ABSTRACT

THE GEOGRAPHY OF BRAIN DRAIN MIGRATION IN THE HEALTH SECTOR: FROM ZIMBABWE TO THE UK

By Tatenda Mambo

This thesis is about the immigration of Zimbabweans to the UK and their participation in the National Health Service (NHS). Given the global movements of nurses, this thesis seeks to document the migrant experience of Zimbabwean nurses and determine whether they represent a brain drain. Data for this study were collected in Zimbabwe and the UK during the summer of 2007 through semi-structured interviews, use a survey and analysis of secondary data. The thesis finds that, immigration of Zimbabweans to the UK and their participation in the NHS in the result of place specific attributes that highlighting the importance of geography. For Zimbabwe to stem the emigration of nurses and realize return migration of this human capital, the Zimbabwean government needs to create opportunity that is globally competitive. Essential factors to address are political, economic and social concerns of everyday life. Without addressing these concerns, the status quo will continue.
THE GEOGRAPHY OF BRAIN DRAIN MIGRATION IN THE HEALTH SECTOR: FROM ZIMBABWE TO THE UK

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# Table of contents

List of tables ............................................................................................................. iii
List of figures ............................................................................................................ iv
Acknowledgements ................................................................................................... v

## Chapter One: Introduction ............................................................................. 1

1.1: Introduction .................................................................................................... 1
1.2: Background Information ............................................................................... 3
1.3: Research questions ....................................................................................... 7
1.4: Research Methodology .................................................................................. 7
1.5: Data Collection ............................................................................................... 11
1.6: Organization of the thesis ............................................................................. 12

## Chapter Two: Literature Review on Brain Drain Migration and the Health Sector ........ 14

2.1: Introduction .................................................................................................... 14
2.2: Migration Theory ........................................................................................... 16
2.3: What are the Costs and Benefits of Migration to Source Areas? ................. 21
2.4: Global Health Labor Shortage ...................................................................... 25
2.5: Mitigation of brain drain migration: Landscapes of the source and destination .... 27
2.6: Missing Links ................................................................................................. 29
2.7: Conceptual Framework and Research Questions ......................................... 32

## Chapter Three: Trajectory of Zimbabwean Emigrants to UK: Place Attributes of Zimbabwe ................................................................................................................. 37

3.1: Introduction .................................................................................................... 37
3.2: Who Migrates? ............................................................................................... 38
3.3: Reasons for Emigration out of Zimbabwe .................................................... 42
3.4: How they Migrate ........................................................................................... 51
3.5: Brain Drain on Zimbabwe? .......................................................................... 52
3.6: Conclusion: Trajectory of Zimbabwean Emigrants in the UK ........................................57

Chapter Four: Experiences in the UK: Place attributes of the UK ....................................59
4.1: Introduction..................................................................................................................59
4.2: Settlement Patterns ..................................................................................................60
4.3: How and Why Zimbabweans fit into the UK Nurse Industry ..................................61
4.4: Zimbabwean Nurses participation in the UK nurse industry ...................................69
4.5: Zimbabwean Nurse Experiences in the UK: Giving up Dignity for Cash .................71
4.6: Conclusion ...............................................................................................................80

Chapter Five: Transnational Activities: Maintaining connections between Zimbabwe and the UK...............................................................83
5.1: Introduction...............................................................................................................83
5.2: Transnational Activities..........................................................................................84
5.3: Future plans and Return Migration ..........................................................................87
5.4: Establishing Roots ...................................................................................................94
5.5: The Role of Government in Return Migration .......................................................97
5.6: Conclusion ...............................................................................................................100

Chapter Six: Zimbabwean Nurses future in the changing UK nursing industry............102
6.1: Introduction..............................................................................................................102
6.2: The Code of Conduct for the Recruitment of International Nurses .......................102
6.3: Shortage Occupation List and the European Union directive ................................106
6.4: Changes to pay Negotiation ....................................................................................108
6.5: NHS Funding for Nursing School ..........................................................................110
6.6: Conclusion ...............................................................................................................112

References.......................................................................................................................113
List of Tables

Table 1.1: Top 20 contributors of nurses to the UK from 1999 to 2007.................................5
Table 3.1: Demographic Attributes.................................................................39
Table 3.2: Gender and Family Migration .........................................................41
Table 3.3: Trajectories & Length of Migration .................................................42
Table 3.4: Why Zimbabweans Emigrate from Zimbabwe ..................................46
Table 3.5: Occupational & Human Capital Components....................................53
Tables 4.1: Where in the UK do they Settle.....................................................61
Table 4.2: The Role of Social Networks in Helping Immigrants Settle in the UK .......67
Table 4.3: Nurse Experiences in the UK ..........................................................72
Table 5.1: Transnational Activities.................................................................85
Table 5.2: Retirement.......................................................................................88
Table 5.3: Establishing Roots...........................................................................95

List of Figures

Figure 1.1: Map of the Total Number of Overseas Nurses Immigrating to the UK from 1999 to 2007 ........................................................................................................4
Figure 2.1: Graphic of the Geographic Perspective............................................20
Figure 2.2: Conceptual framework for the immigration of Zimbabwean nurses to the UK..................................................................................................................... 32
Figure 4.2: Inflow of Zimbabwe Nurses to the NMC registry.............................70
Figure 6.1: Inflow of South African and West Indies nurses from 1999 to 2007........104
Figure 6.2: Inflow of nurses form a selection of countries...................................105
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Chapter One: Introduction

1.1: Introduction

The significance of health care workers has garnered much attention in academic study, because of the huge shortages of health care workers across the globe, both in the global core and especially in the global periphery (Clark, Stewart, Clark 2006; Dale 2005; Batata 2004). The World Health Organization has identified brain drain migration of health professionals out of Sub-Saharan Africa as a major obstacle to achieving the Millennium Development Goals targeting health (Ahmad 2004; Lancet 2005). Immigration of health care professionals from Sub-Saharan Africa to the global core results in manpower shortages across the African continent and drastically reduces the quality of health care (Chikanda 2006, 2008; Clark, Stewart, Clark 2006; Getahun 2006). Countries like Zambia, Malawi and Zimbabwe face major shortages of health care professionals like doctors and nurses resulting in their hospitals being manned by skeleton staff barley able to meet work loads. Collectively Sub-Saharan Africa is believed to experience a shortfall of 600,000 nurses (Clark, Stewart, and Clark 2006). Malawi is estimated to have only 28% of nurse positions filled (Clark, Stewart, and Clark 2006). In 1997, Zimbabwe only had 28.7% of doctor positions filled and 55.6% of nurse positions filled (Chikanda 2008). The poor remuneration and work conditions encourage health professionals in these countries to seek better opportunities which typically lie outside the country.

Countries of the global core where these health professionals immigrate also face manpower shortages in their health delivery systems. The USA is expected to experience a shortage of 275,000 nurses by 2010 (Clark, Stewart, and Clark 2006). The UK is expected to experience a nurse shortage of 53,000 within the next 5-10 years and Australia is expected to have a shortage of 40,000 nurses by 2010 (Batata 2004). In light of these manpower shortages, countries like the UK, Australia and Canada have used immigrant labor to address this problem. Through recruitment campaigns and changes to immigration policy, countries of the global core have admitted health care professionals from the global periphery to fill vacancies (Crush 2002;
Dale 2005; Buchan 2006). These policy changes and recruitment campaigns have created opportunities for dissatisfied nurses in the global periphery, resulting in their emigration. Health delivery systems in the global core provide relatively better remuneration, work conditions and opportunities for further training compared to the global periphery. This act of recruiting nurses from health delivery systems that are already stressed has seen the countries involved referred to as ‘poachers’ and ‘global raiders’ as they further erode the health delivery systems from which the recruited nurses come from (Crush 2002; Ahmad 2004).

Zimbabwe is one such country that is seeing a mass exodus of nurses. Mass emigration of nurses out of Zimbabwe can be linked back to the Structural Adjustment Programs of the 1990’s that increased the cost of living and resulted in budget cuts for health care services (Mhone 1995; Marquette 1997; Potts and Mutambirwa 1998). This emigration of nurses from Zimbabwe has left the health delivery system in a desperate situation. In 1999, the average nurse to patient ratio stood at 1:700 (Chikanda 2008). Today the situation is a lot worse given that as recently as 2008, major government hospitals were shutting down wards as they did not have the manpower and resources to provide medical services (McGreal 2008; BBC 2008). Emigration has drastically reduced the quality of care particularly in public health institutions. Public health institutions are characterized by long wait times due to the reduced workforce, and hurried consultations to accommodate the volume of patients (Chikanda 2008). Manpower shortages have also resulted in nurses wearing many different hats in an effort to address patients’ healthcare needs (Chikanda 2008). These increased pressures are leading to burn out syndrome, dissatisfaction and low moral in the work place (Clark, Stewart, Clark 2006; Chikanda 2006, 2008).

This study argues that Zimbabwe is facing a brain drain in the nursing industry and though the place attributes responsible for the participation of Zimbabwean nurses in the UK National Health Service (NHS) have since changed, Zimbabwe is currently unlikely to realize an increase in human capital in the nursing industry through return migration due to the largely negative place attributes still present and worsening. Though place attributes in the UK are turning negative, new opportunities still exist for Zimbabwean nurses in the NHS. The aim of this thesis is to study the phenomenon of brain drain migration as it relates to the health
sector. This study looks at the migration experience of nurses who currently work in the UK NHS and have emigrated from Zimbabwe. The study takes into account both emigrants who were and were not nurses prior to their departure from Zimbabwe. Emigration is looked at in the context of a geographical perspective that takes into account the globalized nature of the nursing industry. Taking a geographical perspective entails looking at both the source and destination countries involved in the migration process and the particular place attributes that are responsible for the occurrence of migration. In this case the place attributes of Zimbabwe that have caused people to emigrate will be contrasted with the place attributes of the UK which have attracted immigrants into the UK nursing industry.

This research project looks at the migration of nurses because of the dramatic impact they make on the healthcare delivery systems of the global periphery. Nurses in the global periphery tend to be more technically trained compared to the global core (O’Brien 2007). As a result they are typically the first and only line of treatment in healthcare delivery due to the limited supply of doctors. Therefore, large losses of nurses from health delivery systems of the global periphery results in negative consequences as it takes away the only line of medical treatment in some cases. This research project asks what the Zimbabwe situation adds to the understanding of migration and the health delivery system and to what extent the brain drain exists.

1.2: Background Information

For Zimbabwean nurses, the UK is the most popular immigration destination (Chikanda 2006, 2008). Reasons for this are tied to the UK nurse shortage which Zimbabweans come to exploit, the colonial legacy which allows for compatibility and transfer of education and training standards, and social networks that immigrants are able to tap into reducing the costs of migration. In 2002 alone, the UK issued 2,346 work permits for Zimbabwean nurses (Chikanda 2008). The attraction of the UK as a destination country is not isolated to only nurses but is seen across all sectors (McGregor 2007). The nursing industry in the UK today garners a lot of attention because of the direct efforts that have been made to fill vacancies with immigrant labor. A key incentive offered to immigrants joining the NHS among others is a path towards
naturalization. This has resulted in Zimbabwean immigrants from other fields besides nursing join the NHS once in the UK to secure a stable immigration status.

Overall Internationally Recruited Nurses (IRN) make up about 5% of the nurses working in the UK public sector (NMC 2006). Increases in IRN are exhibited in the numbers of new registrants to the Nurse and Midwives Council (NMC) registry. The NMC maintains a register of all nurses and midwives eligible to practice in the UK. Over the last eight to nine years, international nurses have composed approximately 40-50% of new registrants (NMC 2007). By far English, speaking countries have been the largest contributors of nurses to the UK as can be seen in figure 1.1. This is a direct result of the British colonial legacy. The top 15 countries that have been contributors of new registrants to the NMC from 1998/99 to 2006/2007 are all former colonies of the UK expect for the Philippines. Over the last 10 years, the Philippines has been the largest contributor of nurses to the NHS. From 1998/99 to 2006/07, 26,401 Filipino nurses have joined the NMC registry. On average almost 3,000 Filipino nurses have joined the registry yearly over the time period, however, there has been a relatively drastic drop off since 2005/06 which saw just 1,541 Filipino nurses join the registry and then a further drop off in 2006/07 with just 673 joining the registry as shown in table 1.1 (NMC 2006). The Philippines being a large contributor of nurses to the UK comes as a result of a nationally coordinated effort on the part of the Philippines government to encourage the emigration of nurses in order to gain access to foreign capital flows that come in the form of remittances (Brush 2007).

Figure 1.1 Map of the overseas countries that have been the largest contributor of nurses to the UK from 1999 to 2007
Of the top 20 overseas countries (countries outside continental Europe) supplying nurses to the UK, all but 1 are former colonies of the UK as shown in table 1.1. Of these countries, all but five are either part of the global periphery or semi-periphery. Countries of the global core that are found on this list include Australia, New Zealand, Canada, the USA and Singapore. By far the greatest numbers of nurses who immigrate to the UK come from Asia.

From these top 20 countries nine are from Africa and largely constitute countries of the global periphery. Over the nine year period from 1998/99 to 2006/7 a total number of 20,033 nurses from Africa have immigrated to the UK (NMC 2007). This number represents losses to the African continent on a variety of levels which include human manpower, technical skills, time and financial investment.

Table 1.1: Top 20 contributors of nurses to the UK from 1999 to 2007.
It is within the context of these different migration streams that Zimbabwean nurses participate in the NHS. Though Zimbabwean nurses make up a small number of the total nurses joining the NHS, these losses have huge impacts in Zimbabwe resulting in troubles providing health care. The participation of Zimbabwean nurses in the NHS will be discussed in chapter 4.

Though much has been written about the problem of brain drain migration in the health care industry, the migration experience of nurses from Sub-Saharan Africa has largely been absent (Likupe 2006; O’Brien 2007). Little is known about how well nurses from Sub-Saharan Africa and particularly Zimbabwe are able to successfully integrate into the health delivery systems of the global core. Research exists that addresses the source countries of this emigration and the effects that brain drain of medical workers is having (Clark, Stewart, Clark 2006; Chikanda 2006, 2008; Johnson 2005; de Castella 2003); however, little regarding their integration into the source country is documented. There is a lot more knowledge about the experiences of other ethnic minorities (Beishon, Virdee, Hagell 1995; Gerrish, Griffith 2004; Alexis, Vydelingum, Robbins 2007) but little about Sub-Saharan Africa. Likupe (2006) has written about the experiences of Africans and ethnic minorities’ integration into the UK National Health Service (NHS) which have provided important insights. Likupe (2006) finds that

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ethnic minority nurses face discrimination in pay, work conditions, and exploitation by managers. There is clearly need for more research on the experiences of nurses from Sub-Saharan Africa. This study focuses on nurses from Zimbabwe contributing to the literature and providing a better understanding of immigrant integration into the NHS.

1.3: Research Questions

The research questions proposed in this thesis are generated from a conceptual framework that employs a geographical perspective exploring the relationship between global forces and local place attributes. Through this geographical perspective that looks at the particular local place attributes of the source and destination locations, the research questions are designed to address how localized place attributes create unique factors that interact within global parameters resulting in migration flows. As such, the global nurse shortage which is varied between regions of the globe creates a gradient where some locations are more advantageous than others to practice. Contextualized within globalization, emigrants in Zimbabwe are able to flow across this gradient, taking advantage of the opportunities in the UK. The resulting migration leads to costs and benefits which include brain drain, brain gain, brain circulation and remittances (these concepts are further discussed in chapter 2). In order to maximize the benefits of these migration flows, countries introduce policies or mitigation strategies to curtail costs. It is within these concepts, looking at the relationship between local place attributes and global forces that the flowing broad research questions are posed.

1.) What are the place attributes of Zimbabwe?
2.) What are the place attributes of the UK?
3.) What are the transnational connections that exist between the two places?

1.4: Research Methodology

To answer the research questions posed for this thesis, three main methods are employed. These are statistical analyses of secondary data, information gathering through the use of a survey instrument and the use of ethnographic methods. These methods employed
gather data at three different scales namely the country level, experiential level and the individual ethnographic narrative respectively. Employment of these methods at three different levels of analysis allows for a better comprehension of the overall occurrence of migration within the global labor market. Furthermore, deeper understandings of the migrant experience set within the context of the conditions that surround the emigrant’s decision to migrate are highlighted. Analysis of secondary data at the country level is used to look at the general occurrences that are taking place, essentially what constitutes the migration of nurses in the UK and where the Zimbabwean nurses fit within the wave of nurse migrants in the UK. Use of a survey instrument to collect data at the experience level is used to gather data on the conditions found in both the UK and Zimbabwe that contextualize the migration process. The ethnographic approach is used to collect data at the narrative level in an effort to enrich the study by allowing the migrants themselves to directly impart their experience of being a migrant through sharing their stories.

1.4.1: Use of Secondary Data

Secondary data used in this research comes from the Nursing and Midwifery Council (NMC 1999-2007). The NMC is a comprehensive government organization that is responsible for setting standards of education, training and conduct of nurses and midwives and seeks to ensure that standards are met (NMC 2008). The NMC maintains a register of nurses and midwives who are eligible to practice in the UK. Among other things, this register provides information pertaining to the nurses’ country of training which is pivotal for this research project concerning migration. These data are analyzed to highlight which countries constitute active participants in the National Health Service (NHS) and determine what portion of the Internationally Recruited Nurses (IRN) Zimbabweans make up. From this data various graphic representations of the data are provided throughout the thesis. To aid in graphic representation of this data Arc GIS in used as a cartographic tool create maps showing countries that have been major suppliers of nurses to the UK.

1.4.2: Survey Data Collection

The use of a survey instrument is the first step in getting information from the migrants. Surveys seek to generate and analyze data on a specific population group with regard to a
particular subject (Kitchin and Tate 2000). It is important to note that this portion of the study in not intended to provide a representative sample of all Zimbabwean nurses working in the UK but instead to capture the migrant experience of a portion of the population that makes up the group. As a result, snowballing — a technique used to build a sample from the acquaintances of active research participants (Salganik 2004) — was utilized to acquire research subjects. A major drawback that comes with the use of this technique is that it goes against principles of sampling and is not effective in being representative of the population group at large (Kitchin and Tate 2000; Salganik 2004).

Questions asked in the survey address the research questions of this study, essentially what are the place attributes of both the source and destination countries and what are the perceptions of place on the part of the migrants. Other information gathered through the survey include who the migrants are; where they came from, their experiences in the nursing field and what their projected plans for the future. Out of 52 surveys distributed, 36 were returned. The survey method was chosen as it was an efficient way to gather data from the respondents and allow them to take part in the study in a manner that will be convenient for them. The sample population includes individuals who have migrated from Zimbabwe and have worked in the nursing field at some point in their lives. The questions asked in the survey were closed in nature, making this part on the study quantitative.

Upon gathering the data from the surveys, responses from the population sample were then coded in a spreadsheet. In order to discover the underlying structure of the data, exploratory data analysis was done using Minitab. Techniques used to tease out the underlying structure of the data include taxonomy, measures of central tendency and measures of dispersion. The advantage of using exploratory data analysis is that it allows the research to organize data without making assumptions about the data and reveals the underlying structure of the data (Tukey 1997). Data are then aggregated into tables which allow for comparison and contrasting the data.

1.4.3: Ethnographic Approach

Ethnography has long been a method for anthropologic research and has been used in the study of migration since it contributes to further understanding the phenomenon. As argued by
McHugh (2000), an insufficient amount of attention has been paid to, “migration as cultural events rich in meaning for individuals, families, social groups, communities and nations.” The study of migration in geography has tended to focus on approaches to migration that foster explanatory themes and material production through looking at demographics and has shied away from culturalist forms of meaning. Furthermore, as noted by Findlay and Graham (1991) there has been reluctance on the part of population geographers to veer away from the safe path of spatial demography. A deeper understanding of the subtleties that pertain to the migration experience can only be investigated through the use of ethnography as it is able to capture varying tempos and rhythms of movement and connection (McHugh 2000). Ethnography also illuminates the experiences of subjects within sociocultural contexts in search of meaning through interpretive science rather than law through experimental science (Geertz 1973).

The basis for the ethnographic approach to this study is to get to the underlying intricacies that account for the migration experience of nurses from Zimbabwe. In this effort the aim is to allow the nurses themselves to share their migration experience; it is an effort to understand the nuts and bolts of migration through those actively involved in the process. As a result, migration is then not seen through the lens of current theory but creates a window through which new ideas with regard to migration can be learned. The ethnographic methods employed are semi-structured interviews, and participant observation.

According to Benard and Russle (2006), semi-structured interviews are effective when a researcher will only have one opportunity to interview a respondent. The semi-structured interview technique allows for the freewheeling quality of the unstructured interview yet it is somewhat structured as there are certain themes that have to be covered in a chronological order. It can be a very effective technique as it ensures that the required areas of research are covered yet at the same time, there is the flexibility that allows for new leads to be followed.

In undertaking research for this project, the semi-structured interviews were effective as many times there is only one opportunity to meet with the interviewee. Fifteen individuals participated in the semi-structured interviews, twelve in the UK and three in Zimbabwe. These twelve like the participants in the surveys were recruited through snowballing. Both the rigidity
and flexibility of semi-structured interviews are effective as there were some essential issues that had to be addressed in the research, yet there was need for flexibility in going in other directions to get a better comprehension of what is transpiring in the migration process. In so doing certain parts of the interviews were led by the study participants allowing them time to share their stories.

Data acquired from the semi-structured interviews were transcribed and subjected to content analysis. As defined by Ole Holsti (1969) content analysis is, "any technique for making inferences by objectively and systematically identifying specified characteristics of messages". The use of this method allows the researcher to identify the properties of the data (Neuendorf 2005). The categorizations that result provide a meaningful reading of the content being examined.

Participant observation, though also traditionally a technique used in anthropological studies, has now been used as a research technique across fields in the social sciences. Central to the notion of participant observation has been the aim on the part of the researcher to immerse themselves into the culture, society or sub-culture of the group they are studying in order to obtain a great familiarity with their way of life (Johnson, Weatherford, Avenarius 2006). The use of participant observation in this project was very limited. In a few instances the researcher impersonated a potential nursing student and went to a number of intake secessions to determine the entry requirements for nursing school and to gain access to management at the training institutions who had not been so willing to grant interviews. Other activities in which participant observation was used included social gatherings and church functions of Zimbabwean groups.

1.5: Data Collection

Participants in this research project were taken from both the UK and Zimbabwe. The researcher spent 10 weeks in the UK during the summer of 2007. Most of the 10 weeks were spent in London, where a majority the UK research participants live. A total of 36 people participated in the UK through filling surveys and sitting down for interviews. Of the 36, 12 participated in semi-structured interviews. The 12 candidates were selected to fill each of the following groups.
• Nurses trained in Zimbabwe
• Nurses recruited from Zimbabwe
• Nurses trained in the UK
• male and female nurses
• Young and middle aged nurses

The UK participants in the study comprise both immigrants who were and were not nurses prior to their emigration from Zimbabwe. This point is emphasized as the experience of being a Zimbabwean nurse in the UK can vastly differ between these two groups. Throughout the thesis, these differences will be highlighted where appropriate in order to show differences in experiences and differences in the interpretation of similar practices/events.

In addition to the time spent in the UK, the researcher spent an additional three weeks in Zimbabwe where three nurses participated in semi-structured interviews. All three nurses who participated were employed at private hospitals. Numerous attempts were made to interview nurses working at government hospitals, however, these attempts were fruitless. The nurses working at government hospitals were very reluctant to participate, often saying they were not allowed to speak to researchers without permission. Attempts were also made to speak with government hospital administrators, however, these attempts were also fruitless. There is a general resistance to speaking with researchers among government employees. Had more time been available in Zimbabwe, the researcher believes access to government nurses and administrators could have been achieved. Nonetheless, the perspective on the government nurses is acquired from the private nurses because of their prior experience working in government hospitals.

1.6: Organization of the thesis

This thesis is organized into six chapters. Chapter 2 is a literature review which examines literature on brain drain migration, the globalized medical industry and migration theory. Chapter 2 also functions to highlight aspects of the literature that are not adequately addressed. Lastly addressed in this chapter are research questions. Chapters 3 through 5 are devoted individually to answering research questions posed for this thesis. Chapter 3 titled, Trajectory of Zimbabwean Emigrants to UK, addresses conditions present in Zimbabwe that are
responsible for emigration out of Zimbabwe. The chapter highlights the negative place-attributes in the Zimbabwean nursing industry and the society at large that have forced nurses and non-nurses to emigrate out of Zimbabwe in an effort to take better care of their families and provide for themselves.

Chapter 4 titled, Experiences in the UK vs. place differences in the UK, addresses place attributes in the UK that have attracted nurses to the UK NHS and allowed non-nurse migrants to become nurses in the UK. This chapter also documents the work experience of Zimbabwean nurses in the NHS. Chapter 5 titled, Transnational Activities: Maintaining connections in Zimbabwe, addresses transnational links between the UK and Zimbabwe via the nurse migrants and the resulting effects. This chapter also addresses the propensity for return migration and what it could potentially mean for Zimbabwe. The final chapter is a concluding chapter that looks at the future of Zimbabwean nurses participation in the NHS in light of the variety of changes that have been enforced in the NHS. The original place attributes that made the UK an attractive immigration country for nurses have since seen some changes. Changes discussed in this chapter took place both prior to and subsequently after data were collected in the summer of 2007. The cumulative effects of these changes have almost entirely closed the door to new Zimbabweans participating in the NHS as nurses.
Chapter 2

Literature Review on Brain Drain Migration and the Health Sector

2.1: Introduction

The literature on brain drain migration shows that there are contentious issues surrounding the phenomenon. Central to this concept is the movement of skilled and educated individuals from one nation to another, as a reaction to varying geographies of opportunity between the source and destination country (Saravia and Miranda 2004). Put another way, “Brain drain is the systematic, large-scale emigration of a country’s trained scientists and professionals, sometimes referred to as “Professional, Technical and Kindred” workers” (Logan 1999). Important to consider is the opportunity cost of lost talent, which is absent in the economic growth and productivity of the source country (Patterson 2007). Migration and its changing patterns are a function of geography and opportunity (Arango 2000), hence as the geography of opportunities change so do migration patterns. Much of the concern regarding brain drain migration has to do with the movement of skilled professionals from the global periphery to the global core as peripheral countries are loosing their human and knowledge capital acquired at great expense.

Though much attention is paid to the migration of individuals from the periphery to the core, emigration of highly skilled workers also takes place among countries of the core as well. Movement of skilled individuals takes place from the Canada to the United States and from Poland to the UK for example (Dale 2005). Shortages found in core countries that lose part of their labor force results in opportunities for people from countries of the global periphery. This phenomenon has led some researchers to call this brain drain circulation (Saravia and Miranda 2004). The problem with this label is that the migration does not come back full circle to the global periphery in a manner that is stable enough to facilitate development. In many cases, countries of the periphery receive skilled professionals in the form of aid from NGO’s who come under the label of technical assistance. By no means is a situation created where countries can build on this to eventually become self-sufficient (Chikanda 2008).
As there is no consensus on how migration is viewed by researchers, these disagreements are also seen in the study of brain drain migration where some argue that this form of migration results in a brain-gain— a net increase in human capital dependent on return migration — or brain-circulation (Hewitt 2007). Another use of the term brain-circulation as used by Hewitt (2007) refers to, “a framework for modeling the best practices of transnational communities promoting development in semi-periphery and periphery countries” (Hewitt 2007, 15).

Depending on the perspective taken and the examples cited, all three views of the brain-drain can be correct –that being brain-drain, brain-gain, or brain-circulation. Through the lens of the globalized health labor market, main topics of the literature on brain-drain migration will be addressed initially looking at a), the theoretical basis for the concept, b), the multiple views it has and c), major conceptual themes that have emerged in the literature.

Given that Zimbabwe can not expect gains in human capital in the nursing industry considering the reduced opportunities for nurses in the UK, the aim of this literature review chapter is to address the main concepts that are present within the study of brain-drain migration. The first section addresses the theoretical concepts of migration. Here a trajectory of migration theory will be discussed showing how the study of migration has transitioned through different theoretical perspectives. Within this discussion, the theoretical basis for the study of brain-drain migration will be highlighted. This will contextualize brain-drain migration within the wider context of migration theory. Second, the effects that migration has, both positive and negative on the source country will be addressed. Concepts discussed in the section include brain drain/gain, brain circulation, and remittances. Third, a discussion of the effects of brain-drain migration within the medical sector and particularly nursing will be addressed. Here the major facets of the globalized medical industry will be looked at from both the perspective of the global core and periphery. Major disparities exist between these two global hierarchies and the devastating effects this migration is having on the already desperate countries of the global periphery are highlighted.

The fourth section will address means by which the effects of the brain-drain phenomenon can be diminished. Mitigation strategies addressed here focus on actions that can be taken by countries of both the global core and global periphery. Fifth, will be a section
looking at areas regarding the brain-drain that are not present or adequately addressed in the literature. Lastly there will be a section on research questions and the theoretical framework they come from.

2.2: Migration Theory

Researchers have developed a variety of approaches to the study of migration in an effort to better understand it. Through time, theoretical perspectives starting from neo-classical explanations of migration and the eventual shift to transnational explanations of the phenomenon are addressed. In discussing these theoretical perspectives, the theoretical basis for the study of brain drain migration is highlighted. In so doing, this process acts to contextualize the study of brain-drain migration with the larger subject of migration. A key missing link in this literature is different geographies that make possible the migration between the source and destination. Fundamentally left out is a geographic perspective.

A foundational contributor to the study of migration was Ernest-George Ravenstein. Ravenstein (1889) explained the driving force of migration was an inherent desire for people to better themselves. The first contributions to the explanation of migration came from economics in the form of neo-classical explanations. Neo-classical economics sees migration as a function of economic opportunity, where people migrate to areas with better economic opportunities eventually dissipating these advantages and evening the economic opportunities landscape. Imbedded in this theorization of migration are push and pull factors which attract and repel people to and from places (Arango 2000). Migrants under this theorization are seen as economic actors looking to maximize their utility, operating with full information and freedom to make choices (Borjas 1989). The decision to migrate is seen as an investment in human capital expected to result in improved welfare in the future if the expected benefits outweigh the costs (Castles and Miller 2003).

Neo-classical explanations of migration were left behind mainly because they did little to explain the reality on the ground. Such realities include why more international migration is not evident given the vast differences in wages and welfare across the globe and why the rates of international migration differ among countries that are structurally similar. These problems stem from neo-classical explanations ignoring non-economic factors of migration like political
dimensions and cultural determinants which have great importance in migration decisions and success. Neo-classical explanations further reduce societies and individuals to homogeneous groups equating migrants with workers, ignoring non-labor migrants (Arango 2000). Neo-classical explanations of migration also assume freedom on the part of the migrants. However, the decision to migrate is not always made freely and, for the economic migrants, their participation in the host countries economy does not allow them complete agency, hence their ability to compete is hampered (Castles and Miller 2003). Examples of this are seen in the limited economic activities immigrants are allowed to engage in while in the US and other countries of the global core.

Though neo-classical explanations were eventually left behind, the cost benefit calculus and importance of economic factors are still important in understanding migration today. This can be seen in the mass exodus of doctors out of countries like Ghana in search of better remuneration (Eastwood 2005). Today the gravitas of economic factors in migration are understood within the context of other non-economic factors of migration which in many cases are of equal or more importance than economic factors. As such, the cost benefit calculus and the importance of economic factors will be utilized in this thesis in association with other non-economic factors.

Following the limitations of neo-classical explanations, world systems theory emphasizing its historical-structural approach became central (Castles and Miller 2003, 25). Major contributors to the historical-structural approach like Portes and Walton (1981) and Saskia Sassen (1988) used dependency theory to inform their perspective. Emphasized in this Marxist political economy approach is the unequal distribution of political power across the globe which sees migration as a tool for the mobilization of cheap labor for the global core. The importance of migration to the core is demonstrated by Castles and Miller’s (2003,25) comment, “Migration was as important as military hegemony and control of world trade and investment in keeping the Third World dependent on the First”. It is within this theoretical framework that the brain-drain finds its relevance. Criticisms that were raised regarding this approach deal with the way in which micro perspectives were not taken into account essentially reducing individuals to pawns caught up in the interplay of big powers and controllers of capital.
Another criticism rendered was that these explanations did not apply to the increasing diversification of migrant flows between countries that did not traditionally have core-periphery relations (Arango 2000).

In response to both the shortcomings of neo-classical orthodoxy and the historical-structural approach the ‘migration-systems theory’ approach was developed. Migration systems theory looks at migration regionally as a system of countries that exchanged migrants with each other (Castles and Miller 2003). Examples of such regional areas include Latin America, the South Pacific and West Africa. The theory also takes into account linkages between places that are not in close proximity like the migration that takes place between the Caribbean and Western Europe and between West Africa and France. Of interest here is studying the migration flows from both ends and linkages between the places (Zlotnik 1992). A premise that supports this theory is that prior linkages between countries that facilitate migration are evident through former colonial ties, trade, investment, cultural ties or political influence (Massey et al, 1993).

The migration systems approach sees migration as a creation of macro and micro structures. Macro-structures relating to institutional factors of the world political economy which include interstate relationships, laws and structures put up by governments to control migration and the settlement of new migrants. Micro-structures in this context relate to networks, practices and beliefs of the migrants (Castles and Miller 2003, 27). Micro-structures are essentially developments made by the migrants in an effort to deal with the struggles of migration and settling in new areas. Cultural capital which is, “knowledge of other countries, capabilities for organizing travel, finding work and adapting to a new environment” (Castles and Miller 2003, 27) is instrumental in fostering and sustaining migration. Within this theoretical framework greater focus is given to the migrant’s perspective allowing greater insight into understanding the migrant’s experience. This is one of the aims of this research study.

Following migration systems theory, transnational theory followed which did not come as a critique of its predecessor but put greater emphasis on human agency as the world shrunk due to globalization. Globalization is instrumental in accelerating brain drain migration. Technologies of globalization like the Internet enable potential emigrants to gain access to vital
information which is instrumental in making the emigration process a success. The ease with which individuals can now gain information regarding potential destinations and maintain and strengthen links with people abroad has had the effect of making emigration a lot easier (Dwyer 1999; Light 2004). Transnational theory has received a lot of attention from the academic community of late. Debate about this theory introduced by Schiller (1992) states that there has been demise in the territorialization of nation states which has major implications on national identity where migrants are able to take advantage of changes to immigration polices which remove barriers of enter. As such the selective immigration polices allow for smooth movement of skilled labor around the globe. Ong has been another contributor to literature in transnationalism who sees flexible citizenship- the cultural logics of capitalist accumulation, travel and displacement that induce subjects to respond fluidly and opportunistically to changing political-economic conditions (Ong 1999, 6) - as a product of the transnationality of migration.

Though globalization has brought about more fluid movements of skilled labor, migration is not accompanied with the freedom associated with neoliberal ideology. Neoliberal policies under globalization have resulted in tailor specific immigration policies designed only to allow certain actors to participate. Actors allowed to participate are selectively determined in order to address the labor/economic/political needs in the destination country. As such, the actors are not allowed complete agency in their participation, as immigration laws puts limits on their activities. Migrants function in a system of structured options which limits their agency. To maximize benefits, migrants strategize, navigating a course through structured options to realize improved welfare in the future.

Like migration systems theory, migration within the transnational theory framework is looked at from a macro and micro level which are transnationism from above and transnationalism from below. Transnationalism from above is essentially activities undertaken by powerful institutional actors like governments and multinational corporations. Governments of destination countries have taken advantage of how easy it is for them to recruit labor from abroad; as a result major reforms have been made in immigration policy in an effort to take advantage of the human capital that lies abroad (Helweg 2004, p4; Lobo, 2007; Yeboah 2008).
Examples of such reforms have been made by the US government with regards to the H1-B visas. This visa is intended to allow qualified professionals abroad to fill positions in the face of constricted supply. Globalization truly may have brought the world closer; however, the free movement of all individuals is yet to be realized. For many of the global periphery immigration to the global core is dependent on their education, wealth and profession. This calls to question arguments made by researchers like Dale (2005) as to the rights of individuals to have the freedom of movement.

Transnationalism from below involves activities of immigrants and their home country that are mainly grassroots initiatives (Castles and Miller 2003, 27). Transnational theory has led researchers to look at migration from a different stand point, particularly the dynamics created in the immigrant country. These dynamics involve issues like the diasporas of theses migrants in foreign countries. It is by looking at these diasporic communities researchers like Hewitt (2007) evoke the notion of brain circulation. Other areas of interest include ethnic settlement patterns and the creation of ethnic minorities. Further interest has been found in race dynamics that come up due to the establishment of these ethnic communities which in some cases results in racism and in others an acceptance and hence the morphing of racial identity (Tsuda 1999).

As migration theory goes through its transitions, there is greater attention being paid to the nature by which migrants are able to fluidly negotiate and maintain ties between source and destination locations in pursuit of their goals, which are resulting in changes in both source and destination countries. Seemingly missing in the current view of migration is a geographical perspective that stresses the nexus of local and global places. Taking a geographical perspective in this regard entails looking at both the source and destination as geographic locations with sets of particular attributes that are responsible for making migration possible (Yeboah 2008). The geographical perspective also looks at how the activities migrants engage in -transnational in nature- have the respective effect of changing both the source and destination creating different landscapes that are a result of migration and the unique sets of geographical or place attributes that foster the migration. The following is a graphic representation of the geographical perspective presented by Yeboah (2008).

Figure 2.1 Graphic of the Geographic Perspective
Within the context of transitions in the literature on brain drain migration and the missing geographical link, this study will take a geographic perspective looking at the place-attributes of Zimbabwe that are causing emigration, the place attributes of the UK that allow for immigration and transnational ties between the two locations resulting in changing landscapes. Regardless of the theoretical perspective taken on migration it is a geographical phenomenon and is captured in the study by posing three separate questions that address source country attributes, destination country attributes and the resulting transnational connections. It is with this framework the next literature review in structured.

2.3: What are the Costs and Benefits of Migration to Source Areas?

Similarly, as the study of migration adopts different theoretical perspectives, so too does the concept of brain-drain migration, changing with the broader shifts in the discipline. It is important to note here that there is no consensus among all who subscribe to the concept of brain-drain migration as to what stage or theoretical perspective the concept lies. The greatest determinants regarding the various perspectives argued on the matter have to do with context in which the phenomenon is investigated. Perspectives typically cited regarding brain drain migration and its results include brain drain, brain gain and brain circulation. The following sections address all three perspectives providing definitions and showing their differences and resulting effects.

2.3.1: Brain-drain
Born out of the historical-structural approach of world systems theory, researchers found a theoretical basis to explain the occurrence of brain-drain migration. In their view, migration under this framework is the function of unequal power centers across the globe. Migration in this context served as a tool of domination of the periphery by the core as no opportunity is created for the source country to develop a critical mass of human capital to sustain development (Patterson 2007). This conceptualization of brain-drain migration is closely tied to dependency theory. In such scenarios the source country is ever reliant on others as they do not have a critical mass of human capital to be self-sufficient. The global periphery’s reliance on the global core for major innovation of technologies is an example of this dependency. Under the premise that the growth of human capital is vital to the development of the semi-periphery and periphery (Abrokwaa 2000), brain drain is a major hurdle to attainment of a critical mass of human capital and the eventual development of these regions.

2.3.2: Brain-Gain & Brain Circulation

As migration theory shifted towards the idea of migration systems theory, changes in the view of brain-drain migration shifted as well. The major ideas that migration systems theory brought was a look at migration from both ends- the source and the destination- and a look at both the macro and micro level. By looking at migration from both ends, researchers began to look into the ways in which the source countries were being affected by the migrants who were abroad. This was facilitated by taking into account the migrant activities (micro level). Within this context researchers were able to see evidence of source countries benefiting from the migration of its human capital. Proponents to this view believed that such migration could result in a brain-gain – an improvement or development of talent for the source country after return migration. It has been argued by some that this form of migration was a necessary step toward development (Arango 2000).

A brain gain is one of the ways by which source countries of migration benefit from the emigration of their skilled professionals when they return in the future. The Chinese government is currently very active in trying to reverse their brain drain. Through strengthening science, technology and academic research they are trying to encourage Chinese professionals in these industries to return. This approach includes offering Chinese immigrants a globally
competitive environment to undertake their professions in China (Zweig 2006). It is hoped this policy will transfer skills and technology learned abroad back to China (Zweig 2006). The growth of the IT industry in India is largely a result of a brain gain. American educated engineers are instrumental in the transfer of development opportunities to India by transferring technical and institutional know-how and taking advantage of lower price transaction costs (Saxenian 2005). The pace of this transfer of technology has happen much faster and more efficiently than through Multinational Corporations (Saxenian 2005). The great success of countries like Taiwan and South Korea are also largely a function of a return migration, as many of their natives who have acquired professional training abroad, return to practice in their native countries (Zweig 2006).

Fundamental to brain gain is the creation of opportunity that is globally competitive (Saravia and Miranda 2006). The return migration of foreign born academics, scientists and engineers from the global core to their native countries has been made possible due to the commitment on the part of their respective governments to foster a conducive environment for the development of science and technology. Therefore, if countries are unable, or do not have the initiative, to foster such circumstances, a brain gain is rather unlikely. Specifically for the health sector, there is little room to expect a brain gain as there is little that will attract professionals back to their native countries (Clark, Stewart, Clark 2006; Chikanda 2008). A more realistic means by which a brain gain may be realized is through the return of natives when they retire and seek to return to their home countries. Such a situation may present the possibility for a transfer of knowledge and technology, however, these returnees are returning after their prime and do not have as much to give to their countries.

The shift of migration theory towards transnational theory essentially was a function of the greater connectivity of the globe through globalization with greater emphasis being put on human agency (Castles and Miller 2003; Arango 2000). In the same way that transnational theory is not a critique of migration systems theory but an extension of it, so too the concept of brain-gain lead into the concept of brain-circulation. Fundamental to the concept of brain-circulation (not as suggested by Saravia and Miranda 2006) is the view that development is enabled without action by the west, but by the activities of the diasporic communities in the
west working in coordination with the source country (Hewitt 2007). This latest installment to the concept of the migration is taken from examples in East and South Asia. Diasporic communities generate human capital abroad, accrue economic capital through it, sustain social capital to allow continual access to both –the human and economic capital created- and then enable this set of acquired capitals to flow into the homeland (Patterson 2007). The homeland’s role in this equation is to create an enabling environment for this transfer to take place (Patterson 2007).

Central to the views of both brain-gain and brain-circulation is the belief that the loss in human capital through migration results in a net gain. The two ways that benefits accrue are through remittances and a brain gain, if immigrants are to return to their source country (Hugo 2006). The possibility for return immigration is largely dependent on the conditions that are found in source countries. Of emphasis here is the need for push factors to be dissipated, for as long as they exist, emigrants will not likely return to their native countries if they were pushed out. The strategies that have been taken by the Chinese government exhibit a need to address push factors in order to encourage return immigration (Zweig 2006). These two are looked at in greater detail below.

**2.3.3: Remittances**

Remittances over the last few decades have become a major source of income for nations of the global periphery (Akokpari 2006). Morocco alone got US$3.3 billion in remittances for 2001 (de Hass 2006). Remittances are an instrumental tool in addressing poverty as the money goes directly into the hands of the users (Sander and Maimbo 2005). Furthermore, the use of these remittances on consumer goods results in multiplier effects for the society at large (Hugo 2006). Though huge inflows of money enter countries, it does not get into the hands of government that can direct the money towards productive investment. Remittances therefore help alleviate poverty rather than generate directly toward growth and change (Sander and Maimbo 2005). The use of remittances for consumption negatively affects the balance of payments for receiving countries and this is not desirable (Hugo 2006).

However, Morocco is an example where emigration and the resultant remittances have led to economic development, improved standards of living and enabled the emancipation of
subaltern ethnic groups (de Hass 2006). Moroccan remittances are invested largely in rural areas in the form of irrigation schemes and housing. Morocco shows that if directed towards productive activities, remittances can greatly contribute to economic development (de Hass 2006). The Mexican government has initiated an effort to redirect remittances away from consumer spending into cooperative banks as a means of saving and borrowing money for average Mexicans. Such initiatives include remittance bonds and federal matching funds (Saravia and Miranda 2006).

It is important to note that though remittances are a result of migration they are a secondary result. When the literature explores the concept of brain drain migration, remittances are often discussed is the cost benefit calculus to determine whether the loss of human capital and the benefit of remittances shows a net loss. Fundamentally the questions are quite different; remittances are a secondary benefit of migration and should be discussed as such. The act of trying to compare the loss of human capital to the inflow of remittances is comparing apples and oranges. As such, remittances should not be included in a cost benefit calculus of brain drain migration. The loss of doctors from a country’s health delivery system can in no way be to equated as a net gain regardless of the amount of remittances they send to their home country unless the doctors are expendable and therefore not a brain drain.

Looking through the literature on brain-drain migration none of the three perspectives dominates. The lack of a convergence towards one perspective on the subject is a reflection of how complex the issues are and how diverse the contexts of the studies are. Nonetheless, the health sector provides an industry where migration cannot be characterized as anything but a brain drain (Patterson 2007), particularly for the global periphery and semi-periphery. This study will address the question whether Zimbabwe’s experience fit one or all three perspectives.

2.4: Global Health Labor Shortage

The health sector is one that is significantly affected by globalization as healthcare workers are able to fluidly migrate across different regions of the globe. Globalization brings with it easy flow of information through technologies like the Internet and the ease of international travel through global airlines (Dwyer 1999; Light 2004). In addition, countries
across the globe tailor their immigration policies in an effort to selectively admit labor into sectors experiencing short supply (Yeboah 2008). Examples of this can be seen in the US with the introduction of the H1-B visa and in the UK with the Shortage occupation list which are both used to admit immigrants with skills in high demand. Universally, there is a high demand for healthcare workers; as a result, countries across the globe with healthcare manpower shortages look beyond their boarders to fill these vacancies. Ultimately, a global health care market has been created where countries across the globe recruit, poach or scramble their way to healthcare provision using manpower from various origins (Clark, Stewart, Clark 2006).

It is clear that there is a heavy gravitation towards issues of the globalized health labor market in the literature on migration (Clark, Stewart, Clark 2006; Ahmad 2004; Dale 2005; El-Khawas 2004). The reason so much attention is paid to the medical field is in the face of global shortages, the global core is filling vacant health care positions with labor from the already poorly staffed healthcare systems of the global periphery. This results in peripheral countries experiencing worse shortages as they already have skeleton workforces. Africa alone has a shortage of 720,000 physicians (Clark, Stewart, and Clark 2006). Further compounding this is a shortage of nurses since collectively sub-Saharan Africa has a shortage of 600,000 nurses (Clark, Stewart, and Clark 2006). In Malawi only 28% of nurse positions are filled and South Africa has a shortage of 32,000 nurses (Clark, Stewart, and Clark 2006). Other global peripheral regions are also affected. The Philippines in 2004 had 30,000 nurse vacancies, and in 2004 the Caribbean had 35% of nurse positions vacant (Clark, Stewart, Clark 2006). The recruitment of health care workers from the global periphery further compounds this shortage creating a devastating crisis. The overall problem is that there is a global health labor shortage and given the globalized neo-liberal- free trade and movement of- operations of the world, the labor pool has hence become global and individuals seek to get the greatest return for their labor (Pond 2006). There is therefore a manifestation of geographical and opportunity differences between places around the globe.

For countries of the global core, shortages essentially come and go in small spurts, however, due to demographic and social changes that result in increases of the retired population (baby boomers) shortages have accelerated and are expected to get worse with
time. The proportion of the United States population over the age of 65 is expected to grow from 13% in 2010 to 20% in 2030 (Clark, Stewart, and Clark 2006). The United States is expected to experience a shortage of 275,000 Registered Nurses (RN) by 2010 and 800,000 by 2020 (Clark, Stewart, and Clark 2006). Other factors that have accounted for this shortage in nurses has been a decrease in the number of people entering the medical field as women who traditionally trained as nurses now have other career options (Batata 2004). Furthermore, as fewer nurses enter the field the average age of nurses is increasing, making the industry more vulnerable as older nurses retire. There also exists low job satisfaction due to long hours, stress and burnout resulting in some nurses leaving the profession in core countries (Batata 2004; Clark, Stewart, Clark 2006).

The root cause of shortages found in the global periphery comes from a lack of resources. Peripheral countries are unable to train enough people to fill needed positions. Compounding this, they do not have sufficient facilities to train medical staff and they do not have enough personal to do the training (Clark, Stewart, Clark 2006). Work satisfaction for medical professionals in the global periphery is extremely low due to low wages, and extremely poor and dangerous work conditions (Chikanda 2006; Feeley 2006). Health workers often fear exposure to viruses like HIV due to a lack of equipment as basic as rubber gloves. Other causes for dissatisfaction include a lack of medicine, unsanitary conditions and huge nurse to patient ratios (Clark, Stewart, Clark 2006; Chikanda 2006; Feeley 2006). As a result, nurses from the global periphery emigrate in search of better remuneration and working conditions.

Given the crisis brain drain migration has created in the health sector, one would be hard pressed to see a positive aspect to the exodus of medical professionals out of the global periphery. There has been lament on the part of health administrators regarding the loss of medical staff in Sub-Saharan Africa due to their high training standards and costs (Levy 2003). Emigration of each doctor from the African continent represents a loss of US$184,000 (Eastwood 2005) since the training of health care workers is highly subsidized. This alone adds up to not just millions of dollars lost that remittances cannot make up for, but also time, expertise, and mentors (Eastwood 2005). A study of Nigerian medical professionals trained 10 ten years ago shows that 40% of them do not practice in Nigeria (Ihekweazu, Anya and Anosike
2005). It is currently estimated that 70% of all physicians trained in Zimbabwe during the 1990’s left the country (Saravia and Miranda 2004). In Ghana, 60% of its physicians trained in the 1980’s left the country (Saravia and Miranda 2004). Regarding the question as to whether brain drain emigration can result in a net benefit it should be noted that the benefits of migration are context specific (de Hass 2005) and the health sector is not one where there is a net gain.

2.5: Mitigation of brain drain migration: Landscapes of the source and destination

Under the premise that brain-drain results in a net loss, a number of strategies have been suggested to address the problem. At the heart of finding solutions to these problems is addressing the conditions that cause individuals to emigrate in the first place. There should be an effort to create an environment which would make those who have gone abroad return. The section below considers the strategies that have been proposed for both the source and destination countries involved in the brain drain of healthcare workers.

2.5.1: Source Countries Strategies

For the source countries such strategies involve increasing salaries, creating better work conditions, providing opportunities for further education and the provision of necessary equipment and facilities (Zweig 2006; Chikanda 2006). In the case of China, potential returnees expressed a desire to see improvements in democratic freedoms and increased funding for science and technology (Zweig 2006). The desire to see more political freedoms as well were given as reasons by Zimbabwean professors to stop them from emigrating. This goes to show that the wider landscape and attributes of the society have great bearing on the issue of return immigration as well as the decision to emigrate (Logan 1999). Some African counties like Nigeria have tried to give incentives to their health professionals in an effort to keep them from emigrating. However, it is difficult for them to compete with incentives given by the global core (Johnson 2005).

Central to encouraging return migration is the creation of opportunity “in research and development based on national priorities and niches of opportunity” (Saravia and Miranda 2006 pg 613)
1. Implementation of educational strategies that support both targeted national programs and training abroad. 2. Investments in infrastructure for research and development and creating conditions that foster the growth of public sector and private sector demand for research results, technological development and innovation. 3. Build an enlightened leadership and an enabling national scientific community that advocates internally and externally for the coherent development of scientific and technological capacity.

Studies show that when individuals migrate to the global core to acquire higher education it is unlikely that they will return to their native countries to practice their skills. Sixty-six percent of foreign born scientists and engineers in the United States earned their doctorates there (Saravia and Miranda 2006). Furthermore, fifty percent of foreign born graduates in France, the UK and the United States remain in these countries after completing their studies (Saravia and Miranda 2006).

**2.5.2: Destination Countries Strategies**

Efforts to address the brain drain problem on the destination side include ethical recruitment practices, provision of temporary visas to allow for training which can then be disseminated in source countries, the training of local health personal to allow destination countries to be self-sufficient, and creation of incentives to encourage locals to enter into the health profession (Ahmad 2004). Destination countries have difficulties controlling the levels of their medical professionals as influences from outside their countries have effects of the labor situation in their country (Dale 2005). Canada in recent years has seen an out migration of physicians to the US attracted by lower government controls, higher income, lower taxes and a lower cost of living (McKendry et al, 1996). Some nations of the global core have codes of ethics regarding recruitment and there are efforts by the Commonwealth to aid in helping find solutions to these problems through the creation of protocols (Morgan 2005).

Important questions have emerged regarding people’s personal right to the freedom of movement (Dale 2005). Some core country governments are placed in a difficult position as they pledge not to recruit medical professionals from certain countries, however, nationals of those countries come knocking on their doors. Should they not be allowed entry based on the pledge made not to recruit from that country? Given the neo-liberal ideology that dominates
this globalized world, restricting people’s movement appears to be a contradiction. Should the
dream of working in the global core be denied to only medical professionals, what about other
professions? Even China with its authoritarian government has not stopped the movement of
its people. Others suggest that nations of the global periphery should train their professionals
to a level lower than is accepted by the global core (Levy 2006). There is no easy solution to the
brain drain problem. It is likely that brain drain migration will continue as long as there are
unfavorable conditions in the global periphery and ever greener pastures in the global core.

2.6: Missing Links

Three missing links exist in the literature on global brain drain. First is the core’s polemic
role as facilitator and raider of human capital, second is an absence of the immigration
experience of actual immigrants beyond aggregate statistics and third is the absence of a
geographical perspective in brain drain migration.

2.6.1: The Core’s Polemic role as facilitator of development and raider of
human capital

Though the study of brain drain migration has been existent for a while there are areas
on the matter that have received little or no attention. Very little has been said about the
Paradox of the global core’s dual role as facilitator of development in the periphery yet at the
same time raider of human capital from the periphery. Present within the literature is a
mention of how the Millennium Development Goals (MDG’s) regarding health cannot be
reached if the status quo continues unhindered, especially for Africa. Beyond the MDG’s there
is an absence regarding this issue. A lack of intellectual and knowledge capital is one of the
reasons why poverty and underdevelopment are said to be present in the global periphery. The
continual migration of the peripheral regions intellectual talent nullifies the efforts on the part
of the global core to foster development.

2.6.2: The Migration Experience; who are the migrants?

With specific regard to the medical sector, much has been said about the numbers of
professionals who migrate (Clark, Stewart, Clark 2006; Ahmad 2004; Eastwood 2005; Johnson
2005), however, very little is known about what happens after they arrive. Furthermore, not
much is known about the migrants themselves. The nature of much of the literature regarding
brain drain migration of medical professionals has been of a quantitative form omitting the personal experience of the migrants reducing the ability to better understand their migrant experience and therefore brain drain migration.

An assumption by researchers and policy makers that has been taken for granted in looking at the brain drain issue has been that individuals trained in the periphery should perform their skills within the countries they have been trained. It is taken as a matter of fact that the doctors trained in Malawi should remain there and serve their country. This assumption explains why researchers refer to the core countries that recruit from the periphery as “global raiders” (Crush 2005) or that they are stealing the work force of the periphery. Given the lucrative salaries available in professions like nursing abroad, natives of the global periphery are likely to enter into these fields with the intent of working aboard. Through looking at the experience of migrants at the micro-level it is intended that this study will address such concerns that have been left out.

2.6.3: A Missing Geographic Perspective

Missing in much of the literature of the brain drain phenomenon with regards to the medical field is a geographic perspective. Essentially missing here are the unique characteristics that are present within the countries of the global core and periphery that affect the migrants decision to move. The decision to migrate is ever made in the context of the characteristics that make up that place as a unique location, within the parameters of the global environment. Such characteristics include, but are not limited to, the political climate, economic climate, religious climate, opportunities for self improvement and promotion, and the quality of life. The decision to emigrate as it relates to both the source and the destination involves a cost benefit analysis of what is intended to the gained my moving to the new location. Therefore the characteristics that makeup the destination location as well should be looked at to acquire an appreciation of what place attributes are relevant to the decision to emigrate.

Related to this are the connections that are maintained between source and destination countries through the migrants. Migrants through the maintenance of transnational ties greatly have an effect on the geographical landscape between both source and destination countries. The maintenance of family ties across borders has the effect of creating networks that allow for
the migration of other family members or natives from the source (Hermanu 2006). This has the effect of reducing the distance between the source and destination countries as knowledge about the destination reaches the source from people whom they identify with. Transnational ties can also be expressed through remittances which can influence the economic opportunities for those in the source countries. Immigration to destination places also has the effect of changing the cultural, political and social attributes of the destination. Examples of these changes can be seen in places like London and New York which have been influence by Indians and Puerto Ricans respectively. With time, conditions found in both source and destination countries change as will the nature of the connections, thus resulting in new dynamics and complexities concerning migration (Kandel and Massey 2002). For example, as the Hispanic population has grown in Southern California it has made the place more socially and culturally welcoming for Hispanics resulting in larger waves of migration going there vs. Montana. Fundamentally being addressed here is a need to look at places, the conditions that comprise them and the relations between the places and how they change over time.

This thesis seeks to contribute by bringing greater awareness to the makeup of the Zimbabwean nurses in the UK. By incorporating a micro scale to the research approach, contributions are made in noting the manner in which the migrants negotiate the challenges of being migrants and adapting into the UK health industry. However like many other researchers have done this project will bring to light the dangerous crisis being created by the global movement of human capital.

2.7: Conceptual Framework and Research Questions

As noted earlier, theorists of migration concur that this is a period of transnational theory where the territorialism of nation states is diminished allowing migrants to respond fluidly to political, economic and social conditions globally by negotiating citizenship/immigration status (Schiller 1992; Ong 1996). It is within this time of transnational theory that nurse migration is highly active. The relevant theoretical issues raised in this literature review tie together forming a theoretical framework to conceptualize the different factors that are responsible for emigration of Zimbabweans joining the NHS. Out of this theoretical framework research question are posed to address the problem of brain drain
migration in the nursing industry. Figure 2.2 is a graphic representation of this theoretical framework.

Figure 2.2: Conceptual framework for the immigration of Zimbabwean nurses to the UK.

Conceptual Framework for the Immigration of Zimbabwean Nurses to the UK

Noted earlier, the shortage of nurses is global in nature. Between the global core and global periphery these shortages have great variance. Contextualized within the era of globalization, the labor market for nurses has become global. Globalization which allows for greater interconnection around the globe results in the fluid movement of goods, information, capital and individuals (Dwyer 1999; Light 2004). This free flowing neoliberal approach has been accompanied with immigration policies that selectively allow labor to move where needed within structured parameters. Globalization facilitates the migration of nurses globally allowing the actors to connect, acquire information about the respective places and eventually travel to these places.
Differences exist between nursing industries of the global periphery and global core. Nursing industries of the global core are characterized by higher wages, better work conditions, and greater opportunities for further training relative to those of the global periphery. These differences between the core and periphery result in an opportunity gradient for nurses of the global periphery to take advantage of. Hence, there is global movement of nurses largely from the global periphery to the global core.

Migration of nurses on a global scale brings with it costs and benefits. For source countries, emigration of these nurses results in a brain drain that further erodes the health delivery system. Benefits that can accrue through this emigration include a brain gain, brain circulation and secondarily benefits from remittances. In light of this cost benefit reality, countries involved introduce mitigation strategies or policies to reduce or eradicate the costs of this form of skilled labor migration.

Highlighted in this theoretical framework is the manner by which local attributes interact with global forces. This relationship between the local and global factors demonstrates the importance of geography functioning at both the micro and macro scale, as individual Zimbabwean migrants make decisions based on local factors functioning within systems of the global health labor market. The migration in question is a result of a particular set of factors that are location specific, set within the context of global parameters. In light of these theoretical concepts, the following research questions are posed.

1. What are the place attributes of the source country, 2. What are the source attributes of the destination country, and 3. What are the perceptions of place and the resulting transnational attributes. The research questions and their relevant sub-questions are presented below.

1. What are the place attributes of the source country
   - Who migrates?
   - Why they migrate?
   - How they migrate?
   - Does this migration constitute a brain drain?

2. What are the place attributes of the destination countries
- Where in the UK do they settle?
- How and why they fit into the UK?
- What part of the UK nurse industry to they make up?

3 What are the transnational connections that exist between the two places.
- What are the transnational connections to Zimbabwe?
- What are their projected plans for the future?
- What effects the migration of nurses has had on the respective countries?

Question one seeks to look at the current conditions in Zimbabwe that have made the migrants seek greener pastures. The theoretical grounding for this question comes from concepts of opportunity gradients, the nature of the globalized health industry, the brain drain/gain debate and the issues concerning ethical recruitment of nurses. In asking the question who migrates the point is to get a clear understanding of who is making up this migration from both a demographic and human capital perspective. The incorporation of the human capital perspective is drawn from the concept of the brain drain/gain debate and will act to shed light on whether this migration constitutes a brain drain. The question how they migrate seeks understand how Zimbabwean nurses get to the UK and incorporates the concept of ethical recruitment.

Question two similarly garners up the same concepts of opportunity gradients, the globalized health industry and the brain drain/gain debate, however, is also brings in another concept of cultural capital. The concept of cultural capital features both in the questions where in the UK they settle and why they fit into the UK. The presence of cultural capital has been very instrumental as a means of integration into the UK determining where they settle and is a means by which the migrants are better able to fit into the UK. This presence of cultural capital has been instrumental in sustaining the migration between the two countries. The concept of the globalized health market is evoked through exploring how and why it is that Zimbabweans along with nurses from other countries fit into the UK health industry.

Question three deals with concepts of transnationalism as these migrates engage in transnational activities that help to maintain links with their home land and provide tangible
benefits from the source county. The concepts used in this section include the brain drain/gain debate, flexible citizenship and cultural capital. The brain drain/gain concept in addressed in this section through looking at how their transnational activates translate into benefits or non-benefits for Zimbabwe. This is in an effort to address the question, what effects the migration has on both countries. The concept of flexible citizenship applies to questions relating to the migrants future plans and where they are laying roots in an aim to negotiate their citizenship in a way that allows them to take advent age of opportunities that lie in both countries. Cultural capital here is important as it relates to how information is disseminated between both countries essentially making the transnational activities possible.

The above questions are an effort to take into account a geographical perspective in undertaking this research. Framing this study of migration on the basis of a geographical perspective will have the effect of allowing researchers to acquire a better understanding of migration in the context of the attributes created in the respective countries involved and how they affect migration.
Chapter 3
Trajectory of Zimbabwean Emigrants to UK: Place Attributes of Zimbabwe

3.1: Introduction
Zimbabwe like many countries in Sub-Saharan Africa has been adversely affected by the mass exodus of nurses from the medical field. This exodus out of the country has been existent for a while, however since the mid 1990’s this movement of nurses out of Zimbabwe has drastically accelerated (Chikanda 2006). The emigration of nurses out of Zimbabwe has been a response to the drastically deteriorating conditions in the medical field and broader conditions that are present in Zimbabwe. The broader conditions in Zimbabwe which provide the context for the Zimbabwe nursing industry have also resulted in the emigration of individuals across a variety of sectors/industries in Zimbabwe (McGregor 2007). The pathetic economic conditions and the largely uncertain political climate have made life in Zimbabwe very difficult and gives residents no hope for the future (Laakso 2002; McGregor 2007; Raftopoulos 2003).

Opportunities for Zimbabwean nurses in the UK are not as lucrative and in light of this Zimbabwe is in no way positioned to benefit because of the adversely negative place attributes it possesses as a location which push emigrants out. The emigration of Zimbabwean nurses clearly constitutes a brain drain as will be latter demonstrated.

Within the context of the globalized health industry, Zimbabwean nurses in the past have been able to use their training as a means to enter the UK and take advantage of what the UK has to offer allowing them access to better paying jobs, better work conditions and opportunities for further training. The aim of this chapter is to answer the first research question; what are the place attributes of Zimbabwe that account for the geographical movement of this population group? Within the framework of a geographical perspective the Zimbabwe side of the phenomenon is addressed to fill in one side of the migration story. To answer this question four sub questions will be addressed, these are who migrates? Why do they migrate? How they migrate and whether this migration constitutes a brain drain? Essentially being addressed here are the conditions in Zimbabwe that are responsible for the existence of the phenomenon. These questions address Zimbabwe’s place specific attributes behind emigration to the UK.
3.2: Who Migrates?

Migrants take various forms as they move between countries. Individuals can migrate as refugees, entrepreneurs, students, professionals or manual workers to name a few. Consideration of who migrates is largely influenced by the reason people migrate. As such, the demographic make up and classifications of migrant groups differ dependent on the type of migration. Migrants are either classified as forced or voluntary migrants. Forced migrants are typically classified as refugees fleeing from persecution or natural disasters. A common theme of international migration is the movement of refugees which typically takes place on a regional basis (Castels and Miller 2003). The opposite side of this coin is migrants who choose to migrate voluntarily. Migrants who move voluntarily have the option of choice by which they conduct a cost benefit calculus to determine whether or not to migrate (Castels and Miller 2003). These voluntary migrants typically migrate as students, entrepreneurs, manual worker or skilled professionals. The central difference between the two groups is agency, where the forced migrants do not have it and voluntary migrants do.

Although men traditionally dominate migration flows (Mansuri 2007), women play more important roles in migration as their role in the practice has changed over time. The importance of women in migration mirrors the changing important roles women occupy in contemporary society. Traditionally women were relegated to low wage, unstable and transient work as migrants (Massey et al. 1998). The importance of women in migration today is a result of the following changes outlines by Massey et al. (1998); increase in female labor work force participation creating careers sought for social status and income; the increase in divorce rates which have changed the role of women’s income from being supplemental to being a primary source; and, the falling birth rate and extension of formal education which have resulted in women spending less time caring for children and better preparing them for participation in the labor force.

Migration today has largely seen scenarios where countries of the global core manage immigration into their countries based on specific labor needs. As such, countries like the US and the UK have tailored immigration policy to selectively recruit or admit immigrants with specific skill sets in short supply (Lobo 2006; Yeboah 2008). This sections discusses the
demographic attributes of the migrants who make up this study. In addition to the
demographic attributes, trends in family and gender migration will also be discussed. Following
this, there is a discussion on how the research participants have dealt with family in the
migration process. Thus, this section addresses the migrant’s trajectory of migration.

Table 3.1 shows that among the 36 participants in the study, the group is predominantly
female. The predominance of women within the group comes as no surprise given that nursing
is traditionally a female-oriented economic activity in the UK and even more so in Zimbabwe.
The heavy occurrence of women in this migration group goes against the tradition view of
migration that it is mostly young males who migrate (Mansuri 2007). Thus, the heavy
occurrence of women is the result of the particular economic activity in question. This point is
brought to light by one of the male participants DW_C0030, “Because surely back home this is a
ladies job, very few men would do this.” Even when men join the nursing field in the UK they all
tend to go into mental health nursing. All male participants in the study were in mental health
nurses and they noted the major difference with general nursing was that their work was more
physically challenging. A study by Buchan et al. (2006) finds that there are more male nurses
among UK trained nurses vs. International nurses. As such, the occurrence of male nurses in the
global periphery is rare.

Table 3.1: Demographic Attributes

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Married</th>
<th>Single</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Married to whom</th>
<th>Zimbabwean in UK</th>
<th>20</th>
<th>Age</th>
<th>20-29</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Zimbabwean in UK</td>
<td>4</td>
<td>30-39</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Zimbabwean in Zimbabwe</td>
<td>1</td>
<td>40-49</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over 50</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>0</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Predominantly the research participants as shown in table 3.1 tended to be middle
aged. The greatest numbers of participants are found in the group of 30-39 yrs. The findings
from this sample tie in well with the findings of Buchan et al. (2006) in their survey of
international nurses in London which found that the international nurses from Sub Saharan Africa tend to be older or middle aged. In Buchan’s findings the age profiles differed greatly by region with nurses from the global semi-periphery and periphery tending to be middle aged (over 40) and nurses from the global core tending to be younger (under 34) (Buchan et al. 2006). Yet in this sample there are a significant number of research participants in the 20-29 age group. This indicates the migration is across all age groups.

An examination of the marital status of the research participants shows that the majority of participants are married. Only nine are single. Given that the research participants can generally be characterized as middle aged it is no surprise that most of them are married. Of the married participants, predominantly most live in the UK with a Zimbabwean spouse. A small number have a non-Zimbabwean spouse living with them in the UK. To a large extent this seems to suggest that this is a migration of established people who are attempting to reestablish their lives in the UK.

A small number of participants have no children. The predominant trend exhibited in the sample is that most research participants have one or two children and there is a spattering of migrants with three or four children. Given that there is only one research participant without their spouse and most have their children with them in the UK, migration in this context is seen to have taken place as a family decision- as hypothesized by Yeboah (2008)-where the family is seeking to start new lives outside the country. This stands in stark contrast to migration patterns where the breadwinner migrates and supports the family through remittances creating a sojourner family (Gonzales 1990).

Table 3.2 provides details of family migration. The trend is that participants initially emigrated from Zimbabwe on their own and were latter joined by their spouse (12 emigrated and were latter joined by their spouse). Three research participants’ spouses moved in advance of them and they then joined them latter. There is one whose spouse is still in Zimbabwe. For those who were separated from their spouse, half of them took less than a year to be reunited with them, the reminder took up to two years. Looking at how children were dealt with in the migration process, the predominant behavior was to leave the children behind initially. Once the parents had established themselves, they latter followed. Among the research participants
14 were reunited with their children and 2 have not. For most participants, it took one to three years to reunite with their children. For three of the research participants it took less than a year and for another three it took between four to seven years.

Table 3.2: Gender and Family Migration

<table>
<thead>
<tr>
<th>If married to a Zimbabwe</th>
<th>Migrated with spouse</th>
<th>5</th>
<th>Yrs taken to reunite With spouse</th>
<th>&lt;1yr</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spouse joined latter</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spouse moved to UK</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Left spouse in Zim</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Met spouse in UK</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children left behind</th>
<th>Yes</th>
<th>16</th>
<th>Reunited with children</th>
<th>Yes</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>16</td>
<td></td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many children have joined you</th>
<th>0</th>
<th>2</th>
<th>Yrs taken to reunite with children</th>
<th>&lt;1yr</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td></td>
<td>1-3yrs</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7</td>
<td></td>
<td>4-7yrs</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many still in Zim</th>
<th>0</th>
<th>11</th>
<th>Children born outside Zim</th>
<th>Yes</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>No</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 3.3 shows the predominant trend with this group of migrants is that they have lived outside Zimbabwe for a period of 5-10 years. For all but one of the migrants their entire time out of Zimbabwe has been spent living in the UK. There is essentially no step-wise migration with this group. The relatively short amount of time they have spent in the UK suggests that they are recent migrants. Since leaving Zimbabwe the predominant trend has been that emigrants tend not to return to Zimbabwe to live. There have only been four cases where emigrants have returned to Zimbabwe to reside on a permanent basis. Nonetheless, these migrants visit Zimbabwe quite often. The majority of them have visited one to six times since they left. Yet, the majority of the research participants have no intentions of moving to another country. There is however, a substantial number who noted they have intentions of moving to another country (nine). Two participants were not sure if they would want to move to another country.

Though these migrants have been out of the country for a relatively short time period, their desire is to stay in the UK on a more permanent basis. The frequent visits to Zimbabwe
denote a desire to maintain close ties with their home country while they establish themselves in the UK.

Table 3.3: Trajectories & length of Migration

<table>
<thead>
<tr>
<th>Years lived outside Zim</th>
<th>&lt;5</th>
<th>1</th>
<th>Ever gone back to live in Zim</th>
<th>Yes</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5-10</td>
<td>29</td>
<td></td>
<td>No</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>&gt;10</td>
<td>5</td>
<td></td>
<td>No</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of visits to Zimbabwe</th>
<th>0</th>
<th>1</th>
<th>Intend to move to another country</th>
<th>Yes</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-6</td>
<td>30</td>
<td></td>
<td>No</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>&gt;6</td>
<td>5</td>
<td></td>
<td>Not Sure</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where in Zim did you Live</th>
<th>Harare</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bulawayo</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Chitungwiza</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

3.3: Reasons for Emigration out of Zimbabwe

A question scholars have tried to answer for ages is why people migrate (Ravestein 1889; Thomas 1920; Todaro 1996, 1976). This section addresses why the research participants moved; what about Zimbabwe made them move to the UK. These factors will be of two kinds. One set of factors relates to the research participants that were in the nursing industry prior to their emigration from Zimbabwe. The second set of factors relates to all the research participants, those who were in the nursing industry prior to emigration from Zimbabwe and those who were not. There will also be additional information providing a background of the Zimbabwean nursing industry and the state it is in. Narrative from the research participants paints a vivid picture of the factors that caused them to emigrate from Zimbabwe.

Migration results from uneven geographical distribution of resources/opportunities (Arango 2000). This difference in the distribution of resources/opportunities gives rise to an opportunity gradient ‘where all things being equal’, individuals from the geographical areas with fewer opportunities will migrate to the geographical location with more opportunities and therefore take advantage of these opportunities if the costs of migrating are not outweighed by the benefits. These differences between geographical locations which either makes them more or less attractive can be referred to as place differences (Yeboah 2008). It is these place differences that potential migrants take into consideration as they conduct a cost benefit
calculus to determine whether or not they will be migrating. These place differences exist at different scales and occur within different opportunity gradients. The research participants in this study in effect can be split into 2 groups that migrated on different opportunity gradients.

The first group are migrants reacting to place differences found within the nursing industry. This group of migrants is made up of individuals who were qualified nurses working in the nursing industry in Zimbabwe before they emigrated. This group of nurse migrants is reacting to the opportunity gradient that is present within the globalized nursing industry. Since the nurse emigrants are already in the industry their movement is based on the advantageous prospects they are to find performing their same profession in the UK. For them it is essentially low pay, poor work conditions and a lack of opportunities for further training that motivates them to leave. Eleven of the research participants comprise this group.

The second group in question comprises migrants who prior to their migration to the UK were not nurses and have since joined the nursing industry once arriving in the UK. For this group, their migration is a function of the opportunity gradient which exists between Zimbabwe and the UK. This opportunity gradient is much broader and brings with it more possibilities for them to potentially take advantage of. These non-nurses migrants prior to their migration were not reacting to a gradient targeting one specific industry, nursing. Twenty five of the research participants comprise this group. The major difference between these groups regarding their reasons for migrating is the nurse migrants have a common set of place differences that are unique to them within the nurse industry. The other reasons that will be outlined are reasons that can be attributed to both groups.

The time period that saw the greatest number of people leave Zimbabwe (28 out of 36) was between 1994 and 2000 as shown in table 3.4. This particular time period coincides with a number of factors that led to destabilization in Zimbabwe both politically and economically. The notable economic factors for this time coincided with the end of the first phase of Zimbabwe’s Economic Structural Adjustment Program (ESAP) (Potts and Mutambirwa 1998). The ESAP was first introduced in 1990 because of the Zimbabwean government’s inability to sustainably continue its socialist economic policies which were creating problems across economic and social sectors of the country (Mhone 1995). Implementation of this neoliberal ESAP had three
main goals. The first was to deregulation of the domestic economy, the second was to implement less restrictive trade polices, and third was to see reductions in public spending aimed at creating sustainable economic growth (Marquette 1997). A commonly held view among scholars who have studied Zimbabwe’s ESAP is that it made life harder for common people and arguably worsened the country’s economic standing (Marquette 1997; Potts and Mutambirwa 1998). The ESAP saw huge numbers of people enter into poverty as large numbers of people were retrenched. Large increases in the cost of living also occurred as government subsidies were removed resulting in citizens paying more for basic commodities (Marquette 1997).

Fees for some social services like health and education were either introduced or increased to make up for the absence of government spending (Marquette 1997; Potts and Mutambirwa 1998; Skalnes 1993). Compounding the effect, government safety nets disappeared as government subsidies and programs were cut in an effort to reduce government spending (Mhone 1995). Devaluation of the Zimbabwe dollar resulted in cost increases for vital essentials of economic production like petrol, resulting in inflation (Potts and Mutambirwa 1998). All this put together, people had to pay more for basic commodities and social services out of pocket and led to decrease in peoples’ standard of living (Marquette 1997). Zimbabwe’s experience confirms that Structural Adjustment Programs have been very successful. In a number of instances, Structural Adjustment Programs have not been beneficial to other countries in Sub-Saharan Africa and have been blamed for the increase in Africans emigrating to the West (Okome 2006).

Despite economic woes, politics in Zimbabwe played a major role in the exist of emigrants between 1994 and 2000. Invasion of farms in 1997, where war veterans from the liberation struggle invaded white owned farms created a heightened sense of anxiety (Chaumba 2003). These land invasions lead to violent clashes between the war veterans and white farmers, ultimately creating an atmosphere of insecurity as the police largely paid a blind eye to the law, the invasions and the ensuing violence (Hellum 2004; Laakso 2002).

The 2000 parliamentary elections by far were the biggest contributor to political instability and an enormous sense of insecurity as supporters of ZANU-PF (through the aid of
government support) beat, terrorized, raped and allegedly killed movement for democratic change (MDC) supporters (Laakso 2002). Though most of the violence came from ZANU-PF supporters it is important to note that the MDC was also involved in initiating some violent encounters. This instability was largely expressed through political violence that ensued throughout the campaign process and after the results were announced (Laakso 2002). The 2000 elections gave rise to the ruling government’s most formidable challenge since coming to power in 1980. The widespread violence that was seen across the country in both rural and urban areas created an atmosphere of instability as the rule of law was trampled upon (Raftopolos 2003). During the campaign process the MDC-which was born out of the trade union movement-called for numerous work stay aways. This saw economic production in the country come to intermittent halts. These economic-political actions further damaged the already fragile economy which saw a decrease in productivity, increases in unemployment and increases in inflation (Laakso 2002).

Despite this political-economic argument presented above, the emigrants reasons for emigrating translate more to economic rather than political ones. Table 3.4 shows the responses given by research participants as their reasons for emigrating, 41 of the responses are economic. On this multiple response question respondents said they left because of the declining Zimbabwean economy, to get better remuneration, to find better work conditions, and find new opportunities for income. Another major factor that influenced respondents reasons for emigration was social reasons. Social reasons tended to center around family reunion, trying to find better living conditions, fleeing the increase in violence and seeing no future in Zimbabwe. The third largest factor that was given were opportunities for study and self improvement that were limited in Zimbabwe. For many of the participants nursing was not the field they had wanted to study, however the financial incentives in the UK made it easy for them to enter. DW_B0003 remarked that she came to the UK so as to get an education and get a chance at bettering her life.
By far the most important factor that emigrants gave for emigrating from Zimbabwe were economic factors. Given the quick digression of the Zimbabwean economy over the last 10-15 years this is no surprise. Over the past few years Zimbabwe has been experiencing the highest hyper-inflation in the world (CNN 2008). The most recent figures for Zimbabwe’s inflation released by the Zimbabwe Central Statistical Office in October (2008) show the inflation rate at 231,000,000% up from 11,200,000% the previous month (BBC 2008). Prices of commodities have seen ridiculous increases that the government has now allowed some businesses to formally sell their good in US dollars (BBC 2008). In addition, Zimbabwe’s unemployment rate currently stands at 80%, however, this is a conservative estimate (BBC 2008; CIA 2006). According to the CIA (2008) Zimbabwe’s unemployment rate has stood at 80% since 2006.

For the nurse migrants (those who were nurses prior to leaving Zimbabwe) another set of factors have to be considered to appreciate their decisions to emigrate and continue their nursing profession in the UK. The nursing industry in Zimbabwe is plagued with severe shortages which have only gotten worse over the last 10 years. Noted by Chikanda (2006) the brain drain has most affected the nursing industry where there are falling numbers of nurses working in the public sector yet Zimbabwe has been producing at least 300 nurses annually. According to the Central Statistical Office in Zimbabwe there were 8,662 nurses working in the public sector in 1991 (CSO 2000). By 2000 that number had dropped to 7,795 (Chikanda 2006). Within this 10 year period 3000 nurses were produced, however, there is a falling number of
nurses working in the Zimbabwe public health care system. The departure of these nurses from the public sector has seen some move to the private sector and others out of the country. Chikanda (2006) argues that nurses typically work in the private sector prior to emigrating. The private sector provides better remuneration and work conditions (Chikanda 2008). However, some research participants in this study emigrated from the public sector. There is no available data to determine the whereabouts of the nurses who left the public sector over this time period. Interviews conducted with nurses in the private sector also raised concerns about manpower shortages. This suggests that some of the nurses leaving the public sector are emigrating.

There have thus been increases in the nurse to patient ratios. The staffing situations are profoundly worse in the rural vs. the urban areas. Chikanda (2006) notes that in 2000 the urban area of Mutare had a nurse to patient ratio of 1:597 while the rural area of Nyanga in the same province has a ratio of 1:3023. This mass exodus of nurses was highlighted by nurses interviewed in Zimbabwe for this research project. DW_D0031 an intensive care nurse at St Anns; a private hospital in Harare had this to say, “...there is a shortage of staff... I would say its 50 % short. Cause at times when there are meant to be four nurses on duty you will find there are only two.” DW_A0034 another nurse working at a private hospital also said, “Shortages, that has been a main problem. You have to put in treble (three times) the effort. Compared to when I started, you really have to put in more time... there has just been a mass exodus. May be after a month or two someone is leaving again.”

Another concern for nurses has to do with the lack of equipment and basic provisions in Zimbabwe’s hospitals. Over the last 10-15 years nurses have left the country because of the deteriorating work environment in the health sector and the country as a whole. The root to most of these problems can be traced to the Structural Adjustment Programs (SAP’s) which started in the early 90’s and the economic downturn which lead to cuts in medical spending. These cuts resulted in shortages of medical supplies and equipment which in many cases gave nurses few options by which to treat patients and many times made the nurses vulnerable to diseases (Chikanda 2006). Nurses in Chikanda’s research express fears of contracting HIV because they are not provided surgical gloves (2006). These occurrences of nurses fearing
exposure to HIV/AIDS are unfortunately not unique to the Zimbabwean health sector. In Zambia there have been similar worries that nurses are not being protected from dieses like HIV/AIDS as death rates among nurses and clinical officers from HIV/AIDS at 68% far outweigh resignations at 23% and retirement at 9% (Feeley 2006).

All nurses interviewed in Zimbabwe for this thesis often complained about the inability for their salaries to provide them with the life style they desired. Many were forced to moon light or engage in additional income generating activities in order for them to be able to take care of their families. DW_D0031 said that she had resorted to selling snacks and vegetable in order the make enough money to take care of her family. She said her salary was not even enough to cover the cost of her bus fare to get her to and from work for the entire month. When asked about her remuneration DW_D0031 said, “its pathetic, I am not comfortable. I don’t want to weep before I finish the interview.” Regarding the inability of her salary to take care of her family in the current economic climate DW_A0034 said,

“as long as the economic situation does not normalize then the trend is going to continue as it is....with the current situation we can’t afford to send children to good schools... As a nurse in Zimbabwe you can’t afford good education, a good house. As a nurse here you can’t afford that, just can’t afford that. You just have to work overtime or find other things to do elsewhere. I just do other things other than nursing to get extra income just to make sure that my family survives.”

The story of BW_B0023 interviewed in the UK best exhibits the manner by which the economic downturn in Zimbabwe eventually forced the research participants out of the country in order to provide a better livelihood for themselves and their families. BW_B0023 had wanted to be a nurse since she was child. In the early 1970’s when Zimbabwe was still Rhodesia, BW_B0023 completed her ‘A’ levels and applied to nursing school in Rhodesia. BW_B0023 found herself on a two year waiting list. Discouraged by the long wait she applied to nursing school in UK and she emigrated in 1975 to start nursing school. Upon completion of her nurse training and midwifery, Zimbabwe had just gained independence, so she returned home. On going home she said,

“...it was 1980, the independence had come and obviously when I was here (UK) everybody spoke about when we had finished, when we think we have done enough
we will go home. That was it, nobody ever spoke of, oh I will find a job and stay here. We didn’t think like that at that time. Our aim was to go back home (Zimbabwe) and work and that is what I thought.”

Upon returning BW_B0023 was happy to be home and never thought she would leave again. She recounted that she was now able to work in top notch medical facilities that prior to independence excluded blacks from working there. BW_B0023 recounted that she was so secure with her future that she would use her British passport to write her grocery list. However, the good times were to be short lived. By the early 90’s things began to take a turn. Recalling how things began to change BW_B0023 said the following,

“The hospitals when I started in Zimbabwe were very clean very efficient the matrons were matrons. I don’t know how, but somehow things began to break down and were not replaced. Patients increased and yet the staffing establishment was not increased. By then the salaries were not going up. And that does not help because when someone is used to a certain way of life and then it starts to diminish they start to lose interest in their job, because I have to look for other ways of making money… I am not going to put 100% in a job that does not pay me much. And of course people’s attitudes, I don’t know how you would describe it, the respect we had for matrons got lost somewhere along the line...people would say who is the matron, she is just an employee...if she is talking about doing work let her come and do it. Yet at the same time they cannot fire anybody. So things just went down and down and down.”

BW_B0023 eventually decided to return to the UK as a second time emigrant. She said the following when asked about why she emigrated a second time,

“The overall conditions were not good. Our salaries were not rising relative to the inflation. I had to consider my children who were about to go to university and their fees were going up and I would not be able to pay for them. Before, if the child had gotten into the university they would have received a grant. But now they had introduced fees. I know I could not afford them so I thought it was time for me to do something so that they could go
to a foreign university... England appeared to be the easiest way for me as I had been here before.”

On the question as to why they specifically moved from Zimbabwe, again economic reasons were the determining factor. Another big factor in leaving Zimbabwe were the lack of opportunities to get further education. Their desire to seek education in the UK is a function of the opportunities that the migrants could find abroad that were not available to them in Zimbabwe. Their desire to acquire more education is partly why some of them ended up in nursing. The relatively lax requirements and incentives given by the UK made nursing the path with the least resistance. The migrants ease of entry into the UK nursing program will be discussed in greater detail in the next chapter.

Not only the reality of conditions in Zimbabwe but the perception of future conditions also contributed to their emigration. When asked the how the Zimbabwean economy was before they emigrated most said it was average (19) some said it was good (11) and few said it was bad (5). However, when asked how the Zimbabwean economy is today all respondents stated that it was worse since they had left. Though the economy may have been good or average when the migrants left, the writing was already on the wall and harder economic times were on their way. It is not only personal development that contributed to their emigration, but economic insecurity as well. It entails a form of awareness on their part that the future was no longer promising. Major indicators of this were the unemployment and inflation rates which continually rose. To this point DW_C0006 interviewed in the UK said, “I had been doing ok in Zimbabwe however ...things were beginning to get tough in Zimbabwe.”

Looking at the survey results there is a clear slow down in migration flows after 2000. This slow down is easily explained by the introduction of visa requirements for Zimbabweans to enter the UK. Prior to 2000, Zimbabwe, being a former colony of the British, its citizens were allowed to enter the UK without a visa as long as they were able to convince a boarder official that they were not there to engage in activities that would violate British employment law and would not over-stay. As a result, when the political and economic climate in Zimbabwe worsened; Zimbabweans exploited the relatively lax entry requirements and resettled in the UK. As more Zimbabweans fled and overstayed their welcome, the UK instituted a visa policy.
The visa policy came after many Zimbabwean had flown to the UK and were sent back home without leaving Heathrow Airport. It had become almost impossible to convince the border officials that they would not over stay.

Given that economic reasons by far outweigh all others in emigrant’s decision making process as to whether or not they should emigrate, it seems return migration to Zimbabwe is highly unlikely, since Zimbabwe is worse off than when they left. This group of Zimbabwean migrants can be characterized as economic migrants and as a result their return home will be based on economic factors.

3.4: How they Migrate

For economic migrants the manner by which they immigrate is largely determined by their skills and resources of cultural capital. For highly skilled immigrants, recruitment is more likely the manner by which they end up in the destination country (Khadria 2001). The need for highly skilled labor in a country is typically accompanied by immigration policies and incentives to attract this skilled labor. Other researchers argue the greatest determinate for economic migrants are social networks available to them in the destination country rather than identifiable skills (Beaverstock and Boardwell 2000). Raghuram (2004) notes the importance of skill levels are dependent of the particular sector in question. For example, the medical sector requires specific quantifiable skills and in this case, skills become more important to recruiters. This section addresses how the migrants get to the UK; specifically are they recruited or do they migrate on their own accord.

Since the mid 1990’s the UK has been on a very aggressive recruitment campaign of health care workers. In response to an evaluation report on the UK health sector which found that the biggest hurdle to the provision of better health care services was a lack of manpower, the labor government ushered in recruitment campaigns to address these shortages (Buchan et al. 2006). As the law stands today, the National Health Service (NHS), temporary staff working with the NHS and private sector organizations doing work with the NHS must comply with the code of conduct for the recruitment of international nurses which does not allow developing countries to be targeted for active recruitment unless the government of that country formally agrees (Department of Health 2004). Zimbabwe is one of the developing countries on the list from
which the NHS and its agencies are not allowed to recruit from. However, private health care entities that do not work with the NHS are not bound by this code and as such are free to recruit nurses from Zimbabwe.

Among the research participants a very small number of them found their way to the UK by virtue of being recruited. Only two were recruited. This low number is not surprising given that all research participants in this study work for the NHS which is not allowed to recruit from nurses from Zimbabwe. One of the nurses who was recruited and with whom an interview was conducted noted that upon her arrival she was offered a position in an NHS hospital and had to divorce herself from the recruiting agency to take the job. As noted by McGregor (2007) there is neglect around the issue of recruitment of care workers and their exploitation in the UK. A hospital administrator with whom an interview was conducted noted that private health entities were actively recruiting nurses from countries on the banned lists. McGregor (2007) notes that these private entities are able to take advantage of the vulnerability of these recent migrants, often resulting in exploitation and broken promises.

By and large the majority of the research participants came to the UK on their own accord. The ability for these nurses to embark on their own and successfully join the NHS is a clear sign that the code of practice has not been very effective in stopping the flow of nurses from developing countries on the banned list (the ineffectiveness of the code of conduct will the further addressed in chapter 6). The greatest assistance that the research participants got to enable them to enter the UK came from family and friends mostly already in the UK whose assistance included things like paying for air fair, assistance in getting visas and assisting them in conducting job searches. The social networks and the cultural capital that came with them are the real story behind how the research participants migrated to the UK (this point will be further discussed in chapter 4).

3.5: Brain Drain on Zimbabwe?

The theoretical basis for the concept of brain drain migration first came out of the historical-structural approach of world systems theory (Arango 2000). There has been a lot of attention focused on brain drain migration because of the negative impacts it is argued to place on the development of countries outside the global core (Akokpari 2006; Clark, Stewart, Clark
2006; El-Khawas 2004; Getahun 2000). This section addresses the extent to which the sample in this study constitutes a brain drain out of Zimbabwe. In addition, gains they have made in human capital and how growth of human capital can potentially benefit Zimbabwe are addressed. Issues concerning the secondary benefits of brain drain migration like remittances will be discussed in chapter 5.

Table 3.5 shows that research participants were predominantly employed before they emigrated. Eleven of the research participants were employed as nurses in Zimbabwe. The remainder of the research participants were almost equally employed in both skilled and unskilled professions. Some of the occupations that were held by the skilled non-nurse migrants were accountants, pharmacy technicians, teachers and computer technicians. The unskilled non-nurse migrants had occupations that included secretaries, factory workers and retail assistants.

| Table 3.5: Occupational and Human Capital Components |
|---------------------------------|--------|----------------|
| Employed in Zimbabwe before Leaving? | Yes | 20 |
|                                   | No | 8 |
| What job before you left? | Nurse | 11 |
|                               | Skilled-non nurse | 9 |
|                               | Non-skilled non-nurse | 7 |
| Edu level attained in Zimbabwe | O’ Level | 14 |
|                               | A Level | 9 |
| Edu acquired since leaving Zimbabwe | Yes | 33 |
|                               | No | 2 |
| Final level of edu | Diploma | 19 |
|                     | Degree | 10 |
| Country final edu acquired | Zimbabwe | 1 |
|                               | UK | 20 |

Professions and educational attainment that the emigrants held before they emigrated from Zimbabwe show there is clear evidence a brain drain has taken place. The eleven nurses and nine skilled emigrants are all examples of the, “Professional, Technical and Kindred” workers that Logan (1999) refers to in his definition of who comprises the brain drain. These 20 individuals characterize human capital that is no longer available to the Zimbabwean economy or society and as a result represents a loss of investment for Zimbabwe regarding their education and their service to the country. This is especially so for the nurses since they,
like the British trained nurses, do not pay for their education. Once admitted to nursing school the nurses do not have any tuition fees and they receive a bursary to cover living expenses. DW_D0031 said that she got so much for her bursary that she was able to buy building materials for her parent’s house and assist in paying her sisters school fees. For the few who are chosen to enter nursing school, they are a small number of the many who apply and truly represent an investment the country is making. It is estimated that emigration of a doctor from the African continent represents a loss of US$184,000 (Eastwood 2005) since the training of health care workers is highly subsidized. Though the training of nurses cost less this figures provides an idea as how much of a lost investment it is when a healthcare worker emigrates. The loss of nurses is making healthcare delivery more difficult because they are the primary care providers within the Sub-Saharan African context (Ahmad 2004). Taking this into consideration it explains the loss of even a single nurse is great in terms of the potential service, cost of training and time of training.

Furthermore, the nine non-nurse skilled migrants represent a brain drain and a loss as they are now working in the nursing field and not working in the previous field in which they were trained. Essentially they reflect a loss of human capital as they are not utilizing the training they received in whatever field preceded their nurse training. As noted by Lianos (2007), the occurrence of a brain drain in the host country can manifest into a situation of brain loss/over education in the destination country if the migrants training is not put to use. A study of immigrants to Greece found they were more likely than locals to be employed in positions where they were over educated or not employing their previous training (Lianos 2007). Though an immigrant may be qualified in a particular field, their status as an immigrant can exclude them from participating in certain economic activities. As noted earlier, the countries of the global core have been selective in allowing migrants entry based on the specific areas of labor needs. DW_C0030 notes that he had attempted to purse his accounting career in the UK but had been unsuccessful. The following is a conversation between the researcher and DW_C0030:

*Researcher: why were you unable to continue your accounting when you got here?*
DW_C0030: It is difficult here because these are the kinds of jobs that locals here would do, so to break through in that area it takes a lot of effort and patience. Its not a no area but its not easy.

Researcher: So you found it better to go into nursing

DW_C0030: nursing is basically a dirty job and this is why they have shortages here... as a foreigner I was looking to the future and what would let me stay in this country...

From a societal view it would appear as if DW_C0030 and other participants like him are being under utilized/employed. The notion of a societal view is evoked here because nursing is generally viewed as an undesirable occupation in the UK as alluded to by DW_C0030 calling it a dirty job. For some of these skilled migrants, entering the nursing field is a step down on the pecking order and reflects a brain loss. Another aspect of brain loss likely to take place is the longer these skilled migrants stay in the profession of nursing the less likely they will ever be able to return to their previous profession even if they return to Zimbabwe.

For the group of emigrants who became nurses upon arriving in the UK the predominant reason they entered into the field was that their tuition would be waived and they would receive a bursary. When asked why they entered the nursing field in the UK 10 uttered that they did so because it entailed no financial investment on their part and they actually received money for going to nursing school. Essentially they found the nursing option to be the easiest and given their limited ability to raise money for tuition. The alternative to studying something other than nursing would necessitate them to seek additional employment in order to raise money to pay for their tuition. This point of view is expressed by DW_C0014 who said,

"Initially I wanted to study computers but then you had to pay all these fees and my aunt could not afford it. The second best option was nursing because I had no fees to pay and I would get a bursary"

When asked the same question three others responded that they did it for visa purposes. Entry into the nursing field gives foreigners the ability to legally live in the UK on a long term basis. In recent times there have been changes to this rule and these will be discussed in the next chapter. The response by DW_B0003 exemplifies this point saying,
"To be honest the only reason was that was the only course I could do without paying first. Also being a nurse would give me a path by which to stay in the country."

Before leaving Zimbabwe, all the emigrants in the study had acquired at least an ‘O’ level education. The majority of the emigrants (14) had only an ‘O’ level education. A substantial number had ‘A’ levels and diplomas (9). There were very few who had acquired a degree. Given that all the emigrants had at least an ‘O’ level education this proved to be advantageous to them as these qualifications directly transferred over and allowed them to go straight into nursing school. This easy transfer into nursing is the result of the compatibility between the Zimbabwe and UK education systems due to the colonial legacy. In order to enter into nursing one only needs five ‘O’ levels including English. This requirement is similar in Zimbabwe if one seeks to acquire education beyond the secondary level.

Since leaving Zimbabwe, this group of emigrants has been very active in trying to acquire more education. An overwhelming majority of the migrants have sought further education while only two have not. Most of those who have sought further education now have diplomas (19) and the rest have degrees (10). All but one of the emigrants has received their final level of education in the UK. These migrants have been active in taking advantage of the education opportunities that they have found in the UK.

For this group of research participants the picture is rather interesting regarding brain drain. There has been a brain drain and loss when taking into account migrants who were skilled prior to emigrating from Zimbabwe. These skilled emigrants represent an investment of educational resources which have since left for the UK. The other group of research participants constitute emigrants who were unskilled prior to emigrating from Zimbabwe and not part of the brain drain as they do not fit the professional, managerial and technical profile. Both the skilled and unskilled research participants have clearly gained in their human capital development and as such could potentially be advantageous to Zimbabwe. This increase in human capital among the crop of emigrants would suggest the potential for a brain gain if they return home. In order for Zimbabwe to benefit from this increase in human capital there has to be a set of measures in place that would attract these emigrants back. In order for countries of the global semi-periphery and periphery to attract emigrants to return they have to provide opportunities for them that are globally competitive (Saravia and Miranda 2004) as discussed in
chapter 2. Return migration and the prospect of Zimbabwe experiencing a brain gain within the nursing industry will be further discussed in chapter 5.

3.6: Conclusion: Trajectory of Zimbabwean Emigrants in the UK

Migrants who make up this research study in some ways conform to certain views of migration and in other ways do not. The traditional view that migration typically comprises young male does not apply to this group. The research participants in this study were mostly female, a majority of whom were middle aged. The reason for the majority of the migrants being female has to do with particular economic activity in question. Nursing is a profession that is regarded to be a female occupation in both Zimbabwe and the UK, and as such, very few men enter into the field. The migration trajectory of this group has typically been for the women to emigrate first and then slowly reunite with the rest of the family. In this regard, migration appears to the taking place in the form of a family decision vs. an individual decision as traditionally viewed by neo-classical theorizations (Yeboah 2008). The demographic attributes of this research group denotes a migration of established people trying to start new lives in the UK. The vast majority of these research participants are recent migrants as most have been in the UK between 5-10 years. There is a common tendency among the group to visit Zimbabwe regularly, between one to six times for most since arriving in the UK. Yet, there is little interest among this group to migrate to another country. Most have intentions of being in the UK on a long term basis.

The negative place attributes of Zimbabwe have led the research participants to emigrate. A combination of economic, political and social factors have made Zimbabwe a location for which the emigrants in this study saw as disadvantageous enough for them to uproot and leave the country. Factors like hyper-inflation, unemployment, political unrest, violence and poverty due to SAP have made Zimbabwe a geographical location for which individuals are unable to provide for their families and live the life they desire both in current reality and future perception. Many note that they saw no future for themselves and their families in Zimbabwe, hence leaving seemed to be the best option. When deciding where to immigrate, research participants through conducting a cost benefit calculus sought a geographical location with a set of place attributes that would be advantageous and allow them
to thrive. The place attributes of the UK provided the research participants an opportunity to emigrate and change the course they were on. By virtue of a globalized nursing industry, a huge nurse shortage, a compatible education system, free training programs for nursing students and nursing leading to a path towards naturalization; both nurses and non-nurse migrants joined the UK nursing field. Few of the research participants in this study made their way to the UK by the means of recruitment. For the vast majority, they immigrated to the UK on their own accord or informally in the hope of providing a better future for themselves and their family.

The migration of a select group of the research participants in this study constitutes a brain drain. Migrants who were skilled prior to emigrating from Zimbabwe are clearly a loss of human capital which was created in Zimbabwe and so no longer present to actively participate. The brain drain is more so among the nurses as their training and living expenses while training were completely paid for by the Zimbabwean government. Both skilled and unskilled migrants who emigrated from Zimbabwe could potentially result in a brain gain for the country given that almost all have since sought further education while abroad. The fundamental question is how Zimbabwe can create an environment where the place attributes of Zimbabwe become such that they return to Zimbabwe.

Realistically speaking, Zimbabwe will not be creating the right mix of place attributes that will encourage these migrants to return home and provide a brain gain in the nursing industry any time soon. It is more likely that a set of place attributes can be created to encourage return migration but not return migration and a brain gain in the nursing field due to the poor state of the nursing industry and the national economy as a whole. For Zimbabwe to realize a brain gain in the nursing field they have to create opportunity within nursing that is globally competitive (Saravia and Miranda 2006). The notion of return migration will be further discussed in chapter 5. The situation as it stands in Zimbabwe is continually worsening. Brain drain migration and migration in general is going to take place continually until there is a different set of place attribute that do not push people out or better yet pull them in.
Chapter 4
Experiences in the UK: Place attributes of the UK

4.1: Introduction

The UK is a major destination country for international nurses within the global nursing industry. Today the UK employs international nurses from over 30 countries (NMC 2008). The popularity of the UK as a destination country is linked to its colonial legacy by which it (the UK) has strong historical, educational and migratory connections with many English speaking countries across the globe (Buchan 2007). This popularity is further enhanced by the mutually beneficial relationship that exists between migrant nurses and the UK nurse industry. The UK nurse industry is plagued with severe nurse shortages of more than 30,000 nurses and expected to grow to 53,000 within the next 5 to 10 years (Batata 2004). With this shortage, the UK health industry has resorted to a number of policies and programs to deal with this shortage, one of which is the recruitment of international nurses. Internationally Recruited Nurses (IRN-trained outside the UK and continental Europe) that work in the UK largely come from countries of the global periphery. Migration being a function of varying opportunities across geographies, particular place attributes in the UK have pulled these particular migrants to the UK and allows them to thrive. For these individuals, immigrating to the UK translates to higher pay, better work conditions and possibilities for further training. This win-win scenario for both parties (the IRN and the UK health industry) is what has made the phenomenon persist.

Zimbabwean nurses, like most other international nurses, see the UK to be a desirable destination. Chikanda (2006) finds that Zimbabwean nurses who have hopes of emigrating picked the UK as their number one choice. As demonstrated in chapter 3, the deteriorating conditions in Zimbabwe have accelerated the number of immigrants seeking to enter the UK. The research participants in this study clearly reflex a brain drain and even though opportunities in the UK are not as lucrative, Zimbabwe does not stand to gain from this changing scenario. The UK has place attributes that have been instrumental in attracting Zimbabweans’ to the NHS and keeps them within the systems. This chapter addresses the second research question of this thesis: What are the place attributes of the UK that attract
Zimbabweans? This chapter investigates specific place attributes that have made the UK such an attractive destination. To answer this question four sub-questions will be answered. These are where do they settle? How and why the fit in the UK? What is the experience of Zimbabwean nurses in the UK? The aim of this chapter is to shed light on the UK nursing industry and why Zimbabwean nurses fit into it. Examining Zimbabweans participation in the UK nursing industry will also involve exploring the experience of being a Zimbabwean nurse in the UK with the variety of changes that have taken place in the NHS (National Health Service).

4.2: Settlement Patterns

The research participants in this study were mostly taken from London and the surrounding area. Three of the research participants currently reside in Portsmouth but the remaining thirty three reside in London. The literature is quite clear showing that internationally recruited nurses (IRN) are typically found in London (Batata 2004; Gough 2004). Batata (2004) finds that areas in the UK that had the highest vacancy rates are areas that have the highest representation of IRN (2004). Batata’s study finds that the highest rates of IRN reside in London and South East England; the corresponding rates of IRN in these areas are 24% and 16% respectively (2004). Batata’s research highlights the vital role IRN play in the National Health Service (NHS) by drawing attention to the areas that would be hardest hit by shortages in the absence of IRN. Gough (2004) also notes that there is anecdotal evidence that minority ethnic nurses tend to cluster in the London area. A study by King’s fund found that a quarter of all the nurses in one of the trusts in London were from India (Gough 2004). The shortages of nurses in the inner cities of the UK contrasts the trends found in countries of the global periphery like Zimbabwe, where nurse shortages are heaviest in the rural areas (Clark, Stewart, Clark 2006; Chikanda 2006).

Though the research participants in this study mostly reside in London it is not the only place they have lived since coming to the UK as shown in table 4.1. A predominant number of the research participants have not resided in London alone. The research participants have lived in a number of different places besides London ranging from one to five places. Research participants in the study have predominantly lived in their current location from two to eight years. The leading reasons for migrants being attracted to their current location were cost of
living, it being a peaceful place and their jobs. Predominantly migrants showed no interest in moving from their current locations. For those who have no intention of moving from their current location the psychological answers they gave reflect a presence of being settled to a point where tangible factors are not mentioned. Psychological reasons that were given included, feeling settled, happy in their current location, felt content, felt comfortable and that moving would be a hassle. Though there has been movement around the UK, the predominant trend is for the research participants to gravitate around London.

### Table 4.1: Where in the UK do they settle?

<table>
<thead>
<tr>
<th>Current Location</th>
<th>London</th>
<th>34</th>
<th>Portsmouth</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>London the only place lived</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of places lived besides London</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of places lived</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of places lived</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of places lived</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>20</td>
</tr>
<tr>
<td>Attraction to current location</td>
<td>Potential Job</td>
<td>9</td>
<td>Cost of housing</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Quality School</td>
<td>14</td>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Peaceful Place</td>
<td>10</td>
<td>Friends and Family</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Join Family</td>
<td>3</td>
<td>Job Brought me here</td>
<td>8</td>
</tr>
<tr>
<td>Where do you intend to move</td>
<td>Milton Keynes</td>
<td>2</td>
<td>London</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Corby</td>
<td>1</td>
<td>London</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Kent</td>
<td>1</td>
<td>London</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Glasgow</td>
<td>1</td>
<td>London</td>
<td>2</td>
</tr>
</tbody>
</table>

### 4.3: How and Why Zimbabweans fit into the UK Nurse Industry

To answer the question how and why Zimbabwean nurses fit in the UK three points will be addressed; first, the UK nurse shortage and polices to address it, second, the colonial legacy between the UK and Zimbabwe, and third, Social networks (cultural capital) that reduce migration costs. These three factors work together creating place attributes unique to the UK
that allows Zimbabweans to migrate, integrate and thrive in the UK. It is the interworking of these factors that have seen Zimbabwean immigrants join the UK nursing industry and allows the phenomenon to continue.

4.3.1 The UK Nurse Shortage

The UK like most other countries of the global core has been experiencing nurse shortages which are expected to get worse with time. The causes for this nurse shortage are similar across the global core. The fundamental problem is the difference between supply and demand (Clark, Stewart, Clark 2006). There is simply greater demand for nurses than the UK training institutions are able to supply. The greater demand results from poor retention of nurses and an increased older population that requires more medical services (Clark, Stewart, Clark 2006). Linked to the supply side, this shortage comes from the reduced number of people entering the nursing field. The field of nursing has traditionally been seen as a female oriented labor activity. In recent times, women have more career options and as a result fewer of them have entered the field (Batata 2004; Buchan 1999; O’Brien 2006).

Second, the UK is experiencing a demographic shift, where a falling birthrate greatly reduces the potential for new recruits coming from UK female societies that have more economic options (Gerrish, Griffith 2004). With fewer nurses entering the field, the average age of nurses has increased putting the nursing industry in more turbulent waters. The higher average age increases the propensity for retirement, with each retirement further worsening the situation (Clark, Stewart, Clark 2006). The nurse shortage has lead to higher nurse patient ratios, making work more stressful and increasing the propensity for burnout. This has also resulted in some leaving the profession (Aiken et al, 2001).

A third cause for shortages comes from general dissatisfaction with the profession and has resulted in people leaving the field. The NHS has been plagued a with reputation of being a bad employer, as such it is not able to compete with other employers the same way countries of the global periphery are unable to compete with health industries in the global core (Batata 2004; Gough 2004). Within the NHS the declining numbers of nurses entering the field can be attributed to low pay, poor work conditions, and reduced feelings of being valued (Batata 2004). Yet, this low pay and poor work conditions attracts people from Zimbabwe. Batata
(2005) notes that though nurse wages in the UK have risen in real terms over the last 20 years, compared to other careers nurse wages have actually fallen. This has led to other careers being more attractive.

Fourth, Batata (2005) also notes the failure of the NHS to have greater geographical variation in its wage structure which has resulted in areas with higher costs of living having more nurse shortages. Regions like London and the South East of England have a higher cost of living and the relatively flat wage structure puts nurses in these areas at a disadvantage as they are not compensated based on their cost of living (Batata 2004).

A fifth reason for the nurse shortage in the UK has been poor labor force planning, particularly in the early 1990’s. The early 1990’s saw a situation where the number of training posts were intentionally reduced (Batata 2004; Buchan 1999). Nurse administrators with whom interviews were conducted are of the view that there is a failure on the part of the government to strategically deal with the nurse shortages on a long term basis and that they rather focus on short term goals which tend to lead to cycles of shortages (Steele 2008). This point will be further explored in the chapter 6.

The failures of the NHS in meeting health needs were quantified in the Wanless report (2001). The report finds that more funding has to be directed toward to NHS to enable it to increase staff levels. The report also states that the NHS does not have enough doctors and nurses hence, is unable to deliver adequate service (Wanless report, 2001). Prior to this report’s release, the Secretary of Health presented, The NHS Plan (2000) to parliament with the aim or reforming and injecting investment into the NHS. Specifically mentioned to address the staff problems was an effort to end the era of poor funding and increase the moral of NHS workers (NHS Plan 2000). The NHS Plan has specific targets to increase staff levels of doctors, nurses, and consultants within specific timeframes. Under the plan, increases of 20,000 nurses were to be realized by 2004. Buchan (2007) finds the NHS plan to have been effective over the 1997-2004 period as the total NHS staff grew from 846,289 to 1,071,203. Over this time period, nurse staff levels increased by 59,347 to 315,440 (Buchan 2007). NHS plan increases in staff levels were attained through retention practices, modernizing pay structure and increased earnings.
improving working lives of staff, increasing training institutions and international recruitment (NHS Plan 2000).

In order to facilitate the recruitment of nurses, they were put on the shortage occupation list (SOL). The shortage occupation list allows an employer to acquire a work permit for a foreign employee without the need to demonstrate an absence of local manpower to take the job. Professions on the SOL are deemed by the UK government to be in short supply and immigration is accepted as a short term strategy to deal with the shortage (MAC 2008). This process cleared an immigration path so a foreign nurse would be able to immigrate to the UK thus making it an attractive location allowing Zimbabwean nurses to fit into the UK. Given the unfavorable political and economic conditions present in Zimbabwe it is no surprise that Zimbabwean nurses would be eager to go and fill this gap.

4.3.2 The Colonial legacy

The colonial legacy between the two countries has been a plus in making it easy for the UK to recruit Zimbabweans in two ways. The colonial system resulted in a colonial dependency for Zimbabwe. Colonialism effectively resulted in a situation where almost every aspect of everyday life was changed to the British way of doing things. As a result, Zimbabwe adopted the British education system. Zimbabwe so closely mirrored the British education system that even today students in Zimbabwe can take ‘O’ and ‘A’ level examinations that are set in Cambridge. These very similar education systems have made it easier for Zimbabweans to get their nurse training in the UK and fit into continuing education. Entry into the UK nurse training program simply requires five ‘O’ levels including English. This is already a requirement in Zimbabwe to attain any tertiary education.

Nurse training in Zimbabwe/Rhodesia was not always similar for all students. Interviews with nurses who were trained in Zimbabwe before independence revealed that the training standards for African nurses at the time were different from the white nurses. Black nurses, especially in the rural areas were trained at the time to meet the need of the communities that were around them. In those days DW_C0021 who started her nurse training in 1969 said nurses in the rural areas were trained to be able to deal with whatever situation may come up because there was very little access to doctors. DW_0021 noted that such training in Zimbabwe still
continues to meet the needs of remote areas. She further notes that the arrival of independence saw an upgrading of the nurse training in Zimbabwe to meet the standards of other countries, especially Britain.

The upgrading initially started with training medical assistants, followed by maternity assistants and then Registered Nurses (RN’s). DW_C0021 believes that had the Zimbabwean government not upgraded the nurse training, Zimbabwean nurses would not be able to work in the UK. It was an exerted effort on the part of the Zimbabwean government to produce nurses on par with standards of other countries. This point is echoed by Levy (2003) who laments the loss of healthcare workers from Zimbabwe. Levy says after independence Zimbabwe was proud to the able to produce quality health care workers to show they were as good as the British, however, these high standards they sought to meet have lead to the emigration of this vital human capital (Levy 2003). It is the compatibility of standards that has contributed to nurse emigration out of Zimbabwe.

The colonial legacy also functioned in creating information and transportation networks between the two countries. Though no longer a British colony Zimbabwe still has close ties to the UK. The information links that were setup during the colonial era have been strengthened through business activities which continue to link the two places. There are also multiple direct flights between London and Harare each week and these have made it easy for emigrants to be in Harare one day and London the next.

4.3.3 Social Networks

The last way by which Zimbabwean nurses have been able to fit in the UK is through social networks that have been established over the long relationship between the two countries. One would be hard pressed to find a Zimbabwean who does not have a relative in the UK. Nowadays London is commonly referred to as ‘Harare North’. The importance of social networks in migration was given greater relevance under the migration systems theorization. Under this theorization, social networks fall under the micro-structures of migration. Charles Price work on “chain migration” (Price 1963) highlights the vital role social networks play in migration flows. Migrant groups employ beliefs, practices and social resources to develop strategies that enable them to deal with the struggles of migration and settling in new locations
(Castles and Miller 2003. 27). This social capital, also known as cultural capital—i.e. “knowledge of other countries, capabilities for organizing travel, finding work and adapting to a new environment” (Castles and Miller 2003, 27)—effectively reduces the costs of migration and increases potential for subsequent successful migrations (Hermanu 2006). As more migrants from a particular locale successfully immigrate to a new country, cultural capital only gets richer increasing the potential for more successful immigrants to the particular destination country from the source country. The vital links between source and destination countries that keep migrants connected to their home countries result in new dynamics and complexities that make the destination country more welcoming to immigrants (Kandel and Massey 2002).

Networks of Zimbabweans in the UK have been important in helping nurses find their way to the UK in two ways, firstly through the dissemination of information. Participants in this study note that they came to the UK because family in the UK had told them that there were many opportunities they could pursue. It is quite different reading about opportunities from a newspaper versus hearing about it from a relative who lives in the locale. The second way that social networks play a role is through providing financial and establishment support. The prospect of going to a place where one does not know and has no contacts makes it a very daunting task. Table 4.2 below shows the significance of social networks in immigrating to the UK.
Within the context of cultural capital it is clear that the research participants decisions were influenced by networks of relatives or friends who were already in the UK. As table 4.2 shows, the majority of research participants received help to enable them to travel outside the country, though it is clear that not all of them received help. The two leading ways by which help was given to those who traveled outside the country was through paying for their airfare and (or) providing them with a place to stay in the UK. Another way by which assistance was given though not as common was helping with a job search. Settlement issues, especially the provision of a place to stay and assisting in finding employment are clear signs of the advantages of having a network to tap into when migrating. These two particular activities are important in making the UK an easier place to establish one’s self when immigrating to a new place. The importance of cultural capital is highlighted by the informal networks that migrants
have developed to address their needs of shelter, employment, emotional support and assistance toward legal residency as can also be seen among Mexican immigrants to the USA (Kandel and Massy, 2002).

Once research participants have now moved to the UK there appears to a tendency for them to receive less assistance. As shown in table 4.2 only about half of the research participants got assistance in moving to their current location vs. almost three quarters who got help leaving Zimbabwe. The majority of help given once in the UK predominantly came from fellow Zimbabweans. The value of cultural capital is not simply expressed in the help they received in settling in the UK but is also shown in that they have also helped other immigrants to settle in the UK. As shown in table 4.2 a large majority of the research group helped other Zimbabweans settle in the UK. The predominant trend is that most research participants helped one to four people immigrate to the UK. As was the case with the research participants when they immigrated, assistance they gave included paying for airfare, providing a place to stay and assisting in job search. Increasingly, assistance in obtaining a visa comes up with this group as visa requirements largely came into play after they had already immigrated to the UK.

The ability to tap into this cultural capital in many cases is the determining factor as to whether or not Zimbabweans choose to immigrate to the UK. The Zimbabwean community which has been present in the UK for decades in many ways has been an instrumental factor in determining the subsequent success of Zimbabwean immigrants. The following are excerpts from interviews with research participants support this view.

*DW_C004*, “I had relatives here so it was easier”.

*DW_C0026*, “The UK was easiest to come and we had family and friends here. They were the ones who encouraged us to come."

*DW_C0028*, “well it was my dream and it is where my cousin was. If he had been in America I would have tired to go to America. I wanted to go outside.”

*DW_C0029*, “it was a bit of both. Finishing my ‘A’ levels I wanted to go study out of Zimbabwe, be it Botswana, South Africa but the fact that my brother had come here it meant that settling down would be easier for me here.”
4.4: Zimbabwean Nurses participation in the UK nurse industry

Over the nine year period from 1998/9 to 2006/7, a total number of 2,566 nurses have immigrated to the UK from Zimbabwe (NMC 1998-2007). This number however does not include nurses who have immigrated and are working in the private sector. There is strong evidence to suggest that there are many Zimbabwean nurses who are now working in the private sector (McGregor 2007). Considering that the relatively small numbers of nurses trained annually (Chikanda 2006); it will take Zimbabwe many years to replace these lost nurses. What the UK has gained from these nurses is a savings of money for training and the time it would take to train them.

Over this nine year period; an average of 285 nurses have immigrate to the UK annually. This trend however is not likely to continue with time as there has been a reduction in the number of Zimbabwean nurses immigrating to the UK. Unfortunately, even though the number of nurses going to the UK may be falling it does not necessarily mean that the nurses are staying in Zimbabwe (de Castella 2003). Rather, they are emigrating to other countries with place attributes that attract Zimbabwe nurses. Evidence from other researchers’ shows that there have been increases in the immigration of Zimbabwean nurses to countries like New Zealand, Australia and South Africa (de Castella 2003). There is evidence in the literature that South African nurses are filling nurse positions in the UK (Buchan et al 2006). Shortages of nurses in South Africa are now being will by nurses from other peripheral countries like Zimbabwe (de Castella 2003; Crush 2002)

Figure 4.2 graphically shows the number of Zimbabwean nurses who have joined the NMC since 1998. From the late 1990’s there were relatively small numbers of Zimbabwean nurses immigrating to the UK. 1998/99 had 52 nurses join the NMC. The following year however saw an increase of about four times the previous year with 221 Zimbabwean nurses joining the registry. The following years saw a continuous increase in the numbers of nurses joining the NMC until a peak in 2002/2003 where 485 Zimbabwean nurses joined the NMC registry. Since then, there was a year on year gradual decline that eventually reached 90 in 2006/2007.
A detailed look at the numbers of Zimbabwean nurses immigrating to the UK shows what the actions of countries like the UK and other countries of the global core can do to a peripheral country’s health delivery system. Any efforts that have been made to deal with the problem of manpower shortages in Zimbabwe are simply being erased. Given that the financial cost of training nurses in Zimbabwe is completely covered by the government; Zimbabwe is training UK health workers free of charge. How is Zimbabwe expected to meet its own health care needs? As other authors have noted, there is no way that the Millennium Development Goals will be reached if the brain drain continues at this level (Lancet 2005).

In trying to assess the numbers of Zimbabwean nurses working in the UK there is an anomaly that should be brought to light. International nurses that are registered with the NMC are nurses from abroad that were trained outside the UK. Therefore, a nurse who may not be a British citizen but trained in the UK is considered a UK nurse and not an international nurse. This brings to question the UK’s efforts towards self reliance and encouraging locally trained nurses as outlined in the NHS Plan (2000). This is an area that requires more research. Essentially how many of the UK trained nurses are actually British citizens; how successful has the UK been in encouraging more locally trained nurses. If the UK is training immigrants to be
UK nurses that would not suggest progress on the issue of self-reliance. The UK in this case would still be dependent on immigration in order to meet the health care staff shortages. However, there has been no research done on this to determine how successful the UK health industry has been in pursuing self-sufficiency. What is known for sure is that through conducting this research it is clear that Zimbabwean immigrants have been flocking into the nursing field and it would be plausible to suspect that this trend is existent in other immigrant groups. This research project however takes Zimbabwean nurses to be nurses working in the UK of Zimbabwean origin who were either trained in Zimbabwe or the UK.

4.5: Zimbabwean Nurse Experiences in the UK: Giving up Dignity for Cash

Research participants in this study as noted above included nurses who were trained both in Zimbabwe and the UK. Within the research group 10 of the nurses were trained in Zimbabwe and 25 were trained in the UK (see table 4.3). Therefore, the majority of the group constitutes people who either had non-nursing professions in Zimbabwe or were unemployed before arriving. Given that the research sample includes nurses trained in different locations there are differences in their experiences and interpretation of work practices in the UK.

Predominantly most of the nurses in this study have been practicing nurses in the UK for more than three years. Only four have been nurses for less than three years. All nurses who are trained outside the UK are required to undergo an adaptation course registered with a university in the UK in order to ensure quality control. Of the 10 nurses who got their training in Zimbabwe, eight of them completed their adaptation course in less than one year which is normal for nurses whose skills are believed to the competent. This highlights the high standards of nurse training in Zimbabwe. The remaining two took between one and four years to complete their adaptation course to practice in the UK. The extended length of time it took of them to complete suggests that their supervisors were not satisfied with their abilities and therefore required them to take additional courses. This scenario usually takes place when the nurse has not been practicing for a while.
Research participants in this study have mostly worked at only one hospital. Given the relative short amount of time that the participants have been in the UK this comes as no surprise. This rather limited movement can also be a result of the reduced amount of nurse turnover in the NHS. New rules introduced in 2004 under the Agenda for Change (Dept of Health) within the NHS no longer allows nurses to negotiate pay. As a result, they can only get pay increases through time served and further education. Nurses therefore are not able to earn higher pay by moving to a new hospital. As a result there has been reduced turnover of nurses. Following this trend, most nurses stay in one position for longer periods of time. The trend has been for nurses to have worked at their current hospital for between two - six years as shown in table 4.3. Among the research participants the majority of the nurses have no intention of moving from their current hospital. Unfortunately the experience of IRN is not taken into account when determining pay unless they have training in specialized areas of nursing such as intensive care unit nurses, theater nurses or neurosurgical high dependency unit nurses.

A variety of opinions were expressed by the research participants with regard to being a Zimbabwean nurse in the UK. Issues brought up include working long hours, dislike of certain aspects of the job, limited opportunities for training and promotion, a fear of law suites, under utilization of their skills (underemployment) and racism from a variety of avenues. By far the

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**Table 4.3: Nurses Experiences in the UK**

<table>
<thead>
<tr>
<th>Years being a nurse in UK</th>
<th>3-8 yrs</th>
<th>27</th>
<th>&gt;8 yrs</th>
<th>2</th>
<th>Country of nurse training</th>
<th>Zimbabwe</th>
<th>10</th>
<th>UK</th>
<th>25</th>
<th>Other</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Adaptation course</td>
<td>&lt;1 yrs</td>
<td>8</td>
<td>1-4 yrs</td>
<td>2</td>
<td>Number of hospitals worked at</td>
<td>1</td>
<td>20</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Yrs at current Hospital</td>
<td>&lt;2 yrs</td>
<td>4</td>
<td>2-6 yrs</td>
<td>21</td>
<td>Plans to move</td>
<td>Yes</td>
<td>5</td>
<td>No</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied to stay</td>
<td>Specialization</td>
<td>2</td>
<td>Other</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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issue that came up the most expressed by both Zimbabwe and UK trained Zimbabwean nurses was racism. The sentiments expressed by the research participants appear to be quite common in the literature. The notion of racism is one for which there is a lot of evidence in the NHS. Beishon, Virdee and Hagell (1995) find that IRN are often subjected to racism from both their colleagues and patients (also see Carter 2003; Likupe 2005; Alexis, Vydelingum and Robbins 2007). Gerrish and Griffith (2004) also find that 40% of ethnic minority nurses report experiencing racial harassment from colleagues and more than 64% suffer racial harassment from patients. Racism against ethnic minorities in the NHS is sometimes manifest through reduced access to promotion and training opportunities, disregard for the IRN’s prior experience and being expected to only perform low level tasks (Likupe 2005).

Research participants talked about racism largely originating from patients and co-workers. The nurses noted that many a time patients would much rather be attended to by white nurses. Research participants often made it clear that patients would rather listen to a white medical assistant vs. a black registered nurse. A theme that ran across all the interviews was that black nurses in this field had to be very patient in order to succeed. DW_C0006 stressed the importance of developing a thick skin in order to survive racism in the field. These sentiments are echoed in the literature which highlights IRN as having a concept of being ignored as they are often evaded by patients and co-workers alike to inquire patient status from white nurses yet the IRN are the ones taking care of them (Alexis, Vydelingum and Robbins 2007). Another research participant noted that her patients are always keen to find out whether she will be going back to her country. She said she never feels like she is treated similar to her white co-workers by the patients. One of the nurses working in mental health nursing mentioned that patients tended to have a loose tongue and that they always tried to make you feel alien. DW_C0006 had this to say:

“...especially when you come across racist patients. You find that you put your all into caring for them and they are not even grateful. Some do it in a clever way and are curious in finding out whether you will be going back. Others are very open about it which is very demoralizing.”
DW_C0021 also had this to say: "The patients look at the color of your skin and do not believe that you have the ability to be a nurse and don’t expect you to know what you are doing. At times you get the same reaction from subordinates and colleagues. As a result you have to be very vigilant on the job. There can also be very awkward behavior among the staff which is racially motivated”.

Apart from racism from patients, racism from within the institution seemed a significant topic among the research participants. Almost all of them had complaints about their co-workers and managers regarding the way they treated them. Racism that came from co-workers surprisingly did not only come from whites. Research participants made it clear that nurses from other regions of the world seemed to have prejudice against nurses from Africa. It seems to be a situation where people from similar ethnic groups looked out for each other. Given the diversity in the NHS nurse staff, there are likely to be difficulties working with people from different cultures. This point is echoed by Gough (2004) who notes that investment in recruiting IRN should also be followed with investments to ensure proper integration and retention of these nurses. Other researchers note that very little has been done to cater to the needs of IRN’s to ensure their integration, success and satisfaction in the NHS (Likupe 2005; Lipley 2005; Allen and Larsen 2003). Some of the research participants note that it was difficult to get through to both patients and colleagues. DW_C0030 had this to say,

“you can be racially abused. Many a time you could be trying to help someone and you get a lot of ‘F’ words. There are challenges working with both patients and colleagues as cultures differ; Indians, Africans, Filipinos, etc. It takes a lot to get through to patients and nurses.”

On the issue of racism and difficulties with co-workers DW_C0029 had this to say,

“Another problem could be if you encounter someone who is ignorant or racist. It is difficult and quite a challenge to work with people like
that because they take you being black as a weakness. You have to be strong to work with those kinds of people.”

Another concern research participants expressed is communication problems. Participants note they often had problems communicating when they initially arrived because of the variety of dialects and accents in the UK. Research participants note when speaking with British co-workers and patients they often could not understand each other. This problem has been highlighted in the literature by Allan and Larsen (2003) who find that there were problems communicating between the British nurses and IRN’s because of accents. Nurses in the study by Allen and Larsen often found themselves frustrated as in some cases they could not give reports because their British colleagues laughed and giggled when they spoke (Allen and Larsen 2003). DW_C0026_1 had this to say concerning some of the challenges she faces working as a nurse in the UK,

“Being a foreigner, English is our second language. The accent really, for me it was a challenge. I had to listen very carefully. I had to understand the English and the accent. At times people had to interpret for me.”

A second experiential concern raised by research participants is underemployment. The literature is clear that IRN’s undergo a process of deskilling or under utilization when they immigrate to the UK (O’Brien 2006). The fundamental cause of this phenomenon is that the NHS is recruiting qualified and experienced nurses with high levels of technical skills from health care systems that do not emphasize direct care to do low skilled direct care which typically involves activities like toileting, washing and feeding; tasks which are very repetitive and uninteresting (O’Brien 2006). This is exactly what is transpiring with the nurses trained in Zimbabwe who now work in the NHS. IRN often find themselves in frustrating situations as they are not allowed to use their technical skills simply because they have not undergone UK training which certifies their skills. In order for IRN to perform more technical duties and attain a higher nursing grade they have to take additional courses which for IRN is typically delayed due to red tape (O’Brien 2006). Other researchers have noted that the NHS is missing an opportunity in taking advantage of the skills, experience and decision-making IRN have. Research participants
trained in Zimbabwe expressed frustrations at not being able to perform certain tasks which they typically performed when in Zimbabwe. Some mentioned that there are a variety of skills they used to perform as nurses in Zimbabwe which can only be done by doctors in the UK. They also complained that they were never given an opportunity to take initiative or work independently. They always have to wait for direct orders from the doctors or ward managers. A common complaint they had was that anything technical always had to be done under supervision and there is always some paper work involved. DW_C0021’s comment brings this point to life:

“I had more job satisfaction in Zimbabwe. In Zimbabwe nurses have greater latitude to practice their profession. There are many things here that only a doctor can do and no one will do anything about the situation until a doctor comes to do it. Whereas in Zimbabwe the nurses are able to do a lot more. In the UK there is a specialist for everything and that can kill some moral at the work place. Even putting in an IV, here a nurse can not do it. Yet in Zimbabwe we did everything.”

The notion alluded to by DW_C0021 of deskilling being a moral killer is also supported in the literature. Alexis, Vydelingum and Robbins (2007) note that the lack of trust superiors have in the abilities of IRN and constantly watching over them results in many loosing confidence, lowering their self-esteem.

The process of deskilling is interpreted quite differently by the Zimbabwean nurses who were trained in the UK. For these nurses, the low skill duties they are expected to perform have taken them by surprise as their view of the nursing profession was shaped by what they saw in Zimbabwe. UK trained nurses noted that they had to perform duties they did not typically associate with nursing. For some it was something they totally did not expect. DW_C0006 had this to say, “I knew about giving medication, however, this thing of washing and feeding patients I did not like at all. It is just so different from what I used to think…”

A third concern raised by research participants (both Zimbabwe trained and UK trained) is restricted opportunities for further training and promotion. Research participants largely feel that they are often disenfranchised unlike their white counterparts in terms of training opportunities. DW_C004 had this to say:
I have been working as an ophthalmic nurse for three years and I have not been given much opportunity to take further training courses and as a result I do not expect any promotions... they tell us that there is no funding, however, others are being given the opportunity to take courses... it may have to do with me being from Zimbabwe and others being born here. I don’t really know.

DW_C0006 put it quite bluntly when she said:

“...as for whites, a new one comes today and tomorrow they are training. A new black hire comes and it will take two years for them to get a training course... It is not officially written but it is how things work. The whites look out for each other”.

Alexis, Vydelingum and Robbins (2007) also find that IRN were also given little or no access to opportunities such as promotions and training courses. Participants in Alexis, Vydelingum and Robbins study note their managers always had reasons why they are not given access to opportunities yet white nurses who came after them get promotions. O’Brien (2007) also notes that nursing in the UK has established a system where IRN are not easily accommodated for vertical movement as their primary reason for being recruited is to perform duties that the British are not so keen on doing. As such, IRN have traditionally been viewed as cheap labor expected to fill positions in low grade nursing.

Although this may be the trend, some research participants have different experiences. BW_B0023, seems to find herself in a position quite different from other Zimbabwean nurses. BW_B0023 has had no problems getting promotion opportunities. Over the past two years she has turned down promotion opportunities. She explains her reasons for turning down promotions this way:

BW_B0023:...usually black people don’t get much opportunity to rise. The post I am now took me 6 months to rise to it where normally it would be 2 yrs. I had a lot of experience behind me and since I had gotten my training here, they counted me to have 20yrs of experience.
The reason I did not want to raise is that I had seen what had
happened to the other black girls who rise. As soon as you get up there they don’t like you anymore. They only like you when you are rising or when you are at the bottom.

Researcher: Who is they?

BW_B0023: I am talking about the white guys. The white guys do not want to see you above; plain and simple. There was one black girl who had gotten up there; she was a very bright girl. What happened was the one who was above her, a white person started by passing her. The black girl didn’t know what was going on. That is what I saw. I realized that the fall from there is too hard. You are better off as a black person staying on the front line and catching the bullets.

Researcher: so how long has it been since you have risen to any position?

BW_B0023: I was just recently due for a promotion which I turned down. For that position it is a non nursing management position, it is an 8-4 job and I can’t afford it. My salary goes up yes for my basic pay, but I can’t do any extra work. With all the extra work I do, it would be a 20,000 per yr cut if I took the job. I am paying my children’s university fees and I simply can’t afford it.

From what BW_B002 said it is clear that a perception among the black nurses exists that they are intentionally being kept out of higher positions. Even when they do get the opportunity to get a promotion there is a general sense of pessimism that they will not be successful on the top because the whites don’t want them there. Another point raised by BW_B0023 is that a promotion will translate to an elimination of overtime and will equal a pay cut. A number of the research participants did mention that they do work a lot over time to make extra money however non of them have been offered the non-nurse management position so it would be inappropriate to infer as to whether they would turn the position down.

Despite what BW_B0023 says, generally speaking the urgency for promotion and training opportunities are not shared by all the nurses. It appears the greatest determinant to
concerns about promotion and training opportunities are age and family. The younger nurses who tend to be UK trained nurses express greater concern about the absence of promotion and training opportunities. The exception to this is a middle aged Zimbabwean trained nurse who did not have a family and was hence, more career oriented. The older nurses who were largely trained in Zimbabwe highlight the absence of training and promotion opportunities, however, they are not eager get promotions. For this group, their major concern is deskilling, which lowers their self-esteem and makes their work repetitive and boring.

To investigate the other side of this problem, three nurse administrators were asked questions about training opportunities for nurses. Administrators who participated in this research made it clear that due to the financial problems that the NHS is facing there have been major cuts for training courses. The result has been fewer opportunities that are awarded competitively or based on merit. One administrator noted that many a time nurses are not very clear about how the selection process works. For Kings College hospital, evaluations are a major tool used to pick candidates and most nurses are very ignorant about the evaluations and what it means for training opportunities. One of the administrators expressed great frustration at UK nurses attitudes concerning training courses because many of them believe they deserve to be given further training at no cost to them. Fundamentally they said there is a communication gap between the nurses and their supervisors about the process and selection criteria. However, the nurse administrators note they are aware of prejudice on the part of some ward managers. One of the administrators admits that some of the ward managers view IRN as being here only temporarily and therefore there is no point in investing in them if they are only going to leave. However, they did say that to call it a common trend would be unfair.

Levels of satisfaction with the profession seemed to be split fifty fifty between research participants. This spilt in the like and dislike in the UK nursing industry is also noted in Likupe’s research of the experiences of nurses who are ethnic minorities (Likupe 2005). There is a general consensus that the money is good. A number of them said that the money they were making was going a long way back in Zimbabwe. DW_C0030 said, “the money is good. When you send it back home it is helping a lot of people”. Nurses trained in Zimbabwe were happy to get a lot more money for the same job. On the other hand they are not happy being deskilling
or underemployed. Another complaint that many of them had was that they worked really long hours. A typical shift in the UK is normally twelve hours which many thought was too long. The typical nurse shift in Zimbabwe is eight hours. However, many take on extra hours to make over time pay.

Overall the research participants were generally pleased that nursing gave them a legal path by which to stay in the UK. Given the thousands of Zimbabweans that are in the UK illegally and live in fear of being deported if found out, the research participants found that nursing gave them stability and security. DW_C0030 said the following:

“As a foreigner I was looking to the future and what would let me stay in this country. The ability to get papers is what drives me in working as a nurse.”

Though research participants have complaints about a number of things, on the whole they are quite happy with their circumstances. Zimbabwean trained nurses particularly mentioned that if the working circumstances had been the same they would rather be in Zimbabwe.

The above section highlights some of the experiences Zimbabwean nurses face in the NHS. Racism is by far the largest determinant that shapes their work experience. Patients and colleagues alike, subject the research participants to racism which makes their work environment more difficult to navigate. Racism is so ingrained/ institutionalized that it affects the nurses’ perception of other issues like further training, promotions and deskilling. Research participants find that their white colleagues are awarded more training and promotion opportunities. The perceptions on these issues differ between nurses trained in Zimbabwe vs. the UK. The differences between the two groups on this issue have to do with the stages they are in their lives. The Zimbabwe trained nurses who tend to be older and have families are reestablishing their lives in the UK, hence, concerns regarding training courses and promotion are less important. The UK trained nurses who tend to be younger and more career oriented are looking for vertical movement within the NHS. For both however, nursing is clearly a strategy used to secure their immigration status in the UK, whose importance should not be overlooked.

4.6: Conclusion
Available NMC data makes it clear that IRN make up a small percentage of the total NHS nurse work force. The vital role that IRN play in the NHS today is demonstrated through the numbers of new NMC registrants. In recent years the percentage of IRN joining the NMC registry has been as high as 50% (NMC 2008). Since 2000, Zimbabwean nurses have been a major contributor of nurses to the UK, averaging 265 nurses over the 2000 -2006 time period (NMC 2008). Like all other IRN, Zimbabwean nurses tend to gravitate toward London. This is largely a function of the nurse shortages in the UK largely being found in London and the South East (Batata 2006). Though there is gravitation around London the research participants in this study have had a high propensity to live in other regions of the UK.

The work experience of Zimbabwean nurses in the UK is some what mixed with some having positive experiences and others having negative experiences. Findings in this study support those of others that argue the NHS has done a poor job of integrating IRN into the NHS and has failed to utilize many of the nurses’ technical and managerial experience (O’Brien 2007; Likupe 2006; Allan and Larsen 2003). There are many instances of deskilling where IRN are not given the opportunity to utilize their skills. This unfortunately creates a brain loss and is therefore a waste of human capital in the UK and creates an opportunity cost as these skills could otherwise have been used in the home countries of IRN. In order for the UK to better address this problem of brain loss they should not be recruiting experienced technical nurses to do direct care nursing. Another major concern regarding the work experience of Zimbabwean nurses is that of racism at the individual, colleague and institutional level. Related to this, access to training opportunities and promotion result from the British seeing IRN as temporary nurses to undertake direct care nursing. Furthermore, the IRN are perceived to only be here on a short term basis, as a result they see no need to invest in them. In order for all nurses to be given equal access to opportunities the perception of these IRN being here to do dirty jobs should change.

Zimbabwean nurses’ participation in the UK is a function of three particular factors namely the shortage of nurses in the UK, the colonial ties and the social networks emigrants are able to tap into. These three factors have created the right mix of place attributes that have allowed Zimbabweans to enter the UK and integrate in to British society. The historical, colonial
and social networks created the necessary opportunities, training and resources to allow Zimbabweans enter into the NHS as nurses. The combination of negative place attributes in Zimbabwe and positive place attributes in the UK have allowed these immigrants the opportunity and necessary resources to take advantage of the varying geographic gradient of opportunities. In essence, these nurses are giving up their dignity for cash.
Chapter 5

Transnational Activities: Maintaining connections between Zimbabwe and the UK

5.1: Introduction

Transnational activities are synonymous with the concept of migration. Typically when a migrant immigrates to a new country they will almost surely engage in activities that will link them to their home country. The concept of transnationalism has to do with the meshing of different aspects of immigrant life that migrants maintain and renegotiate across political boarders (Owusu 2007). Transnational activities can be expressed in multiple ways, some of which include the movement of people, goods, ideas, remittances and capital (Owusu 2007; Schuerkens 2005). There has been a lot of attention paid recently to large movements of money across the globe in the form of remittances (de Hass 2006; de Hann 2000; Maimbo and Sander 2005; Brown and Connell 2006). Given that the primary reason for migration, is to better one’s situation (Ravenstein 1889), the typical scenario that transpires is that the betterment of the migrant’s situation abroad also translates to the betterment of the migrants kin in the home country.

Remittances that migrants send back to their home countries have been seen to have greater benefits beyond the immediate recipients of the money (Akokpari 2006). The multiplier effects of remittances tend to benefit the larger society as a whole as this money runs through the economy of the home country (Hugo 2006). For a number of these countries, remittances have resulted in higher capital flows compared to foreign direct investment (FDI) and official development assistance (Sander and Maimbo 2005; de Hass 2006). The value of remittances have been so great to a number of countries that countries like the Philippines have made it government policy to encourage citizens to travel abroad and remit their income (Brush 2007). The ease with which immigrants are now able to send money around the world is largely due to the technologies of globalization (Maimbo 2005).

Some have argued that for development to take place in the global semi-periphery and periphery brain drain is a necessary step (Arango 2000). Through the transnational activities engaged in by the diaspora communities of these countries essential components of
development can flow. These include investment, technology and information, and social capital (Patterson 2007). Return migration is an essential component of making this transfer of assets to the home country. Return migration has been synonymous with development in Taiwan, India and South Korea (Saxenian 2005; Zweig 2006). Key to this return migration is a creation of opportunity that is globally competitive (Saravia and Miranda 2006) as highlighted in chapter 2. With a brain drain clearly evident in the Zimbabwe nursing industry, Zimbabwe does not stand the join the list of countries above that have seen return migration lead to development because of the failure to address concerns that cause emigration, even with opportunities shrinking in the UK. In this chapter, transnational activities that Zimbabwean nurse immigrants participate in are examined. This is the third major research question; What are the transnational connections that exist between the two places? Three sub-questions will be addressed: first, what are the transnational connections to Zimbabwe, second, what are their projected future plans, and third, what effect has the migration of nurses had on the respective countries. With regard to the second sub question particular interest is focused on the possibility for return migration and what this return migration could mean for Zimbabwe.

5.2: Transnational Activities

There are a great variety of ways by which migrants transnationally connect with people across the globe. Transnational activities include, “flows of people between countries, money (both capital and remittances), goods, political relations and even political representation” (Yeboah 2008: 43). Today there is almost no limit to the aspects of life that migrants can exchange transnationally. A common trend today is one of transnational mothering as women have become more active in migration acting as bread winners (Wong 2006, 2000). The significance of these transnational activities is their ability to allow people to connect across different geographies (Yeboah 2008: 43). This section addresses the types of transnational activities research participants engage in. They include maintaining contact with family and friends in Zimbabwe, sending remittances back to Zimbabwe, and visiting Zimbabwe. Table 5.1 shows an overwhelming majority of the research participants are active in sending remittances back home.
Of the research participants who are active in sending remittances the majority (19) remitted between 1-15% of their income. A significant number remitted between 16-30% and few remitted less than 1%. From the interviews conducted with the research participants it is clear that remittances that are sent to Zimbabwe play a very important role in the lives of the recipients. On the issue of remittances DW_C0026_1 had this to say, “Because of the economy in Zimbabwe we are the bread winners for people back in Zimbabwe, they rely on us.” de Hass (2006) argues that remittances go a long way in alleviating poverty as the money goes directly into the hands of those who need it. de Hann (2000) notes households in Zimbabwe that have a migrant abroad have better standards of living and better education compared to household without a migrant. Remittances that are sent back are used for a variety of activities, however for the most part these activities are limited to day-to-day consumption activities. Very few research participants made note of these remittances being used for investment. Failure of remittances going into productive forms of investment is unlikely to result in development as recipients remain dependent on the remitters for their income (Hugo 2006). The major investment activity the money was being used for was in the construction of homes.

As noted by Sander and Maimbo (2005), remittances are typically spent on consumption in the Sub-Saharan African context. Of all the activities that remittances (by participants) are used for, the one that came up the most was paying for school fees. The use of remittances on school fees ties in well with research conducted in Ghana which saw 70% of remittances spent

<table>
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<th>Table 5.1: Transnational Activities</th>
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<td><strong>Send Remittances</strong></td>
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<tr>
<td><strong>To Zimbabwe</strong></td>
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<tr>
<td><strong>Remittances as % of income</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Call people in Zimbabwe</strong></td>
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on consumption like education and health care and less than 30% invested in assets like land, cattle and construction (de Haan 2000). With the deteriorating situation in Zimbabwe the education system has also suffered with fewer educational resources for government schools (Power et al 2004). Research participants note that if they want to get a good education for their children in Zimbabwe it would be better for the children to be in private schools as noted by DW_A0034 a nurse working in Zimbabwe, “...with the current situation we can’t afford to send children to good schools and good schools are only private”. On sending remittances to Zimbabwe DW_C0026_2 had this to say, “I send money back as well. I really don’t want my nieces and nephews not to pursue their education because their parents don’t have money. So I would help where ever I have to help”. Other consumptive uses of remittances also included buying food, clothing, paying for repairs, paying for accommodation; largely day to day poverty reducing activities.

Remittances may have negative effects. Some of the unintended consequences of remittances are they can negatively affect the receiving countries balance of payments (Hugo 2006). Given that remittances are largely spent on consumer products, in countries of the periphery and semi-periphery there is a higher propensity that a large number of these consumer goods are imported. As a result, the makers of these products tend to benefit most and since these goods are being imported it has a negative effect on the balance of payments.

Among research participants, there is a strong tendency for them to keep in touch with family and friends in Zimbabwe. As shown in table 5.1, all but one of the research participants regularly calls friends and relatives in Zimbabwe. During interviews some of the participants noted that they call Zimbabwe on a daily basis. Another way by which contact is maintained with kin in Zimbabwe is through regular visits. As noted in chapter 3 all but one of the research participants have at least visited Zimbabwe once since they migrated. 30 of the research participants have visited between one to six times and 6 have visited more than six times. The regularity with which the research participants can keep in touch with kin in Zimbabwe through telecommunication, the Internet and travel is a result of globalization which has been very effective in reducing cost and making these activities available to wider segments of the world’s population (Dwyer 1999; Light 2004). The frequency with which the research participants are
able to visit Zimbabwe is also a reflection of their legal resident status in the UK which allows them to leave and re-enter the UK.

5.3: Future plans and Return Migration

Among the respondents a variety of views were expressed as to where they expected to see themselves in the future. Going back to Zimbabwe was often brought up. For many of the research participants a return to Zimbabwe almost seemed inevitable. This type of longing for one’s home country is quite common among migrants (Gmelch 1980). In many cases the migrants desire to return is tied to their imagined concept of what home was when they left their home country (Gmelch 1980). In many cases there is likely to be a disconnect between the migrants imagined concept of what home is and the reality of what their home country has become since their departure (Tsuda 1999 ; Christophi 2007; Christou 2006). Many respondents express the view that once things in Zimbabwe improve they will make their way back home. However, it is important to note the expected return is all dependent of the conditions in Zimbabwe changing. Though there is ever a longing among immigrants to return home, for many, this remains a longing and more often than not does not become a reality particularly when migrants from the global semi-periphery and periphery emigrate to the global core and acquire tertiary education (Christophi 2007; Saravia and Miranda 2006). Christophi (2007) shows that almost 40% of immigrants who came to study in the US typically do not return home. Saravia and Miranda (2006) note that 66% of foreign engineers in the US acquired their training in the US. Furthermore, 50% of foreign born graduates in France, the UK and the US remain there after completing their studies (Saravia and Miranda 2006).

For many scholars, return migration has been seen to be an important aspect of development. Arango (2000) believes that return migration is one of the means by which countries of the global periphery and semi-periphery can benefit from brain drain migration of their citizens. The basic notion is that the skills and knowledge migrants acquire abroad can be brought back to the home country when they return (Patterson 2007). How successful these return migrants are in bringing “development” to their home countries is difficult to measure. More often than not it is likely that return migrants are not very successful in bringing the particular skills they acquired abroad (Cerase 1974). The expectations for what the returnee is
able to do after being abroad in many cases can turn out to be too high (Cerase 1974). However other researchers argue that the developmental impact of return migrants are dependent on a number of factors that include receptiveness of the home country, whether they are a high or low skilled return migrants, their preparation for return migration and their ability to mobilize the right kind of resources to have an impact in their home country (Ammassari 2004; Cassarino 2004). Assamarri’s (2004) research in Ghana and Côte d’Ivoire finds that high skilled return migrants are able to make notable contributions in political, social and economic sectors upon their return. Both Cassarino (2004) and Ammassari (2004) agree that the utility of return migration in fostering development is greatly influenced by the role of government in creating a receptive environment and providing resources to deal with the challenges of return migration.

There is a strong desire among the research participants to return to Zimbabwe as noted above. Table 5.2 clearly shows that there is an overwhelming majority of research participants who intend to retire in Zimbabwe. With regard to the issue of human capital, this return of professionals has potential for a brain gain, however, if this return takes place in retirement it is likely to negatively affect the utility of this human capital as the returnees are out of their prime working age. What would be more beneficial for a brain gain to transpire is for the migrants to return while in their productive years.

<table>
<thead>
<tr>
<th>Retirement country</th>
<th>Zimbabwe</th>
<th>UK</th>
<th>Other</th>
<th>Not Sure</th>
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</thead>
<tbody>
<tr>
<td>Visit the UK in retirement</td>
<td>Yes</td>
<td>25</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>31</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Will your children ever live in Zim</td>
<td>Yes</td>
<td>30</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
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Table 5.2: Retirement
Though return migration of these research participants would be most beneficial if it transpires during their productive years it is unlikely that Zimbabwe will experience a brain gain within the nursing industry specifically. During interviews an overwhelming theme that persisted is that none of them would return to Zimbabwe to work in the nursing field. They all said that doing nursing in Zimbabwe would be a waste of time because they would not get anything from it (financial benefits). The negative views held about the Zimbabwe nursing industry are highlighted by nurses in Zimbabwe of which 68% are seriously contemplating emigration (Chikanda 2006). When asked if they would continue their nursing profession in Zimbabwe if they had to return some said the following:

**DW_B0003:** Probably not. From what I hear nurses in Zimbabwe make about £50 per month and they go months sometimes without being paid. Furthermore the facilities and conditions are not adequate. I don’t think it is safe for me to be working under those conditions and the money is not good.

**BW_B0023:** No... I could never go to back to making the salaries that the nurses are making now.

**DW_D0018:** Honestly, no. I can’t go to work yet the money is equivalent to bus fair. I can’t do that. Unless things change but otherwise I can’t.

It is no surprise the research participants would not want to work as nurses in Zimbabwe. A few note that they may be willing to work as volunteers simply to help, but not as their main source of income. **DW_C0006** had this to say, “Not as a fulltime thing but may be as a volunteer, mainly because of the money”. Among the research participants only one expressed interest in being involved in nursing financially. **DW_C0026_1** noted that she would be interested in starting a community nursing program. She noted that it already exists in Zimbabwe but she thought there are ways for it to be improved.

A notion that has been taken for granted concerning the nursing industry is that the nurses who are trained within a particular country have an obligation to stay in the country and carry out their profession. This notion has resulted in countries of the global core being accused as global raiders and poachers of healthcare workers (Crush 2002; Ahmad 2004; Kupfer 2004). Some countries of the global periphery (like South Africa) have requested that countries of the global core (like Canada) stop recruiting their healthcare workers (Crush 2002). Such practices
have raised questions among researchers about the notion of people’s rights to have freedom of movement (Dale 2005). As Dale (2005) notes this has put the Canadian government in difficult situations where they are not allowed to recruit nurses from South Africa, however, individual South African nurses show up on their door step asking to be let in. An ethical question that rises out of this is: should only health care workers be denied the freedom to move where they please?

The notion that healthcare workers from the global periphery should work in their countries of training suggests an obligation or duty on their part to serve their countries. Given that the training of healthcare workers in the global periphery is heavily subsidized (Eastwood 2005; Ihekweazu, Anya and Anosike 2005), it makes sense that healthcare workers should have some duty to give back to their countries. Though this may be the case, research participants generally hold the notion that this obligation/duty is not feasible given the current situation in Zimbabwe. An overwhelming theme that is made clear is that they would like to give back to the country, however the situation is one where if they did return home to act on that duty they would not be able to take care of themselves and their families, and they would put themselves at risk of falling ill. Some note that they are able to give more help to the country from outside with the money they send back. A clear message is that the government has to do more to fix the situation to incentivize nurses from leaving. The following are responses given by the research participants on the notion of having a duty to serve the country in light of the nurse shortage.

*DW_C0006:* “yes, as long as the government meets me half way. I can’t take care of HIV patients without gloves or aprons. I can’t put my life at risk.”

*DW_C0021:* “yes, I feel the obligation; especially for our generation. When we went into nursing we did it to help and not for the money. However, given that we don’t get much, then it means nothing.”

*DW_C0030:* “That is not feasible I think. The situation on the ground will not allow you. The only help you give is from outside to provide financial support.”

*DW_D0018:* “To be honest I do have that feeling. In fact some of my things are still packed now from when I wanted to go back to Zimbabwe.
*That desire is there, but then again, you think what is the state of my future. There are children at home who need to be taken care of. I have a lot of responsibilities. The kind of money I will be making if I go back will not even be enough... Those few pounds I get I can manage every month to send something back home.*

Among the research participants many express an interest in starting their own businesses back in Zimbabwe. Return of these research participants to Zimbabwe could bring benefits to the country through increases of financial capital being productively invested in business and would enable multiplier benefits throughout the economy. It would appear that in order for Zimbabwe to benefit from the human capital of nurses that exists outside the country steps have to be taken to improve the nursing industry in Zimbabwe to make it a place where people want to work. As Saravia and Miranda put it, create opportunity that is globally competitive (2006). For the Zimbabwean context the approach to making the Zimbabwe nursing field attractive has to be two tiered. First, focus must be put on the nursing industry where improvements must be made to make it acceptable as a work place for foreign Zimbabwean nurses. Second, economic, political and social conditions have to be improved to provide them as residents of Zimbabwe a good country to live in. As noted in chapter 2, efforts to making the nursing industry attractive include better remuneration, lower nurse-to-patient ratios, supply of basic and up to date equipment, better availability of medicines, and opportunities for further training and research (Chikanda 2006; Johnson 2005; Feely 2006; Saravia and Miranda 2006). The second tier of making Zimbabwe attractive to the human capital abroad has to do with issues like increases in democratic freedoms, investments in science and technology, and a quelling of the political situation. These specific concerns which apply to Zimbabwe as a unique location tie into the concept of place attributes being responsible for migration. Until a better set of place attributes exist return migration is unlikely.

The split interests seen among the research participants in their immigration to the UK to seek a better life and a desire to return home are further highlighted in their responses to the interview question: do you see the UK as your final destination. Though many of the research participants said no, many of them admit that it was likely they would end up staying in the UK for a long time. For most, their desired final destination is Zimbabwe, however the
economic and political conditions in the country have continually gotten worse and as a result they fear they will have no option but to stay in the UK. DW_C0021 had this to say about the question,

No, not really. If things change at home I would go back. When we initially came here we had no intention of staying long. However, things at home keep getting worse so we find ourselves staying. If things don’t change then it seems we have no option.

DW_C0014 also had this to say:

I would like to go back home but the situation at home is bad and I think I would be better of here. Being in the UK I am able to support my family better than I could if I was working in Zimbabwe.

Both of the research participants noted above desire to return home, however, the reality of the situation is they can provide a better life for themselves and their families while living in the UK. As a result their interests are spilt between the two countries.

This realization, that they can obtain a better quality of life for themselves and their families has led the research participants to secure their immigration status in the UK (which for many who trained in the UK is why they went into nursing in the first place). Foreign nurses in the UK are able to obtain a work visa that allows them to work in the UK for periods of three years with each successful renewal. After two renewals they become eligible for indefinite stay. Indefinite stay gives immigrants a secure immigration status that allows them to stay in the UK and no longer be bound to a particular work industry to maintain their immigration status. Some of the research participants have taken to securing their immigration status one step further by obtaining (or are in the process of seeking) British citizenship. Of the 13 research participants with whom interviews were conducted 2 of them already have British citizenship, 10 still had Zimbabwean citizenship and 1 had South African citizenship. Of the 10 that had Zimbabwean citizenship, 7 expressed interest in changing it to British citizenship. The one individual who had South African citizenship was seeking to have dual South African and British citizenship.

The main reason given for this desire to change citizenship was ease of travel. Many of the research participants noted that travelling with a Zimbabwean passport was very difficult
because it presented a lot of hurdles. DW_C0006 had this to say about changing her citizenship to British:

   *DW_C0006: I hold Zimbabwean citizenship and in a few months I will be changing to British.*

   *Researcher: could you tell me why you will be changing it.*

   *DW_C0006: well, it is the easy access to some of the goodies in this country and for traveling purposes. You know when you hold that red book they don’t look at you twice.*

Other reasons mentioned for changing their citizenship were access to better jobs, the freedom to do more in the UK and get better access to the benefits of being a British citizen. DW_C0026 had this to say about why she would like to change her citizenship:

   “...I will stand a better chance with a British passport and I can work wherever I want. I can do part time jobs; I am no longer at one place. Like right now, I am working at a place full time and it’s not by choice. With a British passport all that will change. You can do what ever you want. I can start my own business here”.

It is important to note that not all wanted to change their citizenship though they were in the minority. Of those who did not want to change their citizenship DW_C0021 had this to say, “my citizenship is Zimbabwean. If things continue to get hard we may want to change it but at the moment we don’t intend to change it”. DW_C0021 came to the UK and expected a short stay. However, the situation in Zimbabwe continually gets worse and today she finds herself in a position where she is waiting for things in Zimbabwe to get better for her to return.

Among the research participants, by far the most popular place for retirement is Zimbabwe as shown in table 5.2. A few noted that they were unsure where they wanted to retire and even fewer expressed a desire to retire in the UK or another country. This attachment to Zimbabwe is very strong across the board as expressed by DW_D0018,

   “I would want to retire in Zimbabwe because home is where the heart belongs. But things in Zimbabwe are so unpredictable. At times you want to and at some times you don’t. Suppose if I get my own business in Zimbabwe and I am content I would want to stay at home to be honest. I am tired of

93
working as it is now. Here in England I have worked so much and I am just so
tired of working. Even now if I could open a surgery in Zimbabwe I would
leave...”

An over whelming majority of the research participants further noted they would visit the UK after retirement. Even in retirement there appears to be a desire to continue transnational activities including travel. The desire to travel to the UK in retirement may be tied to the notion that almost half of them do not believe that their children will ever live in Zimbabwe.

Among research participants, there is a strong desire for a majority of them to be buried in Zimbabwe. This desire to be buried in Zimbabwe further makes clear attachment to Zimbabwe among the participants. Some of the research participants note they felt eerie answering the question. There are five research participants who noted that they wished to be buried outside Zimbabwe. Some of the countries mentioned include the UK, South Africa and Nigeria. Those wishing to the buried in these countries are married to spouses from theses countries.

5.4: Establishing Roots

Due to interests pulling the migrants between Zimbabwe and the UK a number of scenarios have developed that have effects of both countries. The concerns of family, career and individual needs have seen the research participants plant feet in both countries through transnational activities. This section addresses the ways in which the research participants are establishing roots and how they appear to be planting feet in both countries. The effects of transnational activities on both Zimbabwe and the UK are also addressed.
The transnational natures of the migrants’ lives are well exhibited in table 5.3. The data shown in this table demonstrates the way in which migrants have in various ways planted their feet in both countries. The majority of research participants responded that they considered Zimbabwe to be home. Only one notes that they consider the UK to be home and few others note they consider both Zimbabwe and the UK to be home. A large number of research
participants did not answer this question in the survey. For some, their reason for not responding to the question was they found it difficult to say where home was. One of the research participants notes that her heart was in Zimbabwe, however, she does not see herself living there in the future. Despite such split commitments, attachment to Zimbabwe as home is exhibited by the research participants as many of them own homes in Zimbabwe. However, there is a substantial number that do not own homes. Home ownership in Zimbabwe is a clear sign of a vested interest in the country. As seen in examples in other countries, remittances typically lead to home construction as can be seen in Ghana (Yeboah 2000). The same scenario appears to be taking place with the Zimbabwean migrants.

A clear sign of the research participants establishing roots in the UK is also seen in the numbers of UK home owners. As shown in table 5.3 the numbers of UK homes owners is similar to the home owner numbers for Zimbabwe. A majority own homes in the UK and there is a substantial number who do not own homes. Few participants own homes in countries other than the UK or Zimbabwe. The activity of the group in home ownership is a clear reflection that they are settling and as such increasing the number of immigrants planning to stay in the UK on a long term basis.

Another way by which the transactional ties of the research participants lives is exhibited by connections with extended family in both countries. All research participants having extended family in the UK is a clear reflection of cultural capital that has been growing over the years. Regarding extended family in other countries, about half of the research participants have extended family in other countries besides the UK and Zimbabwe. Cultural capital once established has a means by which it can sustain its own growth. The more cultural capital a particular group grows the higher propensity there is for the group to grow as it makes available more resources for potential migrants to tap into and as such increases the likelihood for a successful migration (Castels and Miller 2003, 27). Examples of this are seen in the migration of Mexicans to the US where the informal linkages have greatly enriched cultural capital that has made available resources for potential migrants (Kendal and Massey 2002). The cultural capital built in this study not only applies to Zimbabweans seeking to enter the UK but
it is also a cultural capital within the nursing industry. The successful integration of these migrants has strengthened and increased the Zimbabwean community in the UK.

Only a small number of research participants said that they owned businesses in Zimbabwe. This is a clear sign that remittances are generally not going into productive investment. The significance of remittances not going into productive investment is that in time whatever activity the remittances go into could eventually become self-sustaining/sustainable. This would therefore release the activity in question and the local population from being dependent on remittances (Hugo 2006). Successful productive investment would eventually lead to a local source of capital creating the possibility for home grown economic initiatives (Hugo 2006). None of the research participants owned any businesses. One hypothesis for this scenario is that given the research participants are recent immigrants, they would require some time to get settled. Furthermore, their ability to stay in the UK is tied to their employment. As a result, they could only seriously pursue business opportunities when their stay in the UK is no longer dependent on their employment. This hypothesis is supported by DW_C0026 quoted earlier in the chapter saying,

...I will stand a better chance with a British passport and I can work wherever I want. I can do part time jobs; I am no longer at one place. Like right now, I am working at a place full time and it’s not by choice. With a British passport all that will change. You can do what ever you want. I can start my own business here”.

Not surprisingly, none of the research participants also owned businesses in other countries.

5.5: The Role of Government in Return Migration

Earlier remarks made by research participants regarding whether they would be willing to return to Zimbabwe and work in the nursing field highlight failure of the Zimbabwean government in putting together the right mix of polices that will either deter or reduce the propensity for health care workers to emigrate or encourage them to return. To both encouraging return migration and reducing emigration, the instrumental determinants are the conditions found in the source country. Across the globe, countries of the periphery and semi-periphery have been making efforts to stem the tide of their citizens emigrating in search of greener pastures or encourage those abroad to return (Diatta 1999; Zweig 2006; Thomas-Hope
Given that brain drain migration is a reality and is likely to continue, countries should develop a two pronged approach which first encourages people to stay and maximizes the benefits of its citizens who are abroad.

Senegal is one country that has launched programs to inform its citizens about the difficulties of immigrating to western countries given the tightening of immigration policies. The Senegalese government in association with the European Union (EU) has launched programs that help locals seek and create local economic opportunities (Diatta 1999). Such programs in Senegal have led to locally created employment and erased the opportunity costs of migration. Given that governments of the periphery and semi-periphery are unable to discourage some citizens from leaving, the focus should be to find ways that the source countries can benefit from the brains outside the country.

The traditional way countries have sought to benefit from human capital outside the country is through return migration. To realize this, countries across the globe have set up programs to attract these brains and have them stay. In Jamaica, strategies to encourage return migration under the “Returning Residents Programme” and the “Return of Talent Programme” have included providing information, incentives on duty concessions and relocation assistance (Thomas-Hope 1999). Through the use of consulate offices in the west, Jamaica has been able to recruit highly skilled professionals for positions in the public sector from countries like the UK, Canada, the US and the Czech Republic to name a few. Such programs implemented together with actors like the EU and the International Organization of Migration (IOM) have been instrumental in realizing a brain gain (Thomas-Hope 1999).

Another approach to gaining from the human capital that exists in the diaspora is for immigrants to participate on short term projects and workshops that allow them to visit and contribute without having to make the definitive decision to return home permanently. Ammassari (2004) who studies return migration to Ghana and Ivory Coast finds that highly skilled professions would be willing to participate in short term projects provided their costs are covered. The Senegalese government is undertaking programs that allow citizens in the diaspora to start and participate in projects at home (Diatta 1999). Such programs have seen Senegalese living abroad participate in development projects funded with private capital or
together with the host country government of the immigrant (Diatta 1999). Such an approach to allowing skills to transfer with the immigrants residing in the west results in what Patterson (2007) refers to as brain circulation taken out of the Asian context where the home country is linked to the west with human and social capital that can continually have access to technology and innovation which can be transmitted to the homes country.

The needs of health care workers in Zimbabwe have been ignored for a long time. Since the 1990’s, health care workers have often gone on strike to demand higher wages and better working conditions (BBC 1999). Most recently, the government has responded to these strikes with force, seeing nurses and doctors beaten up and put in jail (BBC 2008). As noted by BW_B0023, at times the government has increased salaries for health care workers however; these increases do not match the inflation rate and as such does nothing to improve their financial situations. Paramount to the government seriously trying to reduce the brain drain is the need to create a stable economic, political and social environment. Unless these concerns are tackled first, all other efforts will be futile. The literature makes it very clear that in order for brain drain to be reduced and to foster return migration, the conditions in the home country are most important (Thomas-Hope 1999; Cassarino 2004; Ammassari 2004; Zweig 2006). Basic structures of a society like health provision, education, access to basic commodities like food and petrol, reliable supply of water and electricity, a functioning legal system, the rule of law, and a stable economy are of paramount importance if immigrants are to be expected to return home. The above list may seem rather common sense and obvious, however, this is how far Zimbabwe has fallen and until these issues are addressed nurses and other economic actors will continue to emigrate.

Given the dire need for nurses, the Zimbabwe government ought to provide these nurses with incentives that address their most important needs. The first thing that needs to be addressed are the working conditions in hospitals. Investments need to made in medical supplies and equipment to allow nurses to carry out their duties and protect them from disease. To reduce the work load, large investments need to be directed toward increasing training school capacities. Furthermore, nurses need to be paid a living wage that will do away with nurses being unable to cover transportation cost to get to and from work. Other strategies
to encourage return migration or deter emigration include incentive programs that address issues like housing, education, and transportation (Ammassari 2004). Such programs could subsidize housing, provide education scholarships for children of health care workers and subsidize loans for automobile purchases. With the right mix of incentives, brain drain out of the nursing field could drastically be reduced.

Given that brain drain migration is a reality and the Zimbabwe government will not be able to stop it, their aim should be to devise ways by which they can get the most out of Zimbabweans in the diaspora. Taking lessons from examples in Jamaica and Senegal, the Zimbabwean government should lead an effort to encourage highly skilled nurses working in the UK to participate in education workshops for nurses in Zimbabwe. This would address a major reason for emigration out of Zimbabwe, further training opportunities. Remittances have been a major benefit to countries with citizens abroad. A number of countries have put measures in place that make money transfers easier and allow the society at large to benefit and sometimes access to these money. Senegal, Gabon and Côte d'Ivoire have entered in to a relationship allowing their citizens abroad to move easily make money transfers and this has increased remittances (Ammassari 2004). Remitters have been more able to invest in their home countries increasing their propensity to eventually return (Ammassari 2004). The Mexican government is trying to make remittances available to other citizens as capital for business start ups. Through the use of leveraging mechanisms aimed at redirecting remittances to investment, community banks have been created as a means of saving and borrowing for average Mexicans (Saravia and Miranda 2004). This practice is unique as it seeks to make remittances a national benefit for economic growth (Saravia and Miranda 2004). Given the collapse of the Zimbabwean dollar, similar efforts to encourage remittances and reduce the hurdles involved in sending them back will be instrumental in stabilizing the economy.

5.6: Conclusion

Research participants in this study engage in transnational activities that link them to Zimbabwe in various ways. Their links to Zimbabwe are clearly strong and not likely to fade soon. For many, Zimbabwe is home and there is a longing to return, however, a return is not expected anytime soon given the dire problems that affect the country on many different
facets. The unfortunate situation is that even if a return were to take place, the nursing industry is not positioned to be able to benefit from an influx of this human capital. The nursing industry in no way meets any of the research participants needs and they see better prospects for themselves in undertaking business ventures. Nonetheless, remittances are a benefit that is a result of the human capital outside Zimbabwe. As one of the nurses noted he is definitely able to do more for his family and the country while in the UK than in Zimbabwe. Remittances have been able to provide a livelihood for people in Zimbabwe for whom very few other options are available.

The tug between the research participants interests are made clear by them planting feet in both countries. Their longing to return home has seen many buy/construct houses in Zimbabwe. The homes ownership scenario is clearly the same in the UK where many have also bought houses. Transnational activities among this group are likely to continue. As these migrants establish themselves in the UK they are likely to have the effect of increases the strength on the Zimbabwe community in the UK and provide resources for future immigrants.
Chapter 6
Zimbabwean Nurses future in the changing UK nursing industry

6.1: Introduction

The participation of Zimbabwean nurses in the NHS has been a result of the right sets of place attributes both in the UK and Zimbabwe. There have since been changes in the UK resulting in negative place attributes making it more difficult for recent Zimbabwe immigrants to participate in the NHS as fluidly as they have in the past. Combined these changes have resulted in fewer opportunities for Zimbabwean nurses through giving greater priority for job vacancies to UK and EU nationals, reduced turnover of nurses due to changes in pay negotiation, the removal of general nurses from the shortage occupation list and changes in eligibility for NHS funding for nursing schools. This final chapter discusses the recent changes in the NHS and how they are resulting in negative place differences resulting in fewer opportunities for Zimbabwean nurses to participate in the NHS.

The most recent data available from the NMC shows that across the board there have been drastic notable reductions in the number of international nurses entering the UK. There have been a number of notable actions taken by the UK government that have lead to these reductions. Addressed in this section are the changes that have taken place in the UK that have created place attributes that are not favorable for Zimbabwean nurses. Discussed will be the falling numbers of IRN’s joining the NMC registry. The code of conduct for the recruitment of international nurses will be discussed to reveal how ineffective it has been and why it does not explain the drop in new NMC registrants. Following this, changes to immigration laws that have seen general nurses being taken of the shortage occupation list are discussed. Next, there will be a discussion of changes that have taken place in the NHS which have resulted in reduced turn over of nurses and fewer opportunities for IRN. All of these changes will be discussed in the context of how they affect the future of Zimbabwean nurses participating in the NHS.


The first action the UK government has taken to reduce the number of international nurses entering the UK is the introduction of the code of conduct for the recruitment of
international nurses. At best this code is simply a smoke screen designed to look like a concerted effort to address the problem but clearly shows no results. With the UK heavily dependent on international nurses from the global periphery to help repair its health industry, it and other countries of the global core came under attack. Though the UK may have had a staffing problem they were ‘poaching’ nurses from regions of the world that were affected by very desperate man power shortages (Clark, Stewart, Clark 2006; Crush 2002; Ahmad 2004). For many countries of the global periphery even without them loosing health care workers, their health care delivery systems are in a dismal state of affairs (Clark, Stewart, Clark 2006; de Castella 2003; Johnson 2005).

In response to such criticism the UK Department of Health (DH) responded with a code of conduct for the recruitment of international nurses. Under the guidelines set in 1999 the NHS was not allowed to target nurses from South Africa and the West Indies (DH 1999). Following theses guidelines the DH followed with more robust guidelines. In 2001 the DH introduced a Code of Practice for international recruitments for NHS employers (DH 2001). Under the code any institution or entity under the NHS was not allowed to recruit nurses from high risk areas which tended to be countries of the global semi-periphery and periphery unless there was a bilateral agreement between the country in question and the UK. This explains why the UK has so many nurses from the Philippines as there is an agreement between the two (Brush 2007). There was a further strengthening and extension of the code in 2004. The further extension required all agencies, temporary staff working with the NHS and private sector organizations doing work with the NHS the comply with the code (DH 2004). The main points of the Code are very well summarized by Buchan in his article on the international recruitment of nurses (2007). He outlines the following key points:

• Developing countries should not be targeted for active recruitment by NHS unless the government of that country formally agrees (a list of developing countries is provided)

• NHS employers should only use recruitment agencies that have agreed to comply with the Code;

• NHS employers should consider regional collaboration in the international recruitment activities;
• *Staff recruited from abroad have the same legal protection as other employees;*

• *Staff recruited from abroad should have same access to further training as other employees.*

Though the code appears to be an exerted effort to deal with the problems of recruiting nurses from the global periphery the code clearly has some short falls. First, the code is not designed to stop the flow of nurses from countries of the global periphery. The wording of the code clearly states that they are seeking to stop ‘active’ recruitment as noted in an interview with a Health Administrator in London. Buchan put it this way, “the Code does not “ban” inflow, it moderates active recruitment” (2007). Therefore, as long as a nurse from the global periphery finds their own way to the UK they are able to work for the NHS. Another shortfall of the code is that it does not apply to private institutions. Therefore, as long as a private institution is not servicing any NHS staff needs they are free to recruit from these high risk countries. Therefore, the numbers generated from the NMC registry are not complete as nurses who are recruited from the high risk countries and do not work with the NHS will not be on the list (Buchan 2007; Morgan 2005).

Buchan (2007) and others argues that scrutiny of the NMC registry regarding the inflow of nurses from these high risk areas suggests that the code has done little to slow inflows of nurses from developing countries ( also see Bevan 2005). The very first guidelines that limit recruitment from developing countries were targeted toward South Africa and the West Indies. Looking at the inflow of nurses from South Africa, the data shows that inflow rates of South African nurses to the UK only dropped to levels before the 1999 guidelines in 2005/6 as shown in figure 6.1. 2006/2007 saw a drastic drop to just 39 South African nurses joining the registry however, the reasons for this drop in 2006/07 which can be seen almost entirely across the board and is likely a result of something else other than the Code.

Figure 6.1: Inflow of South African and West Indies nurses from 1999 to 2007
The same is true for the West Indies; the code has not been very effective in reducing the numbers of nurses joining the NMC registry. There have been fluctuations in the numbers of incoming nurses, however, for the most part year on year the numbers either increased or were similar to the level they were before the guidelines were introduced. The same type of trends can be seen across the board for countries that are referred to as high risk countries. Figure 6.2 shows a graphical representation of a select group of countries from the global periphery to illustrate the manner by which the number of inflows changed year on year.

Figure 6.2: Inflow of nurses form a selection of countries
However as stated above, the code seems to have had no effect at all. Judging from NMC data it appears the rate of inflowing nurses only increased with the introduction of the code. The following actions taken by the government can largely explain the reasons for the drastic decrease in the number of international nurses joining the NMC registry. The removal of nurses from the shortage occupation list, changes to international nurse work permits, changes in pay negotiation, and the EU-directive all put together have created unfavorable conditions and opportunities for IRN’s in the UK.

6.3: Shortage Occupation List and the European Union directive

The removal of general nurses from the shortage occupation list in 2006 came as the government felt that general nurses were no longer in such short supply warranting a special notation for immigration purposes (BBC 2006). Having general nurses removed from this category resulted in reduced numbers of general international nurses entering the NHS (RCN 2006). With the removal of internationally recruited general nurses from the shortage occupation list, job vacancies in the UK can only be advertised to international nurses once it has been established there is no one to fill the vacancy first in the UK and within the European Economic Area (EEA). Under the EU directive, nurses from the EEA are given consideration above international nurses. With UK trained nurses and EEA nurses now being given higher priority for job openings, Zimbabwean nurses are beginning to feel pressure. DW_C0026_1 had this to say,

“Now it’s no longer interesting because of the racism. It is now a lot more than before because of shortages of jobs. So they are now preparing to take their children than us so we are now working under pressure; any silly thing you will be in trouble. It’s no longer good.”

Conditions are certainly not as favorable for the Zimbabwean nurses as they used to be. As stated above this government action largely affects general nurses (band 5 and 6). Under the changes brought on by this action there were further changes made to the issuing of work permits which effectively almost entirely stopped the recruitment of general nurses because of the hurdles involved.
Apparently people working within the industry disagree with the Department of Health’s position on the matter. Some in the industry have accused the government of being short sighted. Health care administrators have noted that there is a demographic shift that is taking place in the nurse workforce of the NHS which will see over 150,000 general nurses retire within the next 5-10 years (BBC 2006). The belief among critics is that the NHS will not be able supply the man power needed as this group shifts out of the work force. Experts in the nursing field like Dr Beverly Malone, secretary general for the Royal College of Nurses says the government is making international nurses the scapegoat for the financial troubles that are currently plaguing the NHS. Malone also argues that international nurses have always been part of the NHS staffing strategy and that these actions will have far reaching negative consequences (BBC 2006).

In an interview with a health administrator in London he explained that in order for them to employ an international nurse and get them a work permit they had to prove to immigration that they have failed to find a quailed nurse locally and within the EEA. These changes however only apply to general nurses (band 5&6). Specialized nurses (band 7&8) are still on the shortage occupation list. Therefore, no major hurdles in recruiting specialized international nurses exist. The nurse categories under the shortage occupation list that qualify as specialized include the following; audiology, sleep/respiratory physiology, neurophysiology, cardiac physiology, operating theatre nursing, clinical radiology, pathology, critical care including neo-natal intensive care (RCN 2006; HO 2008).

Apparently since general nurses were taken of the shortage occupation list there have been further changes which have effectively stopped work permits being given to general international nurses. A nurse administrator at Kings College hospital in London stated that he could only recruit an international nurse if the following requirements were met:

- The position had been advertized and could not be filled by a UK nurse or one from the EEA
- The international nurse was qualified as a theater nurse, Intensive care unit nurse or as a Neurosurgical High Dependency Unit nurse
• They need to have at least one year experience in acute care or a lot of experience.

The nurse administrator made it quite clear that a majority of the international nurses do not meet these requirements. So even though recruitment is generally on the decline for international nurses, when they do recruit they take the cream of the crop.

Within the midst of all these changes, in the background the NHS is plagued with huge financial problems. These financial problems have reduced training opportunities for nurses employed with the NHS. Where in the past nurses had ample access to training courses, today those opportunities are slim or non-existent. Health administrators interviewed noted that the cuts were really though as they forced them to choose who to send for training courses given the limited opportunities. One of the administrators said that they were expecting nurses to pay for further training out of their own pocket. The situation today is such that the NHS still has a nurse shortage that stands at around 30,000 nurses (Batata 2004). This shortage unlike before which was across the board is now mostly found within areas of specialized nursing. This brings to light an interesting phenomenon. The UK is not willing to fork the bill to further train their general nurses to become specialist nurses. Instead their strategy seems to be that they are going to recruit their way out of the shortage of specialized nurses.

6.4: Changes to pay Negotiation

Another change that has taken place in the NHS as mentioned above are changes to pay negotiation introduced under the Agenda for Change (DH 2004) which no longer allow nurses to negotiate pay, resulting in reduced turnover of nurses and fewer opportunities for recent graduates. In the past nurses where able to negotiate pay which saw a high turnover of positions. This high turnover translated to opportunities for nurses down the line. With the changes, pay is now determined by training level and experience resulting in reduced turn over since moving to a new position or hospital will not bring with it higher pay. The resulting reduced turnover of nurses is now reducing employment opportunities for newly graduating nurses.

The UK’s efforts to deal with the nurse shortage appear to have paid dividends regarding the area of general nursing. The NHS is currently unable to hire the large numbers of
nurses who are recently graduating from nursing school. This has created the peculiar situation where the UK is still suffering from a shortage of nurses yet recent graduates are unable to find employment. Since the large bulk of the shortages are in specialized nursing areas (Bands 7&8) there are currently few opportunities for recent graduates. The situation has resulted in UK trained nurses seeking employment opportunities outside the country.

Conducting this research a UK trained nurse from Zimbabwe was interviewed who brought to life the above situation. She completed her nurse training and has since been unable to find employment. As a result, she currently is in the process of immigrating to New Zealand to undertake her profession there. DW_D0018 was quite frustrated with the situation and had this to say,

“I am in a very frustrating position, because I think to myself I went to school for three yrs and now to government is saying there are too many nurses. The first priority is being given to British people and you are left there in the dark especially after three yrs of training. You end up having to migrate to other places because you are not guaranteed to get a job here”.

Though it would appear that the NHS has appeared to solve its man power shortage with the general nursing field, many within the field believe within 5-10 years the UK will be recruiting general nurses again (BBC 2006). One of the administrators interviewed for this study made it clear there is a lot of research that has been done to show that the UK nurse industry goes through cycles of migration and every five or so years they are likely to experience shortages. He made it clear the internationally recruited nurses tend to stay for about four years particularly nurses who come to the UK from countries of the global core whose main reason for immigration is typically travel experience (Buchan et al 2006). As a result he believes that within two to five years the UK will have to go on huge recruitment campaigns again because at present countries like the US, New Zealand and Australia are also poaching nurses from the UK. This sentiment is one that is common throughout the literature. Some researchers have raised concerns that if IRN’s are not successfully integrated into the NHS and do not have a satisfied working experience they may leave for other countries of the global core like the USA that have nurse shortages (Gough 2004; Doherty 2008). Doherty (2008) notes that the NMC has received increased requests for nurse qualification verifications. A spike in verification
requests have come from Australia which has been one of the more popular destinations for nurses leaving the UK. Verification requests from Australia increased to 4,746 in 2006/2007 up from 2,708 the prior year (Doherty 2008). Doherty also notes that some prospective nurses who are yet to begin their training say they plan to practice in Australia once they qualify (Doherty 2008). Buchan has raised questions as to whether there will have to be huge recruitment campaigns once the bulk of the older nurses retire (Buchan et al 2006). The administrator at King’s College believes the UK is headed for a worse situation because they are currently missing an opportunity with the recent graduates to train them to the level they require so by the time the cycle of the shortages come through again the shortages will not be as severe in both areas (general and specialized). The current situation where recent graduates can not find employment he attributes to poor workforce planning on the part of the government (see Steele 2008). The future he believes we will see a reversal of the hurdles to getting work permits for nurses and China will be the new recruiting ground since a country to country agreement has been signed and the Philippine has been over recruited.

6.5: NHS Funding for Nursing School

The practice of Zimbabweans immigrating to the UK and then enrolling in nursing school will not continue as it did in the past. Though nurse training is still free there have since been changes to the entry requirements. All nursing school applicants who wish to be eligible for a NHS bursary and have their tuition covered need to meet the following residency conditions regardless of nationality as according to the NHS Financial Help for Healthcare Students guidelines;

• “Applicants must have been ordinarily resident in the United Kingdom and Islands throughout the three years preceding the above date. and;

• Be ordinarily resident in any UK country on the above date and;

• Be settled in the United Kingdom under the terms of the Immigration Act 1971. (In other words, you must be ordinarily resident here without being subject to any restriction on the period for which you may stay).” (NHS 2008)

There are some exceptions that do apply if the applicant does not meet the above conditions. These exceptions are as follows
• Non-UK EU nationals who have been ordinarily resident in the UK throughout the three years preceding the prescribed date. (If, during any part of this three year period, the main purpose for your residence was to receive full time education, you must have been ordinarily resident in the EEA/Switzerland immediately prior to the three year period of ordinary residence in the UK).

• From another EEA country or Switzerland, if you can show that you, your spouse, civil partner, or either of your parents have ‘migrant worker’ status and you have been living in the EEA or Switzerland for three years before the first day of the first academic year of your course, and are ordinarily resident in the UK on the first day of the first academic year in which your course begins.

• You have been recognised by the British Government as a refugee and have been ordinarily resident in the UK since you were granted this status.

• Those who have been refused refugee status but instead have been granted Humanitarian Protection or Discretionary Leave, and have resided in the UK for the three years prior to the prescribed date. (NHS 2008)

With these new residency conditions recent Zimbabwean immigrants are almost entirely excluded from NHS funding. Applicants who do not meet these conditions are still able to enroll in nursing school; however, they have to cover the cost out of their own pockets. The biggest hurdle these new conditions present is the requirement of being ordinarily resident in the UK. Being ordinarily resident requires that the immigrant have a status that is does not put limits on work restrictions and has no time limit. Many Zimbabweans have gone into nursing school because of the potential the nursing profession gives in attaining a secure immigration status. With these changes the horse is being put before the cart excluding Zimbabweans from participating. A health administrator from St Georges College explained that the changes were made because of the perception that nurses trained in the UK did not remain in the UK on a long term basis. As a result the government is looking to train individuals who would have a higher propensity to remain the UK after they had completed their nurse training. The health administrator did note that she personally did not agree with the perception. While conducting this study a number of Zimbabweans noted that they had missed an opportunity as they would
no longer be eligible to jump on the nursing train to stability. There will still be a future for new Zimbabwean nurses in the NHS, however, things will look quite different from the past.

6.6: Conclusion

With all the changes that have taken place within the British health industry the UK is not as attractive a destination for Zimbabwean general nurses. The place attributes have changed such that specialized nurses are the only ones able to break into the NHS easily. A situation now exists where the industry has been flooded with general nurses to a point where even British trained nurses are finding it difficult to get employment. General Nurses being taken off the occupation shortage list combined with the EU directive have given greater priority to employing nurses from the UK and the EEA. Though general nursing is flooded there are still huge shortages of specialized nurses. The cuts in the NHS have led to a decrease in the amount of money set aside for training as a result; the UK will not be dealing with this shortage in house but is going to recruit the necessary man power. Critics of the Department of Health strategy contend that greater shortages loom around the corner as a demographic shift within the next 5-10 years will result in huge shortages of nurses. If this is the case, the recent hurdles to the recruitment of nurses are likely to be reversed creating opportunities for Zimbabwean nurses.

The reduced opportunities for Zimbabwean nurses in the NHS are likely to see an increase in their participation in the private sector be it illegal or result in them seeking employment outside the UK. The care industry in the UK which is largely unregulated has many immigrants in the field who take advantage of the British peoples dislike for the industry. Other researchers have noted huge numbers of Zimbabweans working in the field, some who are bound contractually the private sector and others who need employment that falls below the radar (McGregor 2007). The negative place attributes in Zimbabwe are such that no return migration is likely, hence, immigrants will either be looking for ways to stay in the UK or move to another country. As demonstrated by one of the participants trained in the UK, the lack of employment opportunities have seen some immigrate to other countries of the global core.
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122


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