

Visiting migrant respondents were asked about what had attracted them to the country of their destination. From the analysis of the data, the emerging themes were: (i) prospects

for better remuneration (ii) better quality of life (iii) conducive work environments (iv) professional identity and autonomy (v) exposure to international experience (vi) access to professional development (vii) advantages of closeness to home country.

### **Prospects for better remuneration**

According to respondents' perception, what attracted them to their countries of destination were good working conditions which were packaged to include satisfactory remuneration in form of higher salaries that were to enable them give their children the education they perceived as better and even manage to remit some of it home. As described by visiting informants in the following excerpts;

*The salary that I was offered was good as compared to what I was getting here in Zambia*

*It was good conditions of service, a good salary, school and education for the children.*

*The conditions and salaries are attractive.*

For some of the respondents, the higher salary was evidenced by their capacity to meet the requirements for the immediate family and managing to remit money home as stated by a visiting migrant informant in the statement below;

*That time their currency was stronger than ours and I managed to send money home.*

Satisfaction with the level of remuneration was expressed through the destination country's recognition of the nurses' professional identity and work experience as stated below by an informant;

*The salary they put you on is equivalent to your experience so you do not start as a beginner.*

Further satisfaction with the remuneration in the destination country was expressed as prompt payments of contractual gratuities by employers which was contrary to the experiences that respondents had had in their home country as expressed by an informant in the following statement;

*Gratuity is paid immediately your contract ends. You do not have to wait for the money. Here in Zambia, it is not easy to get anything after working, for example at the end of your contract. One cannot get money worked for quickly.*

Access to expected quality of accommodation and transportation facilities including upkeep finances were seen as part of the good working conditions and better remuneration as expressed by a visiting migrant informant;

*There are good working conditions like housing, transport as well as upkeep.*

It appeared like some of the good work conditions were not the same anymore in some of the destination countries as indicated by informants in the following excerpts;

*At first, it was fully furnished accommodation which is not the same anymore*

*We were also offered fully furnished accommodation at the time.*

### **Better quality of life**

In response to what had attracted respondents to the country of their destination, findings revealed that they were able to describe what they perceived as a better life in the destination countries and reflected on their experiences in their home country to justify

the magnitude of the gap between the two scenarios. Better life experienced in host countries was seen as affordability of daily necessities, the privilege of being on expatriate conditions of employment and having time to rest and relax despite the hard work as compared with the home country situation. Visiting migrant informants had this to say;

*Life there is better, things are cheap. You can work hard but you still can have time to relax. Here in Zambia, one has no time to relax. Always busy to make ends meet. As a night superintendent, I would sleep only a bit and then go for private practice, then come home and go for work (formerly night superintendent of a hospital).*

*I was given expatriate conditions.*

The realization of a long time dream of having access to transportation for family and personal use was overwhelming to some respondents as expressed in this extract by a visiting migrant informant;

*I also managed to buy myself a car. It was like a dream!*

### **Conducive work environments**

A good country was perceived as quiet with an environment conducive for the respondents and in which children would easily adapt, according to excerpts from both visiting and returnee informants;

*The work environment is very conducive.*

*I thought it would be easier for the children to settle as the country has a quieter environment than other countries.*

Information about the destination country was provided by friends who had gone before some of the respondents and included positive work environments and advances in patient care as expressed in the extract below by a visiting migrant informant;

*I had friends there who had gone before me and it sounded like a good country*

*The type of hospital set up, how things are done which is different from the  
Zambian one,*

From the above excerpts, an informant had a mental perception of the health facilities and the procedures in the environment in which they wished to work before migrating. Friends played a role in providing information which influenced their perception of the attractiveness of that environment.

### **Professional identity and recognition**

Excerpts from two visiting informants indicated recognition of qualifications even through shorter adaptation programmes made it easier for respondents to settle. This was an attraction for a country as indicated by two visiting migrant informants;

*They recognize qualifications*

*The period of adaptation is not very long, 6-8 weeks and I was able to do it in  
four (4) weeks and able to settle down and let my family join me.*

### **Exposure to international experience**

A returnee migrant recounted from stories, what had influenced her about a developed country to which she had emigrated, indicating the type of nursing care which she had anticipated to be of a more superior quality than what she had so far known and had this to say;

*The type of nursing care which I heard about which is better than here.*

The statement below provides what another returnee informant had experienced while working in a developing country;

*They have everything that they need to use in a ward compared to here in Zambia I learned how to use modern technology for taking BP, Temperature and advanced techniques for feeding patients with abdominal operations or throat problem (returnee).*

Another returnee from a developed country summed up the experience of nursing care quality, her satisfaction regarding what she earned, her focused job description and identity and role as a nurse;

*There is better nursing care quality and you get to do what is meant for nurses and although the work is quite a lot you earn what you deserve, and things are done in a more organized way, so you have time to do your nursing care properly. This is different from here where nurses have to do jobs for persons in other departments like the porters' work and clerical work.*

### **Opportunities for professional development.**

A visiting respondent working in a developed country described the educational opportunities and related supportive policy processes in the statement below;

*I was provided with education. Education is free but for university level, they give loans. There is also part-time education. They pay partly and you also pay. An education fund is allocated for each person. This is not much but it helps. If you have not gone to school for some time, it accumulates. If you go to workshops or school, you claim and you are given a refund. There is an educator responsible for planning for education. They also make sure you progress; there is level 1, 2, 3, 4 and 4 is the highest and nurses move on promotion. Level 1 is the new graduate and level 4 can be taken for any higher responsibilities.*

Another respondent from a similar region explained the opportunities related to on the job training for capacity building and other educational opportunities which had no bearing on the family income as described in the statement below;

*In the UK, there are more learning opportunities without loss of family income. They recognize qualifications and offer a lot of in-house courses to bring you to the level they want you to reach.*

### **Advantages of closeness to home country**

Nearness to home country for the purpose of convenience in providing family support and supervising investment projects in building from remitted funds also served as an attraction to the country of destination as expressed by a visiting migrant informant;

*It is near and therefore convenient when you want to come home and check on what is happening, for example projects such as house building and the family.*

### **Purpose of coming to Zambia**

In this part of the findings, results for visiting and returnee nurses are presented separately in order to enhance the clarity of the reasons why they were in Zambia. Those who were in the country for the purpose of visiting and with the intention of going back are referred to as visiting migrants or nurse and the nurses who had come back to settle in Zambia are referred to as returnee nurses or migrants.

### **Visiting nurses**

Regarding the reasons for coming to Zambia, there were four themes that emerged from the analysis of data; (i) family commitments (ii) professional obligations (iii) use of remittances (iv) contractual reasons.

#### ***Family commitments***

Family was the most dominant reason for informants' visit to their home country. Their commitment to parental, child and extended family support and the social integration of

their children into the family systems and the country was expressed by informants in the following extracts;

*I came to visit my family. I also wanted to link up with my parents and that there be a reunion between my children and my family.*

*I came to visit my family. I also came to get my mother so that she can have a holiday in the UK with me.*

*I came to see my family, my mother and brothers.*

Introducing children to their country and family also meant changing what a respondent from a developed country considered wrong perceptions of their home country as expressed by a visiting migrant in the following statement;

*I want my children to know their roots. My Children have a very bad picture about their country. Out there poverty is exaggerated.*

The value and confidence in the quality of the educational system in Zambia was indicated by two informants working in a developing country whose children were schooling in Zambia and another who brought his child for tertiary education respectively. This confidence was expressed by informants in the following statements;

*I have been coming home in-between though to see my children. All of them are here in Zambia. I trust the education standard here which is better than where I am.*

*My daughter was doing her GCE, so I came to see if I could find her a place at the university.*

Responsibilities of respondents included the care and upbringing of orphaned children in the family as expressed by an informant from a developed country;

*I am the one supporting my brother's children, 6 of them. They are orphans and are in school and college.*

### ***Professional obligations***

Taking advantage of their being in the country to renew their professional practice license and seeing friends was noted for some of the informants from developing countries as expressed below;

*I came to renew my license and to see friends I have not seen in the period which I have been away.*

*I also came to renew my practicing license.*

### ***Use of remittances***

Money earned out of the country had various purposes including sending some home.

The following statement gives insight into how the remittances to the home country were benefiting the individual respondents and their families as expressed by a visiting migrant informant;

*I bought a plot and I use my money for building. I also have one taxi. I also send money to my mother every two months.*

### ***Contractual reasons***

Other reasons for being in the country were end of contract leave as expressed by a visiting migrant in the excerpt below;

*It was the end of contract leave.*

#### **4.2.2.3 Returnee nurses**

The findings showed that five of the respondents who were in the country were not visiting but had returned to Zambia. Themes that emerged from the analysis of the responses were: (i) family reasons (ii) experiences as migrant nurses (iii) advice to other nurses.

##### **Family reasons**

Decision to come back and settle in the home country due to family reasons were noted among the respondents and expressed by informants in the following statements;

*Basically, because of my family. My husband refused to join me. He had visited England before and he did not like it. We had agreed that I would come back after I finished my adaptation.*

*I was missing home. I was missing the country and my family couldn't join me.*

*I missed my children and it is not good for my husband, my children and I to be in different places.*

Although the money out there was described as good, an informant who returned from a developed country expressed inability to meaningfully invest and monitor the benefits of the remittances made back home due to lack of personal presence;

*Once there, the money is good but it is difficult to invest and to monitor ones investment back home so I decided not to stay there for good (returnee migrant).*

##### **Experiences as migrant nurses**

From the emerging themes in the findings, experiences of returnee informants represented both positive and negative perceptions while working outside their country.

These were related to professional development, work environment and attitudes towards foreign staff.

A returnee migrant from a developed country shared perceived benefits in personal skills development mainly in the areas of new equipment use;

*I learned how to use modern technology for taking BP, temperature and advanced techniques for feeding patients with abdominal operations or throat problem (returnee migrant).*

Another returnee perceived experiencing better quality nursing care according to the excerpt below;

*There is better nursing care quality*

Findings also indicated some negative experiences by some returnee migrants. According to a returnee migrant from a developed country, what people anticipate to get before they migrate in respect to income and the work environment may be different from the reality according to her personal experience as expressed in the statement below;

*What the people hear about a lot of money, and they think they will work in hospitals with all the equipment. I worked in a nursing home and experienced the reality which is not the case.*

Some returnee migrants experienced what they perceived as racial segregation. A returnee migrant from a developed country expressed dissatisfaction with the treatment that she received where she had worked and referred to issues of color and segregation by both fellow staff and patients. She described her perceptions of this experience in the statement below;

*There's racism, gossip and segregation. Some patients would openly say you are black so don't touch me and all that. Others would say oh you black bitch and when they say that you don't go near them.*

She described her feelings and emotional effects that she experienced in the following statement;

*I would feel offended but later on I would say well, it is their country, what can you do you just have to tolerate them.*

Similar sentiments were expressed by visiting migrants from a developing country although the difference in attitude in this case had to do with an imbalance in work allocation, local staff expectations from foreign nurses and unfair treatment when patient mismanagement was suspected. The following statements provide what was perceived as discrimination as expressed by visiting migrants;

*In Botswana treatment is there especially when they know that you are a foreigner. They give you a lot of patients. You are also considered last in terms of off days, leave and other privileges.*

*When you are on duty, they will just sit and will not touch the patients. They say that after all you came for money. Sometimes they will help you in your area sometimes not.*

*When there is a problem with a patient, it is easier for the local nurses and if a foreign nurse is handling that patient, he or she is penalize, for example, an episiotomy breaking.*

### **Advice to other nurses**

According to some returnee migrants, it was important to advise prospective nurse migrants to have information about the environment and the attitude out there so that they are well prepared and able to make informed decisions about leaving for greener pastures.

The following extracts by some migrant returnees suggest some caution for the would be migrants as expressed below;

*That the people there are not as friendly as Zambians.*

*Just to be careful and tell them whatever they'll face and if they can withstand, fine and good.*

Loneliness was another experience that was to be expected according to the excerpt below made by a returnee migrant from a developed country;

*If you talk to a Zambian, you will be on the phone for a long time because they are very lonely.*

#### **Nature of the migrant's job**

Both visiting and returnee migrants were asked about the type of work they were doing and the reasons for the choice of work. What emerged as a main theme from the responses in the findings was related to patient care work and the reasons were expressed mostly as passion for doing work within the confines of their profession. This entailed doing nursing or midwifery work and providing services in the various areas in the public and private sectors.

Respondents expressed commitment to working as nurses according to the following listed excerpts verbalized by informants;

*I'm still doing nursing and also mentoring, for example student nurses on attachment to wards (visiting migrant from developed country).*

*I am a cardiothoracic intensive care nurse (visiting migrant from developed country).*

*I am a staff nurse. I work in the admission and planning unit (visiting migrant nurse from a developed country).*

Regarding the reasons for choice of their jobs respondents expressed passion for the professional work they were doing as indicated in what they stated in the excerpts below;

*I do this because I love my job*

*Bed side nursing gives an opportunity to see different conditions and I am learning. I also wanted something more challenging*

The midwives expressed similar sentiments about their work in midwifery practice as stated by some of the midwifery informants in the following extracts;

*I am a midwife in the maternity and my work involves ante-natal care, delivery, post-natal, under five and PMTCT (midwife from a developing country).*

*I am a midwife and senior registered nurse which is treated like a Ward Sister here in Zambia (midwife from a developing country).*

*I do midwifery work and I love it! (Midwife from a developing country)*

### **Policy issues on managing nurses leaving for greener pastures**

Both visiting and returnee migrants were asked for what would inform policy on managing nurses leaving for greener pastures. Five themes emerged from the analysis of the responses. These were (i) improving work conditions (ii) access to professional development (iii) participation in policy and decision making (iv) improving organizational climate (iv) safe work environment.

#### **Improving working conditions**

Respondents laid emphasis on improving what they referred to as ‘conditions of service’, perceived as the main contributing factor to nurses leaving for greener pastures. What

emerged as conditions to be improved, according to respondents were: (a) deserving salaries and benefits (b) decent accommodation.

Improving conditions of service was also seen as a way of retaining nurses in the country. They implored upon government to make these conditions attractive, according to the following excerpts expressed by informants;

*Because the main reason why people leave is poor conditions of service (returnee from a developed country).*

*Three quarters of nurses want to leave the country because of the poor conditions of service (visiting migrant from a developed country).*

*The government should improve conditions of service to attract nurses and retain them (visiting migrant from developed country).*

Respondents perceived improving conditions of service conditional for nurses' stay and work in the country as expressed by an informant in the following statement;

*If conditions of service are not improved, the government should allow nurses to leave for greener pastures without any hindrances (visiting migrant from a developing country).*

The above statement also implies that government has no reason to prevent nurses from leaving the country if they do not have the capacity to pay deserving remuneration and retain them.

### ***Deserving salaries and benefits***

Deserving salaries were seen as an important component of the perceived improved conditions of service and according to respondents, nurses deserved better and attractive salary packages, comparable to what they were being paid outside the country. Emphasis was laid on paying nurses basing on the work they put in to enable them afford the basic necessities, and described this as a salary that could sustain a living, if they had to come

back to the country. The following excerpts reflect what was expressed by the informants who were visiting migrants;

*Making sure they pay salaries that sustain a living and support responsibilities, making them more attractive (visiting migrant from a developed country).*

*For example, a salary that one can live on (visiting migrant from a developed country).*

*Make sure they are paid for the work they do ((visiting migrant from a developed country).*

Referring to the low salaries in Zambia, an informant compared what she was paid in a developing country, perceived as three to four times more than what nurses were paid in Zambia, citing food as a major concern and an essential that she was now happy to afford, while a returnee informant similarly alluded to the low salaries and the implications on their capacity to provide for the family in terms of food and children's education;

*In Zambia, salaries are low. One has to have 3-4 jobs to manage. Where I am working the money I get is enough for me to afford essentials such as food and other essentials unlike here in Zambia (visiting migrant from a developing country).*

*The salaries are too low. You can't buy food at the end of the month and also you can't educate your children (returnee from a developed country).*

A returnee informant from a developed country expressed the importance of a living wage that could make nurses stay;

*If people are able to live up to the month end then they'll stop leaving*

Perhaps only the old nurses could come back without government making the salaries attractive as alluded to by an informant from a developing country!;

*The Government should increase salaries for the nurses to more than what a nurse is getting in Botswana otherwise nurses, they will not come back home unless the old ones (visiting migrant from a developing country).*

Provision of conditions that support acquisition of benefits related to personal and family transportation and residential homes or properties supported through financial incentives were perceived as important in work conditions policies. According to respondents, these had implications on their future plans as indicated by visiting informants in the excerpts below;

*Incentives for example car loans, house loan.*

*The nurses should have access to loans.*

A respondent from a developing country recounted such policies where he was working and expressed this in the statement below;

*Where I am working, loans are easily accessible and therefore I'm able to make future plans.*

Timely access to retirement benefits was seen as important in the policies. According to an informant, even when nurses retire, life is still not easy for them when it comes to accessing their retirement benefits accrued to them;

*Nurses should be re-assured to get retirement benefits and not to struggle to get what is due to them.*

### ***Decent accommodation***

A mechanism for ensuring availability of decent accommodation was perceived as a necessity for inclusion in policy on managing nurses leaving for greener pastures. Perceptions of strategies for facilitating access to accommodation of desired quality included paying wage packages inclusive of rental costs, without having separate

allowance payments for accommodation, building respondents' own houses and renting, both with government support as expressed by informants in the following statements;

*They should pay lump sum as pay and not allowances (visiting migrant from a developed country).*

*Accommodation should be given to nurses like quality houses. Nurses own no houses of their own and most have not even started building (visiting migrant from a developed country).*

*Government can also build some houses where all health personnel could stay (returnee migrant from a developed country).*

### **Access to professional development**

Professional development was perceived as being achievable through a policy that was non-discriminatory, supporting both short and long term programmes tenable within and outside the country.

### ***Professional development programmes***

The following statements give an insight into what respondents perceived as avenues for achieving professional development;

*Exposures by attending workshops within and outside the country so that they learn new concepts unlike where only the doctors and mostly the same people (visiting migrant from a developed country).*

*Distance learning for nurses can encourage them to stay (returnee migrant from a developing country)*

### ***Supportive financial structures***

National level policy related to budgetary provisions on education of nationals was seen as a mechanism for facilitating access to continuing education for nurses where funds expended would be recovered during an individual's working life. Additionally, awarding of scholarships for deserving individuals would enhance access to professional

development as shared from experiences of a visiting informant from a developed country in the following statement;

*There, government has set up a fund through the tax department for education of citizens. When you finish school, you apply for a loan for college or university. When you complete and start working, you will have a tax number and they will start deducting from you. For brilliant people, there are some special scholarship awards.*

Another respondent recounted accessibility of career development in a developing country in the following statement;

*Career development is easy in Botswana than Zambia. Botswana is near South Africa where one can study from.*

### **Participation in policy decisions**

Government dialogue with nurses and their listening to them was perceived as an effective approach to identifying practical solutions to issues on policy directions. The following excerpts give an insight into what was expressed by visiting migrant informants;

*The government should listen to the nurses. It should meet the nurses and listen and hear what they want.*

*They should have meetings frequently with nurses and talk to them and plan with the nurses.*

*Government should understand and learn to listen to nurses*

***Dialogue with new graduate nurses was perceived as a proactive approach towards mitigating the potential for their leaving the country for greener pastures as indicated in the excerpt below expressed by a visiting migrant informant;***

*The government should talk to those qualifying now.*

### **Improving organizational climate through leadership**

Some informants expressed undesirable treatment of nurses by managers and leaders referring to this as subjecting nurses to negative treatment as indicated in the excerpt below expressed by a visiting migrant from a developing country;

*Managers shouldn't be bullies.*

### ***Teamwork approach***

Promotion of team work approach to managing care with other health care providers at facility level; nurses, doctors and the rest was perceived as progressive towards enhancing a conducive environment for quality care. A visiting migrant shared how this worked, according to their personal experience as expressed in the following statement;

*There we work as a team in various departments, for example doctors, nurses, social workers, therapists who include speech therapists and others and nurses coordinate this (visiting migrant informant from a developing country).*

*Where doctors write notes, the nurse explains their plan. There, documentation is very important (visiting migrant informant from a developing country).*

Emphasizing the importance of nurses and nursing within the work environment and policy levels, respondents expressed the importance of the role and value of the nurse in health care and the need for their recognition through resource investment. The following excerpts express how the respondents described the importance of the professional role and value of the nurse as stated by visiting migrant informants;

*Nurses are educated. They are not general workers. Government should put a lot more resources and value nurses.*

*Government should firmly recognize the importance of nursing.*

*Nursing is extra ordinary. We deal with lives and so they must give us what we deserve.*

The above excerpts indicate that nurses are professionals with a body of knowledge and competencies that justify the basis for patients' and other people's safety once under their care and custody.

Perceptions from experience on how nurses are valued in other countries were expressed in the following statement by a visiting informant from a developed country;

*Out there, our friends appreciate the nurse and they express their gratitude. They treat you like eggs because they really do not want to lose you especially that their own nurses leave to work in Australia.*

### ***Reducing workload***

Reducing workload and hours of work for nurses were perceived as important. Visiting respondents from a developing country shared personal experiences and compared the same to the home country practice as indicated in the following excerpts;

*Workload is very high as in Zambia but the working hours are low unlike here. I work 42 hours each week. Overtime is allowed and paid at the month end.*

*We work very hard there and there are no shifts (visiting migrant from a developing country).*

The workload in the private sector was seen as better as per the excerpt below by a visiting migrant from a developing country;

*Private hospitals workload is quite balanced.*

The amount of work hours experienced by the home country nurses and the possible effect on their abilities and potential to provide quality care were acknowledged in the following statement by a visiting migrant from a developing country;

*The nurses in Zambia really put in a lot of hours and if at the end of the entire hard work one is not able to make ends-meet, it becomes quite difficult to put in your best in your work.*

Long working hours were seen as abuse of the nurses as expressed in the excerpt below;

*They should not be abused like having long working hours.*

### **Flexible emigration policies**

Some respondents perceived having policies that permitted nurses to leave for greener pastures as a more reasonable stand to take as nurse migration was a global issue and as such, could not be controlled by government alone, indicating that controlling nurses leaving for greener pastures would be an infringement on their rights. Respondents perceived nurses as an 'international commodity' who should be allowed to leave for greener pastures as expressed in the following statements by visiting migrant informants;

*Nurses are an international commodity.*

*Nurses should be allowed to go.*

*The government should allow nurses to leave for greener pastures without any hindrances (visiting migrant from a developed country).*

Returnee informants had this to say;

*It is not possible for government to control nurses leaving the country as this will infringe on their human rights (returnee from a developed country).*

*The Government should not stop them from leaving (returnee from a developed country).*

*For those who want to go, I think you can't stop them from going (returnee from a developed country).*

Some respondents perceived nurses leaving for greener pastures as a global issue, making it even more challenging to resolve as stated by returnee informants;

*I'm not sure if the government can do anything because it is not only in Zambia where nurses are leaving. Even in the ward where I worked, most of the nurses*

*were foreigners, and they later left for other countries (returnee from a developed country).*

*Let them leave and some day they may come back (returnee from a developed country).*

Another returnee from a developed country justified why nurses should be allowed to leave in the following statement;

*We work in harsh conditions here and nurses should be allowed to go (returnee from a developed country).*

Even if government put rules in place, they will not be effective because nurses perceived themselves as worth more than the case in their country and had the liberty of choice in terms of where to work as expressed by an informants in the statements below;

*The government can put in place rules but this will not help because they are unable to give us what we deserve (returnee from a developed country).*

*Nothing much can be done because we are professionals. We can choose where to work at anytime (returnee migrant).*

A returnee informant argued and justified her perception of the right to leave for greener pastures in the excerpt below;

*Besides, most of us sponsored ourselves so government can not do much.*

The excerpt above refers to informants meeting their own travel and other costs when leaving for greener pastures.

The following statements express informants' experiences on similar trends in other countries which suggested that Zambia was not the only country affected by nurse migration;

*It is not only in Zambia where nurses are leaving (returnee from a developed country).*

*Where we are, the citizens are also leaving those countries despite us going there thinking it's the greener pasture (visiting migrant from a developed country).*

*Even in the ward where I worked, most of the nurses were foreigners, and they later left for other countries (returnee from a developed country).*

### **Bonding of nurse graduates**

Introduction of effective bonding policy was mentioned by most respondents. Bonding was seen as a way by which government would benefit from the investment in the education and training of nurses as this would ensure that nurses worked for a specified period before they could be allowed to leave for greener pastures. To some respondents, this would also facilitate gaining of experience by potential nurse migrants. Various bonding periods were indicated as expressed by informants in the following statements;

*There should be bonding for those that are government sponsored, for example for two years (returnee migrant from developed country).*

*Nurses should be allowed to leave after they've saved the country for six years, and by this time one would have gained knowledge and skills concerning nursing (returnee migrant from developed country).*

*The government is spending money on us and so should restrict the number of years that a nurse has to serve before they can leave. For example, they can serve for 2 or 3 years (returnee migrant from developed country).*

### **Safe work environment**

Informants perceived conducive work environments in relation to infrastructure and utilities for health facilities, protective clothing, equipment, drugs and supplies.

Improving the infrastructure was seen as a priority in the environment. A returnee respondent perceived health facility dilapidation and the need for its improvement as priority as indicated in the following statement;

*I think the first thing government should do is to improve the infrastructure. Our government hospitals have really gone down in terms of resources and materials. Sometimes they run out of medicines, just about everything else (returnee from developed country).*

Regarding the importance of facility utilities, a visiting migrant from a developing country shared what was available for patient and management use at the health facility where she was working as per excerpt below;

*I am in a small village where I work but there are 5 ambulances, 5 vehicles for administration.*

Protective clothing and better equipment were seen as essential in the prevention of cross infection and a basis for safety considering the perceived potential for diseases and infections in the work environment. Improving work environment and making it safe for nurses and having better equipment were essential, according to some informants from developed countries as indicated in the extracts below;

*Nurses should work in an environment which is safe.*

*The work environment should be improved with better equipment in place.*

Prevention of infections was essential in a work place through provision of protective clothing as expressed by a visiting informant in the statement;

*There are a lot of diseases now as such nurses should be provided with protective clothing for example masks, gloves and other materials.*

Visiting respondents recounted the conducive environment in their work places in developing countries where they were working, making comparison with the contrast in their home country as expressed in the following statements;

*Where I work, we wear gloves as if we are in theatre. Everything is there; gowns, long boots, shoes, glasses to protect your eyes, shoe protectors which you dispose of when you finish a delivery (visiting registered nurse-midwife).*

*All equipment for use is available. There is no recycling of any thing or equipment (visiting registered nurse).*

*In Botswana, nurses do not improvise equipment like in Zambia.*

#### **4.2.2.4 Focus group discussions**

This part of the study focused on the respondents' perceived impact of nurses leaving for greener pastures in relation to the public health care system. A total of four focus group discussions were conducted; one in each of the four districts selected for the study. The groups comprised key informants with varied responsibilities of registered nurse, registered midwife, enrolled nurse, enrolled midwife, nursing services manager and nursing officer. A set of questions guided the group discussions which were moderated by the researcher and this served as a basis for presentation of the findings on major themes and issues that emanated from the analysis of the responses. Although a set of questions existed to guide the focus group discussion, the researcher ensured flexibility in soliciting responses by allowing the respondents to express themselves freely in order to enrich the data. The questions were centered on the following areas:

(i) Availability of nurses

- nurse turnover
- vacancy levels
- availability of experienced nurses

(ii) Utilization of staff

- distribution and skills mix

- working shifts
- nurse performance in relation to scope of practice

(iii) Work implications

- Workload
- Job satisfaction
- Attitude towards work
- Stress and potential for stress

(iv) Quality of care

- Adequacy of coverage of health needs of patients
- Work environment

(v) Supervision

- Adequacy of supervision by nurse leaders
- Motivation for patient care

(vi) Impact on teaching and learning of students

Organization and implementation of the education and training programme

(vii) What has made respondents stay and work in Zambia

(viii) What would inform policy on managing nurses leaving for greener pastures

**Availability of nurses**

This part of the focus group discussion addressed the following areas; nurse turnover, vacancy levels and availability of experienced nurses.

### *Nurse turnover*

Two themes emerged from the discussion on nurse turnover. These were (i) nurses leaving (ii) slow replacements.

The following excerpts by key informants describe the rate at which nurses were leaving the public health institutions;

*I think they are leaving this hospital at a fast rate. At one time we had a lot of nurses but towards the beginning of this year a lot of nurses left (nursing officer at a provincial hospital).*

*We don't know how many leave per month but a lot of them are leaving the institution (nursing officer at a referral).*

*In the labour ward, already one is leaving on Sunday (registered nurse/midwife from maternity).*

Reasons for leaving included greener pastures and transfers related to movement of spouse in case of married female nurses as illustrated in the following statement by a key informant;

*Some left for greener pastures while others were transferred. Mainly the workforce in this hospital is comprised of females so if the husband is transferred the wife also has to go.*

In an institution with enrolled nurse educational programme, new nurse graduates were bonded for half the period of their training. The rate at which the nurses were leaving was thus determined by the bonding policy, although nurses left voluntarily, at different times after serving the bonding period as illustrated by a nurse administrator at a rural hospital with a school for enrolled nurses;

*The rate at which they leave is determined by the number of nurses bonded at one time but not all of them leave at the same time. They decide to leave on their own.*

Some informants described the replacements for nurses who had left as slow considering the gaps left in numbers. A nursing officer in charge of a medical department in a referral

hospital lamented the gaps left by those who had left and the slow rate of replacements as expressed in the following statement;

*In medical department recruitment is very slow. We had 90 RNs but now there are only 33 and we had 150 Enrolled Nurses but now we only have 45. Since they started leaving, we only got a replacement last month.*

### ***Availability of experienced nurses***

The main theme that emerged from the analysis of the responses related to the question on availability of nurses was the gross shortage in the health facilities which reflected the absence of experienced nurses as expressed by some respondents in the following extracts;

*It is difficult to say because even the inexperienced ones are not there (Registered Nurse at a provincial hospital).*

*They are no longer there. We are always having “babies” (Nursing officer at a referral hospital).*

Always having babies’ in the above excerpt denotes the magnitude of the nurse shortage and the inexperience of those available who are most likely young and newly graduated.

This situation had implications on the professional socialization and development of nurses in form of mentoring and role modeling for the younger generation of members of the profession.

*.....and there is no one to mentor. You actually teach yourself as there is nobody to learn from (Registered Nurse, referral hospital).*

### ***Vacancy levels***

Informants confirmed availability of vacancies both in the clinical sites and educational institutions and programmes, where in some cases; the number of vacancies was

described as more than the number of available nurses. This is illustrated in the following statements made by key informants;

*There are vacancies of teaching staff and clinical teachers at the school (nurse educator, school of nursing).*

*In the medical department vacancies are more than the nurses who are there (nursing officer, medical department of a referral hospital).*

A registered nurse in charge of hospital administration in a rural setting indicated how dependent the hospital services were on both enrolled and registered nurses in the delivery of services and gave the available figures in the following statement;

*Currently, we have 45 enrolled nurses and 2 are enrolled midwives. We need 18 RN's to run the hospital but currently we only have 3 who are Zambian of which 2 are in school and we have 2 missionaries so in total we have 5 RNs which is not enough.*

The educational programmes are equally affected by the slow replacement of teaching staff that leave the school. Replacement is dependant on the supply of educators from the university output of degree nurses as recounted by a nurse educator in the following statement;

*From the school of nursing the recruitment is low as it is dependent on the number of graduates from PBN (Post Basic Nursing Department, School of Medicine, University of Zambia) and since there are few students, it is low. For example we had 30 students and only one was recruited. We lost a member of staff who left abruptly but to date he has not been replaced.*

The majority of the vacancies referred to by respondents were for nurses, teaching staff who included tutors and clinical teachers and medical doctors as expressed by a key informant in the excerpt below;

*The majority of vacancies are for the nurses and doctors, clinical instructors and tutors (nurse manager at a provincial hospital).*

According to the informant, bureaucracy contributed to the delays in filling up the vacant posts as indicated in the extract below;

*For the vacant posts like nursing officer, we have recommended persons to act and we have written to the public service commission but we haven't received any positive results (nurse administrator).*

### **Utilization of staff**

Regarding the utilization of staff, in this context nurses, the group discussion further focused on their distribution and skills mix also referred to as working shifts and nurse performance in relation to their scope of practice.

### ***Distribution and skills mix and working shifts***

What emerged from the discussion were shortage of nurses and coping strategies.

According to the informants, the available nurses were too few and were seen to be overstretched when it came to their distribution for work coverage as illustrated by a key informant in the following statement;

*The nurses are really stretched because you find that there are very few nurses in the wards. For example, there may only be 2 midwives for maternity Obs and Gynae wards (midwife from maternity department).*

Maternity department referred to above also included obstetric and gynaecology units.

Informants shared the strategies through working shifts that they used to ensure that patients received care under the circumstances of nurse shortage as described in the statement below by a key informant at a district hospital;

*We put the greater number in the morning because there is far more activity in the morning. We have shifts from 08 00 hrs to 14 00 hrs, 14 00 hrs to 20 00hrs*

*and 20 00hrs to 06 00hrs. We make sure that all the wards are covered (nursing officer in a rural hospital).*

Regarding taking charge of the wards in view of the nurse shortage, enrolled nurses were reported to be in charge of the wards at the rural hospital as expressed by the nurse administrator;

*Enrolled nurses are in charge of wards most of the time.*

Midwives were perceived to be under extreme pressure coping with deliveries as illustrated by a registered nurse/midwife working in the maternity unit of a provincial hospital in the following excerpt;

*Sometimes only one is on duty with 35 maternity patients and 8 deliveries per day for one midwife.*

The shortfall in midwifery staffing was expressed at more than half the required number of midwives despite the stretched responsibilities that included neonatal care as indicated in the following statement made by a nursing officer at a provincial hospital;

*In addition if you look at the staff establishment, you find that there is a shortfall of more than 50% because the one midwife on duty also has to take care of the preterm nursery.*

The staffing in obstetrics and gynaecology unit was perceived as desperate as expressed in the following excerpt;

*In the obs-gyn department, it is very difficult to follow the staff distribution anyhow as long as there is someone in white on duty*

Someone in white on duty in the above excerpt refers to any nurse, whether a midwife or note would be considered better than nothing when allocated to the maternity and gynecology units.

In the medical wards, having two three nurses per shift for 40 to 50 patients was considered being acceptable and better as indicated in the extract;

*In the department of medicine, if you are 2 or 3 nurses then you are ok that's one per shift with 40 to 50 patients (registered nurse, medical ward.)*

In extreme situations, nurses are made to postpone their off duty days meant for their much deserved rest after working under extreme pressure, in order for them to continue working, fill the gaps and meet the need to balance the work shifts when there is no one else available to provide the service as described by a nursing services manager at a provincial hospital in the statement below;

*With this shortage we ensure that we balance the shifts. Others are forced to save their day off so that they work and they get it when they come back from their night shift.*

Other alternatives used to ensure availability of nurses at work were hiring of part time nurses although this was not a reliable approach due budgetary constraints as stated by a nurse manager of a provincial hospital;

*If the situation is out of hand, we request for part time people but we have difficulty paying them.*

### ***Scope of practice***

Major themes with regards to analysis of responses on the scope of practice within which nurses practiced were (i) functioning beyond scope of practice and (ii) doing other people's work.

From the findings, registered nurses were perceived to be performing duties beyond their scope of practice. These included being on call, diagnosing and treating patients and working as hospital administrators and this was perceived as good practice by the facility management as supported by a statement made by a key informant in a rural district hospital;

*The RNs are doing work outside their scope and it is good practice. They are on call and they diagnose and they treat patients, some even work as hospital administrators (Nursing officer).*

Practicing beyond the nurses' scope of practice was seen as taking blood samples from patients for laboratory examination and putting up intravenous fluids and these were perceived as nurses doing doctors' jobs as a registered nurse at a provincial hospital remarked;

*We go outside our scope because we do a lot of other duties like doctors jobs we have to take blood and putting up IV fluids.*

According to analysis of the responses, enrolled nurses in rural settings took on equally more responsibilities of screening patients, providing treatment, nursing and midwifery care as illustrated by an enrolled nurse in a rural health centre;

*In rural areas we go beyond our scope of work. We screen patients, we treat, we nurse and work in maternity. (Enrolled Nurse).*

Even teaching nurses what was perceived to be everything still resulted in nurses performing procedures they had never been taught in school in order to save lives and also to cope through other means like improvising and using shortcuts as recounted by informants;

*We teach nurses everything but they do not practice everything. Sometimes nurses do what they are never taught in an effort to save lives.*

*In obs and gynae, we are always improvising so we are always running around trying to cope.*

*Nurses use a lot of short cuts in an effort to kill time when alone in the ward.*

Doing other people's jobs also meant abdicating nursing duties according to an informant in a rural setting;

*We rarely do our nursing duties. We do other people's work (enrolled nurse).*

From the findings, nurses assumed the responsibilities of every other worker in the health facility and were fillers of the gaps left by other workers when the later worked normal working hours and were off duty after hours, in the night, during weekends and public holidays. This is supported by the statement below made by an enrolled nurse in a rural health centre;

*On weekends, in the afternoon, on public holidays, and at night there is no clerk, dispenser, and clinical officer so as nurses, we have to perform all these functions; screening patients, dispense, work as receptionist especially in rural health centres (enrolled nurses<sup>3</sup>).*

### **Work implications**

Discussion on the work implications of nurses leaving for greener pastures was centered on (i) workload (ii) job satisfaction (iii) attitude towards work and potential for stress.

#### ***Workload***

The themes that emerged from discussion on workload according to responses from informants were:

Increasing workload;

*It is increasing every time especially for the senior nurses they are forced to even do anesthesia (nursing officer in a rural hospital).*

*In obs and gynae, the workload is too much because there are 3 wards with 40 beds in each ward so you just end up running around (registered nurse-midwife in a referral hospital).*

*It is too much compared to that of other members of staff because we perform every one's duties (registered nurse at district health centre).*

Long working hours;

*Sometimes we work up to 12 hours a day and are exhausted by the time we get home (registered nurse at provincial hospital).*

*Sometimes we work from 01 00 hrs to 18 00 hrs the following day (male nurse, health centre).*

Effects on health:

*Since we are overworked, nurses who work in places like the TB ward, we also end up getting sick (registered nurse provincial hospital).*

*Nurses are sick often because they are overworked and sometimes supervisors can't give them sick leave because of the shortage of staff (registered nurse, medical ward - referral hospital).*

*Sometimes we are off duty but we are called to work because the other person is sick. In fact it is a threat to our health (Enrolled Nurse).*

No sick leave:

*Sometimes supervisors can't give them sick leave because of the shortage of staff (registered nurse, medical ward, referral hospital).*

Minimal or no financial rewards for additional work:

*We do more than we are supposed to, we work extra hours and we are not paid for this (registered nurse-midwife, provincial hospital).*

*We are only paid K30, 000(US \$8.00) for this per month (midwife).*

*Even when some NGO's come to partner with the government, the nurses are not paid for the work they do (registered nurse, medical ward, referral hospital).*

Delegation of patient care to family members:

*Sometimes the nurse instructs relatives to give the patient a bath (medical ward registered nurse).*

*The relatives are encouraged to stay on because they are helping to look after the patient (registered nurse, children's ward, provincial hospital).*

### **Job satisfaction**

Themes that emerged from discussions, according to informants were those that affected job satisfaction;

Increased workload due to doing other people's work:

*Job satisfaction can be there if it is a combination of all the members of staff working, but not when working as a nurse because we have to do everyone's job but the other staff never help us( registered nurse, health centre at district).*

*As a midwife, there is no job satisfaction because there is too much to do (registered nurse-midwife, referral hospital).*

*In addition to this, there is too much work due to under staffing so at the end of the day, there is no job satisfaction (rural hospital registered nurse)..*

Working with unskilled workers:

*The persons I work with do not have the training that I have (enrolled nurse-midwife at rural hospital).*

Working round the clock:

*As nurses, we are not satisfied. A nurse is made to screen patients but clinical officers do not help with nursing. They knock off but nurses remain and continue with work (Enrolled Nurse).*

*We are ever on duty from 1<sup>st</sup> January to 31<sup>st</sup> December of each year (male nurse).*

Too much work due to nurse shortage:

*In addition to this, there is too much work due to under staffing so at the end of the day there is no job satisfaction.*

Lack of incentives:

*For others, lack of incentives makes it difficult for them to have job satisfaction, and these are usually dependent on what an individual wants.*

***Attitude towards work and potential for stress***

Findings on discussions regarding respondent' attitude towards their work and potential for stress revealed the following themes;

Effects of not being able to leave:

*They get frustrated if they are unable to leave at the end of the bonding and they disturb the others (nursing officer, rural hospital).*

Poor attitude due to overworking:

*When you are overworked no matter how nice you are, at one point you scream (registered nurse, referral hospital).*

*We are tensed up because there is so much to do so we end up being hostile but we would love to be nice (midwife, maternity unit referral hospital).*

*Generally nurses are good people but we are so overworked (registered nurse).*

Other effects of stress:

*In some places you find that one nurse is taking care of 20 to 30 patients and there is only one nurse on duty at night so when such a person knocks off, they burn out (enrolled nurse).*

Venting of frustrations on patients' family:

*Sometimes because of stress, staff exchange words with patients' relatives (registered nurse, medical ward, referral hospital).*

*Overstaying relatives tend to learn our routines and know us and they start criticizing us.*

## **Quality of care**

The discussion on quality of care focused on adequacy of coverage of health needs of patients and the work environment.

### ***Adequacy of coverage of health needs of patients***

Quality of care provided to patients was perceived as poor as expressed by informants in the extracts below;

*In the department of medicine the quality of nursing now is poor (nursing officer, referral hospital).*

*Quality of care being giving is poor (Enrolled Nurse, rural health centre)*

### ***Work environment***

The issues that emerged from discussion on work environment were (i) unhealthy environment (ii) inadequate supplies (iii) nurse shortage.

#### **Unhealthy environment:**

Some informants perceived what affected the quality of care in the work environment as the dilapidation and poor hygiene conditions of the physical facilities which were at the disposal of patients for their use. Patients were also blamed for the state of these facilities as illustrated by a key informant in the following statement;

*As for the work environment, it leaves very little to be desired especially when you look at key areas in the surroundings like bathrooms, toilets and the kitchens, these areas have not been attended to; there is need for something to be done but other areas are okay. The users are also to blame for this. Some of them are careless.*

Inadequate supplies:

Inadequate supply of protective clothing was perceived as potentially risky to nurses and contributing towards their inability to provide quality care according to key informants;

*There isn't enough protective clothing. For example right now there are no gloves in the hospital and yet we have to do a lot of work and handle body fluids (registered nurse, provincial hospital)*

*Most of the times we do not have gloves to use (registered nurse, medical unit referral hospital)*

*We do not have protective clothing, especially when we have cholera we use our uniform in the cholera centre and on the general areas and then we have to go home with the same uniform (registered nurse, health centre).*

Lack of medicines was perceived to contribute towards poor quality of care as expressed by an informant from a medical ward in a referral hospital;

*Sometimes there are no medicines.*

A registered nurse-midwife from a maternity unit at a referral hospital lamented the poor quality of care due to inadequacies in patient care provisions as expressed in the extract below;

*Women in post natal wards have to share a mattress.*

Nurse shortage:

An informant at a rural health centre attributed the poor quality of care to the shortage of nurses in the work environment as stated in the extract below;

*We are few so we can't give quality care to the patients.*

Another informant referred to the limitations arising from nurse shortage in providing care to patients;

*We just give out medication; the nursing care is done by the relatives (enrolled nurse, rural health centre).*

## **Supervision**

The issues discussed under supervision were adequacy of supervision and motivation for patient care.

### *Adequacy of supervision*

Findings according to responses from the discussion on adequacy of supervision were that it was inadequate due to increase in the workload of those expected to supervise others;

*It's inadequate. The nurse in charge has a lot of administrative work to do with no time to supervise the colleagues (enrolled nurses, rural health centre).*

*It's not adequate because the persons with these responsibilities also have other responsibilities and so they cannot be available in the wards all the time (nursing officer, rural hospital)*

Nurse shortage was given as one of the reasons for the inadequate supervision;

*Sometimes the supervisor is also the general nurse especially when there is a shortage (Ward in charge, provincial hospital).*

*As supervisors, we also find it difficult to supervise because the one to be supervised is also the person in charge in that department so you end up working to lessen the subordinate's workload (nursing officer, provincial hospital).*

A situation beyond nurse shortage was described in the following statements;

*As a supervisor, sometimes I come across a ward with no one and then I am forced to take a nurse from anywhere and put her there (unit nursing officer, referral hospital)*

*Sometimes I work the whole day to cover up and I am forced to work on weekends because there are no nurses (medical ward in charge, referral hospital).*

*Sometimes there is no one to supervise because there are no nurses on duty and sometimes I find the sister in charge alone so I have to join in and help her with the rounds (Nursing Officer, referral hospital).*

Effects of extreme nurse shortages were mentioned in the following statements by key informants;

*In the gynae ward, if I do not come to work as a supervisor, the staff are derailed as there is no direction as you may have nurses from other wards only on duty and there is no planning because everyday there is a staffing crisis to attend to (ward in charge, gynaecology ward).*

*When people from other wards are used, they leave before you come on duty and there is no documenting because reports are verbal (unit in charge, referral hospital).*

Lack of skills was also a contributing factor;

*The other reason is that some of the individuals lack appropriate leadership skills. They lack the drive to push the people under them to work (nurse educator, rural hospital).*

*We are not trained for some jobs (enrolled nurse, rural health centre)*

Incentives for extra work and encouragement through leaders were lacking and affected the drive to supervise;

*Other reasons are that supervisors are not given any incentives for the extra work that they do and they are not given any positive encouragement from their supervisors when they do well, so they are not driven to work harder (clinical teacher, rural hospital).*

Stress was also mentioned for inadequate supervision;

*Another reason is that we are all under a lot of stress here (registered nurse, rural hospital)*

***Motivation for patient care.***

Issues arising from discussion on motivation were remuneration in relation to nurse shortage, workload, lack of basic supplies and frustration.

Remuneration in relation to nurse shortage:

A key informant described the social and economic circumstances of nurses related to inadequate remuneration in view of nurse shortage by describing the prevailing family and workplace situations as the two worlds in which nurses find themselves in, both affecting them as 'external' and 'internal' motivational factors in the following statement;

*There is what we call internal motivation and external motivation. External motivation deals with issues of money or whether one is staying comfortably at home and some of these factors affect internal motivation. Here we are looking at the extra work that we have to do as a result of shortage of nurses and the establishment of the hospital and the number of staff who are there (nurse educator).*

Both remuneration and workload were mentioned as contributors to lack of motivation;

*So how do you get motivation in such a situation and also in terms of money you feel you are not meeting the needs of the family on top of that you have this extra load (registered nurse, rural hospital).*

General poverty, in addition to the prevailing nurse shortage, was perceived as affecting the motivation of nurses to meet the health needs of patients and their own family commitments as illustrated in the statements below;

*They are unable to meet all the needs of the patients and to make ends meet on top of other social problems at home that arise out of the general poverty in the country (Registered Nurse)*

*We are looking at the general outlook of the country as a whole (enrolled nurse).*

Lack of basic supplies:

An informant elaborated the effect of lack of basic supplies necessary for patient care in the following statement;

*We just work because we are on permanent and pensionable conditions of employment but the drive to work is not there because even the things to use on the patients like soap to bath them are not there (registered nurse).*

Frustration:

Two informants from a health centre expressed the lack of motivation in relation to frustrations they were experiencing and how this adversely affected their ability to positively relate to patients through the provision of quality care;

*Motivation is no longer there because we are frustrated*

*There is no time for us to motivate patients as we are also not motivated*

### **Impact on teaching and learning of students**

Analysis of the discussion responses on how nurses leaving for greener pastures had impacted the education and training programmes revealed four main themes; (i) shortage of teaching staff (ii) effects on learners (iii) coping mechanisms (iv) responding to policy direction

#### ***Shortage of teaching staff***

Nurses' leaving for greener pastures was seen as resulting in shortage of teaching staff and the imbalance in the teacher student ratio according to what informants' stated in the following extracts;

*Migration has a big part in it. The teacher student ratio is about 1 to 20. This also creates a problem (Nurse Educator Enrolled Nursing School).*

*At the moment there are only 2 tutors and 1 clinical teacher against 80 students (Head of Enrolled nursing school,).*

*There are supposed to be 15 tutors but we only have 3 who are full time (Head of Enrolled Nursing School).*

In a health centre that had previously provided learning experiences for students, a registered nurse recounted the difficulties of their supervision due to nurse shortage. The staff had instead ended up delegating work to students and this had been seen as relieving the staff of the workload and as a positive experience for the students as indicated in the following statement;

*We had some students but it was difficult to supervise them because of the shortage of staff. They helped ease the load of work. We ended up delegating work to them. On the other hand it helped gain experience (Registered Nurse)*

### ***Effects on learners***

Both the quality of classroom teaching and clinical supervision of students were affected according to comments made by school and clinical staff;

*The quality of teaching is also compromised (nurse educator).*

*On the clinical aspect, with the few RN's that we have on the wards the clinical supervision of students is affected (nursing officer).*

*The students can't apply the principles to the procedures and it's not really their fault, it's due to the shortage of tutors and nurses on the wards (Clinical teacher).*

### ***Coping mechanisms***

A nursing officer in an enrolled nursing school elaborated on the implications of nurse shortage as it affected the school and hospital capacity to implement the training programme in the following statement;

*The few RN's who are there have to take care of other issues in the hospital so students end up spending very little time with the persons who should be supervising them and so we ask the Enrolled Nurses to be involved in clinical teaching but it is quite difficult when compared to what the General Nursing Council expects. If we had adequate RNs in the institutions, then the issue of adequate supervision of students would be well addressed.*

Head of an enrolled nursing school had this to say with regards to coping with the school workload and the challenges posed by a revised curriculum, amidst nurses leaving for greener pastures;

*Some of the Enrolled Nurses who have stayed for a long time have been taken on as clinical teachers and they teach but with the migration of nurses and tutors at the time the curriculum is being revised a lot of challenges have been presented. There is so much to be done. Exams must be set and marked, results must be compiled and one has to teach.*

Coping with coverage of the curriculum was another challenge for the school as described in the following statement made by a nurse educator;

*We concentrate on the most crucial aspects which enable the students to at least be able to graduate. We look at the curriculum and some of the subjects that are really very important and will be met day to day in their practice. We make sure that those are addressed.*

A school head at a rural hospital put the coping approach as follows;

*We also try to involve the nurses from the clinical area in the teaching by supervising the students in the clinical area because they are also understaffed*

*there. This is what we do to try and meet the requirements of General Nursing Council.*

A nurse educator from another enrolled nursing school commented as follows;

*Sometimes the aim is to finish the curriculum and not for the students to understand. We are also forced to help the clinical teacher.*

Educators had to cope with other challenges to do with supplies necessary for teaching of students as expressed by an educator in a registered midwifery school at a tertiary hospital;

*In the midwifery school, it is very frustrating for nurse educators to teach without supplies. Sometimes as staff, we have to buy with our own money.*

*It is also frustrating for students. In future the quality of students graduating will be affected (midwifery clinical teacher).*

### ***Responding to policy direction***

Policy demands from government to increase intakes and supply of nurses in response to the shortage; and complying with the professional standards of education and training set by the regulatory body appeared to be contradicting and was thus a source of further pressure on the already constrained staff as expressed by the head of school at a nursing school in a provincial hospital;

*We are under pressure from all angles. The government wants us to increase the intakes and General Nursing Council of Zambia wants us to follow this curriculum with their standards and we have to meet the deadlines.*

Being under pressure from all angles, in the above statement also included what is exerted on the staff by all the other factors which were as a result of nurses leaving for greener pastures.

## **Why some nurses do not leave for greener pastures**

Family commitments, faith based obligations, financial constraints, patriotism, failed by the system and despair as the last resort were six themes that emerged from discussion on why some nurses had not migrated and instead stayed to work in Zambia.

### ***Family commitments***

Family responsibilities was a common theme from the analysis on discussion regarding reasons why some nurses had not left for greener pastures and instead stayed in Zambia, according to excerpts below,

*For me it is my family responsibilities. Once I'm done I'm leaving. By this, I mean once everyone is independent, and I'm taking my wife with me (Male Tutor).*

*We are just waiting for the young ones to grow older because they need them to be at a certain age, here we don't feel appreciated (rural health centre)*

*I nearly went but I have to take care of my family and my husband who is unwell (midwife).*

### ***Faith based commitments***

An informant gave a combination of family and religious commitments as per excerpt below;

*Family responsibilities and the commitments we make to God that are not monetary but faith based (member of school staff).*

### ***Financial challenges***

A nursing officer shared her experience regarding why some of the nurses delayed leaving for greener pastures in the statement below;

*There is also some bit of money involved such as money for the air ticket and also maybe fees that must be paid for one to adapt to the environment also hinder people from leaving, but as soon as they raise the money, they leave.*

Difficulties related to meeting the financial demands made by recruiting agencies was also a barrier in nurses leaving for greener pastures;

*We want to go but we can't meet the registration resources that recruitment agencies want (enrolled nurses, rural health centre)*

Family concern for the way nurses worked was expressed through an informant who was being assisted to leave according to the excerpt below;

*My relatives are the ones helping me to leave because they are concerned about the way I work (registered nurse from medical department)*

### ***Hope for the future***

An informant did not migrate hoping that the issues contributing to nurses leaving for greener pastures would be resolved in the near future;

*I have a lot of family commitments and I hope that government will in future address the issues (Tutor from School of Nursing)*

### ***Patriotism***

Patriotism for mother Zambia was expressed by informants in the following excerpts;

*I love my country. I don't want to be a foreigner in another country home is home (midwife from obstetrics and gynaecology).*

*I know I can make a lot of money but who will nurse my people and my relatives (Nursing Officer).*

### ***Failed by the system***

According to some informants, they would not have thought of leaving for greener pastures had their aspirations in terms of working conditions and access to professional development been met;

*We thought the conditions would improve but they are worsening so given the chance I will leave (enrolled nurse 1, rural health centre)*

*I have remained because I thought I would advance to an RN but this has failed so I am also on the way (Enrolled Nurse 2)*

*I want to leave because they won't pick me for further studies even though I have improved my grade 12 qualification, it would have been better if we had in service training like teachers; right now we compete for school places with children who are straight from school(Enrolled Nurse 3).*

Competing with school children in the above statement refers to the entry qualifications demanded by the University of Zambia degree programme for nurses where all nurses who wish to pursue university education are required to have the same entry qualifications as the candidates who are younger and have just completed grade twelve examinations.

### ***Despair as the last resort***

According to some informant, the situation had reached out of hand and they had this to say;

*I have been working for 16 years but in future I will look for a job (Male Nurse Tutor)*

*It is better to look after old people abroad and get a good salary than to stay here (enrolled nurse, rural health centre).*

*We can look after anyone as long as we are looked after well (registered nurse, rural health centre)*

What would inform policy on nurses leaving for greener pastures

Themes on issues to be addressed in policy on management of nurses leaving for greener pastures according to participants in focus group discussions were;

- Impartial retention scheme
- Improving conditions of service
- Flexible migration policy
- Bonding of graduates
- Opportunities for professional development
- Increasing the supply of nurses
- Reducing stress in rural settings
- Improving work environment
- Professional identity

***An encompassing retention scheme***

The disparity in addressing the issue of retaining health care professionals was a common theme as a concern among the participants in the four focus group discussions as illustrated in the following statements;

A nursing officer in a rural hospital argued that nurses were in the majority, implying that they provided a larger volume of work and deserved the incentives that were due to medical doctors as expressed in the statement below;

*I see one problem in the Ministry of Health. They look at incentives only for one group of professionals; the doctors and yet there are many other professions in*

*the ministry. The nurse forms more than 75% of the work force but they are the least considered. There are a lot of disparities.*

The training of medical doctors was admittedly more than that of nurses but did not justify denying motivational incentives to nurses according to a member of the school staff as expressed in the following excerpt;

*Even though doctors have trained more than nurses, there must also be some motivation policy for nurses (school staff member).*

It appears from the above excerpt that according to the perception of the informant, the argument for the government existing retention policy that favors medical doctors is based on longer and more training of doctors than nurses and other health care professionals.

Addressing the retention scheme policy to include nurses would attract back some of those who had migrated as stated by an informant in the excerpt below;

*The retention scheme is now just for doctors. Those abroad could probably come back if it was also for nurses (registered nurse, referral hospital).*

The type of retention scheme appropriate for nurses included housing and transportation as indicated in the excerpt by a registered nurse at a referral hospital;

*Let nurses also have incentives or schemes that are just for doctors now such as housing and car loans.*

Nurses in the rural areas perceived themselves as doing all the work and deserving the allowances in the medical doctors' retention scheme as indicated in the excerpt below;

*On our salaries, all those allowances given to doctors must also be given to nurses (registered nurse, rural health centre)*

### ***Improving conditions of service***

Improving conditions of service in the policy was seen to include better salaries that would enable nurses meet their perceived needs as expressed in the extract;

*The impact of the strength of the kwacha should be felt and the conditions of service improved because they have to meet needs here at home (male nurse, rural hospital).*

The impact of the Kwacha as the country's currency meant acceptable salaries that were appropriate both for the nurses in the country and those that might be attracted to return to Zambia by the new policy on managing nurses leaving for greener pastures.

### ***Flexible migration policy***

According to an informant, not even guidelines or increasing the verification fee by the regulatory body will discourage nurses from leaving for greener pastures as expressed in the excerpt below;

*There should be guidelines in place but then nurses can't be stopped from leaving. No matter how high the verification fee at GNC is people will still find money to come and do it (Enrolled nurse, rural health centre).*

A tax system for government to get back part of their investment in the education and training of nurses while allowing them to leave for greener pastures was seen as a way of raising part of the resources required to motivate those who remain in the country as illustrated by a registered nurse-midwife at a referral hospital, in the statement below;

*Government should have a hand in facilitating nurses who want to go so that they take a percentage of their pay or salary to give to those who remain to motivate them so that we benefit as a country.*

Another use for the funds raised from taxing migrant nurses was increasing the supply of nurses and procuring the necessary medicines for patients;

*We can use the money for retaining nurses or for increasing training or to address the issue of drugs and incentives (registered nurse, medical unit referral hospital).*

### ***Bonding of graduates***

Inclusion of bonding in the nurse migration policy would contribute towards addressing the nurse shortage as nurses would be allowed to work for a defined period before being allowed to leave. This would also facilitate benefiting the country through getting back what was invested in the education and training of nurses from tax payers' money as expressed in the statement below;

*The government should find a mechanism for getting back what they put into the training of nurses. In some countries, the nurses have problems leaving because they are bonded to work at the hospital where they are after training. Even if it means being posted to places like it was in the past. They should be committed to work for a period of time after training before they leave (nursing officer, rural hospital).*

### ***Opportunities for professional development***

Funds should be made available for facilitating university education for nurses although sending people to school had a bearing on the already constrained nursing workforce as expressed by a registered nurse at a referral hospital in the following excerpt;

*The sponsorship for degree programmes should be increased but then again the shortage makes it difficult to send people to school.*

Other opportunities related to upgrading opportunities for enrolled nurses as indicated by an enrolled nurse at a rural health centre in the excerpt below;

*We have a lot of EN's who are not given a chance to advance; there is no motivation we need chances to advance.*

### ***Increasing the supply of nurses***

Increasing the number of education and training facilitates was seen as a way of increasing the supply of nurses as the output from the few schools was not significant due to nurse migration as expressed in the extract below;

*Schools are few. Migration will lead to a further drop of output from schools. We need to find further avenues of outputs from schools (registered nurse-midwife, referral hospital)*

### ***Improving work environment***

Employers had an obligation, not only to provide nursing services to the people but also to ensure a work environment that was conducive for providing quality care as stated by an informant in the excerpt below made by an enrolled nurse;

*We are not protected government only wants us to render a service but our environment is not conducive.*

### ***Professional identity***

Going on strike for demanding what was due to them was seen as action that should attract sympathy for nurses and not condemnation as illustrated by an enrolled nurse in the extract below;

*We are not appreciated, no matter how much we do, for example when nurses go on strike they are condemned.*

### ***Reducing stress in rural settings***

An informant perceived allocating medical doctors to rural areas as a way of reducing stress among overworked nurses as indicated in the statement below;

*There are no Zambian doctors in rural areas and we need some. Availability of doctors would reduce the stress levels for us (registered nurse, rural hospital).*

#### **4.2.2.5 Policy makers**

The findings presented in this part of the study are based on the analyzed data on perceived impact of nurse migration. A total of five policy makers were interviewed; three at district, one at provincial and one at national level respectively. The interview questions were centered on the following areas;

- Perceived impact of nurse migration on recruitment
- Advantages and disadvantages of nurse migration
- Perceived impact on training policy
- Policy issues on managing nurse migration
- Work experience for nurses intending to migrate
- Perceived impact of nurse migration on the public health care system

#### **Impact of nurse migration on recruitment**

Impact of nurses leaving for greener pastures on recruitment revealed six themes from the interviews conducted with key policy informants. These were (i) increase in nurse turnover (ii) type of migration (iii) nurse shortage (iv) increase in workload (v) supply and demand (vi) vacancies.

### ***Increase in nurse turnover***

Nurses were perceived to be leaving in big numbers as indicated by a director of a district in a rural area;

*A lot of nurses are leaving the district especially at this hospital and even at the district and they leave a very big gap; there are very few nurses left.*

This trend was supported by a director at national level as illustrated in the following statement;

*In deployment, we may target to have certain areas with manpower but once they are sent to rural areas, they assess the situation and they leave because the place may not be conducive for them to live there as such they come back to urban areas or go to other countries and the balance is not there.*

### ***Type of migration***

For nurses in the rural areas, urban towns along the railway line were perceived as greener pastures and were an attraction to them according to the statement below made by a director in a rural district;

*The impact is that we are having a number of them moving to greener pastures but they mostly move from this province to towns along the line of rail. Very few move from this province to go abroad.*

### ***Nurse shortage***

The magnitude of the nurse shortage was perceived to be greatest in the health centres and underserved areas with some of the health facilities being manned by unskilled workers as elaborated by a provincial director in the statement below;

*The health centres and those in the hard to reach areas are the ones which are most affected. You find that some centres are manned by untrained staff; there are no nurses there and at least each district has got 2 centres that are manned by untrained staff. For example, the biggest district, which is the centre and*

*headquarters of this province, has got 6 centres manned by untrained staff; by people who are just trained as assistants for 6 months so they don't qualify to man the centres. In another big district, I know of 3 centres manned by untrained staff.*

Health centres in urban areas were experiencing extreme shortages of nurses making it almost impossible to deliver the services according to the statement below made by a director at an urban district;

*We have staff shortages in health centres. Work cannot be done because there is a lot of work and sometimes you find that there is only one nurse. It is difficult for the nurse to cope with all the services to be done.*

At national level, efforts made to have nurses deployed rationally has not yield expected results as the numbers continue to dwindle, as illustrated by a director at national level in the excerpt below;

*Migration of nurses has impacted negatively because at national level, we may aim to have 2000 nurses but 2 or 3 years down the line the number of nurses goes down.*

### ***Increase in workload***

The workload was perceived to be too much for the remaining nurses, resulting in long working hours, ill health and poor quality of care delivery as illustrated in the following statements;

*The workload is too much for nurses so they get sick because they work long hours sometimes for the whole day and whole night because of the staff shortages, especially in the large clinics, which are the heavy clinics (director, urban district).*

The above statement was supported by a statement made by a national level director;

*As a result, the few nurses left are overburdened. Instead of doing work meant for one person, they do work meant for 2 or 3 people. As a result they end up providing sub standard quality service.*

### **Supply and demand**

According to the key informants, the supply did not meet the demand for nurses resulting in a low nurse patient ratio. This trend was perceived to remain as a status quo for a long time to come as expressed in the following excerpts;

*The number of nurses available for deployment is less than the requirement and the ratio of nurse to patient is very low (district director)*

*The problem will continue because even though schools continue to supply nurses they are not able to meet the demand (national level director).*

### **Vacancies**

Vacancies existed according to the excerpts below;

*We have less trained staff in our establishment; it currently stands at 47% for the trained nurses (provincial health director).*

*It is difficult to fill up vacancies left by those who leave. For example, a centre for 3 staff is run by 1 and most of our hospitals do not have midwives we rely on general nurses and technicians because they have migrated (district director).*

### **Impact on replacement of nurses**

Replacing nurses has been difficult as posting is centrally done. In addition, incentives which include suitable accommodation and lighting system are a major concern for nurses as expressed in the excerpts;

*It has been very difficult to replace them because nurses are supposed to be posted from Lusaka to the districts (district director).*

*Those to be recruited look at incentives even where there is good housing there is no electricity. There is need for good housing (district director - rural)*

## **Advantages and disadvantages of nurse migration**

### ***Disadvantages***

The disadvantages of migration, according to the key informants were;

Difficult to fill gaps:

*There is nothing good about nurses migrating because when they leave; the gap left is very difficult to fill. If they don't leave it is much easier to man the clinics (rural district).*

*There are many disadvantages because it is difficult to replace those who move out from the health sector. When they move to it is impossible to have them back here because the remuneration that they get here is not attractive. In addition these people just vanish so it is difficult to trace them (provincial health director).*

*When nurses leave, they leave gaps that take long to fill. This has led to a burn out syndrome (district director).*

Country does not benefit:

*As a third world country, it is not an advantage because we train them so that they can serve the local populace; if we train for other countries, it won't serve us any purpose (director, national level).*

Health system suffers:

*When people leave, it reflects badly on the people with authority so there is need for them to do something about it to stop migration from continuing. In the long run we will have our own people suffering while other people are being served (director, national level).*

*It is a minus to the health service (district director)*

### ***Advantages***

The advantages of nurses leaving for greener pastures were;

Economic advantage:

*There are pros and cons of this migration. At the family level for those who are involved their incomes are improved where they go to, that's what they follow. This improves the economy at family level (provincial health director).*

*Those that are going are benefiting because they get more money. They get more motivated because their salaries are more than what they get in our country and they can buy whatever they want (district director).*

### **Impact on training policy**

The following emerged from analysis of responses from perceived impact on training policy;

#### **Government to government agreements:**

*The leaders of developing countries should get together with those of developed countries and come to an agreement that nurses working in developed countries should be taxed and the money sent back to the ministry of health or to schools to compensate for the money spent in training of the nurses (director, national level).*

#### **Bonding of graduates:**

*I think our bonding system has not been strengthened. If our bonding system had been strengthened or revised , for example by putting a clause stating that graduates should work for the period they were trained and for another specified period thereafter (director, national level)*

#### **Role of the private sector:**

*With the introduction of private sector role in training, we expect the training output to improve because the opening of private nursing schools is positive. Unfortunately, the tutors are leaving (district director).*

#### **Good current policies:**

*I haven't heard anything but what I know is that Zambian nurses are considered highly trained where ever they go and they work very well and very hard. This means our training policies are good (urban district director).*

## **Policy issues on managing nurse migration**

Themes that emerged from responses on what would inform policy on managing nurse migration were;

- Rural replacement of nurses
- Improving working conditions
- Bonding of graduates
- Budget structure
- Government to government agreements
- Professional development of nurses

### *Rural replacement of nurses*

Benefiting the rural province in which the nurses undergo their education and training as a priority in nurse deployment was mentioned by a district director in a rural setting as expressed in the statement below;

*First preference should be given to the provinces in which the nurses are trained because people do not want to work in underdeveloped provinces like ours.*

### *Improving working conditions*

Retention through both financial and non-financial incentives and regular vacation were cited as part of the perceived improved conditions of service for nurses as expressed by the directors in the excerpts below;

*The government should design a stoppage policy of some incentives such as house and car loans that are given to doctors. In rural areas they must be given Hondas and houses with solar power just to make them feel like they are part of the system.*

*There must be social amenities for nurses who have graduated, such as housing loans, top up of salaries and responsibility allowance. Nurses must be given a vacation to enable them to relax.*

*For those in the rural health centers we should put up incentives like making lighting systems in their homes and an allowance so that if they match up with their colleagues in towns who are doing part time jobs.*

### ***Bonding of graduates***

Bonding to allow nurses work for a defined period after training, stipulating the period of stay out of the country before they migrate and stake holder dialogue to facilitate a systematic way of migrating were mentioned as part of the perceived content in a memorandum of understanding between nurses and the employers as illustrated by directors in the following statements;

*They should sign a memorandum of understanding stipulating the number of years that they will stay out of the country because some of them go for good (district director).*

*Newly qualified nurses should not go out but they should stay and practice in the country before they go out of the country (district director).*

*As a country together with the employing agents, the public service management division and the public service division there is need for them to have a stakeholders meeting which will come up with some kind of a memorandum of understanding between members of staff and employees to show that people leave systematically (director national level).*

### ***Budget structure***

Making health service a priority as a country through a deliberate policy on resource allocation in the national budget was perceived as way of mitigating nurse migration as illustrated in the statement below;

*It should prioritize because health is more important than other sectors like agriculture because it is a matter of life and death. The ministry must not be limited to recruit staff by the amount of money that they are given. They must be given first priority when it comes to recruitment (director national level).*

### **Government to government agreements**

Allowing nurses to leave on conditions of being seconded to receiving countries with provisions on `staggered work contracts, continued contributions to national pension scheme and government recovery of their investment in nurses' education and training through tax were perceived as appropriate content in a government to government agreement that would better facilitate the management of nurses leaving for greener pastures as illustrate in the following statements;

*Let people leave openly and continue to contribute to their pension and it should be like some kind of secondment. They should go and work there for a specific time and later come back and work here and later go back if they wish to do so (director, national level).*

*Countries where nurses are going should find a way to recover money spent on training (district director).*

*A certain income that they gain out there should go the government (provincial director)*

The regulatory body in the source country was perceived as having a role in the monitoring the movement and performance of the migrated nurses as illustrated by a provincial director in the in the statement below;

*Should they want to move out they should be registered with GNC and their performance as they are working out there should be monitored and the countries where they are should acknowledge this to GNC so that we know where our people are and we can follow them up where need arises.*

### *Professional development of nurses*

Professional development was perceived as important to nurses as expressed by directors in the excerpt below;

*Training is important after a period of years.*

*We must also upgrade our staff to levels that they deserve.*

### Work experience for nurses intending to migrate

The following themes emerged from the findings on work experience;

#### Bonding according to training sponsorship:

*Upon completion of the training, a person should work for the number of years he or she was sponsored to train and for another 2 years as an appreciation to ones own country. Thus they should work for 5 years and doctors should work for 10 years (director, national level)*

*They should serve as according to the level of training that we have given them. For example, for RN's, 2 years bonding would be fair on the part of government and for midwives we should think of putting up a 3 year bonding. For those with degrees they must work for 5 years so that we have trained people in the country before they leave. The government should also be gaining as these people are trying to move at a particular time (provincial director).*

#### Longer bonding period:

*They should be allowed to leave after four years at least after that they should have practiced enough and worked for the community (urban district director).*

*About 10 years after graduation bearing in mind that another person should have qualified and replaced the one who has even left (rural district director).*

*They should not go immediately after training as government spends a lot of money training the nurses so they must work for a period of time such as 15 years before they decide to leave. After that they may even feel discouraged and stay in the country (rural district director).*

## **Impact of migration on the health care system**

Findings from analysis of responses from the key informants regarding the impact of nurse migration on the health care system revealed the following themes;

### **Poor quality of care due to nurse shortage:**

The nurse patient ratio and quality of care had been adversely affected by the shortage of nurses as expressed in the excerpts below by directors in both urban and rural settings;

*It has impacted badly the nurse patient ratio has been affected, thus compromising the quality of health care.*

*We have poor service delivery due to shortage of nurses as most of them have left*

### **Increased workload:**

The workload increased as illustrated in the excerpts below;

*Nurses work in a hurry just to clear the patients because there are too many patients (rural district director).*

*We are also seeing that there is more work for the few nurses who are remaining in these institutions (provincial health director).*

*It has really affected us because the work load is too much for the nurses. Sometimes we have 1 nurse for 30 patients. The nursing care has gone down (urban district director).*

### **Nurses doing other people's work:**

Nurses were seen to be doing other people's jobs, particularly those meant for medical doctors and clinical officers because of the effect of migration as indicated by directors in the following excerpts;

*They have now ended up doing things that should be done by doctors and clinical officers which is not suppose to be the case.*

*Nurses who remain also end up doing other jobs like screening patients because of other people who are leaving.*

Delegation of services to unskilled workers:

Unskilled people were seen to be taking the role of nurses as illustrated by a provincial director in the excerpt;

*In general the effect is that we are seeing people who have less competencies taking up their roles, for example the general workers and classified employees and therefore the standards of health care have gone down.*

Closure of services:

Some of the services had to be closed as illustrated by a director at national level in the statement below;

*It has impacted negatively. At UTH one ward was closed last year because the midwives have all disappeared. The health system in general is compromised and eventually some health centres and wards are closed down due to shortages of staff.*

Recalling retired nurses:

Recalling of nurses retired by age and those who left under early and voluntary retirement government schemes was seen as way of addressing the nurse shortage caused by nurse migration as expressed by a director in the statement below;

*We need to call on our old nurses who have retired or left under voluntary separation but we have left them out on aspects of capacity building.*

### **4.3 CONCLUSION**

This chapter has presented the findings from both quantitative and qualitative data. The quantitative results presented in percentages, figures and graphs relate positively with the

findings presented and described according to themes that emerged from the qualitative findings. The findings from qualitative data were supported by excerpts to validate the key responses from the respondents. According to the findings, the policy issues appear to suggest interventions towards the key findings that contributed to nurses leaving the country as related to those that attracted them in the destination countries.

## **CHAPTER FIVE**

### **DISCUSSION, RECOMMENDATIONS AND CONCLUSION**

#### **5.1 INTRODUCTION.**

This chapter focuses on interpreting and discussing the main findings of the study and is framed in relation to the five areas of data sources namely; records of nurses whose verification of their qualifications were sent to countries outside Zambia for purposes of seeking registration as nurses in those countries; interviewed nurses who were seeking verification of their qualifications in order for these to be sent to countries of their choice; nurses working outside the country and visiting or returned to Zambia at the time of data collection; nurses working in the public health care system in Zambia and directors at district, provincial and national levels of the health care system. The discussion also attempts to relate the findings to the study objectives and describe these within the conceptual framework context which guides the scope of the discussion.

The chapter discusses the findings from both quantitative and qualitative data and attempts where applicable to cite other related studies in order to support arguments regarding evidence as revealed in the findings. Findings in the text are described numerically and in narrative reflecting quotes, excerpts and extracts where quantitative and qualitative data are reported respectively.

## **5.2 EXTENT OF NURSE MIGRATION**

An important aspect to note is that the discussion on the extent of nurse migration is limited by the absence of data on nurses issued with visas or work permits and allowed to travel to their destination countries by the respective embassies based in Zambia.

Permission to collect this data was not given to the researcher as indicated in the appended replies from the embassies. This is also explained earlier under the section on limitations of the study. Despite this situation, discussion on the extent of nurse migration is still appropriate from the perspective of what the country potentially loses, not just in numbers, but the expertise, experience and qualifications of the nurses that potentially leave the country.

In view of this, the extent of nurse migration is discussed in accordance with the characteristics of the nurses whose verifications of qualifications were sent to countries outside Zambia by the country's General Nursing Council, the institution responsible for the regulation of nursing and midwifery education and practice. The justification for this approach is based on the premise of not being able to quantify the number of nurses that left the country from information on verifications alone. Nurses whose verifications are sent outside the country do not give feedback to the Council regarding the subsequent status of their emigration.

In this context, characteristics include gender, age, professional qualifications and work experience of the nurses with sent verifications. Comparisons are made with the characteristics of migrated nurses who were visiting the country and nurses who had not

migrated and still working in the public health system. The importance of this component in the discussion portrays the attributes and work position levels that the nurses had reached in their career paths and reflects their responsibilities, experience and expertise that Zambia is potentially losing to other countries.

### **5.2.1 Gender and age**

Female nurses with sent verifications appeared to be mostly on the move to locations outside the country, according to findings in this study and it appears the majority of these were married nurses. Findings from data on interviewed nurses seeking verification of their qualifications portray a similar gender imbalance pattern. This is expected as the majority of nurses in Zambia are female. The reason for this could be the late introduction of males in registered nurse education and training programmes which was not commenced until 1977 at the Kitwe Central Hospital School of Nursing. This trend was followed by the rest of the registered nursing schools namely, Lusaka, Ndola and Mufulira.

An interesting finding to note is that of marital status, where interviewed applicants seeking verifications comprised more single than married nurses. This contradicts the finding for nurses who had their verifications already sent out to countries. A contributing factor could be that in the earlier period, married nurses had more family responsibilities to shoulder than the unmarried. Considering the fact that family responsibilities and obligations constituted a factor in motivating nurses to leave the country in this study,

unmarried nurses could have assumed responsibilities of caring for orphaned children of family members or their on with the advent of the HIV/AIDS pandemic.

However, it does appear from available literature that the gender imbalance in the nursing profession is not peculiar to Zambia. Studies today point to the fact that the vast majority of nurses migrating are women (Kingman, 2006). Munjanja and colleagues (2004) observe that the gender of nurses in sub-Saharan Africa is mainly female as males constitute only 10% of the nursing workforce in most African countries. From the researcher's experience, a woman in Zambia is expected to move in accordance with the geographical location of her spouse if she has to continually fulfill the cultural norms of matrimonial relationships and roles. The migration of married female nurses appears to be overturning this cultural norm and poses a challenge not only to affected families but to society generally which in most part influences the dynamism of the cultural norms and practices.

Experience of the researcher has shown that in previous years, mobility of female nurses mostly from rural to urban health facilities through formal transfers following marriage was a concern in the public health sector. This influenced the introduction of male nurse training in the registered nurse programmes. Increasing numbers of male nurses potentially leaving the country thus defeats the original purpose of male inclusion in nurse training which was partly to strengthen and sustain staffing of rural health care facilities. This was based on the assumption that males were generally considered more stable in relation to rural-urban mobility in contrast to their female counterparts who

culturally have to leave their employment positions to join their spouses in case of marriage.

Basing on a public service reform impact study on health sector personnel in Cameroon, Ngufor (1999) endorses that family and marriage culture limited distribution of female health workers around the country. This supports the cultural influences attached to female health workers, nurses inclusive, when it comes to the challenge of their distribution for rational staffing of health care facilities, more so in the rural settings of the country.

Although it is not clear how many of the nurses who seek verifications of qualifications ultimately leave the country for greener pastures, experience points to persistency by nurses in processing the required documentation until they finally leave the country. Nurses' verification of qualifications sent outside the country appear to strongly signify their expression of intentions to emigrate and is probably the critical phase in the legal formalization of the process towards transfer of information from the Council register to another country's regulatory organization. Further experience has shown that commencing the process of leaving for greener pastures is involving and thus reflects planning and commitment to leave on the part of potential migrants. The costs involved are enormous when considered against the nurses' income. They involve obtaining records of their education and training from the various relevant educational institutions and reports from the employers regarding their performance, in addition to the nursing council verification of their qualifications, which also gives their professional conduct

records. There is a cost involved at every level of the process which the nurses themselves have to bear, that is, apart from the transportation both within the country and when they are finally leaving. The data on verifications therefore are a critical indicator of the extent of nurse migration in Zambia.

Buchan (2002), however argues that verification data can be used as an indicator of intention to work overseas when there is evidence of the individual's registration by the professional body in the importing country but points out that because registration data have usually been compiled on a consistent basis over time, they provide a valuable source of trend data despite limitations of for example, errors to do with double counting of registration applicants, particularly in countries where registration is at state level, like in the United States and Australia.

Regarding the age of nurses who had potentially left for greener pastures following their verification of qualifications being sent to countries outside Zambia, there were more aged 40-49 years than those aged 30-39 years. Interestingly, interviewed nurses seeking verification of their qualifications were more in the ages of 30-39 than those in the aged 40-49 years. It appears there is a trend for younger nurses to leave the country. The contributing factors could be family responsibilities particularly those related to dependents, rigorous recruitment efforts by the importing countries and early desire for better quality of life. The age group trend was similar for nurse migrants who were visiting Zambia. This age pattern could reflect the commitment of most nurses to work and practice in their home country following their graduation and thus the lack of interest

in leaving for greener pastures in the initial stages of their professional working life and the possible growing influence of the migration motivating factors during the later years.

This finding also shows that the majority of nurses potentially leaving the country are those who have reached the peak of their optimal capacity to serve the country with still service years ahead of them before reaching the statutory retirement age of 55 years. Given what it takes to remain in the country, they would continue working in the public health system contributing towards its goal of health service provision until retirement from active service. The younger nurses and those near retirement age comprise smaller numbers of nurses. The implications are that since these nurses potentially leave the public sector before their retirement age, they most likely resign from their formal employment positions to facilitate their emigration from the country. However, from the experience of the researcher, nurses in Zambia are entitled to what is commonly referred to as unpaid leave. From information on the ground, it is quite common for nurses to use this kind of leave to process their applications for emigration to other countries.

Interestingly, nurses in the retirement age group also potentially left the country and for some, they did so years after they had retired. Age 55 marks the point of retirement for public service workers, according to the Zambian government policy. The majority of nurses are employed in the public sector and so are affected by this policy. Their being employed at this age by recruiting countries could be attributed to the differences in retirement age policies when compared with those in Zambia. This means that the

retirement age limit for countries where such nurses emigrate could be above that stipulated in their own country's labour policies.

Younger nurses aged 20-29 years are also potentially leaving for greener pastures. This applies to both male and female nurses. It appears from the findings that an increasing number of male nurses are potentially leaving the country at a young age, which raises concern regarding the future supply of nurses and the education and training investment benefits for the country and its people.

Similar findings from an assessment of the health workforce in Malawi by the East, Central and Southern Africa Health Community (ECSA-HC, 2004) provide evidence of younger health workers being in the majority among those leaving to work outside that country. These findings show that most health workers who left the health service were between the ages of 25 and 34 years (62%). In this assessment, nurses constituted the majority of health workers who left the health sector from 1996 to 2002. The report also points to the fact that other sources of data, namely the BBC report in a news article indicated an annual 100 nurses leaving Malawi to work in other countries (ECSA-HC, 2004:8).

In previous years, as per researcher's experience in Zambia, mobility of female nurses mostly from rural to urban health facilities through formal transfers following marriage was a concern to the health sector. This influenced a policy decision on the introduction of male nurse training in the registered nurse programmes. Increasing numbers of male

nurses potentially leaving the country thus defeats the original purpose of male inclusion in nurse training aimed at strengthening and sustaining staffing of rural health care facilities. Male nurses have generally been considered more stable in terms of rural to urban mobility in contrast to their female counterparts, who culturally have to leave their employment positions following change of marital status.

### **5.2.2 Levels of qualifications and years of experience**

Regarding the qualifications of the nurses, it appears more registered than enrolled nurses were potentially leaving the country. All the data sources on migrating nurses, namely records on nurses with sent verifications, interviewed nurses seeking verifications and visiting migrant nurses showed a similar pattern regarding qualifications of nurses. This majority in the number of registered over enrolled nurses contradicts the reality as by December 2007, the General Nursing Council of Zambia database showed a total of 14,859 nurses of whom 5,425 and 9,434 were registered and enrolled nurses respectively.

The higher number of registered nurses in the findings of potential migrants is not surprising as the registered nurse is the internationally recognized professional qualification by the International Council of Nurses (ICN). There is also a possibility of some countries seeking only this level of nurses when recruiting from sending countries. From experience, this is the level that has been leaving the country for greener pastures more frequently than the enrolled nurses whose numbers appear to have only begun to increase in the recent past. The registered nurse qualification is at diploma level in

Zambia tenable through a three year educational programme and is a pre-requisite for further education in mainly midwifery, Bachelor of Science and Master's degrees while enrolled nurses train for a period of two years. Nurses in Zambia comprise about 75% of the health workforce in the country. Nurses leaving the country for greener pastures thus had implications for the strength of the health care system and its capacity to facilitate access to health care by the majority of the citizens.

Regarding work experience, there were more nurses with experience of 6-10 years who had had their verifications sent to other countries. This implies more nurses with this experience could have left the country for greener pastures. Registered nurses were still the majority. According to these findings, the number of nurses appeared to decrease with increase in years of experience. This supports the findings earlier reported where numbers of nurses with verifications sent to other countries decreased with increase in age. From this trend, nurses appear to be leaving the country with the experience that would optimize their contribution to improving the health of the Zambian people. Years of work experience was based on the date when nurses completed their basic nursing programme and the date when they first applied for verification of their qualifications. This did not take into account the possibilities of nurses not having worked during the considered period following their completion of training. What the country appears to be potentially losing to other countries are nurses who are young with the majority having post basic qualifications and expertise in the critical areas of service delivery which include midwifery.

In a Malawi health workforce assessment by the East, Central and Southern African Health Community (ECSA-HC, 2004:8), over two thirds (68%) of health workers left the health sector after two to ten years of work experience at their respective health care facilities; a time when, according to the report, the health workers were becoming experienced mid-career employees.

Regarding post basic qualifications among nurses with sent verifications, midwives were the majority and as expected, most of them were registered midwives. Others were operating theatre nurses, Bachelor of Science degree in nursing and registered mental health nurses. Similarly, for nurses interviewed while seeking verification of their qualifications, midwifery was the most common post basic qualification. This potential loss of expertise among nurses is significant, and poses a challenge to the public health system with regards to its potential for capacity to achieve the country's health targets. The large numbers of potential migrant midwives suggests a downward trend in efforts to realize the Millennium Development Goals whose global and national targets is to reduce maternal mortality by three quarters by 2015. Zambia's maternal mortality ratio is estimated at 729 maternal deaths per 100,000 live births (ZDHS, 2001-2002:245) and is reported to be among the highest in the Sub-Saharan Africa. Literature today indicates evidence of skilled attendants as the most effective strategy in reducing maternal mortality. According to WHO (2004), skilled attendants include accredited health professionals such as nurses, midwives and doctors.

It is argued that reduction of maternal mortality should be prominent in and used as an indicator of efforts to strengthen health systems (Worley, 1999). Nurses with specialized training, although not on a large scale in country numbers, take long to train and can create an indelible impact on the health services once they leave the health sector even when in minimal outflows. Buchan (2003) asserts that migration flows among specialist groups, for example in nursing, can undermine a country's health system.

On the other hand, early application for verifications seemed to feature more for most enrolled nurses. This implied their expression of intention to leave at an early stage of their working life and with less experience compared to registered nurses as the findings showed more of them having had only 11-15 years work experience at the time of applying for their first verification. Another possibility for this trend could be the effect of a later opening of opportunity for this level of nurses who previously were not marketable to countries outside Zambia.

### **5.2.3 Nurses' practical experience**

Potentially, the country appeared to be losing nurses not just with years of experience but also experience in practice in various areas of service delivery. This is shown in findings regarding positions that nurses had at their workplace at the time of application for verification and also based on the positions held by nurses who had migrated before they left the country. Nurses who were applying for verification had reached supervisory and management levels at their work places and most of them were working in out-patients and maternity units. The implications of the potential loss of this level of nurses to other

countries include losing skills in not only planning and managing the health service in their areas of practice but also competencies in mentoring of young professionals and making important decisions about their professional development and improvement of the quality of patient care.

There were more nurses at senior level of nursing managers among the interviewed nurses who were seeking verifications. Interestingly, the same applied for enrolled nurses with regards to seniority in work experience. The positions held by migrant visiting nurses before they emigrated had more registered nurses and college lecturers. In previous years, from experience, enrolled nurses had been considered as stable and not marketable in terms of mobility to the outside countries because of their perceived low level qualification and their being mainly practical nurses in their preparation. However, the subsequent curriculum reviews for the training of these nurses in Zambia has upgraded both their entry academic qualifications to almost that of registered nurses. This change has been in response to trends in the disease burden and health needs of the Zambian people. With regards to the enrolled midwifery curriculum, educators have argued through various forums about the difficulties of seeing the difference with that of the registered midwifery curriculum. This could be a reason for the enrolled nurses being more attractive to countries now, combined with other forces driving nurse migration.

### **5.3 COUNTRY OF CHOICE FOR SENDING VERIFICATIONS**

The preferred countries of destination for nurses emigrating were revealed in findings from data on sent verifications and interviewed nurses seeking verification of their qualifications. Findings showed the top six countries in order of nurses' preference as

being the United Kingdom, South Africa, Botswana, New Zealand, the United States of America and Australia. However, nurses appeared to apply to the Council for repeat verifications for sending to some of the countries but even for these, there was a similar pattern of country preferences when compared with the first sent verifications. Repeated sending of verifications to same countries could be an indication of the determination by the nurses to leave and work in their country of choice. This persistence shows that even non responses to sent verifications from countries could not deter nurses from further pursuit of their intention to emigrate. The United Kingdom and United States of America had up to seven repeat verifications by some of the nurses. The influencing factors for this choice and popularity of the United Kingdom in particular, could be attributed to a number of factors related to the history and colonial profile of the nurses' home country Zambia. Zambia had been under the British colony up until 1964 when the country became independent and assumed self rule. Naturally, the foundation for some of the systems could still be British oriented including the educational and legal systems that were in place at the time. These may have had a bearing on, for example, the official medium of communication in the country which is the English language. For a country with 73 ethnic tribes, each with its own special dialect, English appears to be convenient as a uniting medium of communication as it cuts across barriers in general and tertiary education and work environments.

According to records at the Zambia Union of Nurses Organization (ZUNO), Zambia's General Nursing Council was established as a result of the colonial time British nurses' activities which culminated into the enactment of the Nurses and Midwives Act of 1970.

These and other factors could be influencing the nurses' choice of the UK as their destination country. However, when data on all the nurses' verifications sent were further analyzed according to regions, findings showed the African continent as the most preferred and closely followed by Europe, Western Pacific and North America.

The contrary was the case with regards to findings on verifications sent to regions according to basic qualifications as these revealed more registered than enrolled nurses with the first verifications sent to countries in Europe compared followed by Africa. The first six countries in order of popularity also attracted nurses with scarce qualifications which included operating theatre nurses with verifications sent to the United Kingdom, Botswana and South Africa. The pattern for the rest of the qualifications with verifications that were sent was not very different and had the similarity regarding country choices. For example, for the registered mental health nurses, findings showed that more verifications were sent to Botswana, followed by South Africa and the United Kingdom.

For nurse educators, South Africa and the United Kingdom appeared to have been more popular with New Zealand and Botswana in that order. Even when data were analyzed by region, nurses' preferences still showed more verifications bearing scarce qualifications sent to countries within Africa. For example, the first verifications sent by region showed qualifications of operating theatre, registered mental health and nurse educators. These figures on numbers of verifications and the related qualifications are a revelation of what Zambia as a sending country is potentially losing, not only through possible numbers of the nursing human resource for health leaving for greener pastures but also their expertise

in form of knowledge and competencies based on their professional qualifications and work experience.

Regarding countries to which nurses are emigrating, Buchan and Sochalski (2004) state that the number of countries sending international nurse recruits to the United Kingdom has increased from seventy-one in 1990 to ninety-five in 2001. According to Kingma (2006), evidence indicates a major focus on what is referred to as South to North migration and gives an example of Ghanaian nurses moving to the United Kingdom and Vietnamese nurses relocating to France as Ireland recruit Indian and Chinese nurses for positions in their countries. However, Awases and colleagues (2003) assert that the large bulk of Africa's health professionals leave to work in a few industrialized countries, pointing to available data that shows the highest increases being in losses of nurses with most going to the United Kingdom, United States, Canada and Australia.

#### **5.4 THE FAMILY CONTEXT OF NURSES**

Findings from the data sources on interviewed applicants seeking verifications, nurses working outside the country and visiting Zambia, those working in the clinical settings and the educators in the teaching programmes reveal, interestingly, the family dimensions of the nurse, both as a worker and a professional. Apart from the children, the nurses' family encompasses the extended family members for whom they assume responsibility in terms of their social economic welfare and general upkeep.

It appears from the findings that having children motivated the nurses' desire to leave the country for greener pastures and to thus begin the process of emigration through seeking verification of their qualifications from the nursing council. However, nurses with a small number of 1-3 children were in the majority among those seeking verifications and similarly among nurses who had already migrated and were visiting the country. This finding shows that the fewer the children the nurse had, the more likely that they sought verification of their qualifications with the intention of leaving for greener pastures. However, nurses without children appear to have little motivation to leave for greener pastures judging by their small number among those interviewed. This finding also applies to those with larger of children.

Contributing factors to these findings could be several. One would be the nurses' consideration of the ease with which they would emigrate with smaller numbers of children as opposed to transporting and settling too many in schools and in a foreign country. Another could be the desire for maximization of the economic benefits of migration, which could be defeated to some degree with more children, particularly when more of the nurses appear to initiate the migration process and possibly leaving at the peak of their professional career and before reaching their retirement age. Alternatively, it is also possible for migrating nurses to have planned for smaller numbers of children even before migrating.

Age of children appears to be another deciding factor for out migration as findings indicate that the younger the children, the greater the number of nurses who sought

verifications of their qualifications with the intention of leaving the country. Findings show more of these nurses with children aged 0-5 years and 6-10 years in that order. Nurses with older children aged 21-24 years were fewer. Age of children appears to be linked to the finding on the nurses who were potentially migrating where the majority were in the 30-39 age group as earlier reported, an indication that young nurses are potentially leaving the country while in their reproductive age and thus expected to have younger children. This potential departure of younger nurses from the health system appears to threaten the core business of health service delivery which relies heavily on human resources for health, nurses included.

Unlike interviewed nurses seeking verifications and migrated nurses visiting the country, nurses who had not migrated appeared to have had a common denominator based on having children. Interestingly, all clinical nurses working in Zambia in the various health care facilities had children; the majority of them with 1-3 children while others had 7-9 and 10 or more children. The clinical nurses' children were mostly aged 6-10 years. Similarly, all the nurse educators still working in Zambia had children; the majority had 1-3 children. These findings regarding more nurses with younger children could be an indication of a younger nursing workforce of both clinical nurses and nurse educators working in both health service facilities and educational institutions respectively.

When considered against similar findings regarding the number and age of children of nurses who were seeking verification with the intention of leaving the country, the available nursing workforce appear vulnerable to emigration and thus threatening the

stability of the health care system through their attractiveness to countries and the potential to migrate. It is not clear whether the fact that all the nurses including nurse educators who had not migrated had children was a determining factor to their not having migrated. What appears to be the case is that having children, particularly in large numbers, negates the potential for informants to leave for greener pastures. Larger numbers of children, although a small percentage, are also noted among the nurses still working in Zambia in contrast to those who were seeking verification and the already migrated nurses. Larger numbers of children could also be a de-motivating factor for making decisions to leave the country.

An interesting dimension of the nurses' family context in the findings is their characteristic regarding the extended family. Taking responsibility of other family members in addition to their own immediate children appears to be an obligation that nurses have to fulfill from an extended family perspective. This commitment is evident in this study, both among informants working in and outside the country, thus placing a heavy burden on the already constrained resources for those affected, particularly before their emigration. Another characteristic is that of family members referred to as dependants. Findings from three data sources namely nurses seeking verifications, nurses working outside the country and visiting Zambia and those that had not migrated, show that most of them had dependants under their care.

This tendency appears to follow the pattern of the Philippine nurses who bring their families to their host countries including siblings and parents. This practice contradicts

that of their South African counterparts who, when they leave to work abroad, leave their children with members of their extended family and return after earning the finances to meet their intended goals.

Similarly, most of the nurses working in the public health sector in Zambia dependants. There were even nurses with over ten dependants! The situation with the nurse educators was the same. More of them had dependants living with them. These findings are not surprising as from available experience, nurses are members of the communities in which they live and experience the adverse effects of poverty and the disease burden particularly HIV/AIDS and the subsequent consequences of orphans. It is likely that most of these dependants are orphans and as expected in the traditional African family context, educated and working family members are expected to play a role in supporting others in realizing their life goals particularly during the formative stages of their preparation for adult life, and nurses are no exception to this daunting task.

## **5.5 DETERMINANTS OF NURSE MIGRATION**

Factors influencing nurses to leave for greener pastures are discussed according to findings related to nurses leaving their employment and leaving the country and their motivation for the choice of the country of destination. The data sources for the findings on what influenced nurses' decisions to leave the country were interviews of nurses seeking verifications and nurse migrants working outside the country and those that had returned to work and settle in Zambia. Findings on contributing factors to nurses' leaving their employment and the country were reflected mainly as themes and sub-themes.

### **5.5.1 Factors driving nurses to leave employment**

Informants were dissatisfied with the conditions under which they were employed and worked and thus referred to them as a major influence towards their decision to emigrate. According to the findings, discontent with employment conditions was a major contributing factor to nurses leaving their employment and the country, mentioned by interviewed informants seeking verifications and the migrant nurses working outside the country. Informants commonly referred to this as poor conditions of service, a term used to describe the contractual terms for nurses and other workers in the government civil service within which the public health sector is a part.

Outlined as part of the poor working conditions was what informants perceived as poor remuneration, seen as a major factor responsible for their expressed inability to meet their daily life basics. Remuneration included what informants received as salary and the concern pointed to the fact that this was so meager it could not stretch over the time-based monthly remuneration. Migrant nurses, both visiting and returnees, equally attributed the economic hardships experienced before their leaving the country to the low salaries. Informants desired to have a sustaining salary perceived as one that would stretch within the working month and in addition provide for gradual savings for eventualities. Informants expressed the desire to save money and felt insecure with the inability to do so. This desire for more money was expressed as essential if the conditions of service were to be responsive to the informants' financial needs and obligations as indicated in the excerpts;

*Very little is left for me*

*I want to have enough money in the bank for other things*

Incentives were also perceived as part of the remuneration. Mentioned among these were what was referred to as risk allowance and access to loans. Risk allowance was seen as compensation for working in clinical care settings that considered as exposing nurses to infections as expressed by an informant;

*There is no risk allowance for diseases.*

According to informants, access to loans was seen as a latitude for acquisition of costly but essential aspired valuable assets and the lack of it influenced nurses to leave the country. The aspiration for acquisition and ownership of these valuables could be a reflection of the positive and higher level self image of nurses both as professionals within the health care environment, community and society at large and their perception of what is deserving to them based on their profession with a body of knowledge and the breadth of their contribution to the health care system. The implications are that a re-packaging of the working conditions for nurses would have to take into consideration what the informants perceived as remuneration with a higher salary inclusive of the incentives as described in order to meet their expectations. Arrowsmith and research colleagues (2001) refer to allowances as other sources of income that increase job attractiveness and argue that these exist in virtually all countries, citing access to loans among such incomes.

A striking finding is the contextual role of the informants in the family and how this influenced their decision to emigrate. Although other studies, for example a WHO (2004)

survey found family related matters as one of the reasons for nurses' migration, the understanding of the family by the nurses that participated in this study goes beyond their siblings, encompassing the extended family, who they perceive as their family and for whom they appear to have a social and economic obligation.

Kingman (2006) attributes this to poverty and observes that the poorer the country the nurse comes from, the more likely it is that family needs override the personal and professional influence in the nurse's career choices. In this study, the value with which the informants perceive the importance of their contribution to the upbringing and education of members of their families appear to focus on facilitating the latter's social and economic independence in adult life and expresses the nurses' intense and deep rooted caring affect that could likely have its roots in their professional context of the caring value of nursing. It may also be a manifestation of their professional socialization. Informants gave being unable to provide for the family as one of the contributing factors to their decision to quit their jobs and leave the country, portraying an attribute that supports the concept of the caring value of the nursing profession.

Poor living conditions mentioned by informants were illustrated by describing the perceived poverty in the respondents' way of living which was seen as contradicting that of an income earning professional person. To the informants, a working person of their professional level is expected to have adequate income for their living and this inadequacy adversely impacts on their way of life which they find unacceptable. Their

perceived poverty is attributed to the hardships they experience in acquiring basic provisions including meeting food requirements for the family.

*Food also waits for month end to come and even then, the money is not enough and not manageable.*

From the researcher's experience, not being able to provide food can be demeaning to the family members more so to the head of the household as this implies inadequacy of efforts in productive activities that rewards one with the means for a living.

According to findings, this poverty is perceived by informants to be reflected in other aspects of their lives and poor accommodation is particularly singled out as being sub-standard for their status as professionals. An extreme example of the poor living conditions is indicated in the excerpt from the findings by an informant;

*Here, I have no decent accommodation. I share a house with three other families. We also share the toilet which is a pit latrine.*

What is expressed in the above excerpt is incongruent with what nurses learn through their professional preparation regarding personal and community health and the context in which they live as members of health communities and professional practitioners. This contrast is in itself a driving factor towards a perceived change in the livelihood of informants.

Emigrating to external geographical locations gives informants new expectations and hope for a better quality of life. The risks and unfamiliarity of prospective new environments are overcome by the desire and conviction for the perceived change in the quality of life. Findings revealed the search by informants for better quality of life as one of the reasons for leaving employment and deciding to leave the country. Their

perception of emigrating signals potential for improving their life style as supported by the excerpt from an interviewed informant seeking verification;

*I want to go to greener pastures so as to improve my life and way of living*

According to findings, informants felt professional autonomy and identity was important in the work setting and general health community and their emigration provides the prospect of finding its worth in new environments. Entry into a profession is usually by choice and what influences such decisions can be an array of possibilities envisaged only by the individuals. The search for identity and autonomy as professionals can also be a reflection of what the informants conceive and expect as the professional status and power dimensions of nurses and the control of their practice, making its absence a visible gap that cannot be accepted. In these findings, professional autonomy and identity was a common theme from informants seeking verification.

Findings specific to nurses who had left to work outside the country included search for international experience, poor leadership in health service, and early retirements as some of the reasons for their leaving employment. The search for international work experience was interestingly more common among returnee nurses as their recounting of this intention revealed what appears to be a level of curiosity into what the nursing and health service world is like beyond their country boundaries. Although some of the visiting informants also mentioned the interest in exposure to what it was like in other countries, this appears to have been a more important motivating factor for leaving employment and the country in the case of the returnee informants as it is mentioned by the majority of them. International exposure creates job opportunities for acquiring new knowledge and

skills in other health conditions not experienced back home and the relative nursing care as indicated in the excerpts by returnee informants;

*... .. see how other nurses work and see how to nurse different conditions in different parts of the world.*

*I left mostly to gain international experience. I was seeking a job opportunity in my relevant field.*

Whether the returnee informants felt they had achieved this objective by having migrated to other countries is not clear from the findings based on the analysis of their responses. This finding can also be considered as an expression of either their satisfaction of having acquired the international experience as per their expectation or even an indication of their disappointment arising from having had higher hopes and subsequently experiencing the contrary while in the destination countries.

Poor management and leadership in health service delivery was another reason for emigration of informants. This is elaborated in the context of perceived management intimidating behavior in the workplace which is perceived to weaken the organizational workplace climate and ultimately negate informants' interest in their continued employment in that kind of work environment. Another attribute of poor leadership from the findings was lack of counseling provisions for staff. Informants felt their working under the unsatisfactory conditions of service warranted management and leadership understanding and support and the contrary worked against their desire to continue with their employment status. An aspect of perceived poor management and leadership in the findings was lack of access to professional development opportunities in form of financial support for furthering studies of nurses. The dimension of this finding is seen as

having an adverse effect on the informants' potential to make progress along the career paths and related promotional ladder. The implications are that informants perceive this as a barrier to their future career in nursing and resorted to emigration as the solution. In the past decades, nurses' values and behavior towards management and the leadership bordered mainly on obedience and succumbing to corrective and punitive interventions. It appears from this finding that the current generation of nurses values more of what is in it for them particularly a career path supported by furthering their education as opposed to ordinary promotions to higher positions. The expectation of a supportive management and leadership with counseling capacity and systems in place entails a perception of more respect for management and leadership competencies than just the superior positions that they hold.

In addition, corruption appears to have been of concern to some informants. Although this is not clearly elaborated, it appears to be perceived through national level activities. Instead of contributing to the fight against corruption, migrating to other countries is perceived as a way of avoiding its effects for some of the respondents. However, some of the migrant nurses were influenced to leave the country by the fact that they had to join their spouses who had left earlier.

Early retirements resulting from government policy on job cuts forced some of the informants to seek other avenues of livelihood by leaving the country. According to the World Health Organization, there is scarce health worker retirement rate information available currently (WHO, 2006). Auer and Fortuny (2000) generalize the trend of

preference towards early retirement by workers in many countries, before reaching their statutory pensionable age while Greene (2000) concedes that a similar trend is gaining momentum among health workers.

In this study, the implications for the affected entailed separation from public service before the pensionable statutory retirement age of 55 years. This finding is specific to visiting informants who either had themselves left the public sector under this scheme or had to make decisions to leave the country following the job loss by their spouse, when options for sustaining their survival were not perceived possible within the country.

What the respondents received as retirement rewards for their services in the public sector is perceived as inadequate and unsatisfactory. However, for some of the respondents, the separation package facilitated acquisition of much needed assets in the form of housing units and this appears to have been a positive outcome of the forced job redundancies. The excerpts below by visiting informants support the findings related to early retirements;

*At that time, there was voluntary separation. So I went on voluntary separation.*

*I felt belittled by being paid such a small amount by the government after leaving.*

*I was in a pool house. I was given money and I paid for the house which I bought.*

## **5.6 INFORMANTS' ADVANCE JOB SEARCH**

Nurses who participated in this study could safely be labeled as risk takers. Whether the informants knew the risks they were taking by desiring to go to a country even when there was no job for them there yet is not clear. From the findings, the interest and urge to

leave the country appears independent of the availability of a job in the receiving country. All interviewed nurses seeking verification of their qualifications except one had not yet secured any job in their prospective destination countries. The reason for this could be their determination to leave at all costs, pushed by the employment circumstances in the public health system, and also their preparedness to face the possible risks in an unknown country. Normally, one's securing of a job implies one's capacity to survive financially and materially but to these nurses, the future held their immediate and long term livelihood and so to them, it was important to find that life.

## **5.7 FACTORS EXPECTED TO CHANGE INFORMANTS' DECISION TO MIGRATE**

In as far as changing their decision from migrating to staying and continue working in Zambia, findings pointed to what nurses seeking verification had earlier given as their reasons for wanting to leave the country. A whole package of what they considered to be due to them in form of remuneration; higher salaries, incentives, living conditions, empowerment for acquisition of estates and transportation were mentioned as if provided, would make them change their decision and stay to work in the country. This assumes the country's capacity to pay them according to their expectations, with due regard to their role in health service delivery. The statement by an informant seeking verification elaborates this finding;

*If the working conditions were improved and salaries increased, incentives given, accommodation provided, and the loans were accessible, I would stay.*

Their entitlement to leave appears a necessity, indicating the lifting of the suspension of vocational leave as one of the factors that would make them change to work in the

country. In addition, informants called on the government to address the issue of nurse shortage as it affected and resulted in work overload and stress and employing enough nurses was seen as a solution to the problem. Recognizing nurses as professionals was repeated just as earlier indicated in informants' reasons for leaving the country.

## **5.8 ATTRACTION TO DESTINATION COUNTRIES**

The discussion on findings regarding factors that had attracted informants to countries of destination are based on analysis of two data sources; interviewed nurses seeking verification of their qualifications and intending to leave for greener pastures and nurses who had already migrated and still working outside the country, either on visit to Zambia or had returned to settle in their home country. A result worth noting is that although the findings are from data sources of nurses who were in the process of preparing to emigrate and those that had already migrated and were working or had worked in countries outside Zambia, there were more commonalities than differences in what attracted both types of study participants to the countries they had preferred to emigrate to.

One common finding regarding what informants perceived as attractive in countries that they selected for their destination was prospects for better remuneration. This comes as a subsequence finding on dissatisfaction with salaries earlier reported as a reason for informants' resignation of their employment positions in the public health system. It appears making a decision to emigrate to a country was guided by the possibility of earning what was not feasible in their previous employment positions in their home country and the potential the destination country to reward them in accordance with their expectations. Better remuneration was perceived to be a higher salary. Informants appear

to have had prior information about what to expect and this assisted in their decision making regarding a country that would be responsive to their aspirations as indicated in the excerpt by informants seeking verifications;

*They pay nurses good salaries*

*Salaries are better there*

This information had facilitated their preparedness and confidence for working in the receiving country by both informants that were seeking verifications and preparing to leave and those that were already migrants.

Informants were critical of their quality of life in Zambia and perceived migration as a way to a better life. The destination countries they had selected appear to have given them advance assurance of appropriate rewards for their work. Better living conditions and access to transportation were seen as a means of filling the gap in the type of life style that was to fulfill their dream of a worthwhile working life. However, from their expressed desires, their dreams of this envisaged life appeared utopist due to a marked absence of due regard for possible eventualities to the contrary. The statements by informants seeking verifications below expound their aspirations;

*I want to have a better life than the one I have in Zambia*

*The country I have chosen is able to provide what I want*

From the above excerpts, a possible reason for the positivistic expression in what the prospective receiving country was able to provide could be attributed to informants' careful selection of the country due to its determining factor in the achievement of the goal of a better life than in the home country. It could also mean having prior information

about the country pros and cons of the immigration policies in the recruiting country. In view of this, selecting the destination country appears to be a critical phase in the whole process of leaving for greener pastures because of its role in the ultimate benefits of migration.

Informants who had already migrated mentioned professional identity and autonomy as an attraction to a destination country. In the perspective of informants, this included recognition of professional qualifications. The reason for their being the only ones who brought this up, according to findings, could be the influence of their practical experience and the perceived benefit of such recognition in the respective host countries as seen in the excerpt from a visiting informant;

*They recognize qualifications.*

Another possibility could also be an expression of the informant's satisfaction at being recognized as a professional in their host country.

Both nurses seeking verifications and migrant nurses appeared to appreciate quiet and peace as their perception of an environment that was conducive to their work. Informants appeared to link the conducive environment they desired in the receiving country to potential for easy adaptation of their children. Prior information on the description of the physical structures of the health facility and advanced health service technology provided added value to the destination country. The statements below by visiting informants' illustrate this finding;

*I had friends there who had gone before me and it sounded like a good country.*

*I thought it would be easier for the children to settle as the country has a quieter environment than other countries.*

*The type of hospital set up, how things are done which is different from the Zambian one.*

Returnee nurses indicated gaining international experience as having had a role in their choice of a recruiting country. The reason for this could be part of their reflection on their investment in emigrating and their perceived benefits from having left for greener pastures seeing that they were now back to their home country. Their experience also points to the professional nurse's scope of practice where their role was more focused on providing care which was different from the practice in their home country, where they do menial jobs that demean the status of the nurse and the profession, signaling non recognition of the level of their academic and professional preparedness and practice and the effect of work dissatisfaction. A returnee's statement gives this illustration;

*There is better quality and you get to do what is meant for nurses and although the work is quite a lot, you earn what you deserve, and things are done in a more organized way, so you have time to do your nursing care properly. This is different from here where nurses have to do jobs for persons in other departments like the porters' work and clerical work.*

It is worthy noting that the gains from the international experience equally reflect expressed earnings that were perceived to be commensurate with informants' performance and contribution to health care, an indication that could imply satisfaction with their income, described as deserving.

Informants perceived their inability to furthering their professional development in the country as resulting from the lack of a more encompassing policy framework supportive

of up to tertiary level continuum of education and beyond. As can be seen from the findings, both migrant and nurses preparing to migrate expressed the desire to further their education and saw this as the gate way to personal and professional development. This is suggestive of a free education policy with provisions for educational loans for the tertiary level and a supportive national funding framework policy. In this study, recruiting countries with such opportunities attracted both seeking verifications and migrant nurses as they perceived themselves with a better future career.

Another common finding was related to the proximity of the nurse migrants' original country which facilitated ease of their movements between their host and home countries. The reason for the preference of such a country could be to promote home country investment of migrants' earnings and further facilitate family support. In this way, informants would be able to maintain relationships over and above those that are through the traditional means of communication. It is thus likely for informants with this interest in mind to look across the home country's borders for a more convenient recruiting country which, because of it being potentially developing, may not necessarily be so affluent and lucrative in comparison to the countries in the industrialized world.

Decisions of informants seeking verification were influenced by the ease with which they communicated with their potential immigration countries. Since these nurses had not migrated yet and had not gone through the whole process up to registering or acquiring a job out side the country, the concept of ease of communication could have been based on the information and influence from others' experiences. Another reason for this could be, they could have in some situations, potential migrants have to send mail to countries by

postal means and such mail can be prone to undue delays as some nurses do not have access to internet facilities while others may not have the competency that would ease their communication. In this way, it is easier to consider the ease with which communication flows between the time when this is initiated and the feedback on acceptance of either registration of the potential nurse migrant or a job offer in the recruiting country.

From the findings, applicants for verifications also saw the potential for their integration into the communities of their receiving country citing concern for racial inclinations. With experience of other nurses who could have left earlier to countries where this was rife in work settings, it is possible to have had such type of information shared with others that had not migrated. It is important for potential migrants to be cautious and avoid such negative experiences.

For informants seeking verification, information on availability of food in a prospective host country appeared to be a salient requirement for decision making on emigrating to that country. The reason for this expressed desire in the destination country spans across the nurse's working life of inadequacies in daily basic provisions both for themselves and their families. Food as a basic need is expected to be available even at just the minimum level. This expression was mentioned by two informants seeking verification implying starvation as a reason for wanting to leave in the hope that the greener pastures could hold the 'food relief' in form of its affordability and decent earnings. This supports the finding that respondents were not managing in terms of basic provisions for their daily

living including those of their families, a situation insinuating an urgent need for increase in their income in their home country.

Some of the findings on what influenced informants to decide on leaving their employment and the country in this study appear to be summed up in some of the available literature. For example, the International Council of Nurses (ICN, 2004), refer to them as 'push factors' which include low wages, poor career opportunities and unsafe practice environments.

According to JLI (2004b) highly skilled workers are shifting from poorer to wealthier regions with regional and international migration assuming new dynamics.

Some literature on international migration refer to what influences out migration of nurses and other health workers as push factors and the attraction to destination countries as pull factors. According to Kingman (2004), the push and pull concepts appear to be the jargon used by economists and policy makers to describe factors that drive migration. She indicates what drives a nurse to leave her country of origin as low salary, and high remuneration, safe work environment, and professional development opportunities as some of the factors that attract nurses to the receiving countries. Dovlo and Martineau (2004) outline the push and pull factors that influence the decision by health workers to leave as the way services are governed, job satisfaction, social and welfare benefits, occupational protection and career development prospects which are all limited in the sending country. In addition, non remuneration factors have also been pointed out as

responsible for out migration and poor leadership in health services is one such factor associated with poor motivation from poor management (JLI A WG, 2004a).

It is interesting to note that the majority of the interviewed informants seeking verifications had intentions of being out of the country for a short period of 2-3 years only. There were even a few respondents who even indicated they would be away for less than two years. The contrast was the case with the visiting migrant nurses whose majority had intentions of being away for an indefinite period, suggesting no indications of when they would come back. The migrant informants who planned to be in their host countries for 2-3 years did not indicate coming back either after their initial stay implying they would most likely make their next move elsewhere. The most likely reason for this difference in intentions of the two groups could be the influence of experience regarding life abroad which those seeking verifications lacked as they had not yet emigrated and could only make their judgment basing on information which was all they had. The migrants had most likely 'tasted' the better quality of life and could not see themselves regress to the life they had left considering the future gains from their decision to migrate. It was also possible for informants seeking verification to decide on longer stay once in the destination countries considering the evidence from their migrated colleagues.

The tendency by trained workers of not coming back to their home country, according to Martineau (2004) is the salary differential between employers abroad and those at home resulting in the inability of the income in the home country to provide the expected quality of life perceived appropriate for their skills and the level of their children's

education. In the case of the informants in this study, this is another likely reason for their decision to be away for an indefinite period. Improved remuneration back home would thus be a likely attraction for returning to the home country.

## **5.9 WHY SOME NURSES HAVE NOT MIGRATED**

Although workers leave their home countries and migrate across and beyond borders, not everyone desires or leaves their country for greener pastures irrespective of the conditions prevailing in the source country. Findings on why informants still working in Zambia had not migrated when others were leaving are from the data sources on nurses working in clinical settings and educators from the training programmes who completed self administered questionnaires. Other data sources were focus group discussions undertaken in the four participating districts. On the whole, findings revealed that most of the nurses who were still working in Zambia did not have the intention of leaving to work outside the country.

The various reasons given were that others found the quality of education in Zambia better while some pointed to patriotism for their country and there were still informants, though few, who were still satisfied with working conditions, and fewer others whose right time had not come yet. However, there were others who made it clear they were still working in Zambia hoping the work conditions would be made better in the future. Family responsibilities were also a contributing factor while others would have left but were still processing their papers and mobilizing resources particularly finances required to facilitate their travelling.

Nurse educators, on the other hand, mostly gave family reasons for their not leaving although there were some who hoped for improvements in work conditions in the future. Others saw the quality of education in Zambia as being better. Few of them expressed patriotism and while fewer were processing papers in preparation to travel. Findings from focus group discussions indicated intentions for some of the nurses to leave but delayed by similar reasons of family commitments and financial constraints. Focus group discussions revealed similar reasons.

These findings are supported by Hammar and Tamas (1997) who argue that in international migration, not everyone migrates from their country and that the majority actually remain when others are leaving for other countries. These figures reveal what the public health care system can take advantage of through cultivating retention values in the remaining nurses still working in the country basing on the migration driving forces given by nurses seeking verifications and the already migrated. This also gives hope for the future investment efforts in increasing supply and responding to demands and should provide a platform for retention policies including rewarding of nurses that stay to serve the Zambians.

## **5.10 MIGRATORY MOVEMENTS OF MIGRANT NURSES**

Findings in this study show more informants who left for greener pastures during the years 2000-2004 and the rest left in 1990-1994. Politically, the beginning of the 1990s is the era in which the Third Republic of multiparty democracy came into power in the

governance of the country. The early period of the new millennium was time for general and presidential elections in the country. The periods showing peak out migration of the informants could be related to these political activities and their influences depending on what would have been the expectations and experiences of the informants and their perceptions of their professional and career prospects. Out migration is seen in the findings as what could hold the promise for a better life for the informants.

Botswana, New Zealand and the United Kingdom were the first destination countries for the informants when they first left Zambia. Migratory patterns show most informants moving to other countries from their first destination countries and only fewer informants had not moved from their first destination country. There were also informants who still had intentions of migrating further although these were even fewer.

Those with intentions to make further moves to other countries indicated they desired to do so in 2-4 years' time to the United Kingdom and the USA respectively, giving improving their knowledge as their reason although the majority did not attach a time frame for their move. However, despite these movement patterns, most informants indicated they would come back to Zambia and some specified they would do so in 5-7 years time. The rest indicated they would not come back to their home country. Kingman (2006) refers to these movements as a 'carousel golden ring' and argues that not all nurses aim to have this migration pattern but rather work in the affluent counties to achieve their goal of education and experience and thereafter return to their home or

another developing country. Findings in this study indicate such inclinations by the informants from their migratory movements.

An observation from the findings is that the majority of the informants did not have any desire to go back to the public health care system on return to Zambia other than a small number who indicated they had intentions to work in the public health facilities again. Most, however, planned to work in other areas other than nursing while others wished to set up their own private practice. The reasons for this are likely to be work place related including the impact of the informants' previous work experiences in the public health care system. The informants' experiences abroad could also have influenced their decisions regarding where not to work on their return.

### **5.11 EXPERIENCES OF MIGRANT NURSES**

Both positive and negative experiences were indicated in findings on migrant nurses while working in their respective destination countries. Experiences related to professional development included use of modern equipment and technology and what was perceived as better quality of nursing care as illustrated by some of the returnee informants;

*I learned how to use modern technology fro taking BP, temperature and advanced techniques for feeding patients with abdominal operations or throat problems.*

*There is better nursing care quality.*

This possibly reveals informants' comparison and judgment of what constitutes advanced equipment and technology in the host country in relation to work experience

and available resources the home country environment. It also shows a level of satisfaction in having affirmed what had attracted them in the recruiting country.

Several negative experiences were indicated in the findings. Financial gains from migrating was not as expected for some informants indicating that not all employers in receiving countries commit themselves to providing what is due to the migrant nurses as indicated by one of the returnee informants;

*What the people hear about a lot of money, and they think they will work in hospitals with all the equipment. I worked in a nursing home and experienced the reality which is not the case.*

The statement above could also be an expression of disappointment where financial gain and ideal work environments were the informants' main decision and expectation for leaving their home country in contrast to informants who appeared to have achieved their goal.

Cultural differences, racism and irrational work allocation were experienced by some of the informants and affecting them emotionally as indicated by returnees;

*There's racism, gossip and segregation. Some patients would openly say you are black so don't touch me and all that. Others would say oh you black bitch and when they say that you don't go near them.*

*In Botswana, treatment is there especially when they know you are a foreigner. They give you a lot of patients. You are also considered last in terms of off days, leave and other privileges.*

Such experiences by individuals without a racial background appear to have contributed to their decision to opt for returning and settling back home. This is particularly that Zambians are renowned for their receptive and accommodating values and behavior even

towards strangers without any hint for possible danger as indicated in the advice to potential migrants by a returnee;

*That the people are not as friendly as Zambians*

It appears informants' expectations were to find Zambian-like nationals and fellow workers in their host countries!

## **5.12 PERCEIVED IMPACT OF NURSE MIGRATION**

### **5.12.1 Nurse shortage**

Most respondents who completed a self administered questionnaire on perceived impact of out migration of nurses from Zambia indicated that nurses leaving for greener pastures created nurse shortages in the clinical settings. Findings from focus group discussions describe the rate at which nurses were leaving as indicated by a nursing officer at a provincial hospital;

*I think they are leaving this hospital at a fast rate. At one time, we had a lot of nurses but towards the beginning of this year, a lot of nurses left.*

Findings revealed rural to urban migration of nurses which resulted in nurse shortage. The rate at which nurses were leaving was recognized not just at health facility level but at the districts and national level as well. When deployed to districts, nurses appear to assess the conduciveness of the setting and often return to urban areas or leave the country altogether. This finding is exemplified by directors at district and national levels;

*A lot of nurses are leaving the district especially at this hospital and even at the district and they leave a very big gap; there are very few nurses left.*

*.....once they are sent to rural areas, they assess the situation and they leave because the place may not be conducive for them to live there as such they come back to urban areas or go to other countries .....*

*.....we are having a number of them moving to greener pastures but mostly move from this province to towns along the line of rail. Very few move from this province to go abroad.*

Recruitment difficulties were characterized by inability to fill the vacancies left with experienced nurses. It appears experienced nurses were hard to come by as recruitment resulted in filling up vacancies with inexperienced nurses where this was possible considering the findings from respondents. The gravity of this situation was described by key informants in the statements;

*It is difficult to say because even the inexperienced ones are not there (Registered Nurse at a provincial hospital.)*

*There are no longer there. We are always having 'babies' (Nursing Officer, referral hospital).*

Always having 'babies' as the available nurses being recruited could, in this context, refer to new graduates or those with minimal experience who, from the trend could be waiting to gain their ground in their preparedness to leave and once the 'babies' leave, they are replaced by another stream of newly qualified and this goes on. This cyclical pattern can be seen as another type of 'carousel' in which new graduate nurses are continuously recruited to replace the inexperienced ones who appear to be continuously on exit from the public service before gaining experience.

A nursing officer gave numbers to describe the seriousness of the nurse turnover from the medical department and the unsatisfactory pace of nurse replacement;

*In medical department, recruitment is very slow. We had 90 RNs but now there are only 33 and we had 150 ENs but now we only have 45. Since they started leaving, we only got a replacement last month.*

Nurse shortage appears to be real and a concern in both clinical settings and institutional programmes of nursing and midwifery education rendering the caring, teaching and learning; a challenge to care providers, teachers and students. In the clinical sites, vacancies were described as outstripping the number of nurses available not just in the provincial and rural areas but even at the very national referral health facility on which the country depended for specialty services as the statements and figures explain;

*In the medical department, vacancies are more than the nurses who are there (Nursing Officer, medical department of a referral hospital).*

*Currently, we have 45 enrolled nurses and 2 are enrolled midwives. We need 18 RNs to run the hospital but currently we have 3 who are Zambians of which 2 are in school and we have 2 missionaries so in total we have 5 RNs which is not enough (hospital nurse administrator, rural hospital).*

According to findings from focus group discussions with key informants, medical services were also affected by the nurse shortage. This is explained in the statement by a registered nurse working in the medical department;

*In the medical department, if you are 2 or 3 nurses, then you are ok, that's one nurse per shift with 40 to 50 patients.*

The gravity of implications that arise from the nurse shortage in the medical departments should be perceived from the aspect of the current disease burden in the country and the bed occupancy of the health care facilities in relation to common health morbidity and mortality conditions.

The nurse shortage appears to affect other levels of staff and the schools of nursing and midwifery are no exception. All nurse educators indicated the resultant impact of shortage of educators in their schools, who in this study, refer to tutors, lecturers and clinical teachers. Difficulties in the recruitment of experienced educators were confirmed

by most educators, according to the findings. Like in the case of clinical nurses, those recruited were inexperienced, implying they were new either graduates or had a little experience before being recruited to the specific schools. The shortage resulted in vacancies in the schools and there were other shortages as well, as exemplified by a key informant at a provincial hospital;

*The majority of vacancies are of the nurses and doctors, clinical instructors and tutors.*

From the findings, out migration appears to be a major contributing factor to the shortage of teaching staff in the schools of nursing and midwifery and the imbalance in the teacher student ratio. The resultant shortage is reflected in the statements made by key informants;

*At the moment, there are only 2 tutors and 1 clinical teacher against 80 students.*

*There are supposed to be 15 tutors but we only have 3 who are full time.*

Amid the picture of nurse shortage, the positive aspect is that responsibility for nursing and midwifery care from a management perspective was mostly under the registered nurses. This was mentioned by most clinical care nurses, although there were some clinical settings under the management of enrolled nurse. However, further findings showed that in some areas, managers placed anybody available at the time, while other areas had untrained or unskilled workers as in charge of patient care. In the rural areas, enrolled nurses appear to be in charge of patient care most of the time as illustrated by a nurse administrator;

*Enrolled nurses are in charge most of the time*

Management of the health care units and departments were equally affected by the nurse shortage. In the Zambia's health service structure, according to the researcher's experience, the ward sister or manager is the officially designated registered nurse by promotion charged with the ward management and the daily operations of the ward unit including patient care. These findings, however, show that only one respond of the 309 mentioned the ward manager as the person in charge of their clinical setting while the registered midwife was mentioned by only 4 of the respondents as being in charge of the maternity workplace. This finding emphasizes the magnitude of the crisis caused by the nurse shortage and the glaring reality regarding unanswered questions on the safety of the patients in the public health care system. One would be tempted to ask; if this is not the reality, then what is reality?

JLI (AWG, 2004) endorses migration as a major contributing factor to continuing shortages of health workers and generalizes the effect of the phenomenon in all the countries in the region although at varying degrees.

#### **5.12.2 Difficulties with staffing for patient care**

Nurse managers and leaders face difficulties in staffing of health facility units due to the severity of the nurse shortage. Plans on nurses' skills mix in the allocation for patient care further confirms the nurse shortage in the findings which show one nurse per average of 40 patients during each working shift as indicated by most respondents. Findings further reveal clinical settings with instances when patients were completely on their own with no one on duty for the average of 40 patients. The nurse shortage made it difficult for

nurse managers to staff health facility units and departments. This is exemplified by a midwife from maternity department of a referral hospital in the statement;

*The nurses are really stretched because you find that there are very few nurses in the wards. For example, there may only be 2 midwives for maternity, Obs and Gynae wards.*

*In Obs and Gynae, it is very difficult to follow the staff distribution anyhow as long as there is someone in white on duty.*

The challenge in the rural setting is not different where maternity services are concerned as a midwife described by key informants at provincial hospital;

*Sometimes only one is on duty with 35 maternity patients and 8 deliveries per day for one midwife (registered nurse/midwife).*

*.....there is a shortfall of more than 50% because the one midwife on duty also has to take care of the preterm nursery (Nursing Officer).*

There are times and situations when nurses are not given their due time to rest or off times even after working under extreme pressure because of the nurse shortage. A nursing officer at a provincial hospital lamented this pattern of managing, with regret, while knowing fully well that this was not in the favor of management and the nurses as shown in the statement;

*.....others are forced to save their day off so that they work and they get it when they come back from their night shift.*

The magnitude of the nurse shortage was demonstrated by closure of a whole ward unit at the country's referral hospital because of shortage of midwives. A national level director lamented this development in the following statement;

*It (migration has impacted negatively. At UTH, one ward was closed last year as the midwives have all disappeared. The health system in general is compromised and eventually some health centres and wards are closed down due to shortage of staff.*

### **5.12.3 Service beyond the scope of nursing practice**

Out migration of nurses appears to have adversely affected the nurses' scope of practice as only a small number of the clinical nurses were able to provide care within their scope of practice. According to findings, nurses perceived themselves as going beyond the call of their profession in the delivery of care. They did not just provide care but some took total responsibility of the patients' lives without input from other both available and non-available and expected care team members. The rest of the respondents practiced beyond their scope with others indicating their work included that which is supposed to be done by physicians and other health workers.

Screening, diagnosing and treatment of patients is the preserve role of physicians and those delegated with such tasks like clinical officers, in ideal staffing situations. For the larger group of respondents in this study, their work included the roles of screening patients, diagnosing and treating patients, being on call for the health facility when off duty and taking charge of the general operations of the entire health facility or hospital. Doing work meant for physicians was perceived as prestigious for some informants. This can be attributed to the professional status of physicians which from experience in Zambia, prides itself with a long term seven year period of medical schooling in comparison with the rest of the health professionals like nurses, pharmacists, radiographers, laboratory technicians and others whose curricula spans over a lesser three to four years of professional preparation. This is seen in the nursing officer's statement that describes the tasks some nurses have to assume as being positive;

*The RNs are doing work outside their scope and it is good practice. They are on call and they diagnose and they treat patients.*

This can also mean that formal preparation of nurses at the level that capacity builds them for advanced practice to fulfill such roles would be well received as they are perceived to add value to nurses and their practice. However, this can also be an expression of the low esteem with which nurses perceive their profession and its practice but whether this would be the remedy would best be answered through further research that would explore this possibility.

#### **5.12.4 Excessive workload**

Nurses leaving for greener pastures had resulted in excessive workload for the remaining nurses, according to findings in this study. Both clinical nurses and nurse educators perceived this workload increase in the clinical areas and schools. On the other hand, key informants from the focus group discussions perceived the increase in the workload as not static but continuous implying that the departure of nurses from the health care system was a phenomenon that was on going. Nurses appear to be flexible as they assume any role in order to fill any gaps left by other health care professionals as the statement by a nursing officer in a rural hospital indicates;

*It is increasing every time especially for senior nurses they are forced to even do anesthesia.*

This workload had a number of implications on the nurses' responsiveness to health care demands including doing every one else' work, and difficulties with coping with regards to patient care as illustrated by key informants;

*It is too much compared to that of other members of staff because we perform every one's duties.*

*In Obs and Gynae, the workload is too much because there are 3 wards with 40 beds in each ward so you just end up running around.*

Another finding is long working hours due to excessive workload. The efforts that nurses invest in their work in responding to the health care demands of their patients and the exigencies of their jobs can only be likened to the pattern of a circus in terms of the perspective of it being out of the reality of any health management and community considering their energies and capacity as human being and workers. The statements below illustrate the work scenario;

*Sometimes we work up to 12 hours a day and are exhausted by the time we get home.*

*Sometimes we work from 01 00 hours to 18 00 hours the following day.*

The finding on long working hours is supported in the statement by a district director;

*The workload is too much for the nurses so they get sick because they work long hours sometimes for the whole day and whole night because of staff shortage.....*

Respondents' perspective on the manner in which this type of working is affecting the health of the nurses appears to be quite explicit in the findings. Some of the nurses overwork in TB work settings and indicate they are not given sick leave by management when unwell but are forced to continue working when there is no one to place on duty to continue with patient care. Some nurses are called back to work when off duty in order to just have someone on duty. Respondents lamented the lack of reward mechanisms for not just the excessive work load but their abuse by the system. In this scenario of extreme nurse shortage, it is difficult to blame even the nurse leaders and managers for what could be referred to as abusing nurses because even the nurse leaders themselves are also

victims as they are at a loss for strategies that would effectively respond to such unusual situations of excessive workload in view from grave inadequacies of nursing staff.

Findings indicate informants suggesting monetary or other rewards for the excessive workload and even for time to facilitate their recovery from continuous working and refer to these as incentives. However, nurses still appear to oblige and respond to these work and management demands despite their being so unrealistic in normal life.

In an effort to cope with the work demands, nurses 'delegate' patient care to the patients' families as in the statements by some registered nurses from medical and children's wards respectively;

*Sometimes the nurse instructs relatives to give the patient a bath.*

*The relatives are encouraged to stay on because they are helping to look after the patient.*

Experience indicates that in this age and era of chronic illnesses particularly HIV/AIDS, some patients spend longer periods in the hospitals. Stress appears to burden both nurses and family carers in health care facilities. According to findings, relatives of such patients end up learning the care routines and because of their higher expectations, criticize nurses on duty and at times exchange words with them when their nursing care perspectives and expectations are not met. This is implicit of both nurses and family members referred to as 'relatives' being under pressure from over work and the later not having the relevant training and experience in professional caring of patients.

In the education and training programmes, coping mechanisms included involvement of clinical nurses who are non school staff in classroom, clinical teaching and supervision of students. Addressing the demands of the curriculum amid the staff shortage called for coping in order to ensure students' completion of training by focusing on what were considered as the essential components that would prepared the students to function effectively on completion of their training. A head of an enrolled nursing school put this in the following perspective;

*We concentrate on the most crucial aspects which enable the students to at least graduate. We look at the curriculum and some of the subjects that are really important and will be met in day to day of their practice. We make sure that those are addressed.*

#### **5.12.5 Job dissatisfaction**

Respondents' job satisfaction was adversely affected by nurses leaving for greener pastures as indicated by clinical nurses and nurse educators. This frustrated most of them. Reasons for this were highlighted in the findings from focus group discussions and included nurse the same nurse shortage and the resulting excessive workload, doing other peoples' work, lack of incentives and working round the clock. This is summed up in the statements by key informants;

*As nurses, we are not satisfied. A nurse is made to screen patients but clinical officers do not help with nursing. They knock off but nurses remain and continue with work..*

*We are ever on duty from 1st January to 31<sup>st</sup> December of each year.*

### **5.12.6 Work attitude and stress**

Frustrations were typified in attitudinal behavioral terms and attributed to stress and these at times affected nurse patient relationships. This is expressed by a key informant in this statement;

*When you are overworked, no matter how nice you are, at one point you scream.*

*We are tensed up because there is so much to do so we end up being hostile but we would love to be nice.*

Being hostile and screaming appears to be a way by which nurses vent their stress and frustrations but regrettably, this is towards patients and their family members who may not be aware of the underlying causes of this behavior. This can be likened to the analogue of fighting elephants and the suffering of innocent grass in the process.

However, negative attitude of nurses as care providers in Zambia has at times been an issue of concern to both management and the public.

Experience from the General Nursing Council points to reported cases by consumers of health care services about uncaring behavior of nurses in form of patient negligence, verbal abuse and uncaring attitude which the Council has had to deal with. Corrective measures, which are mostly punitive in nature, have gone to the extent of suspension and in more serious cases, removal from the professional register. Whether the Council interventions are appropriate in view of the findings in this study is not clear.

### **5.12.7 Poor quality of care**

Ability to provide care was perceived to have decreased as indicated by most respondents and was seen as fluctuating by others. In addition, there were respondents who perceived

their ability to provide care as having increased due to nurses leaving for greener pastures. The latter's perception could be influenced by their belief in increasing their effort in providing patient care due to the recognition of the prevailing nurse shortage and the resulting excessive workload. Alternatively, excessive workload which nurses have to deal with could be interpreted to mean increased ability to care for more patients.

Nurses' responsiveness and coverage of patients' health care needs was described as very inadequate by the majority. Key informants perceived the quality of care provided had deteriorated over time and was further perceived as poor as indicated by a nursing officer in a referral hospital;

*In the department of medicine, the quality of nursing now is poor.*

This poor quality of care can be seen as a consequence of the out migration of nurses and the inability of the remaining nurses to cope with the care demands.

#### **5.12.8 Unhealthy work environment**

The environments in the respondents' work places were perceived as unhealthy and this was attributed to several reasons, according to findings from focus group interviews. Key informants described the environment as being unhealthy indicating poor hygienic conditions of dilapidating physical structures considered not appropriate for patients' use. Inadequate supply of protective clothing, according to informants, put the nurses at risk when handling infectious materials like body fluids and when nursing patients with highly infectious conditions as some indicated by two registered nurses;

*.....For example, right now there are no gloves in the hospital and yet we have to do a lot of work and handle body fluids.*

*We do not have protective clothing, especially when we have cholera we use our uniforms in the cholera centre and on the general areas and then we have to go home with the same uniform*

Informants appear to express their fear of being infected in the course of performing their nursing duties and also of cross infection as they work in both the secluded cholera centres and general patient care units. Expression of concern for their families is shown when they indicate going home after work in the same nurses uniforms perceived as contaminated and a risk to their families.

In addition to nurse shortage, the inadequacies in the resources included medicines and provisions for patient' use as lamented by key informants;

*Sometimes there are no medicines*

*Women in postnatal wards have to share beds*

*We just give out medication; the nursing care is done by relatives.*

In the schools, findings show that the commitment by the teaching staff to ensure that students continue learning at all odds goes to the extent of selfless sharing of their own meager resources to supplement government efforts;

*In the midwifery school, it is very frustrating for nurse educators to teach without supplies. Sometimes as staff, we have to buy with our own money.*

These statements appear to be expressions of helplessness whose solutions are beyond the practical capacity of neither nurses themselves nor their managers and leaders but are seen as a barrier to provision of quality care.

### **5.12.9 Poor management and leadership**

Management and leadership response to supporting nurses through provision of the necessary resources for enhancing the quality of patient care was seen as wanting as most respondents felt management did nothing. Findings were similar for nurse educators. The quality of management and leadership supervision and support was also seen as not having shown any improvement in the circumstances of nurse migration impact. It appears from these findings that clinical nurses and nurse educators have higher expectations from management and the leadership in nursing in form of supportive interventions that are responsive to the issues and challenges resulting from nurses leaving for greener pastures. Nurses appear to expect understanding considering the stressful conditions under which they work. Among their expectations were the provision of the relevant materials and supplies to ease their work and this was both for the clinical nurses and those in education. In addition, organizational climate was seen as not conducive and this was in form of perceived intimidating behavior on the part of those who were in management and leadership. Lack of management and leadership skills were also mentioned as a contributing factor to the perceived poor performance.

However, from the focus group discussion findings, it appears these results are an indication that clinical nurses and nurse educators saw the impact issues from their work perspective only without due consideration of how technically and professionally incapacitated their management and leadership had become as a result. For example, nurse managers and leaders were challenged by the nurse shortage. Two nursing officers

of different departments of a referral hospital described their style of management in practical terms in the statements;

*.....sometimes I come across a ward with no one and then I am forced to take a nurse from anywhere and put her there.*

*Sometimes there is no one to supervise because there are no nurses on duty and sometimes I find the sister in charge alone so I have to join in and help her with the rounds.*

In the researcher's opinion, the challenges, even for the most innovative management and leadership style, would still remain onerous in view of such gross nurse shortage.

Findings further revealed that respondents lacked motivation for patient care. Nurse shortage, excessive work load, poor remuneration, poverty, lack of basic supplies and frustrations were seen as causing lack of motivation among nurses. Key informants indicated nurses being unmotivated in their work;

*We just work because we are on permanent and pensionable conditions of employment but the drive to work is not there because even the things to use on the patients like soap to bath them are not there.*

*Motivation is no longer there because we are frustrated.*

The implications are that being on permanent and pensionable employment conditions in this context does not serve as a motivating factor but appears to encourage retention as it discourages nurses from leaving for fear of loss of the retirement benefits due to them. Nurses prefer to continue working until their statutory retirement age in order to receive their benefits. This could also be a sign of insecurity associated with leaving the home

country when the future in the foreign land is unknown or where the grass may not actually be greener after emigration.

However, the lack of motivation appears to contradict the reality of practice on the ground because from the findings, nurses are generally seen to oblige in taking on any kind of responsibility either assigned to them or assumed including working long hours in response to heavy work load, be it within or beyond their competence and scope of practice. They may not be motivated but they demonstrate willingness to do their work.

#### **5.12.10 Positive impacts of migration**

Although findings mostly reflect the negative impact of out migration of nurses from the country, they also reveal some benefits of nurses leaving for greener pastures. These are seen to benefit the migrant nurses themselves and their families in form of fulfilling their aspirations of professional development, better remuneration and acquisition of personal effects. Families benefit through remittances sent by nurse migrants. According to Huston (2006), different countries have experienced different impacts resulting from the push and pull of international nurse migration. Among the positive impacts cited is the economic benefit related to the generation of remittance as income.

Mansoor and Quillin (2007) assert that remittances are an important source of income even for people in Europe and Central Asia (ECA) and constitute the second most important source of external funding after direct investment. In many poor countries, the remittances comprise the largest source of income. Mansoor and Quillin (2007) further maintain that although the links between remittances and poverty are mixed, an

examination of the economic impact of remittances reveals a positive impact on long-term growth. The contribution of remittances globally is estimated at more than 70 billion dollars to world economies (Olton, 2004). Findings in this study indicate that other than personal benefits of moving to work outside the country, the Zambian migrant informants appear to demonstrate their resourcefulness through the support that they render to members of their families both in their host and home countries respectively. These family members most likely include orphaned children. Investing in development projects in their home countries are other avenues of their resource utilization.

### **5.13 ISSUES TO INFORM POLICY**

Findings on the four qualitative data sources on issues that would inform policy regarding managing nurses leaving for greener pastures are shown in **Table 5.2**. A common theme that cuts across all data sources is *improving working conditions for nurses*. The commonality of this finding reflects its importance in the out migration of nurses from the country. It appears to represent that which is the core element in the migration decisions of nurses from the country and is thus pivotal to averting the nurse migration trend in the country. Poor working conditions appear to be thus the major factor that pushes nurses out of the country hence the need for addressing the issue in the relevant managing nurse migration policy.

*Improving the work environment* was mentioned in all data sources except the policy makers. The reason could be that the latter are remote from the clinical settings and direct patient care environment and thus lack insight of the hands on experience. The need for policy on positive work environments is justified by the fact that they support excellence

and decent work. Such environments strive to ensure the health, safety and personal well-being of staff, support patient care and improve the motivation, productivity and performance of individuals and organizations (RNAO, 2006). According to ICN (2007), positive changes in the work environment result in a higher employee retention rate which leads to better teamwork, increased continuity of patient care and ultimately improvement in patient outcomes. Such environments also demonstrate a commitment to safety in the workplace and lead to an overall job satisfaction.

*Bonding of graduates*, with suggestions of time frames during which nurses should work in the country as a way of paying back to the country for investing in their training, were suggested in findings in all data sources except nurses seeking verifications.

Interestingly, nurses seeking verification and about to leave the country did not think about the need to be bonded, perhaps because of the effect of the push factors urging them to leave. However, having bonding as a policy contradicts the right of nurses' freedom of movement. Huston (2006) argues that there must be some kind of balance between the right and autonomy of individual nurses to choose to migrate, particularly where the push factors are overwhelming, and the concerns of the exporting country regarding losing their scarce nursing resources. The effectiveness of bonding nurses to curtail nurse migration in Zambia based on the findings in this study is not clear particularly as experience shows that government bonding of graduates has been tried before and has not yielded the required results. Although the suggestion came from most data sources, it could be a desperate way of trying to address the issue in view of non-availability of tangible and effective measures of managing nurse migration. This method

has the disadvantage of infringing on the rights of nurses and other health professional who may wish to emigrate to work in other countries.

The issue of having *national financial structures* supportive of the educational aspirations of the citizens was mentioned by migrant nurses and policy makers. Migrant nurses' experiences are most likely the influencing factors as the nurses are able to compare what obtains in their host countries and how this would work in their home country. Such a policy would, however, entail the overhauling of the national budget system as the beneficiaries would not necessarily be nurses or the health sector alone but generally the civil service which is the government machinery of public social services.

Past experience shows the difficulties of introducing policies that relate to financial rewards to public workers of one ministry or department as generally, all public workers perceive themselves as not being justly rewarded and supported in terms of furthering their education and enhancing their careers. Such a policy would, however be advantageous as it would imply investing in the future and enhancing the socio-economic development of the country. in addition, a policy of this nature would facilitate access to professional development as it would avail finances for educational loans and would be a motivating factor to stay and work in the country for those whose reason for leaving for greener pastures is to further their education. The lack of access to professional development as a theme was expressed as one of the factors contributing to nurses leaving for greener pastures by all sources except nurses seeking verifications and thus forms an important policy issue on nurse migration management.

Both migrant nurses and focus group discussion participants pointed out the lack of *professional identity and autonomy* of the nurse. Although this is not well illustrated, it appears this partly relates to how nurses perceive themselves as professionals with a body of knowledge and special competencies that are life serving. Their great numbers and their role allude to the volume of services that they provide, justifying the image of the nursing profession and their worth including what they deserve as rewards and the reason for their search for recognition and autonomy.

It would be interesting to further explore in-depth what nurses perceive as recognition and autonomy and how they would like to practice if this was fully availed to them. Perhaps the empowerment with specialized skills in service provision would be part of the autonomy given the fact that the Nurses and Midwives Act already provides for a broad scope of practice for both nurses and midwives.

*Government to government agreements* from the policy makers and *supportive mechanisms for migrant nurses* whose source is nurses seeking verifications appear to be linked in that both target nurses who already outside the country. Although just from one data source, agreements at governmental level would benefit the sending country, in this case Zambia much more by defining a ‘win-win’ collaborative approach considering that the developed countries have a critical nurse shortage and have the capacity to pay the nurses they recruit better, and the fact that Zambia, as a developing country on the other hand, has invested her meager resources from tax payers’ money into the education and

training of nurses who leave to benefit other countries. The tracking down of nurses' migratory movements would pose a challenge for government as its effectiveness would have to rely on nurses providing regular information on their movements, a requirement which not all might adhere to. This finding could be an expression of some kind of fear of the unknown and a plea for paternalistic protection by nurses seeking verification and about to go to strange countries. This however, is not strange as moving to new geographical locations is a major change process in one's life and such an expression could be what the nurses see as a gap in the whole process of migrating.

The source for this finding is the policy makers, specifically the district directors. This could be because they are on the ground where the effects of nurse migration are more visible and this suggestion could be an expression of their desperate need for nurses.

*Attracting retired nurses* might work but only for those not in other employment or occupations. The most likely reasons are that retired nurses may have last worked before the current era of severe nurse shortage and might find difficulties in coping with the current challenges which include the high disease burden where the majority of the patients are bed ridden, requiring critical care nursing. The shortages or lack of medicines found in the results of this study might constitute further challenges to the retired nurses. From what is happening, a lot of them have gone to the private sector or are 'rearing and selling chickens' and the like and if this is proving to be more lucrative, it would take real attractive pay packages to entice them back. Otherwise only the much older and desperate ones who are less multi-skilled would come back to nursing work in the public health care system.

It is interesting to note that nurses who were already working in other countries and were visiting Zambia are the ones who mentioned the need for policy inclusive of *deserving salaries and benefits, decent living conditions, participation in policy decisions, improving organizational climate and reducing workload*. Again, exposure to better experiences in other countries appears to be a major contributing factor to their looking at issues from a comparative and critical perspective. The call for deserving salaries and decent living conditions are evident in the findings indicating that policy and practical interventions would contribute greatly to mitigating nurse migration. In addition, it appears nurses demand to be heard through dialogue with government and input into policy decisions implying they understand their own issues better and have thus the capacity to directly articulate them more effectively themselves, and not through other health professionals that represent them by virtue of their employment portfolios. From the findings in this study, it appears nurses demand to be at the table where policy decisions are made. This is also an indication that nurses demand for avenues for this process which they currently do not appear to see, according to their perception.

*Improving organizational climate* as a policy issue was related to management and leadership approaches in managing the nursing workforce amid the shortages and other challenges. There was a perception of intimidation and suggestion that some of them were not trained for the job. From experience, most nurses are promoted to management and leadership positions based mostly on experience or because they are the available nursing human resources. A policy on formal preparation of such individuals would equip them with the necessary knowledge and skills for the challenging responsibilities

and would motivate and improve their performance and merit confidence and respect from their staff. A policy issue on *reducing the workload* would have to involve a broad based strategy inclusive of addressing the nursing shortage; *increasing the supply of nurses* through expansion of the education and training facilities, increasing intakes of nursing students, investing in the university education of nurses in order to prepare more nurse educators and leaders as a means of empowering them for effective responsiveness to the prevailing challenges and the need to improve the quality of health care services.

One strong policy that would serve as a pillar and require action in this regard is a policy on *expansion of the retention scheme* to make it inclusive of nurses who, according to findings in this study, perceive themselves as marginalized as the scheme favors physicians. This would also justify the investment in the preparation of nurses which is for the most part, government sponsored. The data sources for policy issues on *increasing the supply of nurses*, *expansion of the retention scheme* and *reducing stress in rural areas* were the focus group discussion, an indication of the key informants working in the clinical settings experiencing the impact of nurse migration on patient care. The reduction of stress is related to issues of workload and nurse shortage which require encompassing policies on managing nurse migration.

## **5.14 RECOMMENDATIONS**

The recommendations are based on key findings from the study which are also linked to main themes that emanated as issues for articulation into policy on managing nurses leaving for greener pastures.

### **5.14.1 Improving employment conditions: the government**

Findings in this study show an array of factors that motivate nurses to make decisions to leave their employment and the country for what is commonly referred to as greener pastures. A common theme that cuts across the data sources is *discontent with employment conditions*, referred to in the Zambian civil service terminology as *poor working conditions* as a driving force for nurse migration from Zambia. The present nurses believe in their rights to equal work and equal pay. There are no physicians working round the clock and nurses are continuously with the patient and thus demand to be paid for the work they do. It would be in the government's and country's interest to make a bold decision and take the necessary stride in determining modalities of mobilizing resources essential for re-structuring the work conditions of nurses. The issue of low salary is very clearly expressed in the findings as unsatisfactory. It is admittedly costly to award all nurses with hefty salaries at one time, to the level of their satisfaction.

What is recommended is a phased approach whereby government scans the nurses' salaries in the region and pegging these in form of staggered annual increases and targeting the overall amounts that would be acceptable to the nurses. Annual salary increases as a policy might motivate nurses to stay and look forward to the regular

increases and potential improvements in their ‘take home pay’. Attached to the nurses’ formal income is what the findings show as ‘incentives’ which appear to be expected by nurses as part of their financial rewards and although not very clearly elaborated, part of these incentives appear to be monetary in nature. However, it would be important to establish what these are from the nurses themselves and award them, again, in accordance with the exigencies obtaining.

Awarding salary increases to nurses alone might stir up some discontent among other government workers as past practice has shown that when salaries are adjusted, the increases are awarded across the board for all government employees in the various sectors; for example, in education, agriculture, and others. This is understandable for government because of its paternalistic role to its workers and citizens. However, the finding in this study which asserts that nurses work round the clock with patients’ lives under their care should serve as a major justification for awarding them deserving salaries.

#### **5.14.2 Establishing positive practice environments: a multifaceted approach**

From the findings, it is evident that it is not only the low salaries that initiate migration decisions among nurses. Unhealthy work environments are among the contributing factors to nurses leaving for greener pastures. It appears from the findings that nurses express fear of infection in their work environments due to non availability of what they refer to as ‘protective clothing’ in form of gloves and other items as they inevitably touch potentially infective patients’ body fluids. The investment in nursing and patient care should thus include this consideration by ensuring broad based budget lines that include

protective clothing for nurses as the risks involved in view of their occupation are well known, especially with so much that is written about the HIV virus and how it can be spread through contaminated blood and other body fluids of those infected or with the disease.

According to findings, nurses would like to have the pre-requisites for providing patient care. A review of the equipment and supplies available in the health care facilities should be conducted as a basis for determining what is required to further improve the work environments.

Developing safer work environments should be a responsibility of all stake holders at every level of the health care system as efficient delivery of health care is team based and as such, other health care professionals should equally be concerned about their safety and that of the patients and the public. This approach is supported by the International Council of Nurses (ICN, 2007) who reason that other disciplines should be involved in developing policies for safe work environments and that this should include, as a starting point, the development of a workforce profile for health care organizations inclusive of areas like absenteeism, vacancy and turnover rates, and demographic information on nurses. Nurses' profile should include age and experience. The ICN (2007) argues that such data forms a base for decision making and suggests that nurses can themselves play a major role in advancing the development of positive practice environments. In this regard, a multidisciplinary team should be formed and mandated to drive the safe environment agenda and be able to report at the highest level possible in order to instill the necessary enthusiasm for results.

### **5.14.3 Facilitating professional recognition and autonomy: a stakeholders approach**

From the study findings, recognition of the nurses appears to refer to the importance of their nursing qualification, the knowledge base, the profession with a body of knowledge, the work nurses do, their contribution to health care and their contribution to facilitating access to health.

According to the researcher, this area requires to be explored or researched for further detail and clarity that should form a basis for determining the relevant interventions that should lead to the desired recognition and autonomy of nurses. However, the *Zambian Nurses and Midwives Act No 31 of 1997* provides a broad scope of practice for both nurses and midwives and this is meant to facilitate provision of a wide range of nursing and midwifery services including advanced procedures like life saving skills in midwifery including vacuum extraction, nurse prescribing and others procedures. What might empower nurses and midwives to the level of professional autonomy would be the establishment of education and training programmes awarding specialist qualifications as advanced practice nurses and midwives. This could be achieved through establishment of continuing education programmes via distance learning, short and long term courses and full time education at the University of Zambia and other higher education institutions. Other programmes to be included should be management and leadership, nursing and midwifery education and others through both at under graduate and post graduate university programmes. Schools of nursing and midwifery should also offer, as part time, similar programmes to nurses. This could also be a source of income generation for both

the schools and the university's department of nursing. The General Nursing Council of Zambia, Zambia Nurses Association, University of Zambia department of nursing and the schools of nursing and midwifery should initiate this development in collaboration with the Ministry of Health and other stakeholders through mobilizing resources, programme design and facilitating course implementation. This type of development would also respond to other factors contributing to nurse migration, for example, the desire for access to professional development, improving the image and status of the nursing profession and the self perception and worth of the professionals themselves.

Findings on the need for financial structures and budget lines that support access to educational loans for tertiary education in Zambia link well with availing opportunities for professional development of nurses. The government should review the national budget to broaden it for inclusion of such loans as a way of responding to nurses' and other professionals' needs. This would be a motivating factor for them to stay and work in the country.

#### **5.14.4 Addressing the nurse shortage: a complex paradox?**

The perceived impact of nurses leaving for greener pastures show the public health care system in a crisis reflected by gross shortages of nurses and other health workers and the inability by the system to deliver quality health services to the citizens. This is an issue that requires a comprehensive review of the whole demand and supply process of nurses in the country. The solution to the nurse shortage appears to be cyclical and rather complex in nature but it is feasible. What is required foremost is government willingness

and commitment to resolving the issue. A phased approach should be designed with a focus on the financial, human and material resources required at each level of the process including the physical facilities related to educational institutions. This should begin with a critical analysis of what it would take to increase enrolments in schools of nursing and midwifery. Re-opening of schools that were closed in the earlier years for non-suitability for nursing or midwifery education and training as is the case now is not in itself sufficient for the production of quality graduates. The need for improvements in the quality of these facilities and that of the currently running institutions is an essential part of the process of managing nurse migration as these institutions provide an environment that attract and motivate both the teaching staff and the learners if well refurbished and managed.

While it is acceptable that numbers of nurses are important, the quality of nurses is even more critical and important for quality patient care. Increasing intakes therefore corresponds with the demand for more nurse educators for both classroom and clinical roles in order to facilitate quality teaching and learning. According to findings in this study, training institutions are also affected by migration of nurse educators and are currently experiencing shortages. This calls for the need to increase nurse educators through increasing intakes at the University of Zambia in order to increase the output of degree nurses who are the graduates that are deployed to teach in the schools of nursing and midwifery.

Image building of the profession should involve the department of nursing at the University of Zambia which is currently the highest institution of learning for nurses in the country. University education for nurses in Zambia was established in the mid-70s through the creation of a post-basic nursing department in the school of medicine. While similar programmes that were created much later in the region have since progressed and grown into schools of nursing with autonomous administrative structures, Zambia's department of nursing has maintained the status quo.

The commencement of the Masters degree is noted as part of the required growth at the department but the major move should be the establishment of the department into a school of nursing with its own dean or administration. Such a school will enhance the decision making powers of the profession at that level and should respond to the demands of expanding access to professional development for nurses by introducing a four year generic Bachelor of Science in Nursing (BSc N) as a direct entry programme for school leavers. The current BSc Nursing programme whose candidates are the qualified registered nurses with diploma qualification and a minimum of two years work experience should be transformed into one with specialty areas; in for example, education, management and leadership, and other relevant areas and the title of the degree qualification should reflect the respective specialization. This will place this qualification at a higher level, and will thus be different from what should be introduced as direct entry generic Bachelor of Science degree in nursing programme, considering that the candidates and thus subsequent graduates will have undergone the registered nursing diploma programme already. Access to professional development can be further

enhanced through short courses during semester breaks at the university's department of nursing. Such programmes will be more cost effective considering that they will be available within the country.

Both schools of nursing and midwifery and the department of nursing at the University of Zambia will require a strong budget supportive of the intended transformations aimed at increasing the number of nurses through expansion of the educational opportunities for nurses in the country. The schools of nursing and midwifery which produce nurses should be elevated through affiliation to the University of Zambia as part of a professional image building process that can contribute to attracting more nursing candidates and increasing the supply of nurses as a response strategy to the country's demands.

A major component of this process of addressing the nurse shortage is the need for the introduction of a *broad based retention scheme* inclusive of all nurses. According to the study findings, the majority of informants have not migrated for various good reasons which the system should take advantage of. There is hope that not all is lost and this could also mean the shortage in health care facilities being exacerbated by not only international migration but other attrition reasons like deaths due to HIV/AIDS, resignations to move out of nursing altogether, internal mobility from public to private sector particularly the non-governmental organizations and retirements. According to the findings in this study, nurses have expressed concern at the existing retention policy which they perceive as being in favor of physicians. Government's commitment to managing nurses leaving for greener pastures should be demonstrated through their

recognition of this policy gap and developing an encompassing policy that will result in the retention of nurses and their willingness to stay and work in the country and thus justify tax payers' investment in their education and training.

The government should take advantage of the nurses who have not migrated and probably will not do so and should reward them by addressing issues recommended to ease their stress. They should source partners in managing nurse migration. According to the World Health Report (2006 pg. 79), external agencies could help to improve worker performance in low income countries by providing salary support for the medium term. Such assistance would assist Zambia in the interim.

#### **5.14.5 Creating a dialogue forum: an initiative for proactive policy planning by nurse leaders**

Given the critical and strategic role of human resource in health organizations, the implementation of human resource for health policies requires that decision making and management be more proactive (Bach, 2000). In this regard, nurse leaders through the Zambia Nurses Association, the General Nursing Council of Zambia in collaboration with the Ministry of Health and private sector nurses should initiate the creation of a dialogue forum that can meet regularly and provide a platform for expression and sharing of issues affecting nurses and provide input into health service delivery and nursing workforce policy in particular. This forum should have higher level government representation that can facilitate articulation policy issues on nursing and nurses. In addition, the highest level forum at health ministry should have nurses who will participate in policy decisions to enhance the status and image of the profession and

advocate for quality of health care issues. this forum could further address issues of professional image building taking advantage of the media and other avenues for educating the public on the role of nurses and their advocacy public access to for quality health care. Implementing results from this study through this forum will foster a more proactive approach to human resources policy for managers and policy makers and anticipate potential effects of trends affecting health systems, the health workforce and health care in general.

#### **5.14.6 Flexible migration policy: benefits of remittances**

There is a tendency to view migration negatively, despite its potential to contribute positively to social and economic transformation within the sub-Saharan region.

According to Ratha (2005), recent analysis has shown that internationally remittances exceed total international development aid and were estimated to equal US\$126 billion.

These remittances have been reported to influence poverty alleviation (Adams and Page, 2005), investment (Chami et al., 2005) and human resource development (Pogue, 2007).

Although it might be difficult to quantify the remittances by nurses who leave Zambia for greener pastures, the country could be financially gaining, through the nurse migrants' families and their own investment back home. From this premise, government should consider having flexible migration policies for nurses as this in addition, empowers the nurses themselves economically, otherwise they would all come back if this was not the case.

#### **5.14.7 International agreements: health and immigration departments**

These should be developed jointly between Zambia as a developing and sending country and the wealthier recruiting countries to facilitate ethical recruitment of nurses and other health workers. In addition, these agreements should outline broadly the investment by Zambia in education and training of the nurses and the reimbursement strategies that should be made by the recruiting countries which should be among other areas, the education and trading of nurses. These countries should participate in financing the strategy on increasing the numbers of nurses described earlier from schools of nursing to university level nursing and midwifery education. For this to work effectively, the government Immigration Department should establish electronic database systems and maintain data on inflows and outflows of immigrants and emigrants. This data should include personal data, professional and other qualifications of individuals, etc. it would be beneficial to learn from countries that maintain such data in terms of structuring, tracking changes and updating the information.

#### **5.14.8 Areas for future research**

The following areas are suggested for future research:

1. Extent of nurse migration study that would access data on nurses who are recorded as having traveled to their destination countries.
2. Migration impact study that would establish the cost of education and training of nurses and how migration impacts on the national budget
3. Nurse migrants' remittances: Do they contribute towards social and economic development.
4. The public's knowledge and attitude towards nurse migration in Zambia

## 5.15 CONCLUSIONS

This section concludes the study by highlighting the key findings as they relate to the conceptual framework and the study objectives. The conceptual framework is a combination of two theories; the World Systems Theory (Maresova, 1999) and the Push and Pull Theory (Dorigo and Tobler, 1983). As described earlier, the World Systems Theory structures the regions of the world into three distinct zones geographically, namely the Core, Semi-periphery and Periphery. The interpretation and understanding of this theory is that the Core regions are the highly industrialized, wealthy countries with strong governments while the Periphery ones are the poor countries which, according to the theorists, lack strong governments and are controlled by other states. They focus on low skill, labor intensive production of raw materials and the demand for low-cost labor in Core countries results in international migration from the Periphery. The Semi-periphery on the other hand, are the countries that geographically are between the Core and Semi-periphery regions in terms of economic capacity and are less dependant on the Core as they are said to have diversified economies and stronger states than the Periphery countries. the Push and Pull theory assumes that in international migration, there are push factors that force or push out people to move to other countries and that on the other side, there are factors that pull those migrating to go to those countries. *The Core and Semi Periphery in this study are the greener pastures.*

### 5.15.1 Conceptualizing the Push and Pull factors in themes

The main findings in form of themes that emerged are shown in Fig. 5.1 which represents the push and pull factors with particular reference to Zambia the periphery and core

countries respectively. The push factors forced nurses to leave their home or periphery country while the pull factors attracted them to the core or destination countries. With regard to push factors that contributed to nurses leaving for greener pastures, the figure below shows discontent with working and living conditions which were characterized by inadequate income and poor housing facilities. Nurses were also pushed out by the lack of professional recognition and autonomy and poor leadership in health service settings. The family, including the extended family appears to be very important in the nurses' lives. From the findings, it appears nurses' caring role is enshrined in their personal life values as it goes beyond caring for the patients and other clients to that of their siblings and orphaned family children and other young people within the family context.

Generally, what constituted the pull factors in the Zambian study, according to findings were the opposite of what pushed them out of their country. The core countries were perceived to offer a better life for nurses in the form of attractive employment conditions that offered better remuneration of higher salaries and other perks which include what informants referred to as decent accommodation.

Availability of affordable food as one of the attractions to a destination country could imply the inability of nurses to afford food in their own country. Decent living and capacity for personal ownership of housing and transportation was what nurses desired. This was evident from nurses who had migrated to the Core countries as they enthused about their kind of life and what they had acquired while there. The work environment was another area of attraction described as being advanced in modern equipment and

technology that enabled nurses to practice within their scope of practice, focusing on nursing duties, which appeared to generate job satisfaction for them. The desire for professional development also was a pulling factor, particularly where this was financed by employers and where one could access educational programmes without disruption to their income. This shows the respect and value that nurses have for knowledge and skills advancement and their realization of its necessity for improving their performance and career advancement.

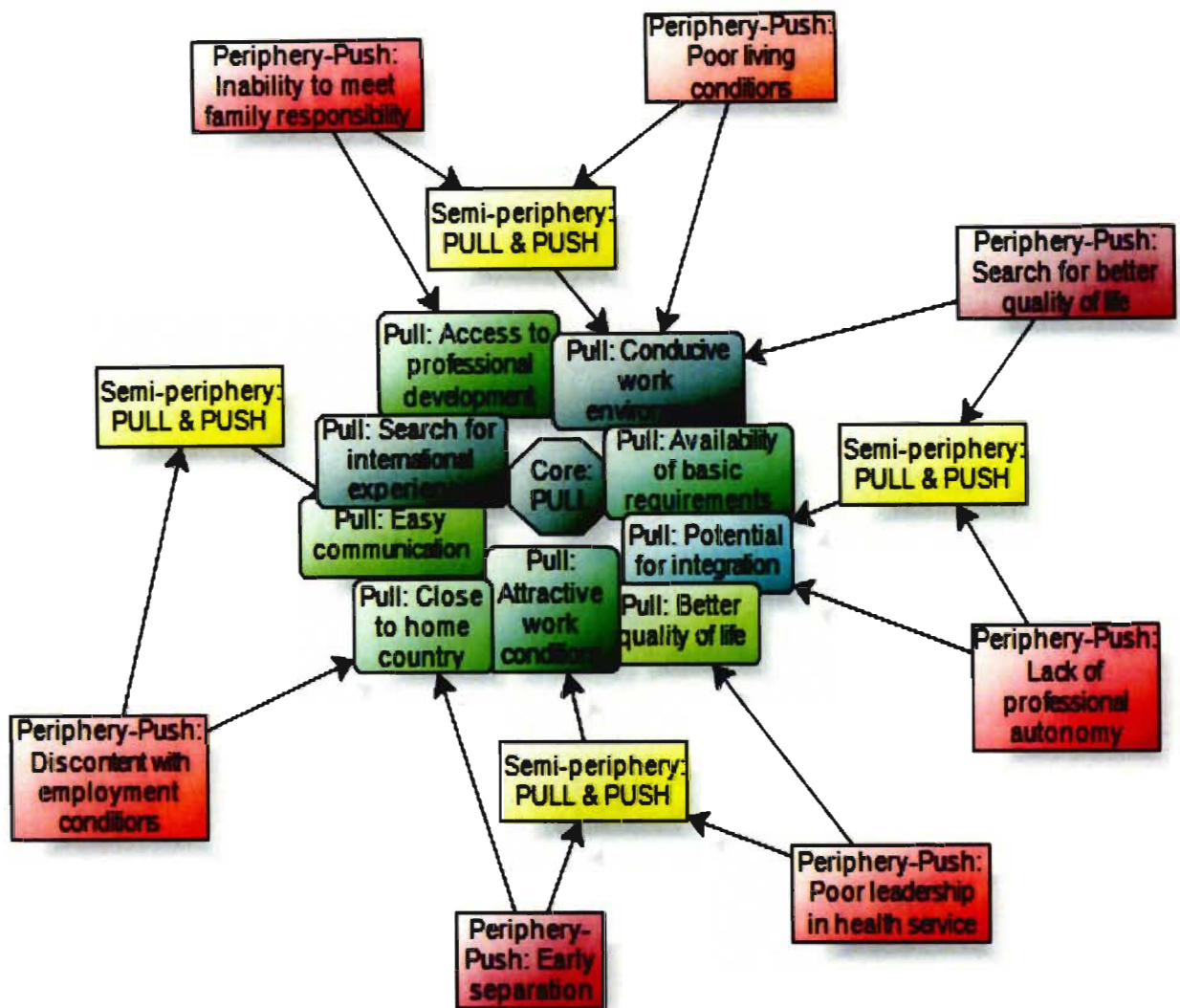


Fig. 5.1 Conceptual Framework showing the Push and Pull thematic findings in the Periphery, Semi-Periphery and Core.

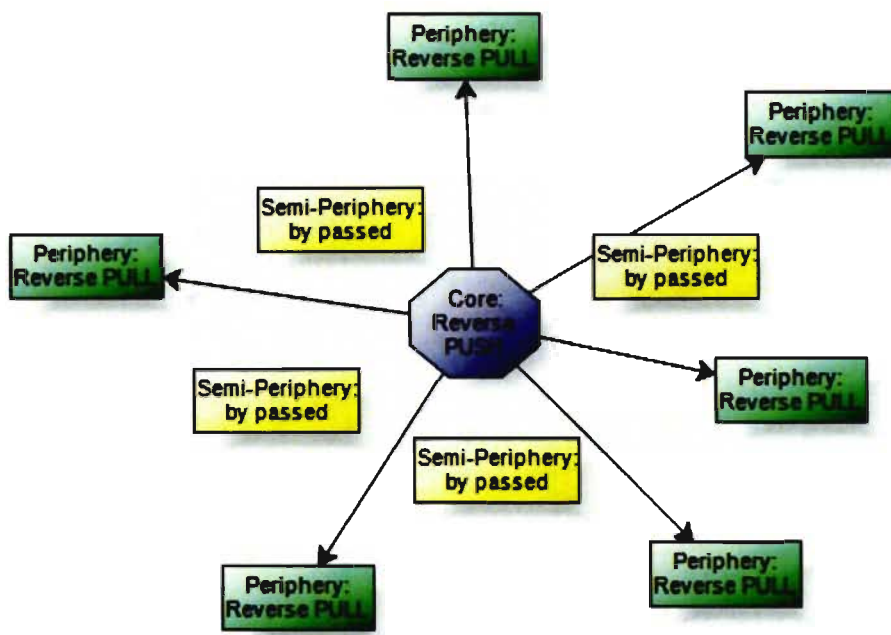
### **5.15.2 Returnee nurses: a reverse push and pull factor framework**

According to findings, returnee nurses, despite being pushed out of their home country and being attracted by the greener pastures to the core countries, they were pushed back to their home country by push factors in the core countries and pulled back to their home countries by pull factors. These factors in this study are referred to as reverse push and pull factors and are presented in a reverse push and pull model below (Figure 5.2).

The main reverse push factors were dissatisfaction with working conditions including remuneration and work environments that were not as well equipped as had been expected. The racial overtones experienced from both fellow staff and patients in the core countries and overt racism as well as feeling segregated affected the nurses continued stay in those countries. Even within the countries in the African region, nurse migrants were looked down upon as economic migrants. They experienced unfair work allocation and were sidelined when certain privileges to do with leave and other forms of rest were considered. As foreigners, they were subjected to stiffer penalties when their professional conduct was found wanting in comparison with the indigenous nurses.

The reverse pull factors in their home country included the family, some of whom were not able to join the nurse migrant and fear of family break up due to living apart where spouses did not accept to join the nurse migrant. The inability to meaningfully invest their remittances in their home country also contributed to the return home of some of the nurse migrants as they found it difficult to do this and monitor through their personal presence. The reverse push and pull factor framework (Fig. 2) can therefore be used as an

argument against the push and pull theory on the basis of the findings in this study. the main argument is that the push and pull theory does not take into consideration the factors that push back nurse migrants out of their host (core ) countries and the factors that contribute to pulling them back to their home (periphery) country, despite the economic hardships and other factor that initially influenced their decision to leave.



**Fig. 5.2 Reverse Push and Pull Model representing the returning back to home country by returnee nurses**

In conclusion, although the study is on international migration, findings showed that not all rural nurses left for other countries but that others moved from rural to urban areas as that is where they perceived the grass to be greener than the rural setting.

In addition, international migration appears to overturn the cultural beliefs and practices and the traditional role of the woman as the majority of the nurses migrating in this study are female nurses, most of whom are married. Female spouses are culturally perceived as having the house keeping and child rearing roles, with male spouses going out in search

of employment and source of living to provide for the family. The findings in this study show the contrary, which is a challenge to the culture values and practices.

## REFERENCES

- Abel-Smith (1986) *The patterns of medical practice in England and the Third World. The principles and practice of primary health care.* Geneva, Switzerland, Christian Medical Commission, World Council of Churches.
- Adams, O. Kinnon, C. (1998) A public health perspective. In: Zarrilli, S., Kinnon, C. (eds): *International trade in health services: A development perspective.* United Nations/WHO. Geneva.
- Adams, R., Page J. (2005) Do international migration and remittances reduce poverty in developing countries? *World Development* 33: 1645-1669
- Adepoju, A. (2004) *Changing Configurations of Migration in Africa.* Migration Information Source, Migration Policy Institute. Washington DC.
- Adversario, S. (2003) *Nurses' exodus making health system sick.* Interpress Service. [www.ipsnews.net](http://www.ipsnews.net)
- Africa Working Group of the Joint Learning Initiative on Human Resources (2004) *The Health Workforce in Africa: Challenges and Prospects. A report of the.* WHO. World Bank and Rockefeller Foundation. Global Health Trust.
- Ahmed, I. (1997) *Exit, Voice and Citizenship.* In: *International Migration, Immobility and Development: Multidisciplinary Perspectives,* Hammar, T., Brochmann, G., Tammas, K., Faist, T., (eds).Berg. Oxford.
- Arrowsmith J. et al., (2001) Performance-related pay in health care. Review Article. *Journal of Health Services and Research Policy*, 2001, 6:114-119 in: World Health Organization. *The World Health Report (2006) Working Together for Health.*
- Auer P. & Fortuny M. (2000) *Aging of the labor force in OECD countries: economic and social consequences.* International Labor Organization. Geneva
- Awases, M. et al., (2003) *Migration of Health Professionals in Six Countries: A Synthesis Report.* World Health Organization. WHO-AFRO.
- Babbie, E., Mouton, J. (2002) *The Practice of Social Research.* South African Edition. University Press. Oxford.
- Bach S. (2000) *HR and new approaches to public sector management: improving HRM capacity.* Annecy, World Health Organization Workshop on Global

Workforce Strategy 2000. [<http://www.who.int/health-service-delivery/human/workforce/Documents.htm>] <http://www.human-resources-health.com/content/1/1/1> Accessed 10/31/2007.

Bach, S. (2003) Health services and employment relations: The management of reforms. Thomson Learning. London.

Beaverstock, J. (1996) Re-visiting high-waged labor market demand in the global cities: British professional and managerial workers in New York City, *International Journal of Urban and Regional Research*, 20 (4): 422-445.

Bhagwati, J. (1976) The International Brain Drain and Taxation. A Survey of the Issues. In: J. Bhagwati (ed.), *The Brain and Taxation. Theory and Empirical Analysis*. Amsterdam. North Holland

Bjeren Gunilla (1997) *Gender and Reproduction in: International Migration, Immobility and Development: Multidisciplinary Perspectives*. BERG. Oxford.

Bless, C., Higson-Smith, C. (1995) *Fundamentals of Social Research Methods: An African Perspective*. Second edition. Junta and Co. Ltd.

Bond, P., Dor, G. (2003) *Uneven Health Outcomes and Neoliberalism in Africa*, Discussion paper for the Regional Network for Equity in Health in Southern Africa (EQUINET).

Brenner, M. et al., (1985) Introduction. In: M. Brenner, J. Brown, & D. Canter (Eds.). *The research interview: Uses and approaches* (p.1-8). Orlando, FL: Academic Press.

Brown Anthony (2001) News Editor Sunday August 19, 2001, *The Observer*, United Kingdom.

Buchan, J. (2002c) Global nursing shortages. *BMJ*, 324: 751-752.

Buchan J. & Calman L. (2005) *The Global Shortage of registered nurses: an overview of issues and action*. International Council of Nurses. Geneva.

Buchan, J. et al., (2003) *International nurse mobility; trends and policy implications*. World Health Organization. Geneva.

Buchan, J. Dovlo D. (2004) *International recruitment of health workers to the UK*. London: Department for International Development, Health Systems Resource Centre. Available from: <http://www.dfidhealthrc.org/Shared/p>

- Buchan, J. Sochalski, J. (2004) Nurse migration: Trends and the Policy Context. P. Unpublished. In Kingman M (2006) Nurses on the Move: Migration and the Global Health Care Economy. Cornell University Press. United States of America.
- Bundred, P., Levitt, C. (2000) Medical migration: Who are the real losers?, in the Lancet, 2000, Vol. 356, pp. 245-246.
- Carrington W., Detragiache, E. (1998) How big is the brain? IMF Working Paper 98/102. Washington: International Monetary Fund. Available at: [www.imf.org/external/pubs/ft/wp/wp98102.pdf](http://www.imf.org/external/pubs/ft/wp/wp98102.pdf)
- Chami R. et al., 2005 Are immigrant remittance flows a source of capital for development? IMF Staff Papers 52: 55-81
- Chanda, R. (2002) Trade in Health Services. Bulletin of the World Health Organization, 80: 158-163.
- Central Statistical Office [Zambia], Central Board of Health Demographic and Health [Zambia], and ORC Macro. 2003. *Zambia Demographic and Health Survey 2001-2002*. Calverton, Maryland, USA: Central Statistical Office, Central Board of Health Demographic and Health, and ORC Macro p.245.
- Cohen D. et al., (2003) Sustaining Human Resource Capacity in Zambia. UNV Mission 11-15 August 2003.
- Consten, E. et al., (1995) A Prospective Study on the Risk of Exposure to HIV During Surgery in Zambia. *AIDS* June; 9(60): 585-8.
- Corcega, T. et al., (2002) Nurse supply and demand in the Philippines, in The UP Manila Journal, 2002, Vol.. 5, No. 1, pp. 1-7.
- Denzin, N. K. (1989) Interpretative Interactionism. Newbury Park. CA: Sage Publications.
- DFID (June 2003) Supporting Zambia's Multi-Sectoral Response to HIV/AIDS, Program Memorandum. P.53.
- Dovlo, D., Martineau, T. (2004) A Review of the Migration of Africa's Health Professionals. Joint Learning Initiative on Human Resources for Health. The JLI Africa Working Group
- Dovlo, D, Nyonator F. (1999) Migration of Graduates of the University of Ghana: A Preliminary Appraisal. Human Resources for Development Journal (HRD), ISSN 08-59-8037 Volume 3, Number 1. Praporomrajchanok Institute, p34-37.

- Dorigo, G., Tobler (1983) Push-Pull Migration Laos, *Annals, Association Geographers*, 73 (1): 1-17.
- East, Central and Southern African Health Community (2004) Challenges Facing the Malawian Health Workforce in the Era of HIV/AIDS. ECSA Health Community HIV/AIDS Publications No 11.
- Faist, T. (1997) From Common Questions to Common Concepts. In: *International Migration, Immobility and Development: Multidisciplinary Perspectives*. BERG, Oxford. Pp 247-276
- Fink, A. (1995) *How to sample in surveys*. Sage Publications. Thousand Oaks.  
 Flick, U. (1998) *An introduction to qualitative research*. Sage. London.
- Fischer, et al, (1997) Interdependencies between Development and Migration. In Tomas Hammer, Grete Brochmann, Kristof Tomas and Thomas Faist, eds., *International Migration, Immobility and Development* (Oxford: Berg), pp. 91-132.
- Frank, A. (1970) The Development of Underdevelopment. In: Rhodes, R. I. Ed. *Imperialism and Underdevelopment*, Monthly Review Press, New York.
- General Nursing Council of Zambia (2002) Register for Nurses and Midwives. Lusaka, Zambia
- General Nursing Council of Zambia (2005) Register for Nurses and Midwives. Lusaka, Zambia.
- Giddens, A. (2004) *Sociology*. Blackwell Publishing Ltd.Oxford.
- Gish, O., Godfrey, M. (1979) A reappraisal of the 'brain drain' -with special reference to the medical profession. *Soc Sci Med [Med Econ]* 13C(1): 1-11
- Glover S. et al., (2001) In: *Migration: an economic and social analysis*. Home Affairs. London.
- Goldfarb, R. et al., (1984) Can remittances compensate for manpower outflows: the case of Philippine physicians, in *Journal of Developmental Economics*, 1984, No. 15 pp 1-2; 1-17.
- Government of the Republic of Zambia (1997) *The Nurses and Midwives Act, No 31 of 1990*. Lusaka, Government Printers.
- Greene J. (2000) Physicians enticed into early retirement. *American Medical News*, 2000.43: 1-2
- Guba E., Lincoln Y. (1994) Competing Paradigms in Qualitative Research. In N. K. Denzin and Y. S. Lincoln (Eds.) *Handbook on Qualitative Research – Thousand Oaks, CA:Sage*.

- Hammar T., Tamas K. (1997) Why Do People Go or Stay? In Hammar T. et al. eds. *International Migration, Immobility and Development: Multidisciplinary Perspectives*, pp 1-19. BERG, Oxford
- Hammersley, M. (1990) Reading ethnographic research: A critical guide. Longman, London.
- Hancock Beverly (2002) An Introduction to Qualitative Research. Trent Focus Group (1998).
- Hardon A et al. (1995) Applied Health Research Manual: Anthropology of Health Care. The Authors. The Netherlands.
- Harris, J., Todaro M. (1970) Migration, Unemployment and Development.
- Hawthorne, L. (2002) Qualifications recognition reform in Australia: Applying competency-based assessment to overseas-qualified nurses. In: *International Migration*, vol. 40, No. 6.
- Hefti, A. (1997) Globalisation and Migration. European Solidarity Conference on the Philippines: Responding to Globalization, 19-21 September, 1997. Boldern House, Mannedorf, Zurich, Switzerland.
- Held, D. et al (1999) Global Transformations: Politics, Economics and Culture. Cambridge.Polity.
- Henning, E. et al., (2004) Finding your way in qualitative research. Van Schaik Publishers.
- Hoffmann E., Lawrence S. (1996) Statistics on international labour migration: A review of sources, and methodological issues. ILO. Geneva.
- Howell, M. (2003) Doctors laving Philippines to become nurses [www.sfgste.com](http://www.sfgste.com) In: *New Internationalist* (2005) Health and Migration: the Facts. *New Internationalist* 379. <http://www.newint.org/issues379/facts.htm> accessed 18th December, 2007.
- Huston C. (2006) Professional issues in nursing. Chapter 6- Importing foreign nurses. Philadelphia: Lippincott, Williams, and Wilkins.
- International Council of Nurses (2003) ICN Workforce Forum Report, 29<sup>th</sup> –30<sup>th</sup> September 2003, Oslo, Norway.
- International Council of Nurses (2004) The Global Shortage of Registered Nurses: An Overview of Issue and Actions. ICN, Geneva.
- International Council of Nurses (2007) Positive Practice Environments. International Centre for Human Resources in Nursing. Fact Sheet. ICN-CIE-CII, Geneva, Switzerland.

- International Monetary Fund. (2000) World economic outlook. Washington DC.
- ILO (1999) Terms of employment and working conditions in health sector reforms. Geneva.
- Jinks, C. et al. (2000) Mobile Medics. The mobility of doctors in the European economic area. *Health Policy*, 54:45-64.
- Joint Learning Initiative (2004) The Health Workforce in Africa: Challenges and Prospects. A report of the Africa Working Group of the Joint Learning Initiative on Human Resources. WHO. World Bank and Rockefeller Foundation. Global Health Trust.
- Kaplan, D. et al., (2000) Brain drain: new data, new options. South African Network of Skills Abroad. Available at <http://www.uct.ac.za/org/sansa/>
- Khalil, A. (1999) Unchecked exodus. *Cairo Times* 1-14 April 1999. Available at <http://www.cairotimes.com/content/issues/health./brain.htm>
- Kingma M. (2006) *Nurses on the Move: Migration and the Global Health Care Economy*. Cornell University Press. United States of America.
- Kinoti S. (2003) The impact of HIV/AIDS on the Health Workforce in sub-Saharan Africa. Joint Learning Initiative consultation Commission Paper (Africa Working Group).
- Kramer R. (2005) Skilled Africans filling key positions abroad are draining home countries of vital expertise. *AllAfrica.com* January 31<sup>st</sup>, 2005.
- Krueger, R. A. (1994) *Focus groups: A practical guide for applied research*. Newbury, CA: Sage.
- Lacey, A., Laffy, D. (2001) *Trent Focus for Research and Development in Primary Health Care : Qualitative Data Analysis*. Trent Focus, 2001.
- Lechner, F. (2001) *Globalisation Theories: World System Theory*. The Globalisation Website, 2000-2001.
- Lincoln, Y., & Guba, E. (1985) *Naturalistic Inquiry*. Newbury, CA: Sage.
- Tikki P. et al., (2002) Brain drain and health professionals: A global problem needs global solutions. *BMJ* 2002; 324:499-500 (2 March) *Research Policy and Cooperation*, World Health Organization, Geneva, Switzerland, INCLEN Trust.
- Mahler, J. Sarah (1999) *Engendering Transnational Migration: A Case Study Of Salvadorans*. *American Behavioral Scientist*, Vol. 42 No. 4, January 1999 690-719. Sage Publications, Inc.

- Mangwende P. Health sector records massive brain drain. Daily News (Zimbabwe) 10<sup>th</sup> April 2001.
- Mansoor, A. Quillin, B. (2007) Migration and Remittances: Eastern Europe and Central Asia. <http://go.worldbank.org/E3DJ4L4R00> accessed 9/25/2007.
- Maresova, Jarmila (1999) Labor Migration to Australia. Czech and Slovak Temporary Workers in Vienna, in: Paradigms and Contentions, IWM Junior Visiting Fellows Conferences, Vol. 7 Vienna.
- Martineau, T. et al. (2002) Briefing note on international migration of health professionals; Leveling the playing field for developing country health systems. [www.liv.ac.uk/lstm/hsrhome.html](http://www.liv.ac.uk/lstm/hsrhome.html)
- Maresova, Jarmila (1999) Labor Migration to Australia. Czech and Slovak Temporary Workers in Vienna, in: Paradigms and Contentions, IWM Junior Visiting Fellows Conferences, Vol. 7.
- Mason, J. (1996) Qualitative research. Newbury, CA: Sage.
- Massey, S. D. et al., (1993) Theories of International Migration: Review and Appraisal. Population and development reviews, 19, 1993 No. 3 pg 431-466.
- Mehmet, O. (2002) The emerging global labour market: some implications for international health (2<sup>nd</sup> draft). WHO consultation on imbalances in the health workforce. Ottawa 10-12 March 2002. (Unpublished).
- Mejia, A. and Pizurki, H. (1976) World migration of health manpower. WHO Chronicle 30:455-460.
- Mejia, A. (1978) Migration of Physicians and Nurses: a worldwide picture. International Journal of Epidemiology 7(3): 207-215.
- Mejia, A. et al., (1979) Physician and Nurse Migration, World Health Organization, Geneva.
- Ministry of Health (1991) National Health Reforms. Government of the Republic of Zambia. Lusaka
- Ministry of Health (2004a) Human Resources for Health: A synopsis of the current staffing crisis and outline of proposals for action. Government of the Republic of Zambia. Lusaka
- Ministry of Health (2004b) Human Resource Crisis in Zambia. Government of the Republic of Zambia. Lusaka.
- Ministry of Health (2004c) Human Resource Crisis in Zambia. Government of the Republic of Zambia. Lusaka.

- Ministry of Health (2004d) The Human Resources Task Group: Concept Paper. Government of the Republic of Zambia, Lusaka.
- Ministry of Health (2004f) The Human Resource Crisis in Zambia. Government of the Republic of Zambia. Lusaka
- Ministry of Health (2006) Organization Structure Report for the Ministry of Health. prepared by Ministry of Health in consultation with Management Development Division, Cabinet Office. Lusaka.
- Miles, M. B., Huberman, A. M. (1984) Qualitative data analysis: A source book of new methods. Beverly Hills, CA: Sage.
- Munjanja O. et al (2005) The Nursing Workforce in sub-Saharan Africa. Issue Paper No 7 for the International Council of Nurse. Geneva.
- Mutizwa-Mangiza, D. (1998) The Impact of Health Sector Reform on Public Sector Health Worker Motivation in Zimbabwe. Major Applied research 5, Working Paper 4, Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- Nandray S. 1992 Unhealthy prescriptions: the need for health sector reform in India. *Informing and Reforming: Newsletter of the International Clearinghouse of Health Systems Reform Initiatives (ICHSRI)*; 2: 7-11.
- Nawaal D and Hobbs J (2004). London Reversing the Medical Brain Drain. Health South Africa, Inter Press Service (IPS), 30<sup>th</sup> June, 2004.
- Ngufor GF. (1999) Public service reforms and their impact on health sector personnel in Cameroon. August, 1999. ILO.
- Nyathi, N. (2000) Black brain drain turns into a flood. The Financial Gazette 4 January 2000. Available at [http://www.fingaz.co.zw/2001/January/January\\_3/141.shtml](http://www.fingaz.co.zw/2001/January/January_3/141.shtml)
- O'Brien-Pallas L. et al., (1997) Strengthening nursing and midwifery: A global study. Geneva, World Health Organization.
- OECD (2003) A needle in a haystack: Migration statistics and GATS mode 4, Paper presented at the UN/EU Conference of European Statisticians, Geneva, 29-30 Apr. 2003 (Paris 2003b).
- Olton J. (2004) Leadership challenges in a global community. Presentation, CGFNS Distinguished Leadership Award. Philadelphia.
- Omeri, A. and Atkins, K., (2002) Live Experiences of Immigration Nurses in New South Wales. Australia: Searching for Meaning. *International Journal of Nursing Studies* 39:495-505.

- Pang, T. et al., (2002) Brain Drain and health professionals, in British Medical Journal, 2002, vol.324, pp. 499-500.
- Pogue T. (2007) Mobility of Human Resources and Systems of Innovation: A Review of Literature. Institute of Economic Research on Innovation (IERI), Faculty of Economics and Finance, Tshwane University of Technology. Knowledge Systems Research Unit  
Human Sciences Research Council.
- Polit, D. F.; Hungler B. P. (1997) Essentials of Nursing Research: Methods, Appraisal, and Utilization. 4<sup>th</sup> edition. Lippincott. Philadelphia.
- Polit D. F. and Beck C. T. (2004) Nursing Research: Principles and Methods. Seventh Edition. Lippincott Williams & Wilkins. Philadelphia.
- Pries, L. (1996) Internationale Arbeitsmigration und das Entstehen transnationale sozialer Räume: Das Beispiel Mexico-B Faist, T. and et al, (eds.), Neue Formen der.
- Quan, K. (2005) Nursing shortage worldwide. <http://nursing.about.com> In: New Internationalist (2005) Health and Migration: the Facts. New Internationalist 379. <http://www.newint.org/issues379/facts.htm> accessed 18th December, 2007.
- Ratha D. (2005) Workers' remittances: An important and stable source of external development finance. In World Bank Global development finance 2003: Striving for stability in developing finance. Washington DC: World Bank.
- Rubin, H. J., Rubin, I. S. ((1995) Qualitative interviewing: The art of hearing data. Newbury, CA: Sage.
- Scott, D. W. (1995) Conditions related to the academic performance of African American Polytechnic Institute and State University. Unpublished doctoral dissertation, Virginia Polytechnic Institute and State University.
- Schiller, N. G. et al., (1992) Towards a transnational perspective on migration: race, class, ethnicity and nationalism reconsidered. Annals of New York Academy of Sciences, v.645, New York, N.Y.: New York Academy of Sciences.
- Silverman, D. (2002) Doing Qualitative Research: A Practical Handbook. Sage Publications. London.
- Sison, M. (2003) Health system suffers brain drain. [www.ipsnews.net/migration/stories/brain\\_drain.html](http://www.ipsnews.net/migration/stories/brain_drain.html)
- Smith, M, Guarnizo L. (eds.) (1998) Transnationalism from Below: Comparative Urban and Community Research. New Brunswick N.J.: Transaction Publishers.

Sochalski, J. (2003) Model of the international migration of nurses. University of Pennsylvania, Philadelphia, PA

Steffen M. Brain Drain Hurting Germany. DW-WORLD. DE, DEUTSCHE WELT

Stiwell, B. et al. (unpublished) Developing evidence-based ethical policies on the migration of health workers: Conceptual and practical challenges. *Human Resources for Health* 2003; 1:8.

Studlar, T. (1979) Great Britain in: International Labor migration in Europe, Krane Ronald E. Praeger Publishers, Praeger Special Studies. New York.

Sulaimanova, S. (2004) Irregular Labor Migration from Central Asia to the United States. Paper presented to the 2004 Central Eurasian Studies Society 5<sup>th</sup> Annual Conference, Bloomington, Indiana. 14<sup>th</sup>-17<sup>th</sup> October 2004.

Taran, P., Geronimi, E. (2003) Globalisation, labour and migration: Protection is paramount, *Perspectives on labour migration*, p.10. 3E Geneva, ILO.

Tawfik, L.; Kinoti, S.N. (2003) The Impact of HIV/AIDS on Health Systems and the Health Workforce in sub-Saharan Africa June, 2003. Support for Analysis and Research in Africa (SARA) Project USAID, Bureau for Africa, Office of Sustainable Development.

Tata, S. (2002) Presentation to WHO International Consultation on Assessment of Trade in Health Services and GATS: Research and Monitoring Priorities. WHO Geneva, Switzerland.

The Economist: Our country needs you, 17<sup>th</sup> May, 2003, p. 33.

Tikki Pang et al, Brain drain and health professionals: A global problem needs global solutions. *BMJ* 2002; 324:499-500 (2 March) Research Policy and Cooperation, World Health Organization, Geneva, Switzerland, INCLEN Trust, Manila Philippines; London School of Hygiene and Tropical Medicine, London WC1E 7HT

Todaro, M., Muruszko L. (1987) Illegal Migration and US Immigration Reform: A Conceptual Framework. *Population and Development Review*, 13: 101-114.

UNCTAD (1997) International Trade in Health Services: difficulties and opportunities for developing countries. In: *International trade in health services: a development perspective*. UNCTAD-WHO. Geneva 1998.

- UNFPA (1993) *The State of World Population – 1993*, United Nations, New York
- United Nations Population Division (2003 ) *International migration report 2002*.  
[www.unpopulation.org](http://www.unpopulation.org)
- United Kingdom Central Council for Nursing and Midwifery, 2005. London. UK.
- US Government (1997) *The health professional shortage area, nursing relief act of 1997*. House of Representatives, Sub-committee on immigration and Claims, Committee on the Judiciary, 1997.
- Vujicic, M. et al. (2004) *The role of wages in the migration of health care professionals from developing countries*. *Human Resources for Health* 2 (3), World Health Organization, Geneva, Switzerland.
- Wallerstein, I. (1974b) *The Rise and Future Demise of the World Capitalist System: Concepts for Comparative Analysis*. *Comparative Studies in Society and History* 16: 387-415.
- Wallerstein, I. (1974c) *The Modern World System: Capitalist Agriculture and the Origins of the European World, in the Sixteenth Century*. New York Academic Press, in: Lechner F. (2001-2002) *World-System Theory: Synopsis and Analysis*. Globalization Website.
- Wallerstein, I. (1998) *Utopistics: Or, Historical Choices of the Twenty-First Century*. New York: The New Press.
- Weiner R. et al.; (1998) Mitchell G, Price M. *Wits medical graduates: where are they now?*. *S Afr J Sci* 1998; 94:59-63[ISI].
- Williams, M. (2003) *Making Sense of Social Research*. SAGE Publications Ltd. London.
- World Health Assembly (2001) *Fifty-fourth World Health Assembly: summary records of committees*. Geneva, World Health Organisation (WHA 54/2001/REC/3).
- World Health Organization (2004) *Addressing Africa's Health Workforce Crisis: An Avenue for Actions*. The High Level Forum on the Health MDG's, Abuja. WHO. Geneva, Switzerland
- WHO, World Bank & Rockefeller Foundation (2004) *The Health Workforce in Africa: Challenges and Prospects*. A report of the Africa Working Group of the Joint Learning Initiative on Human Resources. Global Health Trust.
- WHO (2002) *Nursing Midwifery Services: Strategic Directions 2002 – 2008* World Health Organization. Geneva. p.28.
- WHO (2004) *Making pregnancy safer: The critical role of the skilled attendant: A joint statement by WHO, ICM, FIGO*. WHO, Geneva.

- WHO (2005) World health report 2005: making every mother and child count. World Health Organization, Geneva, Switzerland.
- WHO (2006) The world health report 2006: working together for health. WHO. Geneva, Switzerland.
- Williams, M. (2003) Making Sense of Social Research. SAGE Publications Ltd. London.
- Worley, J. (1999) Population and Reproductive Health Specialist, Carole Presern, Senior Health and Population Adviser, and Julia Cleves, Acting Chief Health and Population Department, UK Department for International Development, Personal communication, August 1999 in Ravindran, TK Sundari & Berer M. Safemotherhood Initiatives: Critical Issues.
- Woodward, D. (1998) Globalisation, uneven development and poverty: recent trends and policy implications. New York: Social Development and Poverty Elimination Division, United Nations Development Programme; 1998. (Working Paper No. 4).  
1.
- Woodward, D. et al. (2001) Globalization and health: a framework for analysis and action. Bulletin of the World Health Organization, 79:875-881.
- Xaba, J. and Phillips, G. (2001) Understanding nurse recruitment: Final report (Pretoria, DENOSA).
- Zachary G. (2001) Labour movement: shortage of nurses hits hardest where they are needed most. Wall Street Journal 2001; 24:1.
- Zarilli, S. Kinnon, C. (1998) International trade in health services: a development perspective. United Nations Conference on Trade and development/ World Health Organisation; 1998.
- Zlotnik, H. (1995) South-to-North Migration of Women. International Migration Review, vol. 24, no. 1, pp. 229-54. Unpublished document UNCTAD/ITVD/TSB/5;WHO/TFHE/98.1.
- Zlotnik H. (2004) International Migration in Africa: An Analysis Based on Estimates of Migration Stock. United Nations DESA/ Population Division. Migration Policy Institute. Washington DC



**Annexure 2 A**

C/O General Nursing Council of Zambia  
Plot No. 9171, Reserve Road off  
Lunumba Road  
P.O Box 33521  
Lusaka

26<sup>th</sup> October 2005

The Ambassador  
Embassy of the Republic of South Africa  
Lusaka  
Zambia

Dear Sir,

**Re: Request for permission to collect data on nurses issued with visas and work permits to work in the South Africa.**

I am a student at the University of KwaZulu-Natal, Durban, in the School of Nursing, Faculty of Health Sciences. I am requesting for permission to collect data from your embassy on nurses who have been issued with visas and work permits to work in South Africa. The title of the study is "Migration of nurses and the perceived impact on the public health care system in Zambia".


The aim of the study is to determine the extent of nurse migration in Zambia and to describe the reasons why nurses migrate and why others stay and to further describe the perceived impact of nurse migration on the public health care system.

Considering that information to be collected may be personal and sensitive, I wish to point out that all information will be kept in strict confidence, thereby ensuring anonymity of the nurses whose records will be included in the study. Names of nurses will not appear, as records of nurses from which data will be collected will be treated in a way that will minimize risks of their being identified. Furthermore, numbers will be assigned for identification of records instead of nurses' names and the information that will be collected will be used solely for the purpose of the study. There will be no link between the information to be collected and the names of nurses whose records will be selected for the study.

Enclosed herewith is a summary of the research proposal. Kindly note that I had written to you late last year 2005, on the same subject but I had used the University of Kwazulu Natal address. I am now in Zambia as can be seen from the above address.

It will be highly appreciated if my request receives your favorable consideration.

Yours sincerely,  
Fleanor Judith Msidi



Cc Professor O. Adejumo: Research Supervisor

The University of Kwazulu-Natal  
School of Nursing  
Faculty of Health Sciences  
2<sup>nd</sup> Floor Memorial Lower Building  
Durban South Africa, 4041  
KwaZulu-Natal

el 224893



THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 260-1-250067  
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**Assurance No. FWA00000338**  
**IRB00001131 of IORG0000774**

Ridgeway Campus  
P.O. Box 50110  
Lusaka, Zambia

9 May, 2006  
Ref: 002-10-05

Mrs Eleanor Judith Msidi  
General Nursing Council of Zambia  
P.O. Box 33521  
LUSAKA

Dear Mrs Msidi,

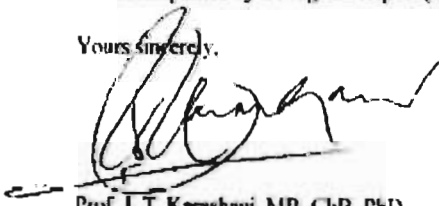
**RE: RESEARCH PROPOSAL ENTITLED: "MIGRATION OF NURSES AND THE PERCEIVED IMPACT ON THE PUBLIC HEALTH CARE SYSTEM IN ZAMBIA"**

The above research proposal was presented to the Research Ethics Committee meeting held on 26 October, 2005 where changes were recommended. We would like to acknowledge receipt of the corrected version with clarifications. The proposal has now been approved. Congratulations!

**CONDITIONS:**

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a Progress Report (Progress Report Forms can be obtained from the Secretariat).

Yours sincerely,

  
Prof. J. T. Karashani, MB, ChB, PhD  
CHAIRMAN

Date of approval: 9 May, 2006

Date of expiry: 8 May, 2007

All correspondence to be addressed to the  
Permanent Secretary  
Telephone 253040/5  
Fax 253344



In reply please quote

No. ....

REPUBLIC OF ZAMBIA

## MINISTRY OF HEALTH

7<sup>th</sup> November, 2005

NDEKE HOUSE  
P O Box 30205  
LUSAKA

Student No. 204519373

University of Kwa Zulu Natal  
School of Nursing  
Durban 4041  
**SOUTH AFRICA**

Dear Mrs. Eleanor Judith Msidi

**RE: PERMISSION TO CONDUCT STUDY ON NURSE MIGRATION IN  
OUR HEALTH FACILITIES, ZAMBIA**

I refer to your request on the subject above.

The Ministry of Health deems Human Resources for Health, a critical input to quality service delivery in our health facilities. To this effect, the Ministry of Health has prioritized interventions to mitigate the impact of health worker attrition at various levels of care. But these efforts require substantial evidence to support effective implementation.

Therefore your study is timely, and the objectives are in line with the need to understand the impact of nurse migration on health service delivery in Zambia.

I wish therefore to permit your study.

It would be pertinent that relevant ethical clearance is also obtained locally prior to the commencement of the study.

I look forward to the findings of this study, and anticipate important contribution to the Government process on alleviating the problem of human resources for health in the country.

I wish you success in your studies.

Yours sincerely

Dr. S. K. Miti  
Permanent Secretary  
**MINISTRY OF HEALTH**

*Embassy of the United States of America*



February 1, 2007

Eleanor Judith Msidi  
c/o General Nursing Council of Zambia  
Lumumba Road  
PO Box 33521

Dear Ms. Msidi,

We have received your January 29<sup>th</sup> request for information for your study, "Migration of nurses and the perceived impact on the public health care system in Zambia," which you also sent to us in October of 2005 and April of 2006. As we explained in our letters then, the Embassy will be unable to provide you with the information you requested. Visa applications are highly confidential, as they contain a great deal of personal information. Privacy issue concerns require that we use this information for official use only and prevent us from releasing it to the public. In fact, we are legally prevented under Section 222f of the Immigration and Nationality Act 222 F from disclosing this information. Your assurance that information would be confidential does not meet the requirements of US law. In addition, the Embassy does not maintain records categorizing visa applications according to profession.

As we mentioned before, is possible that you may have more success contacting organizations that work with foreign-born nurses in the United States, such as the Commission on Graduates of Foreign Nursing Schools ([www.cgfn.org](http://www.cgfn.org)) or organizations such as the National Association of Hispanic Nurses ([www.thehispanicnurses.org](http://www.thehispanicnurses.org)) or the National Coalition of Ethnic Minority Nurses ([www.ncemna.org](http://www.ncemna.org)) that have international memberships.

You may be able to find general information about visas on the State Department's website, [www.travel.state.gov](http://www.travel.state.gov). We will be unable to assist you, but I wish you luck with your research.

Sincerely,

A handwritten signature in black ink, appearing to read "Wendy Kennedy".

Wendy Kennedy  
Consular Officer

*Embassy of the United States of America*



February 1, 2007

Eleanor Judith Msidi  
c/o General Nursing Council of Zambia  
Lumumba Road  
PO Box 33521

Dear Ms. Msidi,

We have received your January 29<sup>th</sup> request for information for your study, "Migration of nurses and the perceived impact on the public health care system in Zambia," which you also sent to us in October of 2005 and April of 2006. As we explained in our letters then, the Embassy will be unable to provide you with the information you requested. Visa applications are highly confidential, as they contain a great deal of personal information. Privacy issue concerns require that we use this information for official use only and prevent us from releasing it to the public. In fact, we are legally prevented under Section 222f of the Immigration and Nationality Act 222 F from disclosing this information. Your assurance that information would be confidential does not meet the requirements of US law. In addition, the Embassy does not maintain records categorizing visa applications according to profession.

As we mentioned before, is possible that you may have more success contacting organizations that work with foreign-born nurses in the United States, such as the Commission on Graduates of Foreign Nursing Schools ([www.cgfns.org](http://www.cgfns.org)) or organizations such as the National Association of Hispanic Nurses ([www.thehispanicnurses.org](http://www.thehispanicnurses.org)) or the National Coalition of Ethnic Minority Nurses ([www.ncemna.org](http://www.ncemna.org)) that have international memberships.

You may be able to find general information about visas on the State Department's website, [www.travel.state.gov](http://www.travel.state.gov). We will be unable to assist you, but I wish you luck with your research.

Sincerely,

A handwritten signature in blue ink, appearing to read "Wendy Kennedy".

Wendy Kennedy  
Consular Officer



**SOUTH AFRICAN HIGH COMMISSION, LUSAKA**

**26D CHEETEH ROAD, KABULONGA LUSAKA  
PRIVATE BAG W369, LUSAKA**

Ms Eleanor Judith Msidi  
C/O General nursing Council of Zambia  
Plot No 9171 Reserve road off  
Lubumbashi Road  
P O box 33521

**LUSAKA**

**DATA ON NURSE VIAS AND WORK PERMIT**

Be informed that this office has never received any application for nurse going to South African on work permits and visa.

Thank you  
**Johanna Maria Dibe**  
**2<sup>nd</sup> Secretary: Immigration and consular services**  
**Date: Friday, November 03, 2006**



RESEARCH OFFICE (GOBAN MBEKI CENTRE)  
WESTVILLE CAMPUS  
TELEPHONE NO.: 031 – 2603587  
EMAIL: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

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22 NOVEMBER 2005

MRS. EJ MSIDI (202520238)  
NURSING


Dear Mrs. Msidi

ETHICAL CLEARANCE APPROVAL NUMBER : HSS/05127A

I wish to confirm that ethical clearance has been granted for the following project:

**"Migration of Nurses and the perceived impact on the Public Health Care system in Zambia"**

Yours faithfully

  
.....  
MS. PHUMELELE XIMBA  
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

**THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.**

cc. Faculty Officer  
cc. Supervisor (Prof. O Adejumo)

Annexure 1 B



THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 260-1-250067  
Telegrams: UNZA, LUSAKA  
Telex: UNZALU ZA 41170  
Fax: + 260-1-250753  
E-mail: unzmec@zantel.zm  
**Assurance No. FWA00000338**  
**IRB0001131 of IORG0000774**

Ridgeway Campus  
P.O. Box 50110  
Lusaka, Zambia

9 May, 2006  
Ref: 002-10-05

Mrs Eleanor Judith Msidi  
General Nursing Council of Zambia  
P.O. Box 33521  
LUSAKA

Dear Mrs Msidi,

**RE: RESEARCH PROPOSAL ENTITLED: "MIGRATION OF NURSES AND THE PERCEIVED IMPACT ON THE PUBLIC HEALTH CARE SYSTEM IN ZAMBIA"**

The above research proposal was presented to the Research Ethics Committee meeting held on 26 October, 2005 where changes were recommended. We would like to acknowledge receipt of the corrected version with clarifications. The proposal has now been approved. (Congratulations)

**CONDITIONS:**

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a Progress Report (Progress Report Forms can be obtained from the Secretariat).

Yours sincerely,

  
Prof. J. T. Karashuri, MD, ChB, PhD  
CHAIRMAN

Date of approval: 9 May, 2006

Date of expiry: 8 May, 2007

Annex: 1

THE UNIVERSITY OF KWAZULU-NATAL.

Checklist for collecting data on verification of qualifications issued to nurses by the General Nursing Council of Zambia

Section A: Demographic data

1. Sex

1. Male

2. Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

Section B: Professional data

4. Professional qualifications

Professional qualification (s)	Tick	Where trained	Year graduated
Registered nurse			
Registered midwife			
Enrolled nurse			
Enrolled midwife			
Registered mental health nurse			
Enrolled mental health nurse			
Public health nurse			
Nurse Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

Section C: Data on verifications

5. Verification of professional qualifications issued

Country to which verification(s) sent	Year verification(s) sent	Applicant's workplace at time of sending verification(s)

Annex 2:

THE UNIVERSITY OF KWAZULU-NATAL

Checklist for collecting data on nurses issued with visas for entry to destination countries and work permits

Section A: demographic data

1. Sex

1 Male

2 Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

Section B: Family responsibilities

4. Number of children

Section C: Professional data

5. Professional qualifications

Professional qualification (s)		Where trained	Year graduated
Registered nurse			
Registered midwife			
Enrolled nurse			
Enrolled midwife			
Registered mental health nurse			
Enrolled mental health nurse			
Public health nurse			
Nurse Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

Section D: Data on emigration

6. Year visa issued

7. Country of destination

8. Year work permit issued

9. Whether period of stay in destination country specified

1 Yes

2 No

10. Approved period of stay in destination country

Annex 3:

THE UNIVERSITY OF KWAZULU-NATAL

Interview guide for nurses seeking verification of their qualifications

Section A: Demographic data

1. Sex

1 Male

2 Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

Section B: Family responsibilities

4. Number of children (write number against the number of children that you have in the box below)

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

5. Age of children in years

- 1 <5
- 2 6-10
- 3 11-15
- 4 16-20
- 5 21>

6. Number of dependants living with you

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

7. Is your husband/wife outside Zambia?

- 1 Yes
- 2 No

8. If yes, in which country is your husband/wife?

- 1 Australia
- 2 Botswana
- 3 Namibia
- 4 New Zealand
- 5 South Africa
- 6 UK
- 7 USA

8 Other (specify).....

9. What is he/she doing outside Zambia?

- 1 Working
- 2 Studying
- 3 Nothing
- 4 Other (specify).....

10. Do you intend to join your husband/wife?

- 1 Yes
- 2 No

11. How long do you plan to stay in the country where you intend to go?

- 1. <2year
- 2. 3-6 years
- 3. 7-10 years
- 4. >10 years

Section C: Professional data

12. Professional qualifications

Professional qualification (s)		Where trained	Year graduated
Registered nurse			
Registered midwife			
Enrolled nurse			
Enrolled midwife			
Registered mental health nurse			
Enrolled mental			

health nurse			
Public health nurse			
Nurse Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

13. Position at place of work (write number against your position in box)

1 Registered nurse

2 Ward sister

3 Nursing officer

4 Lecturer/Tutor

5 Clinical teacher

6 Enrolled nurse

7 Other (Specify).....

14. Name of institution where you are currently working

.....

15. In which department or area are you currently working?

1 Outpatient

2 Medical

3 Surgical

4 Maternity

5 Community

6 Other (specify) .....

16. Which country do you want to go to?

- 1 Australia
- 2 Botswana
- 3 Namibia
- 4 New Zealand
- 5 South Africa
- 6 UK
- 7 USA
- 8 Other (specify).....

Section D: Qualitative data

17. What are the factors that have contributed to your decision to leave your employment

18. Why do you want to leave Zambia?

19. What are the factors that have made you choose that country?

20. Have you already secured a job in that country?

- 1 Yes
- 2 No

21. If yes, how did you get the job?

- 1 Through friends
- 2 Through the Internet
- 3 Through an agency based in Zambia
- 4 Through an agency based in that country
- 5 Other (specify).....

22. What would make you change your mind to stay and work in Zambia?

23. What do you suggest should be put in place to manage nurses leaving for greener pastures (nurse migration) considering the interests of both the nurses and the country?

**DECLARATION BY POTENTIAL PARTICIPANT**

I hereby confirm that I have been informed about the nature and purpose of the project and that the information given will be kept confidential.

Signature of Participant

Date

.....

Annex 4

THE UNIVERSITY OF KWAZULU-NATAL

Interview guide for nurses who have migrated and are in Zambia at time of data collection

Section A: Demographic Data

1. Sex

1 Male

2 Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

Section B: Family responsibility

4. Number of children

1 1-3

2 4-6

3 7-9

- 4 10>
- 5 None

-

5. Age of children in years

- 1 <5
- 2 6-10
- 3 11-15
- 4 16-20
- 5 21>

6. Number of dependants who lived with you before you left Zambia

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

7. Number of dependants living with you now outside the country

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

8. Is your husband/wife outside Zambia?

- 1 Yes
- 2 No

9. If yes, in which country is your husband/wife?

- 1 Australia
- 2 Botswana
- 3 Namibia
- 4 New Zealand

- 5 South Africa
- 6 UK
- 7 USA
- 8 Other (specify).....

10. What is he/she doing outside Zambia?

- 1 Working
- 2 Studying
- 3 Nothing
- 4 Other (specify).....

11. Did you leave Zambia to join your husband/wife when you first left the country?

- 1 Yes
- 2 No

12. If yes, in which area of work or profession is your husband/wife?

- 1 Medical
- 2 Nursing
- 3 Teaching
- 4 Agriculture
- 5 Other

13. How long do you plan to stay in the country where you are now?

- 1 <2 year
- 2 3-6 years
- 3 10 years
- 4 >10 years
- 5 Indefinite period

**Section B: Professional data**

14. Professional qualifications: Tick your qualification (s) in the appropriated column and indicate where you trained and year you completed training

Professional qualification (s)	Tick	Where trained	Year completed training
Registered nurse			
Registered midwife			
Enrolled nurse			
Enrolled midwife			
Registered mental health nurse			
Enrolled mental health nurse			
Public health nurse			
Nurse Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

15. What was your last position at your work place before you left Zambia (write number against your last position in box)

- 1 Registered nurse
- 2 Ward sister
- 3 Nursing officer
- 4 Tutor
- 5 Enrolled nurse
- 6. Other (specify).....

Section C: Migration information

16. Which year did you first leave Zambia?

.....

17. Which country did you go to when you left?

.....

18. Which other country/countries have you worked in since then? Indicate number against the country/countries in which you have worked in the box below

- 1 Australia
- 2 Botswana
- 3 Namibia
- 4 New Zealand
- 5 South Africa
- 6 UK
- 7 USA
- 8 Other (specify).....

19. What are the reasons for your coming to Zambia now?

- 1 Renew my practicing license
- 2 Seek verification of my qualifications for registration in another country
- 3 Visiting my relations
- 4 Have returned for good
- 5 Other (specify)

20 Do you intend to move to another country?

- 1 Yes
- 2 No

21. If yes, which country do you intend to go to?

- 1 Australia
- 2 Botswana
- 3 Namibia
- 4 New Zealand
- 5 South Africa
- 6 UK
- 7 USA
- 8 Other (specify).....

22. Why do you intend to move to that/those countries?

.....

.....

.....

23. When do you intend to go there?

- 1 less than one year from now
- 2 two –four years from now
- 3 five-seven years from now
- 4 Other (specify).....

24. Do you intend to come back to Zambia?

- 1 Yes
- 2 No

25. If yes, when do you intend to return to Zambia?

- 1 less than one year from now

- 2 two –four years from now
- 3 five-seven years from now
- 4 Other (specify).....

26. What are your plans on return to Zambia?

- 1 Work in the government hospital/health care facility
- 2 Work in the private sector
- 3 Set up my own practice
- 4 Work in a non-nursing area
- 5 Other (specify).....

27. Have you been sending money to Zambia?

1 Yes

2 No

28. If yes, what was the intended purpose of this money?

- 1 Support education of my brothers/sisters
- 2 Support education of my children
- 3 For upkeep of my spouse and children
- 4 Upkeep of my parents
- 5 All of the above
- 6 Other (specify) .....

Section D: Qualitative data on migration

29. What were your reasons for leaving your employment and the country Zambia?

30. What had attracted you to the country where you went?

31. What is the purpose of your coming to Zam32. What type of work are you currently doing and why did you choose that work?

33. If not currently working, why are you not working?

34. How should Zambia manage the issue of nurses leaving for greener pastures in the interest of both the nurses and the country?

**DECLARATION BY PARTICIPANT**

I hereby confirm that I have been informed about the nature and purpose of the project and that the information given will be kept confidential.

**Signature of Participant**

**Date**

.....

## Annex 5

### THE UNIVERSITY OF KWAZULU-NATAL

Topic guides for focus group discussions with nurses and nurse educators working in Zambia

Subject area: Impact of nurse migration (nurses leaving for greener pastures) on the health care system - discussion on nurses' and nurse educators' perception on the following:-

#### 1. Availability of nurses

- Nurse turnover
- Vacancy levels
- Availability of experienced nurses

#### 2. Utilization of staff

- Distribution and skills mix
- Working shifts
- Nurse performance in relation to scope of practice

#### 3. Work implications

- Workload changes
- Job satisfaction
- Attitude towards work
- Stress and potential for stress

#### 4. Quality of care

- Adequacy of coverage of health needs of patients/clients
- Work Environment

#### 5. Supervision

- Adequacy of supervision by nurse leaders

- Motivation for patient care

#### 6. Impact on teaching and learning of students

- How has it affected the organization and implementation of the teaching and learning programme of students both in the school and the clinical areas?

- How do the teachers ensure that the teaching and learning of students meet the requirements set by the regulatory organization and the ministry of health?

7. What has made you stay and work in Zambia?

8. Guidelines for managing nurses leaving for greener pastures (nurse migration)

- What would you suggest as guidelines for managing nurse migration for policy formulation in Zambia?

Self-administered Questionnaire on the impact of nurses leaving for greener pastures (migration) on the health care system to be completed by nurses

Section A: Demographic data

1. Sex

1 Male

2 Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widow

5 Separated

Section B: Family responsibilities

4, Number of children

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

5. Age of children in years

- 1 <5
- 2 6-10
- 3 11-15
- 4 16-20
- 5 21>

6. Number of dependants living with you

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

Section C: Professional data

7. What is/are your professional qualification(s)? (Tick in the space provided)

Professional qualification	Tick against your qualification(s)	Where trained	Year completed training
Registered nurse			
Registered midwife			
Enrolled nurse			
Enrolled midwife			
Registered mental health nurse			
Enrolled mental health nurse			
Public health nurse			

Nurse Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

8. What is your position at your work place? (Write number against your position/response in box)

1 Registered nurse

9. Enrolled nurse

10. Ward sister

11. Sister in charge

5. Nursing officer

6. Tutor/Lecturer

7. Student nurse

8. Other (specify) .....

Section D: Availability of nurses – tick your response for each question in the box

9. How has nurses leaving for greener pastures (migration) affected availability of nurses in your work place?

It has increased availability of nurses through replacements

It has decreased availability of nurses

It has had no effect on availability of nurses

10. How has nurses leaving for greener pastures (migration) affected recruitment of nurses in your work place in the last three years? Tick in box against your response(s)

Difficult to get experienced nurses

Only inexperienced nurses have been recruited

No effect on recruitment of nurses

Section E: Utilization of staff

11. Who is in charge of wards/the health center most of the time?

Registered nurse

Enrolled nurse

Other (specify).....

12. In a general medical ward with an average of 40 patients, how many nurses would, on average, be available on duty to provide care to the patients during the following shifts?

Morning shift

Answer .....nurses

Evening shift

Answer ..... nurses

Night shift

Answer ..... nurses

14. How has your scope of nursing practice been affected by nurses leaving for greener pastures (migration)?

I practice within my scope of practice and do nursing duties only

I practice beyond my scope of practice and do doctor's work or other people's work most of the time

I practice beyond my scope of practice and do doctor's work or other people's sometimes

#### Section F: Work implications

15. How has your workload been affected by nurses leaving for greener pastures (nurse migration)?

Workload has increased

Workload has decreased

No effect on workload

16. Has the leaving of nurses for greener pastures affected your job satisfaction? Write the number of your answer in the box below.

1 yes

2 no

17. If yes, how have you been affected?

I am always frustrated in my job

I am frustrated in my job most of the times

I am occasionally frustrated in my job

18. Has the attitude of nurses towards patients and the rest of their work been affected by nurses leaving for greener pastures? Write the number beside your answer in the box below

1 yes

2 No

19. If yes, how has the attitude of nurses been affected by nurses leaving for greener pastures?

Extremely negatively

Very negatively

Negatively

Extremely positively

Very positively

Positively

20. Has your ability to provide care been affected by nurses leaving for greener pastures?

Write the number beside your answer in the box below.

1 Yes

2 No

21. If yes, what has been the effect?

It has increased my ability to provide care

It has decreased my ability to provide care

My ability to provide care increases and decreases at times

It has had no effect on my ability to provide care

#### Section G: Quality of care

22. What, in your opinion, is the adequacy of coverage of health needs of patients in view of nurses leaving for greener pastures?

Grossly inadequate

Very inadequate

Inadequate

Very adequate

Adequate

23. Nurses leaving for greener pastures has encouraged the institution management team to:

- Increase the pre-requisites and supplies needed to do my job
- Decrease the pre-requisites and supplies needed to do my job
- Do nothing about the pre-requisites and supplies needed to do my job

24. How has nurses leaving for greener pastures affected the quality of supervision by the nurse leaders in your work place?

Quality of supervision has improved:  
strongly agree



Agree

Strongly disagree

Disagree

Agree

25. What guidelines should be put in place for both the nurses and the country to facilitate better management of nurses leaving for greener pasture?

.....

.....

.....

26. Do you have any intention to leave and work outside the country?

1 Yes

2 No

27. If yes, where do you want to go?

28. What has made you stay and work in Zambia?

1 Family responsibility

2 Good working conditions

3 Hoping to have better working conditions in future

4 Other reasons (specify) .....

**DECLARATION BY PARTICIPANT**

I hereby confirm that I have been informed about the nature and purpose of the project and that the information given will be kept confidential.

Signature of Participant

Date

.....

: Self-administered Questionnaire on the impact of nurse migration on the health care system to be completed by nurse educators (Tutors and Clinical teachers)

Section A: Demographic data

1. Sex

1 Male

2 Female

2. Age

Marital status

1 Single

2 Married

3 Divorced

4 Widow

5 Separated

Section B: Family responsibilities

4. Number of children

1 1-3

2 4-6

2 7-9

3 10>

5 None

5. Age of children in years

- 1 <5
- 2 6-10
- 3 11-15
- 4 16-20
- 5 21>

6. Number of dependants living with you

- 1 1-3
- 2 4-6
- 3 7-9
- 4 10>
- 5 None

Section C: Professional data

7. What is/are your professional qualification(s)? (Tick in the space provided)

Professional qualification	Tick against your qualification(s)	Where trained	Year completed training
Registered nurse			
Registered midwife			
Registered mental health nurse			
Diloma in Nursing Education (DNE)			
Public health nurse			
Nurse			

Tutor/Lecturer			
BSc Nursing			
Masters Degree			
PhD			
Other (specify)			

8. What is your position at your work place? (Write number against your position/response in box)

- 1 Registered Nurse Tutor
- 2 Lecturer
- 3 Senior Tutor
- 4 Senior Lecturer
- 5 Clinical Teacher
- 6 Nurse Education Manager
- 7 Principal Tutor
- 8 Other (specify) .....

Section D: Availability of nurse educators (Tutors and clinical Teachers) – (tick your response for each question in the box)

9. How has nurses leaving for greener pastures affected availability of nurse educators in your work place?

It has increased availability of nurse educators

It has decreased availability of nurse educators

It has had no effect on availability of nurse educators

10. How has nurses/nurse educators leaving for greener pastures (migration) affected recruitment of nurses and nurse educators in your work place in the last three years?

Difficult to get experienced nurse educators

Only inexperienced nurse educators have been recruited

No effect on recruitment of nurse educators

Section E: Utilization of staff

11. Who is in charge of the school most of the time?

Nurse Education Manager

Senior Tutor

Tutor

Clinical Teacher

Other (specify in space below)

.....

12. How many students are there in the school?

Answer.....

13. How many nurse tutors are there in the school?

Answer.....

14. How many clinical teachers are there in the school?

Answer.....

Section E: Work implications

15. How has nurses/nurse educators leaving for greener pastures affected your workload?

My workload has increased

My workload has decreased

No effect on my workload

16. Has the leaving of nurses/nurse educators for greener pastures affected your job satisfaction? Write the number of your answer in the box below.

1 yes

2 no

17. If yes, how have you been affected?

I am always frustrated in my job

I am frustrated in my job most of the times

I am occasionally frustrated in my job

18. Has the attitude of nurses/nurse educators towards patients, students and the rest of their work been affected by nurses leaving for greener pastures? Write the number beside your answer in the box below.

1 yes

2 No

19. If yes, how has the attitude of nurses/nurse educators been affected by nurses/nurse educators leaving for greener pastures?

- Extremely negatively
- Very negatively
- Negatively
- Extremely positively
- Very positively
- Positively
- Other (specify)

20. Has your ability to provide teaching of students been affected by nurses/nurse educators leaving for greener pastures? Write the number beside your answer in the box below.

1 Yes

2 No

21. If yes, what has been the effect?

- It has increased my ability to provide teaching
- It has decreased my ability to provide teaching

My ability to provide teaching increases and decreases at times

Other effect (specify).....  
Section G: Quality of teaching and learning of students

19. What is the adequacy of coverage of learning needs of students in view of nurses/  
nurse educators leaving for greener pastures?

Grossly inadequate

Very inadequate

Inadequate

Very adequate

Adequate

20. Nurses/ nurse educators leaving for greener pastures has encouraged the  
institution management team to:

Increase the pre-requisites and teaching materials needed to do my job

Decrease the pre-requisites and teaching materials needed to do my job

Do nothing about the pre-requisites and teaching materials needed to do my job

21. How has nurses/nurse educators leaving for greener pastures affected the  
quality of supervision by the nurse leaders in your work place? (Tick your response in  
box).

Quality of supervision has improved:

Strongly agree

Agree

Strongly disagree

Disagree

22. What guidelines should be put in place for both the nurses, nurse educators and the country to facilitate better management of nurses/nurse educators leaving for greener pastures?

23. Do you plan to leave Zambia and work outside the country?

1 Yes

2 No

24. If yes, where do you want to go?

.....

25. What has made you stay and work in Zambia?

1 Family responsibility

2 Good working conditions

3 Hoping to have better working conditions in future

4 Other reasons (specify)

#### DECLARATION BY PARTICIPANT

I hereby confirm that I have been informed about the nature and purpose of the project and that the information given will be kept confidential.

Signature of Participant

Date

.....

THE UNIVERSITY OF KWAZULU-NATAL

Annex 8: Guide for interviewing policy makers, directors and managers

Section A: Demographic data

1. Sex

1 Male

2 Female

2. Age

3. Marital status

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

*Section B: Data on level of employment*

4. What is your job title?

6. How many years experience have you had in this job?
7. At what level is your job responsibility
8. National

Provincial

District

### Section C: Qualitative data

#### A. Recruitment of nurses

##### Impact on recruitment

7. How has migration of nurses impacted on recruitment and deployment of nurses to the health care facilities?

##### Advantages and disadvantages

8. What are the advantages of nurse migration, if any and what are its disadvantages?

#### B. Education and Training of nurses

9. What has been the impact of nurses leaving for greener pastures on training policy decisions?

#### C. Managing nurse migration

Suggested guidelines

10. What guidelines would you suggest regarding managing nurses leaving for greener pastures in the interest of both nurses and the country?

Recommended work experience before migrating

11. At what stage after training should nurses be allowed to leave for greener pastures?

D. Impact of nurse migration on the health care system

12. How has nurses leaving for greener pastures impacted on the health care system?

DECLARATION BY PARTICIPANT

I hereby confirm that I have been informed about the nature and purpose of the project and that the information given will be kept confidential.

Signature of Participant

Date

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