Becoming an African Health Care Migrant Worker in the West: A Case Study of Ghanaian Migrants in Columbus, Ohio

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This thesis titled
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ABSTRACT

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Becoming an African Health Care Migrant Worker in the West: A Case Study of Ghanaian Migrants in Columbus, Ohio

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The international migration of African health workers has recently received mounting attention from academics and development agencies. While much research exists on push factors of their migration in Africa and the facilitating role played by international recruitment agencies. Little is known about how Africans become health care workers in their new location, how they build and use their job-related networks and how they interact with larger immigrant communities.

In an attempt to fill a gap in the literature on the international migration of African health care workers, this thesis has conducted a series of in-depth semi-structured personal interviews and observations of Ghanaian migrants in Columbus, Ohio. This research used a snowball sample method to recruit participants as well as employed a computer-assisted qualitative data analysis.

The findings of this research suggest that job related and immigrant community networks play a significant role in the migration of Ghanaian health care workers to the US. Moreover, these networks help to recruit other Ghanaians immigrants who are already in the US to take a career path in the health care sector.
This thesis is dedicated to my family with love, especially to my mother Comfort, my siblings William, Fred, and Freda, and Kakrah my husband who were my source of inspiration and support throughout the process.
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CHAPTER ONE: INTRODUCTION

The international migration of health care workers has recently received mounting attention from academics and development agencies (OECD, 2011; Greysen et al., 2011; Dwyer, 2007). This attention is due to both the aging population in developed western countries and high incidences of diseases in developing countries including low-income countries in Africa. Although much of the growing demand for migrant health care workers has been created by the ongoing demographic changes in the West, it also reflects the declining supply of well-trained young workers (Dovlo, 2004). Western countries that draw greatest numbers of migrant health workers include the US, UK, Canada and Australia, while Ghana, Nigeria and South Africa have been the three countries in Africa that contribute the most workers (Greysen et al., 2011). In past, due to this migration couple with bad economic condition in African countries, may have contributed these African countries struggling to provide enough health care for their residents. For example, more than 60 percent of immigrant physicians working in the US are from low- and middle-income countries (Dwyer, 2007), including African countries which are battling an extremely low ratio of health care workers to population.

In 2006, there was an estimated shortage of more than 4.3 million health professionals across the world, and 57 countries were identified as suffering a critical shortage in health workforce. Out of these countries with shortages, 36 were located in sub-Saharan Africa (OECD Policy Report, 2010). Despite this fact, Greysen et al., (2011) note that one out of every eight medical doctors trained in sub-Saharan Africa is lost to developed countries through migration.
In addition to the many socio-economic factors that have prompted African health professionals to leave their home countries, the recent growth of international recruitment services has also contributed to their massive emigration to the West (O’Brien and Gostin, 2011, p. 40). Bueno de Mesquita and Gordon (2005, p. 33) point to private sector agencies as important facilitators of international health care worker migration, as they assist both migrants and potential employers by handling a web of immigration bureaucracy and even offering the new employees induction training programs in Western destinations. According to Connell (2007), for instance, recruiters place advertisements on their organizational websites in order to reach potential recruits. Some recruiters also use Internet classified advertisement sites such as Workopolis, Monster.ca, and Charity Village. Because the Internet is internationally accessible, any interest-based advertising or recruitment campaign can achieve international reach (Runnels et al., 2011).

Much research exists on the push factors of this migration, such as less desirable conditions in Africa, the facilitators of the migration, including recruitment agencies, and the impact of the migration on Africa. However, little is known about what happens to the health care migrants at their destinations, how they form and benefit from job related networks, and how they are integrated into the larger immigrant communities. Migrant networks, especially job related networks, may also play a significant role in facilitating African health care workers’ settlement and migration processes to the West. According to Roth et al. (2012, p. 351) for instance, social networks play an important role in how and where immigrants are integrated into their destination to form stronger ethnic ties.
Additionally, Epperson (2009, p. 315) argues that as increasing numbers of African health professionals participate in the migratory movement to the West, more information and options about potential employment and settlement in their new location are now available to the many migrants still in Africa. The so-called ‘weak ties’ between those who already migrated and those who might want to relocate certainly help to increase the flow of ideas and opportunities between Africa and the West.

1.1. Research Questions

This study examines the recruitment and employment of African health care workers in the US health care system, explores the role played by job-related networks among African health care workers in their migratory, settlement and employment processes, and examines how they engage with local African immigrant communities in Columbus, Ohio. The research questions for this study are as follows:

1. How are African health care workers recruited and placed in jobs in the US health care services?


3. How do African health care workers build and use immigrant communities’ networks in Columbus, Ohio?

For the purpose of this study, African migrant health care workers were defined as nationals primarily educated in Africa or other parts of the world, yet who are working in the health sector in the West, either temporarily or permanently. They would include medical doctors, nurses, pharmacists, dentists, and laboratory technicians. Also the
definition of the West in this study includes developed countries in North America, Europe, and Australia.

1.2. Significance of Study

To provide a study on “accidental” networks among Ghanaian health migrants in the US. This research matters because it evaluates how Ghanaian migrants health care workers interact and engage with their larger immigrant communities in Columbus, Ohio to build stronger accidental networks which help in their goal of becoming health care workers and their settlement processes.

To highlight the growing demands of health care workers in the US and the significant roles played by job and non-job related networks in Ghanaian migrants changing their professions, to take up health care jobs in the US. There is so much focus on the push and the pull factors, meaning bad and good economic conditions in African and the West respectively that makes health care workers to migrate and less is known about growing demand, and the role that job related networks play in the recruiting and placement of these workers in the health sector of the West. So this study again is relevant because it can form the basis for further research in the field.

This research is also significant because large amount of academic articles have study the push and the pull factors of health care workers migration from Africa to the West. However, little is known about African immigrants employment history in the West, which this study explores.

My research adds to existing literature on other factors preventing return migration of African health care workers to Africa. Return migration is complicated issue
on the basis of this research because some specialties chosen by these immigrants in the West do not exist in Africa or even where they are the technological disparities makes it difficult for such practices. Hence the study is also important because it will add to existing literature on the topic.

1.3. Methodology

The purpose of this study is to examine how African health care workers are recruited and placed in jobs in the US health care services, how they build and use their job related networks, and how they create and take advantage of their immigrant communities’ networks in their recruitment, employment and settlement processes in Columbus, Ohio. This thesis has used qualitative methods to verify, analyze, interpret, and to understand health care workers migration from African to the West as suggested by Winchester (2010).

1.3.1. Participants

The sample size used for this study was 11. It includes seven males and four females and the ages range from 35 to 49 years. Pseudonyms were used for respondents in this research to preserve their anonymities. The study was conducted in Columbus, Ohio and all participants were located in Columbus with the exception of one. This other participant was interviewed in Accra, Ghana. The participants were selected in this way to have an understanding of their experiences in both the US and Ghana on this research topic. Participants were considered suitable for the study on the basis that they were from Africa. As a result, the research did not take into account whether they were trained in Africa or in the US as health care workers. Nevertheless, the participants chosen for this
study were all Ghanaians because it was relatively easier for the writer to build rapport with them as a Ghanaian than with other Africans. Of the eleven participants, ten nurses are either Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) and the last is a Respiratory Therapist. In the study it was less challenging finding nurses because of the informal networks that exist among them.

The search for the participants in the research could not be carried out through home care agencies and health care facilities as planned so it started with a personal contact with one of respondents. This respondent suggested I talk to Kofi my next interviewee, which created a Snowball Sampling method as suggested by Johnson et al. (2004) to identify other health care workers. The snowball sampling process occur when respondents identify and introduce other possible respondents to the researcher. As people greed to be part of this research, they were asked to help identify other Ghanaian or African migrant health care workers who would be willing to also participate. The interviewees were given the chance to select the interview site or venue of their choice, so some of the interviews were conducted in churches and homes of respondents. Additionally, two of the interviews were conducted on the phone for participants who could not make it to a face-to-face interview. Although, the phone interview was suitable and convenient as noted by Warren (2002, p. 98), the face-to-face interview had a better form of social interaction. Five of the interviews were conducted at the Jesus Power Assembly of God Church and four in the homes of the respondents. My personal position as a Ghanaian and relations I have in Columbus also influenced my methodology. This is because I had the opportunity to follow family members to church and also to go for
grocery shopping in African markets where I did some of my observations for this research.

1.3.2. Methods

In order to enhance credibility in this research multiple approaches of qualitative research methods were utilized. The methods included in-depth semi-structured personal interviews, observation, and the review of literature from both secondary and tertiary sources in order to collect and analyze data and to draw conclusions. To explain further, in-depth semi-structured interview methods were used to ensure that each of the three research questions was adequately answered; there was also room for follow-up questions and answers, specifically to probe for more information (Burck, 2005, p. 240). In addition, open-ended interview questions were used because, as a qualitative researcher, the use of “open-ended interview questions” (Warren, 2002) in the in-depth semi-structured interviews was to avoid dictating or providing answers for the interviewees. The interview protocol was designed to cover storytelling, descriptive and opinion questions (Baxter, 2010, p.106), such as:

1) Tell your medical training and employment history in your home country (or any other countries) prior to your arrival in the US?

2) Describe your migration process?

3) In your opinion how do you see the demand for health workers in the US compared to the demand in Africa?

These questions were also designed in this way to make room for further follow-up questions.
Another qualitative research method used was an observation (Alder and Alder, 1994), which was conducted at the Jesus Power Assembly of God Church during a naming ceremony and at Ohio Health hospitals in Columbus, Ohio. These observations were conducted where there were Ghanaian migrant health care workers to gain, greater in-depth understanding, as suggested by Dowler, (2001), of their job related networks and how they engage or interact with their immigrant communities during these functions. The observation carried out at the Ohio Health Hospital was to understand the US health care system in which Ghanaian migrants worked, especially how flexible or demanding their work may be.

1.3.3. Data Analysis

The pre-written interview questions in this study were taken to the field. The answers from the respondents and the observation notes were hand written and transcribed. Each interview took between 20 to 50 minutes. The answers and notes were hand written and transcribed because some interviewees were not comfortable being recorded for confidentiality reasons. The grounded theory (Burck, 2005) approach, which suggests analyzing initial interviews to find trends (concepts) in order to develop theories and also to format the rest of the interviews, was utilized in the data analysis process. After the first-three interviews were conducted, they were analyzed to generate ideas based on the responses given by the participants. The data generated from the interviews were used to identify gaps and new concepts, which were explored further. As a result, additional questions, such as why Ghanaian migrants decided to enter the health care
sector of the US, how they selected their current place of residence, and what their knowledge of recruitment agencies was added to the interview protocol.

Additionally, in the data analysis process, NVivo, which is computer-assisted qualitative data analysis software (Peace and Hoven, 2005), was utilized. The data generated after transcription of the interviews was imported into the NVivo software. This was used from open-code to focus-code reducing the data into meaningful themes comparing and adding new theme, editing the notes, and exporting the finished data for the final report.

Study Area: African Communities in Columbus, Ohio

According to Capps et al. (2012), black African migration to North America dates back to the earliest days of European colonization. The first recorded passage of slaves from Africa to this region occurred in 1519, to Puerto Rico, now a US territory. However, Capps et al. (2012) note that large-scale voluntary migration from Africa to the US is a relatively recent phenomenon. Half this increase occurred within the past decade, as there were only 574,000 black immigrants of African origin in 2000. By 2009 the total black immigrant population had quadrupled to 3.3 million, while the African immigrant population had risen to 1.1million. African immigrants comprised 3 percent of all immigrants and a similar share of total US black population of 39 million. In addition, Capps et al. (2012) note that historically African immigrants to the US had their origins in West Africa, mostly Anglophone countries. Additionally in 2009, Nigeria, Ghana, Kenya, Liberia, Cameroon, and Sierra Leone accounted for 46 percent of all black African immigrants in the US. In addition, in 2010 the American Immigration Council
(2012) reports that African immigrant groups with the largest presence in the US include Nigerians (219,309), Ethiopians (173,592), Ghanaians (124,696) and Kenyans (88,519).

Furthermore, Capps et al. (2012) note that the annual flow of legal immigrants to US was about 1 million, with approximately 10 percent of them coming from Africa. Family reunification is the most common mode of legal admission to the US, including people who bring their spouse to live with them or who are sponsored to immigrate by their parents, siblings, or adult children. Another 14 percent were admitted for employment (Capps et al., 2012). The distribution of African immigrants is heavily concentrated in a handful of states, including New York, Texas, California, Florida and Illinois. Additionally, quantities of African immigrants have settled in the southeastern states of Georgia, Virginia, and North Carolina and the northeastern states of Maryland, Ohio, and Pennsylvania. Furthermore, according to Capps et al. (2012), African immigrants are among the best educated US immigrants because they are disproportionately admitted through the diversity program, which requires that immigrants have at least a high school degree or two years of experience in an occupation. The relatively high educational attainment and English proficiency of African immigrants appears to translate into high labor force participation although not necessarily high earnings (Capps et al., 2012).

In Ohio the total black population in 2012 was estimated to be 1,413,110. The total number of blacks in Columbus was 220,241 (US Census Bureau, 2010). Franklin County houses 91 percent of the city’s native-born population. However, nine percent of the people living in Franklin County were foreign-born including the black population.
Africans had the third largest percent (25.1%) of foreign-born population after Asia and Latin America, which rose to 30% in 2012. This increase in the percentage of Africans may be attributed to both the increase in migration and the rise in newly born children to African immigrants including Ghanaians. According to the US Census Bureau, between 2008 and 2012 there were 2,091 Ghanaians in Columbus and 2,479 Ghanaians in Franklin County. The number of Ghanaiian immigrants may seem very small because the US Census Bureau does not keep track of undocumented immigrants in the US, some number of Ghanaians living in Ohio may fall within the undocumented category (Agbemabise, n.d.).

In Franklin County, Ghanaians immigrants are likely to settle close to each other. For example, Agbemabise (n.d.) note that Ghanaians tend to connect with each other in any place they find themselves in the world. This is to nourish their connection and provide support for new immigrants from Ghana. Additionally in Columbus, they are found to form ethnic, religious, and professional associations to maintain these bonds. Agbemabise (n.d.) explains that this may be one of the reasons for the large number of Ghanaiian churches in Columbus. To illustrate this, he mentions that there is an estimate of over 30 Ghanaiian churches in Columbus and over 10 unofficial extra ones operating in salons and people’s apartments and basements.

Beyond cultural organization, Ghanaians in 2002 had about 19 small business owners operating in Columbus, Ohio. Ghanaians have created businesses that cater to their needs as well as those of other Africans and the wider local community. Some of these enterprises include Ghanaiian restaurants, travel agencies, legal firms, health care,
beauty salons, groceries, and apparel shops (Agbemabise, n.d.). Some Ghanaians are also employed in health care facilities in Columbus as health care practitioners.
CHAPTER TWO: THE MIGRATION OF HEALTH CARE WORKERS FROM AFRICA TO THE WEST

2.1. The Supply Side of African Care Workers’ Migration

Mobility of humans is a fundamental part of human development because it plays a central role in global and local processes of social, economic and political changes in transforming the world (De Haas, 2009, p.2). Kingma (2006) has highlighted that, given the choice, most people would prefer to remain in their home countries. However, there are a series of push and pull factors that motivate a person to leave home and family to pursue opportunities elsewhere. The push and pull factors of migration explain that people move either because social and economic forces in their place of origin compel them to do so or because they are attracted to places of destination by one or more social and economic factors (Boyd, 1989, p.640). In the health sector Dovlo (2004) identifies the push factors as events in the country of origin that motivate professionals to leave, while the pull factors are the deliberate and/or unintended actions from recipient countries that attract health professionals to their health services. Some of the push factors are to escape oppressive political climates, to pursue better economic opportunities for themselves and their families, to better their education or those of their children, or just for adventure. According to Awases et al. (2004), the advent of more efficient electronic communication networks since the 1990s has made movement of health professionals much easier than before, as potential migrants are now better informed of opportunities in other countries.
A large body of literature has attempted to identify a list of push factors causing the out migration of African health care workers (Chikanda, 2007; O’Brien & Gostin, 2011; Troy et al., 2007). Poor economic conditions and opportunities in Africa may cause these highly educated and highly skilled health care workers to leave. For instance Awases et al. (2004) explains that low budgetary allocation to public health institutions in Africa is due to governments being put under pressure by multi-lateral lending institutions to reduce public expenditure. Thus low health care budgets may be leading to shortages of protective clothing, and basic equipment and drugs and, payment of low salaries for staff under the health care system across the Africa continent. According to Snyder (2009) conditions in the source countries, including warfare and insecurity, lack of basic health resources, and gender or ethnic discrimination may influence the decision to migrate. For example, it is pointed out that in Zimbabwe, the poor economy is the number one reason why health care workers emigrate to developed Western countries (Chikanda, 2007). Awases et al. (2004) also identifies some common reasons for African health care workers dissatisfaction, such as delayed salaries, delayed promotions, lack of social and or retirement benefits, lack of proper equipment to carry out the procedures professionals have been trained to perform and deliver, and an inability to afford the basic necessities of life in Africa.

Aiken et al. (2004) also notes that in some countries, despite their own domestic health care needs, they cannot create enough jobs for the health professionals they train, thus motivating them to emigrate. Moreover, Kingma (2006) describes salary disparities between health care workers in the West and in Africa as a contributing factor in health
care workers migration to the West. He notes that nurses in Canada earn about fourteen times more than what Ghanaian nurses earn, even after adjusting “purchasing power” in Ghana. Additionally in Uganda, nurses earn less than $100 per month, compared to an average of $3000 in the US (Nguyen et al., 2008).

However, De Haas (2009) contends that the decision to migrate (or not) and the act of migrating can be seen as an expression of human development because people need a certain minimum of social and economic resources in order to be able to migrate. It is therefore no coincidence that skilled workers, like health care workers, and wealthy people tend to be more mobile than relatively poor and unskilled people. As a result this is among the reasons why African health care workers continue to migrate. Despite the fact that most authorities consider financial motivation to be the major push factor to the mass migration of African health care workers, Wills-Shattuck et al. (2008) argue that financial incentives is not the only push factor in African health care worker migration. Migration, rather, tends to increase because little attention is being paid to improve other factors such as career development and good management, acknowledgment of the efforts of health personnel, and provision of infrastructure.

Ray et al. (2006) find that health care workers’ migration in general tends to be permanent. When health care workers return to their countries of origin, the skills they have obtained abroad are often not transferable due to technological disparities between the West and Africa. Hence, return migration may be unattractive to some African health care workers after their attainment of higher education in the West.
2.2. The Demand Side of African Health Care Workers’ Migration

A broad range of social, political, professional and economic factors influence the decisions to migrate. Several of these factors are beyond the control of policy-makers within the source country’s health care sector because employment prospects in the destination country are key factors in prompting health professionals to cross national and continental boundaries (Vujicic et al., 2004, p.1). The attraction of higher wages and the demand for workers in the developed countries is indeed another main driving force behind international migration of both skilled and unskilled laborers (Stalker, 2001). According to Awases et al. (2004) the most frequently mentioned pull factors include stable socio-political environments, professional work environments that are more conducive to training and skills development, proper equipment, tools and facilities that are more conducive to advanced practice and procedure, more attractive salaries, social and retirement benefits; and sensitive employment policies that recognize good performance.

Brush et al. (2004) note that within the first two decades of the twenty-first century, the US population is projected to grow at least 18 percent, and the population aged 65 and older will increase at three times that rate. In the light of global shortage of health practitioners, it will be a huge national challenge to meet the demand for Registered Nurses (RNs) that its aging population will require. Nevertheless, nursing is one of the fastest-growing job sectors in the US. Its nursing education system has been unable to keep pace with the demand for nurses (Pittman et al., 2007), which has in turn created a job market for African health care practitioners.
According to the US Department of Health and Human Services’ (HHS), the US was weathering a shortfall of 111,000 Full-Time-Equivalent (FTE) RNs in 2000, and the number grew to 275,000 by 2010. The imbalance is expected to nearly triple in the subsequent decade, reaching a shortfall of 800,000 FTE RNs by 2020 (Brush et al., 2004). This challenge has led to high demands for health care workers in the US and the need to find a prompt solution to the problem. The recruitment of foreign nurses can begin to fill in these gaps. Brush et al. (2004) has identified the demand-driven US nurse shortage as also representing a strong migratory pull factor for nurses in Africa, which stimulated the growth of for-profit organizations to serve as brokers to ease the way for nurses to emigrate.

The rising demand for health care migrants has resulted from several other factors, including the physical expansion of hospitals, physician shortages in primary care, and the use of nurses as case managers in disease management companies (Pittman et al., 2007). According to Lowrey et al. (2012) the pool of doctors has not kept pace and will not because while medical school enrollment is increasing, it is not increasing as fast as the population growth. The number of training positions for medical school graduates is lagging and younger doctors are on average working fewer hours than their predecessors. Moreover, about a third of the US’s doctors are 55 or older and nearing retirement.

Although several countries have raised entry barriers for particular categories of migrants, such as low-skilled workers and asylum seekers, the immigration of high-skilled workers, such as health care workers, has been facilitated by many factors both in
the source and destination countries (De Haas, 2011). A number of receiving countries has eased immigration restrictions for health professionals, which is evidence of the high demand. Hagopian et al. (2004) note that the US policies have always been generous toward the migration of physicians, even taking into account toughened medical licensing examinations and tightened immigration rules over the past four or five decades. The diversity visas (lottery visas) in the US were listed as an example of easing the migration (Meeus, 2003). A growing number of advanced countries offer fast-track labor-market access for skilled migrants through special temporary visa programs, such as the H-1B visa in the US or the “Blue Card” in the EU (Djajić et al., 2012). This easier access to a visa gives the health care workers a great advantage compared to unskilled workers. Some newly built communities in the US have used a variety of creative measures to attract and keep their foreign nurses, such as providing low rental housing or homebuyer’s assistance in areas with higher costs of living (Brush, 2008).

The US faces a shortage of physicians in many parts of the country and this shortage is going to get exponentially worse when President Obama’s health care law insures millions more Americans starting in 2014 (Rampell, 2013). Even without the health care law, the shortfall of doctors in 2025 would still be estimated to exceed 100,000. With the health care policy this shortage is expected to be higher. This will again create very high demand for health care workers, which may result in further pulling international migrants to the US, including those from Africa.

Hagopian et al. (2004) also listed two main reasons why the US continues to be the primary destination of International Medical Graduates (IMGs) and health care
workers. First, as a form of foreign aid, the US has provided specialty training that physicians could take back to their home countries. Second, health care workers or IMG fill positions in certain specialties and locations that may be less attractive to native doctors and nurses to correct the inadequate medical service problems in rural or underserved areas. Additionally, foreign professionals seldom migrate because of unemployment back home or because of the absolute income differential between prospective US salaries and what they earn at home. Instead, it is the relative gap between available salaries and work conditions in their own countries and those that are normatively regarded as acceptable for people with their level of education (Portes et al., 2006).

2.3. Facilitators of African Health Care Workers’ Migration

This section examines factors and facilitators of the international migration of African health care workers while the previous two sections have focused on the pushed and pull factors. This section examines the enabling factors of their migration. Networks connect migrants and non-migrants across time and space. Once begun, migration flows often become self-sustaining through the establishment of information networks, assistance and obligations, which develop between migrants in the host society and friends and relatives in the sending areas (Boyd, 1986). Largely globalization and increasingly porous country borders have facilitated the movement of health professionals (Pagett et al., 2007). The recruitment process of migrant workers varies greatly depending on socio-economic conditions in the source country as well as skill shortages in receiving places. High levels of recruitment may have been enabled by the
extensive and widespread presence of recruiting agencies around the world. According to Brush et al. (2004), recruitment of foreign nurses is not a new phenomenon; US health care institutions have done it for more than 50 years. What differs today, however, is the marked expansion of organized international nurse recruitment the growth of private, for-profit agencies to do this work and a greater number of countries sending nurses to the US (Brush et al., 2004). In the same fashion, international migration of nurses for instance, has become a multi-billion dollar industry. The trade and services of the industry has generated numerous business ventures that support it either through education, companies that facilitate immigration, recruitment agencies, travel agencies, banks, and even telephone companies that cater to the immigrant health care workers (Kingma, 2006). The strategies for health care workers recruitment involve advertising in national newspapers and journals, text messaging to health care workers, personal emails and Internet sites, and recruitment workshops (Mills et al., 2008). Offers for employment are accompanied by immigration assistance, guaranteed earnings, and moving expenses. In these cases, the relationship between the recruiter and the migrant health care worker generally continues for several months or even years. Furthermore, on average, hospitals pay recruiting agencies $5,000–$10,000 per nurse. In return, nurses are contracted to work a minimum of two to three years in their hiring institution (Brush et al., 2004). Although the initial cost of recruiting foreign nurses is higher than that of hiring domestic nurses, hospitals in the West save money in the long run by hiring African health care workers. With immigrant workers, hospitals do not have to continue to raise salaries,
increase benefits, and provide other monetary incentives needed to retain domestic nurses (Brush et al., 2004).

Ray et al. (2006) report that in some cases these agencies require multi-year contracts from migrants and levy heavy penalties for breach of contract. In addition, some US based agencies also have offices in low-income regions, including African countries, to further facilitate the recruitment process of health care workers from a wide range of countries (Brush et al., 2004). A recent Academy Health report identified 28 US recruitment companies active in Africa, and 40 companies reported that they were actively recruiting nurses from “disadvantaged regions” around the world (O’Brien and Gostin, 2011). According to Mills et al. (2008) recruitment agencies, such as O’Grady Peyton International (USA and UK) and Allied Health (Australia), have established offices in South Africa to facilitate recruitment, while corporations such as Shoppers Drug Mart (Canada) and Rite Aid actively recruit from South Africa using a series of touring recruitment workshops across the country.

In addition, another important enabling factor of health care workers migration is safely assumed to be the existence of networks among them. Many migrants move because others with whom they are connected previously migrated (Arango, 2000). Migrant networks are sets of interpersonal ties that connect migrants, former migrants, and non-migrants to one another through relations of kinship, friendship, and shared community origin. Network connections increase the likelihood of international migration because they lower the costs and risks of movement and increase the expected net returns of migration. Having a tie to someone who has migrated yields social capital
that helps to gain access to an important kind of financial capital, high foreign wages, which offer the possibility of accumulating savings abroad and sending remittances home (Palloni et al., 2001). Generally, the greater the barriers to movement, the more important network ties become (Massey et al., 1993).

2.4. Employment and Settlement after Migration

According to Redfoot et al. (2008, p.264), the immigrant labor market for long-term health care in the US includes at least three relatively distinct segments:

- Registered nurses, who must navigate complex systems of credentialing medical practice after immigrating;
- Licensed practical nurses, most of whom were registered nurses in their countries of origin; and
- Unlicensed aides and other long-term care workers, some of whom are “Decredentialied” nurses seeking entry to a career in health or long-term care.

Before commencing employment in their migrant destinations, health professionals have to fulfill the appropriate registration and licensing requirements specified by related government agencies. Most Western governments require medical doctors and nurses trained in other countries to undergo an extensive re-training and a lengthy certification process before they are allowed to practice their profession (Okeke, 2012).

According to Hagopian et al. (2004) one of the most common initial points of entry for international medical graduates into the US medical workforce is residency training program enrollment even if they have already completed postgraduate training in their home countries. Among other requirements, foreign doctors must prove that they speak English; pass three separate steps of the US Medical Licensing Examination; get American recommendation letters, usually obtained after volunteering or working in a
hospital, clinic or research organization; and be permanent residents or receive a work visa. As overseas-trained medical graduates, they also have to pass an additional clinical skill assessment test (Bach, 2003).

For foreign nurses, the Commission on Graduates of Foreign Nursing schools (CGFNS) will certify foreign nurses’ credentials, including education and English proficiency, through what is called a VisaScreen (Pittman et al., 2007). Redfoot et al. (2008) reports that this credentialing process often poses a significant challenge to migrant nurses and leads to the ‘decredentialing’ of otherwise well qualified registered nurses to licensed practical nurses or aides.

Newly arrived immigrants, including African health care workers, typically do many of the ‘3-D’ (dirty, dangerous and difficult) jobs earning a low pay in the West (Stalker, 2001). It is often the case that they are employed in so-called ‘noncompeting positions’ that native workers have deserted as they move up in the occupational pecking order (Waldingen, 1996). It is also true that the links between the workplace and the immigrant community play a key role in converting these positions into platforms for upward movement over-time. Generally speaking staff nurses in hospitals, nursing homes, and public health-settings are favored among all other positions, which explains why female immigrant medical workers are heavily concentrated in the staff nurse positions. However, Portes et al. (2006) challenge this by arguing that because they do not come to escape poverty but to improve their careers and life chances, immigrant professionals seldom accept menial jobs in the US. Even if they start off at the bottom of
their respective occupational ladders, immigrant health professionals sooner or later move up to the positions that better reflect their individual skills (Portes et al., 2006).

Along with employment, settlement is another important step that immigrant health care workers take after arriving in a destination country. Both the location and the kind of initial job placement play a significant role in determining where they settle, how they integrate, how they interact with immigrant communities in the area, and how they connect to people back home. According to Wu (2008), migrants’ first place of residence is largely predetermined by the location of kin or friends. New arrivals to the city might stay with members of their social networks or rely on the information controlled by the networks to find a place to stay. The social networks that sustain migration flows also lead to spatial concentration of migrants, often in the form of satellite communities of migrants.

Social structure of employment and residence location also factor in shaping settlement orientation (Korinek et al., 2005). Immigrants settling in communities with well-established networks generally seem to be incorporated into US society more smoothly than do those in communities with poorly developed networks. Communities with mature networks provide newcomers with emotional and cultural support and various other resources including initial housing and information about job opportunities. The latter can lead rapidly to access to labor market niches and the acquisition of new skills (Hagan, 1998 as cited in Bailey and Waldinger, 1991). According to Arango (2000), community networks among migrant workers are cumulative in nature. These networks abroad tend to grow ever larger and denser as every move constitutes a resource
for those who stay which widens the networks and the probability of their further expansion. Sulanyman (2011) added that at a point, immigrants witness the clustering effects of culture, language, and the increase in the number of "homeboys" and "homegirls" meaning people from the same country. This process of “islandization” may lead to the rediscovery of their ethnic, sub-ethnic, and African high school affiliation as the bases of the identities they choose to embrace or reinforce as new immigrants in the host society. According to Sulanyman (2011) some African organizations were created as a result of such acts of self-definition among the African immigrants in the US. The process of self-definition can also aid in the formation of religious groups that may play an important role in the adjustment of African immigrants to American society.

Professionals who increasingly operate in global social space may be compelled to construct entirely new social relationships as a result of work-related experiences they encounter in their jobs and social interaction that may carry over into their non-work private lives (Kennedy, 2004). Barre et al. (2003) also attribute the recent network formation among some expatriate scientists from Africa working in various Western countries as a way for mutual support and information sharing. These self-organized expatriate scientist communities often mobilize for a common action in an ad hoc manner, by word of mouth, via the Internet or through the social connections that develop in the host country (Barre et al, 2003). Typically, certain neighborhoods become centers of immigrant settlement, marked by distinctive businesses, associations, social facilities and places of worship. Such neighborhoods are the basis for ethnic community formation and cultural and linguistic maintenance (Castle, 2006).
Finally, although there are a number of enabling factors of health care workers migration, Gold (2001) argues that close friends, former co-workers or broader social groups may provide valuable resources, but not all migrants have access to such dense and generous connections because of isolation and lack of privilege to build networks after migration.
CHAPTER THREE: BECOMING A HEALTH CARE WORKER IN THE US

A large amount of literature shows that the recruitment and placement of foreign health care workers into the health sector of Western countries requires overcoming many obstacles (Bach, 2003; Okeke, 2012; Constable et al., 2002; Pittman et al., 2007). Regardless of the qualifications or certificates these practitioners acquired from their home countries, they still have to endure the often-tedious licensing process in the US. This process poses a barrier to many foreign health care practitioners entering the US health sector (Hagopian et al., 2004; Rampell, 2013) because getting a license to practice involves a large amount of time, effort and expense. However, according to Bach (2003) these licensing systems have a legitimate need to ensure that foreign trained health care workers meet the recipient countries’ requirements so as not to jeopardize standards of patient care.

This chapter investigates how Ghanaian health care workers in Columbus, Ohio were recruited to and placed in the US health care services. It also highlights the growing demands for health care workers in the US health sector.

3.1. Recruitment

The recruitment process once they arrive, many migrant medical doctors and nurses face a unique set of challenges because of the highly professional and technical nature of medical practice in developed Western countries. Most countries require medical doctors and nurses trained in other countries to undergo extensive re-training and a lengthy certification process before they are allowed to practice (Okeke, 2012). The migrant Ghanaian health care workers involved in this research told me about their own
or others’ recertification process in the US. Although they were licensed to practice in
most countries they informed me that licensing procedure for foreign health care workers
entails such tasks as requesting transcripts from institutions in the home country,
certifying the transcripts in the US by accredited agencies, paying registration fees, and
studying for the relicensing exams. Several of these factors were identified as being
impediments to some Ghanaian health care workers. Ultimately some were prevented
from entering the US health sector on arrival so they found themselves taking other jobs
rather than their own specialty areas. To illustrate this idea Kofi, a nurse from Ghana,
indicated that,

I was a trained nurse in Ghana, but I had to take the National Council Licensure
Examination (NCLEX) to be issued a license and that was hell. I did not
understand a lot of the terminologies, names and functions of several pieces
equipments used here in America as compared to Ghana, hence I ended up failing
the NCLEX twice.

He passed the examination on his third attempt. For some it takes several years to get
back into the health care sector, while some may not have the opportunity to enter at all.
Then they are diverted into other ventures abandoning the health care profession entirely.
While this remains an issue for immigrant health care workers, it is understandable that
US health services requires certification in order to protect its patients by ensuring that
appropriate health care workers are recruited into the system.

In addition, age was identified as another blockage to successfully passing these
licensure exams for some of the respondents, especially those who were in their late
thirties or older. Generally speaking, younger migrants seem to be more successful in
passing the exams while those who have been academically inactive for a long period of
time tend to struggle although they are a lot more experienced and skilled than their younger colleagues. For instance Efua remarked that,

The exam is really difficult and I know quite a number of people in my church who are old and were big time nurses and midwives in Ghana but have failed several times and have given up. They are either working in nursing homes as aids or doing other things.

In another quote Efua said,

I came to the US still young, not married, no kids, but I had completed my nursing training and had practiced for two years. I took the NCLEX immediately and I got it! It is not something that is beyond our capabilities.

This respondent’s experience correlates with the research finding by Redfoot et al. (2008) that the process may lead to “decredentialing”, meaning health care workers take lower positions than their qualifications in the health care sector. Efua also attributed this to the fact that many health care professionals were misled in the recruitment process and assumed they would easily pass. However, in other interviews some respondents advise that while waiting to take these exams, it is always prudent for Ghanaian health care workers to continue educating themselves to keep the brain active by taking courses in mathematics or English and also not to combine education with work. According to some respondents, this will make their transition process easier.

In addition, my respondents and I observed that immigrant nurses have to go through the Ohio Board of Nursing for approval and direction on how to complete the application process. To illustrate this Nana Ama indicated,

If you are a foreign nurse and you enter into the US, no matter the state that you go to, you have to go to the Board of Nursing in that State. They have their website, which shows you the criteria and the steps to follow to become a registered nurse.
As noted in this quote, foreigners have to follow a host of rules, regulations and requirements to become qualified health care practitioners in the US. However, the detailed guidelines and procedures vary state by state, which poses a significant challenge to the newly arrived migrants who may not know which part of the country they will settle in. One of the informants, Nana Ama, gave details of what she had to go through to be a registered nurse in Columbus, Ohio.

Quote: Nana Ama’s Story

In Ohio, I have to go to the Board of Nursing. I told them that I am a foreigner from Ghana. They have their website, they will give you the website address that you should go there. There, I saw all the criteria and the steps that I have to follow to be certified as a registered nurse in the US. I searched for it and I printed out the information I needed.

They wanted some information like my credentials from Ghana from the school that I went to, to be sent to the Ohio Board of Nursing. It can’t come through me. So you send the forms and you ask your school in Ghana to send your results to Ohio Board of Nursing. They can’t send it to me personally and you can’t deliver it personally either. If you don’t do this they will think you have altered the results in a way. So they want it to come from my school and not me.

So after completing the forms, I sent it to Ghana, so the Ghana education service can gather my information regarding where I was schooled etc., and contact them. In my school, the principal will complete all the forms, including all the courses that I took, the hours that I did, all the clinical, etc. will be specified. This will be completed and submitted on my behalf to Ohio Board of Nursing.

They can see if it is equivalent to that of Ohio Board of Nursing. If Ohio Board of Nursing gets it, then you either have to write English as a second language or English as a spoken language (which they call TOEFL or something like that). So when you take the exams the results will also go to the Ohio Board of Nursing. From there you go to the Credential Evaluation Service for your credentials, so they will compare it to the criteria they have here in Ohio, if is equivalent. They will send feed back to Ohio Board of Nursing explaining whether what I have is equivalent to what is here, or if it is okay for me to write the NCLEX Exams and be a registered nurse (RN) over here in Ohio. If you say you were a nurse in Ghana, your credentials must tally with what is done here.

If it is, Ohio Board of Nursing will write to you and say they have all your information and you have been declared eligible to take the NCLEX exams. So you have to pay some amount of money. When you pay the money, then they will make you go and do your finger print. This is to make sure that you don’t have
any criminal records and that you are clean. You will also be given an authorization note to go take the test, which is called the Authorization to Test (ATT). So, you cannot enter the exam hall without the ATT that you take in order to write your exams. When they sent me my ATT, I had to register and pick a convenient date that I wanted to write my exams. It comes with the address, direction and the place to take the exams. I think the exams start at 7 or 8 o’clock in the morning. You have five hours to answer the questions. The exam is computerized, and when you finish and you pass, the computer shuts down automatically.

The NCLEX exams are such that the more questions you answer the harder they become. So your result should be climbing up, meaning you are doing well. Because your questions are getting harder and you are still getting them right, your mark goes up, but while the questions get harder, if you get it wrong, it drops. If that continues then the computer will cut you off automatically and it means you have failed.

Here the exam is far different from what we see in Ghana, and is never the same. A lot of people complain that the NCLEX is hard because you will never know. So if God is by your side and you write and pass then you can check your results in 24 hours. But you can also tell right after the exam whether you passed or not. You can check with your password, and if you pass, it will let you know and if you fail it will also tell you. So if you fail then you go back and do it again. If you pass, then the Ohio Board of Nursing will write to you that you have passed, congratulations. And then, they will send your certificate to you. So when they send you the certificate then you can go and find your own job to do.

- Source: Personal Interview

She also maintained that there are books to prepare for the exams and that candidates have opportunities to take the exams as many times as they wish, but there are no remedial classes for this purpose in Columbus. The applicants can only home school themselves or take pre-requisite courses in colleges to take the exams.

Several informants mentioned some public or private institutions that they or their friends attended in Columbus. However, there are reasons why applicants prefer one to the other. Entering public colleges, as compared to the private colleges, is challenging because their affordability creates a long wait just for an admission form due to the number of applicants. So applicants are placed on the waiting list for a long time, in some
cases a year or two before admission. Additionally, those who are new in the field may be required to take a series of pre-requisite courses before they get into the main program.

On the other hand in the private institutions applicants pay more but spend considerably less time to complete their training because some pre-requisite courses are waived for them. To demonstrate this, Samuel, a Ghanaian health care worker explained,

Initially, I wanted to go to Columbus State but I was put on the waiting list for a year. Beside that I had to take a number of pre-requisite courses before I could enroll into the proper program. So, my friend advised me to go to a private institution. So I enrolled in one, my credits from Ghana were transferred and they waived some of the courses for me.

This helped to shorten his training period.

Beyond the enrolment in institutions, some academic research, including Kingma (2006); Ray et al. (2006); O’Brien and Gostin (2011) and Mills et al. (2008), insists that recruitment agencies play a key role in the migratory process of African health care workers, such as linking them up employers, helping them with the application process, documentation and their settlement in the West. My Ghanaian migrant health care workers for this research contended the claim was unfounded. They mentioned that they had heard about agencies recruiting medical practitioners abroad but have not seen and do not know any agent or organization doing that. In both Ghana and Columbus the respondents stressed that the recruitment requirements for foreign health care workers in the US are too cumbersome to be done by these agencies. In addition, Kay, a Respiratory Therapist, pointed out that,

It happens in the Philippines but for Africa I have no idea. My field for instance it is a very specialized area and we don’t have any in Ghana, so I trained in the US. And when I go back home I will not find such an area to practice the skills I have
learned here. The equipment isn’t there for this kind of work, and there are no such training programs there.

He explains that they sustain patients on life support and there are no such degrees in Ghana. This was a significant finding with regard to the study of Ray et al. (2006), which reports that when health care workers return to their countries of origin, the skills they have obtained abroad are often not transferable due to the technological disparities between the West and Africa. In addition, Kay elaborated that some patients with very complicated health conditions are flown to the US for treatment because there are no such practitioners in Africa. So, he argued that most migrants have to be trained or retrained in the US to be qualified health care workers, rather than being recruited from Africa directly.

On the other hand Nana Ama acknowledged that there are some UK recruitment agencies operating in Ghana. According to her, they recruited some of her health care colleagues from Ghana to the UK. When the recruiters were satisfied with their applications, she added, they selected them. On arrival, those migrant health care workers underwent a process called “adaptation” for a year or two before they were allowed to search for jobs or were helped by the agencies to find one.

De Haas (2011) reports that several countries have raised barriers for particular categories of migrants, but that many factors have often facilitated immigration of high-skilled workers. In this research the respondents generally agreed that US immigration regulations tend to be generally friendly towards highly educated immigrants. They readily admitted that their educational status contributed to making their migratory process achievable. This also confirms why the respondents in this study were highly
educated with bachelor degrees and certificates. Three of the respondents also entered the US through the diversity visa lottery, meaning they were strategically selected by the host government for their academic qualifications.

3.2. Job Placement

Aside from the processes that these Ghanaian migrants go through for recruitment, Stalker (2001) also reports that some migrants do many of the ‘3-D’ (dirty, dangerous and difficult) jobs in the West for survival. In this research the participants interviewed said their job finding process in the US did not differ significantly from what Stalker’s report described. However, they pointed out that most Ghanaian migrants in Columbus, Ohio, have gone through various stages before they eventually landed the health care jobs they have now. The pattern of employment for these migrants shows that their initial jobs did not have much to do with their educational backgrounds or qualifications from Ghana. Billo, one of the respondents in this research, describes his experience below,

It was tough and rough, as a graduate I did all kinds of jobs, which were stressful and tedious. I started with LEDO pizza in Maryland, Columbus Steel in Columbus Ohio, DWS, and AWS as a home health aide.

My respondents also told me that they did menial jobs across all sectors, which required little or no training with low remunerations. In addition they had taken at least three or four different jobs before getting their licenses or training as health care workers. To illustrate his frequent job change, Seth, a nurse from Ghana, indicated,

In the US, I started at level zero because no matter how educated you are when you come to the US you have to start very low and rise from there. I started from a warehouse doing picking, packing, cleaning, and much more. There is no guarantee for these jobs in the US. In the peak season you see them employing
many, but, when the peak season ends, they fire most of them. So I was moving from one job to another.

Later, he enrolled in an STNA class and had a license to practice as an Assistant Nurse.

On the other hand, some of the participants in this research started from the health care sector, but at very low entry-level jobs such as nurse assistants, transport assistants, patient escort or transporters, housekeepers and interpreters. The transition for both trained and non-trained migrants entering into health care jobs in this research was observed to be the same. In the US they all took the same exam to qualify as health care practitioners. This was because the trained migrant health care workers could only practiced when they have retrained in the US. These participants also took up jobs, which had no connection with their educational history from Ghana. In addition, they moved through series of industries before entering into the health care jobs in the US. Table 3 below sums up how each of the interviewees has journeyed through their quest to become health care workers in Columbus, Ohio excluding one participant interviewed in Ghana.
Table 1: A Summary of the Ten Interviewees’ Migratory Paths to Health Care Work Columbus, Ohio

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Education In Ghana</th>
<th>Job In Ghana</th>
<th>Job History in the US</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kofi</td>
<td>Diploma in Nursing</td>
<td>Nurse</td>
<td>Cashier (Wal-Mart)</td>
<td>Forklift Driver (RH Warehouse)</td>
</tr>
<tr>
<td>Billo</td>
<td>B.Ed Science (Biology Major)</td>
<td>Public Records and Archives Administration</td>
<td>LEDO Pizza</td>
<td>Columbus Steele</td>
</tr>
<tr>
<td>Seth</td>
<td>A-Level Science</td>
<td>Pupil Teacher</td>
<td>Picking-Warehouse</td>
<td>Packing-Warehouse</td>
</tr>
</tbody>
</table>
Table 1 Continued

<table>
<thead>
<tr>
<th>Name</th>
<th>Education</th>
<th>Occupation 1</th>
<th>Occupation 2</th>
<th>Occupation 3</th>
<th>Occupation 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kwame</td>
<td>B.A. Political Science</td>
<td>Graduate Teacher</td>
<td>Cleaning – Contact King</td>
<td>Clerk – Huntington National Bank</td>
<td>STNA – Mental Retardation Developmental Disabilities (MRDD)</td>
</tr>
<tr>
<td>Freda</td>
<td>Teacher’s Training College</td>
<td>Teacher</td>
<td>K-Mart</td>
<td>Nursing Assistant – MRDD</td>
<td>LPN – Mother Angelica</td>
</tr>
<tr>
<td>Kay</td>
<td>Bachelor’s Degree in Science</td>
<td>Custom Officer – Ghana Custom Service</td>
<td>Auto Part Company</td>
<td>Coca Cola</td>
<td>Respiratory Therapist – Riverside Hospital</td>
</tr>
</tbody>
</table>
Table 1 Continued

<table>
<thead>
<tr>
<th>Name</th>
<th>Education</th>
<th>Occupation</th>
<th>Experience</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nana Ama</td>
<td>Diploma in Nursing</td>
<td>Nurse</td>
<td>Packing - Decision One</td>
<td>STNA - Nursing Home</td>
<td>RN</td>
</tr>
<tr>
<td>Efua</td>
<td>Diploma in Nursing</td>
<td>Nurse</td>
<td>RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fred</td>
<td>Computer Programming</td>
<td>Military Police</td>
<td>Security</td>
<td>Picking – Limited Brand</td>
<td>STNA-MRDD</td>
</tr>
<tr>
<td>Samuel</td>
<td>Bachelors’ Degree</td>
<td>Ministry of Tourism</td>
<td>Patient Escort-Riverside Hospital</td>
<td>LPN-Riverside Hospital</td>
<td>RN-Riverside Hospital</td>
</tr>
</tbody>
</table>

Source: Compiled from interview data
Samuel, a respondent, observed that people enter the health sector at lower levels, but take health courses to move up in the sector. He noted that some organizations with which they work would pay or subsidize their tuitions for them to further their education. In this situation, when they finish their education, they work for the organization using their newly acquired license. The organization signs a contract with them for some years, after which the employee is free to move from the organization to a different one if he wishes. He demonstrated this by using himself as an example,

I was employed as a patient escort, and then they helped me do my LPN and my RN. I am still working for them.

However, he explained that in situations where there are no such opportunities, the people educate themselves while still in their menial health care jobs, and in such cases there are no contracts between the employer and the employee. They can choose to leave whenever they wish.

3.3. Demand

There is a saying, that you look at the flow of the water and you dive into it. I am here, what do I do? I decided to enter the health sector because of the high demands and the opportunities in the sector. I must do something to improve myself in order to survive.
-Fred

As shown in Table 3, seven of the ten of the Ghanaian health care workers came to the US with qualifications that were not particularly related to a health care profession. Their professions in Ghana ranged from teachers, computer programmers, military police, customs officers, and senior officers to governmental ministries. Their decisions to be health practitioners and especially nurses started in the US as opposed to Ghana. The participants indicated that they jumped into the health sector for various reasons
including that the sector is flexible for people with children; it is not labor-intensive; it pays well; it could easily be combined with education; and it is a sector where nobody seemed to care about people’s foreign accents. However, the key reason pointed out by all of these respondents as to why they entered the US health care sector was the high demand for employees, which was also reported in Pittman et al. (2007). This report notes that the rapid physical expansion of hospitals and physician shortages in primary care has led to record high demand for health care workers in the US. They maintain that it is the only sector where people rarely become redundant. Nana Ama, a registered nurse, in a commentary indicated:

In America as people complain that businesses are going down in most sectors of the economy the health sector is still booming, it can never go down. We still take medicine like nothing; we get sick because of the environment and the food we eat. So it is the only sector which is booming though others are going down. Majority of people are entering the health care sector, for instance, in church today, a lot of the women are LPNs, or RNs, or STNAs. The men are also educating themselves to be nurses and also to open their own training agencies in the health care sector. Because the health care sector can never go down, diseases, old age cannot be eradicated from our life...

Kay, an interviewee further elaborated on the high demands by saying that:

I believe the US has a lot more demand for health care professionals than Africa does because of the baby boomers who are growing old. Many younger generations do not want to train as health professionals. Also, the US wants to reduce the patient-health care worker ratio, which means that more health care workers will be needed to meet the growing demands.

Chikanda (2007); Troy et al. (2007); Ray et al. (2006); and Dovlo (2004) insist that many Africans migrate to the West as health care workers because of the growing demands, but Ghanaian respondents in this research rather revised that claim by arguing that an acute shortage of health care workers in the US has turned African migrants into
health professionals. That is, high demand causes “new comers” (new migrants) to enter the health sector, abandoning their former professions.

This study further reveals that demand in the US health sector for health care workers, especially nurses, is not only an indication of the country’s aging population, an increase in chronic diseases, or even poor or bad nursing, but it is an indication of the expanding health care industry as noted by Pittman et al. (2007). This increase in workers was also identified to promote longevity, disease prevention and eradication, and to further reduce the current ratio of 26 to 27 patients to one nurse.

3.4. Summary

Becoming a migrant foreign health care worker in the US was partly identified to come with several requirements depending on the category of the medical field an individual may be entering. The procedures were indicated in this research to be tedious and lengthy, which makes some Ghanaian health care workers spend several years just trying to enter the health care system while others eventually give up and leave the sector.

Equally important, a large amount of literature argues that there is a presence of recruitment agencies in Africa hiring African health care workers to the West (Kingma, 2006; Ray et al., 2006; O’Brien and Gostin, 2011; Mills et al., 2008; Connell, 2007). However, in this research respondents challenged this claim as they maintain that they were not hired by recruitment agencies because the process of hiring foreign health care workers in the US is complicated. In other words they came from Ghana to the US with support from friends and families but not recruitment agencies.
Last a large number of the respondents in this research were also found to have backgrounds not relating to health care jobs, but rather came to the US to be trained as health care workers because of the demand in the sector.
CHAPTER FOUR: BUILDING AND USING JOB RELATED NETWORKS AMONG GHANAIAN HEALTH CARE WORKERS

Globalization has made cross-border movements of people easier than before (Pagett et al., 2007), it was helped greatly by advancement in telecommunication and transportation technologies. Information about resources, social amenities or facilities, employment opportunities, and better conditions of service elsewhere are accessible through the use of information technologies such as the Internet, mobile phones and other social networking tools. A large amount of academic literature has attributed the high incidence of migration globally to the above reasons (Pagett et al., 2007; Epperson, 2009; Awases et al., 2004). In addition to this, in this research, it was also observed that the connections that exist between the Ghanaian migrants health care workers, their colleagues, and families in the US also made their migratory decision obtainable. To illustrate this, Kwame, a respondent who came to Columbus as a graduate teacher explained how he had been of support to other migrants,

Each year when the US visa lottery is open, I apply for most Ghanaians I know. Is rather unfortunately that no one has won. However, when people I know are coming from Ghana, I swear an affidavit on their behalf. But I do not take care of them in any way because they might have friends and family members in Columbus.

In addition, most of my respondents told me that they had been able to plan ahead of time about where they wanted to stay, what they wanted to do, and how they would do it at their destination because of the personal networks they had. These connections were identified to continue strengthening as the respondents linked up with their friends by living with them or close to them, and joining associations and/or religious groups their
networks belong to. To further elaborate on this, Sam, who worked as a patient escort on arrival indicated how he helped one Ghanaian migrant,

I have helped my friend’s friend. He came to the US but did not have anybody to live with. So my friend pleaded with me if I could take him in. So I said yes and my friend gave him my contact and he called me and I took him in. He lived with me for three years before leaving.

This chapter investigates how Ghanaian migrant health care workers build and use their job related network in Columbus, Ohio. It will highlight how these migrants form their job-related networks and the benefits they derive from them in their migratory processes and their employment in the health care sector of the US.

4.1. Forming Local Job-Related Networks

Some of the respondents highlighted the fact that their relation with their networks started while they were in Ghana and continued in the US. In Ghana, some of these respondents explained that they had worked in industries and studied in academic institutions that were not health care related. However, in the US they found some of their colleagues working in the health care sector. Because, their colleagues were the people they had sought and received help from before and after arrival in the US, they advised them to take the health care professions and in other cases helped them find jobs in the health care sector. For example, Samuel, a respondent in this research, illustrated this by indicating,

When I arrived in the US, I contacted my old friend from Ghana who lived in Columbus at that time. I told him I needed a job and he helped me find one in a hospital as patient escort.

So even though he was not a health care worker in Ghana, his first place of employment in the US was in the health care sector because of the link with his friend.
On the other hand professionals who connect with their colleagues in global social space have been shown to construct entirely new social relationships as a result of work-related experiences they encounter in their destinations (Kennedy, 2004). In addition, to the networks that existed before these Ghanaian migrant health care workers in this research migrated to the US, they were also found to have developed other links in the US on arrival. These connections were found to have begun when the respondents enrolled in various academic institutions, to train as health care practitioners. As they enrolled in these academic institutions they had the opportunity to interact with other colleagues through various activities, including the sharing of ideas, working in teams, and spending leisure time together. In so doing, they developed friendships with other Ghanaians, Africans, Americans and others in the health care sector. To demonstrate this, Kofi, a trained nurse from Ghana explained,

Right from day one, we were somehow compelled to work with each other to achieve academic excellence; sharing study guides, helping with homework, and bringing lunch to school to share among ourselves. This enabled us to continuously enjoy the company of each other and enjoy variety of dishes from some countries. I have also had the opportunity to be part of organizing a few birthdays parties, naming ceremonies, and funerals with friends and colleagues from other African countries.

In addition, the respondents remarked that they became friends with some of their instructors they met in the health care field by building rapport with them. Some were not only working as instructors but also worked in health care centers. They observed that the instructors also linked them up with various job opportunities in the health care sector. The formation of these job-related networks in the US after migration has increased and expanded their opportunity not only for a job search, but also help in their search of place
of settlement, and help with their emotional and financial support. This has greatly reduced the various risks or pressures of being outside their home country.

Another way in which these health care workers connect among themselves is through the bigger umbrella in the health care sector, which they find themselves or operate under. For example, according to Kay, a Respiratory Therapist, after obtaining a license to practice as a Respiratory Therapist the individuals must be registered under the National Board for Respiratory Care, just as the nurses are registered under the Board of Nursing. African health care workers often meet their future friends and colleagues on these boards who might help them later in locating better jobs in the health care sector.

The Ghanaian migrant health care workers interviewed also stated that although they are affiliated with nationwide professional networks, they would rather engage or interact informally among themselves in the local health care sector. None of my interviewees is aware of any organized association in the health care sector for Ghanaians or Africans.

4.2. Use of Local Job-Related Networks

Knowing somebody is the best and the easiest way of finding a job.
- Samuel

I depend on my friends who are in the nursing field. If there are job vacancies in our health care institutions, we talk among ourselves and prompt each other about the opportunities.
- Kwame

In terms of hiring and employment, the research participants indentified the role of their job-related networks in major ways: first, thanks to the networks, they were recruited into the health care services of the US. Second their networks served as referees
for them, informing them about vacant positions in health care organizations, assisting
them with the application processes, preparing them for the interview processes, and
lastly, wherever possible, lobbying for them to be recruited in their organizations.

Some of my respondents particularly those who have worked in the health care
institution for years told me that they have encouraged other Ghanaians to seek jobs in
their health care institutions by using them as referees. In that case, the respondents
explained that because of the trust that the health care organizations have for these
referees, the people they recommend are likely to be considered for such positions. So,
although the referees might not interrupt the recruiting processes in any way they played
a vital role in recruitment by being mentioned as referees in their applications.

Those also working in health care admitted that when there were vacant positions
in their work places, they would tell other friends about it. They look at the possible
positions whether it is for State Tested Nursing Assistant, Registered Nurse or Licensed
Practical or Respiratory Therapist and inform their friends who are already in the health
care sector accordingly. They connect their friends who hold those licenses or certificates
by asking them to put in their applications for vacant positions.

Some of the respondents also stated that they helped their friends with their
application process. They teach them how to complete the application form to gain
employment in their health care organizations. They stated that because they have gone
through the same process, they were better informed to help their friends complete these
applications in a proper way. They also explained that since they work in these
organizations they can also better guide their friends not to “mess up with the process,”
meaning that they give out warnings against things that could jeopardize their candidacy.

In addition, the respondents also pointed out that they prepare their friends for the
interview process. They pass on their experiences on the job and how their interviews
were conducted to their friends in the health care sector. They brief them on what to say
and how to say it during their interviews to be hired in their health care organization.

Equally important, they elaborated that they guide them on materials to read and things to
know before they go to the interviews.

Lastly, some of the Ghanaian health care workers interviewed also commented
that wherever possible they lobby people in authority or their Human Resource Managers
to make sure that their friends were recruited into their health care organizations. To
illustrate this for example, Samuel, a nurse, indicated,

If a friend needs a job and there is a vacant position in my organization I try to
lobby for him to be employed.

The respondents explained that many Ghanaian migrant health care workers in Columbus
have benefited from all or some of these aforementioned network helps. The job-related
networks of these Ghanaian migrants were also identified to have made some of their
fellow Ghanaians take up health care jobs in the US. For instance, they observed that
some friends they worked with back in Ghana in a completely different job sector had
taken up health care jobs in the US. The respondents pointed out that such friends also
influenced their decisions to be trained as health care workers because of the high
demands, the high remuneration and relatively ease to find jobs in the health care sector.

Although, even if without training in the health care sector, the new Ghanaian migrants in
the research were helped by their friends to find jobs in the sector. They took jobs, which
require little or no training such as State Tested Nursing Assistants, Patient Escorts, Housekeepers, and interpreters (between Ghanaian and English). As the respondents continued to do these jobs, they enrolled in colleges to further their education for higher positions in the health care sector. So, they move from these lower level positions to higher positions such as the Licensed Practical Nurses and Registered Nurses, which is illustrated with the flowchart below.

![Flowchart of Path to Promotion for Ghanaian Migrants without Previous Medical Training](image)

Figure 1: Path to Promotion for Ghanaian Migrants without Previous Medical Training

In the same fashion, the respondents stated that although they have no formally organized association for Ghanaian health care workers in Columbus, Ohio, they support themselves in various ways, including helping each other find places to live, giving donations to their friends in the sector when the need arises, supporting them to organize events, and being part of personal or family ceremonies, such as naming, funerals and parties. In so doing they also get to meet new people in the health care sector, which leads to further expansion of the job-related networks that work informally.
In like manner, although their job-related networks played significant roles in helping them adjust in their new environment, it was also observed that there were healthcare hiring organizations in the US, which also help in their recruitment processes. In addition to the responses given by some of the Ghanaian migrant healthcare workers, other claimed that they do not depend on their job-related networks for jobs in the healthcare sector. These participants depended on hiring organizations, such as the Career Builder, Moister, and Seniorbridge.com. for job in the health care sector. This confirms the study of Gold (2001) that close friends, former co-workers or broader social groups may provide valuable resources, but not all migrants have access to such dense and generous connections because of lack of ability to build networks. According to them these for-profit hiring organizations find sick people who need assistance of nurses (home aides) to work with and often have them work for the agencies by recruiting other Ghanaian migrants to be affiliated.

Despite these facts, some of the respondents also claimed that they do not work for hiring agencies because when they recruit these for the organizations, the agency denies them many benefits, such as health insurance and some allowances. Most immigrants prefer to go direct to the health care organizations through friends because they get access to all that they are entitled to.

4.3. Summary

In this Chapter, it was found that the connections that exist between the Ghanaian migrants health care workers and their job-related networks in the US did not only make their migratory goals obtainable, but also played significant roles in their settlement,
recruitment and employment into the US health care sector although not all the migrants depended on these networks. In conclusion, it was found that although there were no internationally recognized job-related networks that these respondents identify with, they tend to depend on their local or “accidental” job network for a wide range support.
CHAPTER FIVE: BUILDING AND USING GHANAIAN IMMIGRANT COMMUNITY NETWORKS

A large amount of academic literature has examined why African health care workers leave their home countries. Some of their investigations reveal that bad economic conditions, conflict situations, gender and ethnic discrimination, lack of facilities to work with, lack of opportunities to improve themselves, unemployment, poor wages, lack of motivation in the origin, job prospects, and the high demand for health care workers in their new locations are reasons why they migrate (Boyd, 1989; Dovlo, 2004; Awases et al., 2004; Troy et al., 2007; Snyder, 2009). Along these factors, in the previous chapter it was also found that job-related networks played a vital role in their hiring and migratory process of health care worker to the West. However, basically, this chapter points out that information has helped immigrants other than health care workers and that networks go beyond the job-related. In this research, several Ghanaian health care workers mentioned other networks, such as churches, associations, families, friends, and old classmates, have made their migration process much smoother. This process includes their settlement and their hiring processes in Columbus, Ohio, much faster than they would have been otherwise.

This chapter investigates how Ghanaian migrant health care workers in Columbus, Ohio, build and use their immigrant communities in their settlement, employment and hiring processes in the US health care services.
5.1. Ghanaian Churches in Columbus

Since this is a new environment, when Ghanaian immigrants come to Columbus, and they become members of the church, we help them find jobs and link them up with people who can provide them with all the necessary guidelines they need.
- Nana Ama

As mentioned in the quote above by Nana Ama, the church also plays significant roles in the adaptation processes of Ghanaian immigrants in Columbus on arrival. In addition, in this study, it was observed that, network building among Ghanaian migrant health care workers and the immigrant communities does start even before they arrive in the US, which is in agreement with Arango’s (2000) research findings that point to the cumulative nature of immigrant networks. The respondents noted that aside from their main job related networks the immigrant communities played important roles in their preparations towards migration, such as helping them with letters of invitations, affidavits of support, and finances. Additionally, the immigrant community networks played a role in several respondents’ decision to move from one job to another or from different sectors to the health care jobs. For example, those who came with professions, such as teaching, accounting, and administrative as police officers, army officers, and social workers were found to have been diverted into the health care field. Others who could also not find jobs in their fields were advised by various members of the immigrant community to take up jobs in the health care sector due to its bright future prospects. They are also given directions on what to do to become health care practitioners. The types of institutions available, either private or public can influence the newly arrived as to which institution to enroll in. This explains why Nana Ama a respondent mentioned that many of her church members are either health care practitioners or training to become practitioners.
In the same fashion, the respondents in this study identified themselves with religious bodies, such as the Jesus Power Assembly of God Church, the Apostolic Church of Ghana, Ghanaian Presbyterian Church, and the Baptist Church, all in Columbus. Their engagement with the church does not end on their first visit, but continues with the congregation visiting them at home and offering help for a smoother settlement in the new environment. Depending on where in Ghana these new members are coming from, they might be introduced or linked to particular groups of Ghanaians in the church who belong to the same ethnicity, which correlates with the research finding of Agbemabise (n.d.) that Ghanian migrants connect in places they find themselves according to the ethnicity. In terms of jobs they also connect with people who have recently undergone training in their field to help them do likewise or people who have been in the field for a long time. When this is not the case, they were introduced to old members of the church for general help and wise advice. To illustrate this, Efua, a nurse in this research indicated that,

At church my pastor knows I am a nurse and some church members do as well, so any time nurses come from Ghana with the Diversity Visa Lottery, they direct them to me for advice. I counsel them on how to take the licensure exams, including how they can find reading materials, what to do if they want to take pre-requisite courses to freshen up their skills, the colleges available they can enroll in, and how to complete their applications. I give my number to them and I continue to guide them through the process.

The churches, also connect these migrant health care workers and other members of their congregation to job openings in the health care or other sectors. Others also will automatically ask the members of their churches for support when they need jobs. For
instance, Nana Ama, in the following commentary demonstrated how she got her current job,

One of my friends at church told me that a man she knew was looking for nurses to hire, she gave me the address and the directions. I went there and completed the application form.

She was hired for the job. She mentioned that, at times, these Ghanaian health care workers if not given the right directions may be misled by others, which makes them waste years without making much progress concerning their desire to join the US health care services.

In the various religious groups including the Jesus Power Assembly of God Church, the Presbyterian and the Baptist Churches, some of these Ghanaian migrant health care workers continue to be helped by these networks. In a like manner, migrants in other fields are also linked to people in their respective jobs for advice. In this research, the churches were observed, aside their job-related networks, to be playing significant roles in the hiring and placement of these Ghanaian migrant health care workers in the health sector of the US. As discussed in Chapter Three, these Ghanaian health care workers go through a number of stages before they get the US health care jobs. The respondents’ historical trends of employment were also indentified to be influenced by the larger immigrant communities to which they belong.

The respondents also told me that their long engagement with the churches could be attributed to how they were affectionately received as new comers. At the Jesus Power Assembly of God Church in Columbus, the respondents explained that when they had first attended the church, they were warmly received, which made some of them remain
in the church over a decade. For example, Nana Ama explained how she felt at home on
her first visit as,

It was like one big family from home and we have all met again. I did not feel like
it was my first time in the church. It was awesome. We sang and prayed with one
accord, and it was very pleasing to me.

The respondents also observed that as part of the church proceedings new people who
visit the church are introduced. They explained that as they visited the church for the first
time, they were made to introduce themselves to the congregation as new members. This
procedure included getting up to mention their names, where they came from, what they
do, how they heard of the church and whether they came to be members of the church or
came for a visit. The congregations then came to greet them, talk to them, shake their
hands, and hugged them to make them feel at home.

It was also observed during one of the church services I attended that the
congregations were levied for funerals and burial services of their members and the
church has also a welfare scheme to which members made a monthly contribution.

Another key point was that the members of the church were also encouraged to report the
demise of their family members, births to their families, and other challenges ahead of
time so appropriate measures are put in place to support them.

5.2. Ghanaian Immigrant Organizations and Communities

Aside from the churches, other associations were also observed by these Ghanaian
migrant health care workers to be playing a similar role in their hiring and settlement
processes in the US. My Ghanaian informants mentioned that they were members of
various immigrant associations in Columbus, such as the Asantemaa, Kwahuman, Brong
Ahafo Association, the Young Intellectuals Association, BONABOTO (from northern Ghana), Akwapimam Association, the Ghana Veteran Association, and Tepaman Association which also support them. To illustrate this, Fred, a nurse who is also a member of the veteran association in Columbus indicated,

In the veteran association, we have many people working in various fields, so when you contact them they can easily link you up for jobs. Some of these soldiers who came from Ghana we have helped them find jobs in various industries, which they have, some training. For sometime now, I have personally not searched for a job, but if I want one it would be easy because of this group.

In addition, the respondents pointed out that they chose to be members of these associations because they considered them to be their external relations, which makes them feel secure in their new location because they may not have family relations in Columbus or the US. As members of these associations, the respondents reported that they are required to pay monthly dues, give donations, attend meetings and in some cases visit members when they are bereaved, have babies, or are sick. This also confirms the study of Barre et al. (2003) that the recent network formation among some expatriate scientists from Africa working in the Western countries is a way for mutual support and information sharing with non-scientific immigrants. The respondents also acknowledge that their connection with the larger immigrant communities had been of great importance to them and their people back home. For instance, Seth, a nurse who is a member of the Tepaman Association, mentioned that,

We contribute towards projects, which are undertaken by the paramount chief of my town. Every year we have our annual meeting and raise funds in a chosen state in the US to support the various projects being undertaken by our chief. These projects may include building libraries, school buildings, health facilities and constructing of boreholes.
He added that mostly the paramount chief would communicate to them about the things that the community needs. They raise funds to support the paramount chief to accomplish those objectives. In addition, they also depend on these immigrant community networks and associations for various purposes, such as naming their children, bereavement, fun activities, employment, and in their day-to-day decision-making. They also help new members by accommodating them, helping them find roommates, and driving them around for shopping.

Equally important, the respondents in this research also stated that their strong network building among their migrant communities in Columbus has been made possible by such social activities as naming ceremonies, weddings and birthday parties which hardly require any formal invitation to attend. They often mobilize by word of mouth and in some cases printing posters and posting them in vantage places like African markets or shops, and in their churches where their fellow migrant Ghanaians may come to shop or may come for fellowship respectively. The posters are used to advertise activities, such as naming ceremonies, birthday parties, people searching for roommates, prayer and fasting programs, concerts, and funeral announcements as shown in Figure 3 and 4 below.
Figure 2: Advertisements at African Market, Columbus, Ohio. Photo taken by Francisca Lekey.
Figure 3: Advertisements at a Ghanaian Church, Columbus, Ohio. Photo taken by Francisca Lekey.
It was also significant that my respondents get help from the immigrant communities by staying closer, which explains why they like to share their accommodations or look for roommates among themselves. To illustrate this Billo, a respondent, told me that,

I thought it was ideal for him to come to Columbus because then he will be close to me and I can easily help him faster than when he is living miles away from me in a different city where he does not know anybody.

-Billo

The above remark by Billo, a migrant Ghanaian nurse, is indeed discussed in many studies arguing that migrants’ first place of residence in the city is largely predetermined by the location of kin or friends (Wu, 2008). New arrivals to the city might stay with members of their social networks or rely on the information provided by the networks to find a place to stay. In addition, respondents in this research noted that they also chose their settlement patterns on the bases of other factors, which include, the desire to live close by where they can find their religious affiliations, hometown associations, local shopping for grocery, salons, and clothing from back home, lower standards of living and job opportunities. During the initial stages these health care workers lived with their friends or families who might have lived in Columbus for years and were equipped with tangible skills and experience to give them good counsels concerning their new environment for work and living. Samuel, one of the respondents stated that,

My sister had lived in Columbus for 15 years before I came. When I arrived from Ghana she took me from the Greyhound bus station to her house. So although it was my first time in Columbus I was not terrified, I knew she would be around to help. I stayed with her and she supported me until I could be on my own.
These immigrant communities helped these respondents with their day-to-day activities until they can be on their own. Some of them said that they chose to continue living together even after their employment in order not to break the helpful bond, which is also argued for by Wu (2008) as often resulting in satellite communities of migrants.

5.3. Summary

In this Chapter, it was also observed that connection among various Ghanaian immigrant communities in Columbus have made their migratory decisions obtainable, which led to further expansions of their networks. As the network continues to expand, it serves as a bridge between those back home and these new immigrants and makes their migration decisions easier. The desire to settle closer to family members, friends, religious affiliations and associations on arrival additionally creates a bigger immigrant community that could help to assist their adaptation efforts.
CHAPTER SIX: CONCLUSION

Understanding the mass emigration of health care workers has been extremely difficult for African countries over the years. Although a couple of policy measures may have been put in place to reduce the rate of migration, their effectiveness in bringing migration under control has been at best questionable. In an attempt to learn other reasons causing their continuous migration, this research identifies that Ghanaian migrants interaction and engagement with the larger immigrant communities has resulted in the formation and existence of both job and non-job related networks in their new location. These networks make their migratory goals obtainable, but also helps to minimize their risk of settling in their new environment. It does this not only for them, but also helps other non-trained migrants to train as health care workers in the US.

Also a large amount of literature argues that health care workers from Africa are hired by recruitment agencies in African to the West (Kingma, 2006; Ray et al., 2006; O’Brien and Gostin, 2011; Mills et al., 2008; Connell, 2007), although this may be true, in this research it was opposed by the respondents that a large amount of migrantGhanaians came to the US to be trained as health care workers. The respondents contended that the claim of international recruiting agencies recruiting health care workers from Ghana to the US is unfounded. This is due to the fact that they found the process of acquiring a license to practice in the US health care services as very complicated and would be very challenging for international recruitment agencies to hire Ghanaian health care workers from Ghana to the US.

Additionally, the respondents reversed the claim by arguing that the acute shortage of health care workers in the US and the prospects in the sector have lured of
them from other professions, such as teaching, military, policing, computer programming, and accounting into health care services.

It was also found in this research that the tedious nature of certification for these foreign migrant health care workers tends to create some impediments, which make them leave health care job and/or take up menial jobs in the sector or in other jobs, which are also found in research findings of Pittman et al. (2007) and Stalker (2001).

Again, it was revealed that although various academic scholars identify international health care organization to be playing important roles in the migration and recruitment of health care workers in Africa to the West, on the contrary in this research accidental job-related networks are found to play a significant role in helping Ghanaian migrants to become health care workers in the US. These networks were observed to play major roles, such as serving as referees, informing respondents about vacant positions, assisting with application processes, preparing respondents for interviews, and lobbying for them to be recruited in their health care organizations. Additionally, these networks also support in their migratory processes, settlement and offering physical and emotional support to them in their new environment.

In the final analysis, it was discovered that there were no structured organizations or associations for Ghanaian health care workers in Columbus, Ohio, but the immigrants depended on these “accidental” networks and/or their immigrant community for support.

In this research several limitations also existed. First, large portions of my respondents were not health care workers before they came to the US. They became health care workers in the US. As a result of this my research protocols were adjusted because some of the questions were not applicable to these respondents. My sample may
have also influenced the context or the results of this research because it was not a representative of all health practitioners in the US. The sample was made up of only nurses and a respiratory therapist, meaning other practitioners were not interviewed to understand how they also transition to health care jobs in the US. If I had interviewed medical doctors I would have been able to find out whether or not International recruitment agencies might be recruiting these doctors.

Second, my own personal position as a Ghanaian might have also played a role in recruiting all Ghanaian respondents for this research instead of Africans in general. This was because respondents were comfortable to introduce me to other Ghanaians because felt they would be more willing to be part of this research because of my nationality. In addition, my personal contact with the first respondent may have also led to my recruitment of more males than females in this research. This does not necessarily mean that there are more males in the health care jobs than females. The first respondent was a male who led me to another male and this led to a snowball approach until all my respondents were recruited.

Third, it was also challenging to find the appropriate word for “recruitment.” My respondents used it to mean how they transition from other sectors into the health care jobs in the US, while others used it to mean employment.

Finally, another limitation was that I left out how long these migrants have lived in the US and how long it took non-trained migrants to become health care workers. As a result it was difficult to explain the difference between how quickly the already trained and the non-trained migrants became health care workers in the US.
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APPENDIX: INTERVIEW QUESTIONS

1) Please tell me about your medical training and employment history in your home country (Any other countries) prior to your arrival in the US?

2) Tell me about what prompted your decision to migrate to the US?
   Describe your migration process?

3) Tell me about your employment history in the US?
   Do you still practice what you were trained for in your home country?
   If not why? If yes, what additional training(s) did you enroll in to qualify for in the US?

4) Have you helped anyone in Africa migrate to the US? Describe that process?

5) What role have you played in helping new African health migrants get a job in the US?

6) Are you involved in community activities with other Africans?
   Tell me about or describe your involvement in these activities?

7) Are there particular people or organizations in the community you rely on if you need to find a job or other things?
   Describe how they have been of support to you (on arrival or before arrival in the US)?

8) Do you belong to any African migrant association in Columbus? Do you know of any African migrants associations? If yes can you please tell me what they do?

9) Are there particular people, organizations, agencies in the health sector that you would rely on if you need to find a job, accommodation and other support?
   How did you get involved?
   How have you benefited from each mentioned?

10) Tell me about the particular people and other activities you involved in back home?
11) In your opinion how do you see the demand for health workers in the US compare to the demand in Africa?