The Experience of Sub-Saharan African Overseas Qualified Nurses Working in Rural NSW: A Hermeneutic Phenomenological Study

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# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AHS</td>
<td>Area Health Service</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AIN</td>
<td>Assistant in Nursing</td>
</tr>
<tr>
<td>ANMF</td>
<td>Australian Nursing and Midwifery Federation</td>
</tr>
<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia</td>
</tr>
<tr>
<td>ASGC</td>
<td>Australian Standard Geographical Classification</td>
</tr>
<tr>
<td>ASGS</td>
<td>Australian Statistical Geography Standard</td>
</tr>
<tr>
<td>DON</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FLECC</td>
<td>First Line Emergency Care Course</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>OQHP</td>
<td>Overseas Qualified Health Professional</td>
</tr>
<tr>
<td>OQN</td>
<td>Overseas Qualified Nurse</td>
</tr>
<tr>
<td>RCA</td>
<td>Refugee Council of Australia</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Areas</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Certificate of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged. I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services or nominee, for the care, loan and reproduction of theses, subject to confidentiality provisions as approved by the University.

Signature of Candidate
Sophia Dyvili
Acknowledgments

I would like to extend my sincere thanks to the nurses who participated in this research study. It was a privilege to be invited into their homes and gain understanding of their migration experiences. I felt honoured. Without their time and generosity this project would not have been.

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I am thankful to my family overseas for their patience as I would go for days without making those long distance international calls. My daughter Zola and niece Neziwe had to put up with me when stress levels were high – thank you mantombazana.
Paid Editorial Assistance

During the final stages of thesis preparation, paid editorial assistance was obtained from Carmel Davies. Carmel Davies was provided with a copy of the final draft for proofreading. The assistance she provided related to identifying issues relating to language, grammar, spelling and punctuation, consistency and completeness of style. Such recommended changes were made in line with the Australian Standard for Editing Practice (ASEP) Standard D – Language and Illustrations, and ASEP Standard E – Completeness and Consistency. Carmel Davies did not alter or improve the substantive content and conceptual organisation of the thesis. Carmel Davies had no similar academic specialisation to the author. A fee was paid for this service from personal funds.
Publications Resulting From the Thesis

The following articles derived from this thesis were accepted for publication:


Abstract

The phenomenon of international nurse migration is not new. More nurses are seeking employment across national borders. Trends of international nurse recruitment show an increase in the movement of nurses between developing and developed countries. By 2007, Organisation for Economic Co-operation and Development (OECD) countries reported 11% of nurses working there as foreign-born. Australia joined other developed countries in actively recruiting nurses from overseas to meet their domestic demand for nurses; and these overseas qualified nurses (OQNs) included those from sub-Saharan Africa. In Australia, OQNs are found in both urban and rural areas. Experiences of OQNs in their destination countries have been discussed extensively in the literature. However, experiences of OQNs in rural and remote areas of their destination countries, Australia included, remain minimally explored as evidenced by limited published research; hence, the study focus on rural areas. Furthermore, there is less information specifically on the experience of sub-Saharan African nurses in Australian rural areas. It is unknown if their experiences are similar or different from those of migrant nurses from other continents.

The research study sought to explore the experience of OQNs following their migration from sub-Saharan Africa to work in Australia. The study explored how these OQNs gave meaning to and made sense of their migration process and their daily working and social life experiences in rural New South Wales. Gadamerian hermeneutics guided the processes of this inductive study. Eighteen sub-Saharan African OQNs shared their experience through individual face-to-face interviews and a focus group discussion. They were conveniently selected, mainly through the snowballing technique.

Three themes were identified from the hermeneutic analysis of the participants’ transcripts and presented as findings chapters. Chapter 6, The Move Across the Indian Ocean, presented the first theme as participants described their experiences as they left their countries and arrived in Australia. Chapter 7 described the New Life in an Alien Land as perceived by participants as they negotiated the Australian workplace systems and way of life. Chapter 8 presented the third theme, Developing a Sense of Belonging and Moving On, as participants sought ways of becoming part of their communities and moving on with their lives in their newly adopted country. The findings are discussed together in Chapter 9.
The findings of the study indicated that participants embarked on their migration journey in response to push and pull factors of international migration, although the process for them was more complex. Participants experienced a warm welcome from management teams in rural Australia. However, they soon had to contend with negative responses by some of their colleagues and patients in the workplace which led to the participants’ perception of being alienated in the workplace through discrimination and disadvantage based on race. Participants called on their resilience and persistence to remain focused on their migration goals. The study also uncovered cultural differences that participants had to negotiate as they settled into a new life in rural Australia.

This thesis makes an original contribution to scholarship by adding more knowledge on international nurse migration. Recommendations for further research and to help guide nursing practice, nursing management and international recruitment are made.
Chapter 1: Introduction to the Study

Introduction

Chapter 1 introduces the research study. It identifies the research questions that guided the study and the purpose of the study including its significance in the discipline of nursing. The chapter also gives an overview of the content and structure of the study as it informs the reader of the processes that were undertaken in each chapter.

Background

This study sought to explore the experience of overseas qualified sub-Saharan African nurses in rural New South Wales (NSW), Australia. Participants in the study migrated to Australia as early as 2003. Migration of nurses and midwives between countries has been taking place for decades. It is only in the past two decades that migration has occurred in such a high proportion that it has attracted world attention, including that of international organisations such as the International Council of Nurses (ICN) and the World Health Organization (WHO). This surge in migration has been attributed to a critical global shortage of nurses and midwives that has seen economically advantaged countries recruiting overseas qualified nurses and midwives. Some nurses in these economically advantaged countries have been frustrated and demoralised leaving the profession due to, among other issues, poor working conditions, low pay, harassment and staff shortage (Alexis & Vydelingum, 2004).

Meanwhile, the expansion of health services and an increase in the elderly population have resulted in higher demands for nursing services. Australia, like other developed nations, has increasingly relied on the recruitment of overseas qualified nurses (OQNs) (Australian Institute of Health and Welfare [AIHW], 2009, 2012; Stankiewicz & O’Connor, 2014). These OQNs, some of whom migrated from sub-Saharan Africa (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Francis, Chapman, Doolan, Sellick, & Barnett, 2008), have settled in rural areas of Australia where the nursing and midwifery shortage has been especially significant (Francis et al., 2008; Wellard & Stockhausen, 2010). Socioeconomic, political, professional and personal factors in their countries of origin have been identified as playing a major role as motivators for migration among the international nurse recruits (Beaton & Walsh, 2010; Chikanda, 2005; Larsen, Allan, Bryan, & Smith, 2005; McGillis Hall et al., 2009).
Experiences of OQNs in their destination countries have been discussed extensively in the literature (Alexis & Vydelingum, 2004; Beaton & Walsh, 2010; Hatzidimitriadou & Psinos, 2014; Kishi, Inoue, Crookes, & Shorten, 2014; Mazurenko, Gupte, & Shan, 2014; Primeau, Champagne, & Lavoie-Tremblay, 2014). The literature provides evidence of a global nursing shortage, a considerable increase in international nurse migration, the reasons why nurses migrate and the information on the source countries and recipient countries in this migration process. However, the experiences of OQNs – especially in the rural areas of their destination countries – remain minimally explored (Dywili, Bonner, Anderson, & O’Brien, 2012; Wellard & Stockhausen, 2010). There is limited published research relating to the experiences of OQNs working in rural and remote areas of their destination countries, Australia included (Dywili et al., 2012); hence, the study focus on rural areas. Furthermore, there is less information specifically on the experiences of sub-Saharan African nurses in Australian rural areas. It is unknown if these are similar to or different from those of migrant nurses from other continents. The voices of those African nurses who settled in the rural areas have been particularly quiet in the ongoing dialogue pertaining to international migration.

As international nursing shortages continue to escalate, so too will the international recruitment of nurses. Since there have been reports of exploitation and negative experiences of some nurse migrants (Larsen, 2007), it is important that employers in health organisations provide positive experiences that will maximise benefits for both the migrant nurse and the health service. Therefore, it is essential that the experience of OQNs is understood, hence the need for research in this area. It is also important to understand the experience as it may impact on the performance and retention of staff in rural areas which subsequently may affect nursing care.

The study adds to other research studies on international nurse migration, particularly building upon research work already carried out on OQNs in metropolitan cities of Australia (Deegan & Simkin, 2010; Walters, 2008). It contributes another facet to knowledge and understanding of international nurse migration by exploring the experiences of sub-Saharan African nurses. Furthermore, it is unique in that it focuses on sub-Saharan African nurses living and working in rural NSW. The focus on OQNs from sub-Saharan Africa is particularly significant because of the complexity of working in a new environment that is socially, culturally and linguistically different. The research study gave participants the opportunity to share their experiences. Their stories were heard and validated; they know
that people value and care about their migration experiences and about what these experiences mean for them.

**Purpose of the Study**

The purpose of the study was to explore the experiences of OQNs following their migration from sub-Saharan Africa to work in Australia. The study sought to explore how these OQNs gave meaning to and made sense of their migration process and their daily working and social life experiences in rural Australia. The study was inductive in nature as it was built from the data collected. This helped to gain an understanding of their motivations and experiences as they migrated from Africa to Australia and their experience as they lived and worked in rural NSW.

**Research Questions**

The study sought to explore the experience of OQNs as they migrated from sub-Saharan Africa to live and work in rural Australia. The three research questions that guided the study were:

1. What was the experience of the sub-Saharan African OQNs as they migrated from their countries to rural Australia?
2. What is the experience of sub-Saharan African OQNs as they live and work in rural Australia?
3. From the sub-Saharan African OQN perspective, what does it mean to be a registered nurse living and working in rural Australia?

**Organisation of the Thesis**

This section presents an outline of the ten chapters that make up this thesis.

The introductory chapter informs the reader about the background to the study, its context and its purpose and significance. It also defines the scope of the study and gives an overview of the thesis. This introductory chapter ends with my migration journey to Australia.

Chapter 2 examines the literature relating to migration as a concept and labour migration theories. The global market demands for nurses are reviewed. The chapter provides a review of factors influencing international nurse migration including influences of both source and recipient countries. Overseas qualified health professionals (OQHPs) in rural areas of destination countries are also discussed. Further, the chapter gives a brief historical
background of Aboriginal Australians to provide the contextual rural environment for the participants. Finally, the chapter discusses OQNs in Australia and the African spirit of *ubuntu* that participants carried along with them.

Chapter 3 details the study’s qualitative methodological framework. Using a qualitative research approach gives a deeper understanding from the perspective of an OQN. The chapter discusses and justifies the use of a phenomenological research paradigm and presents an overview of the development of phenomenology as a research framework. As well, the reasons it was selected are examined and justification is made for the choice of Gadamer’s hermeneutic phenomenology. The chapter then expands on Gadamer’s theoretical stance on historicity, language and dialogue, and fusion of horizons.

Chapter 4 describes the methods that were undertaken to apply the methodology to this study. These include recruitment procedures, participant selection, data collection and management methods, data analysis and ethical considerations.

Chapter 5 introduces and describes the participants. Participants were registered nurses (RNs) with qualifications from sub-Saharan Africa, working in rural NSW. Participants embarked on their migration journey to Australia initially leaving their families behind in Africa. The description of participants gives an insight into the uniqueness of each sub-Saharan African OQN as they migrated.

Chapters 6, 7 and 8 present the findings of the study. Each of the three chapters describes one of the three major themes that emerged from the analysis of findings. Chapter 6 describes the first theme, *The Move Across the Indian Ocean*, which involves the motivations of participants to migrate to Australia and their initial experiences. Chapter 7 describes the second major theme, *New Life in an Alien Land*, which includes feelings of loneliness, stress and guilt due to family separation; racial discrimination; disadvantage from inconsistent work orientation and cultural shock. Chapter 8 discusses the final theme, *Developing a Sense of Belonging and Moving On*. Over time, participants noted positive change towards them by their colleagues and patients. With that feeling of acceptance, participants saw their future as being in Australia and they desired to be part of their communities.

Chapter 9 discusses the findings and relates these to the literature. Four aspects of the experience are discussed. These are ‘Taking the Plunge’ as participants made the decision to migrate to unknown lands; ‘New Beginnings in a New Environment’ as participants started a new life in their newly adopted country; ‘Culture, Race and Colour’ where cultural
differences and discrimination based on race and colour are discussed; and, finally, ‘Developing a Sense of Belonging’ which includes issues relating to resilience and persistence as well as future plans as participants became part of their communities.

Finally, Chapter 10 concludes the thesis by discussing the implications, recommendations and conclusions drawn from the findings. The recommendations emerge from the study findings and are pertinent to nursing practice and research. They also relate to other stakeholders in the process of migration such as migration agents and managers of rural hospitals. Recommendations were made for both source and destination countries on how to respond to the ever-increasing movement of nurses across international borders. This final chapter also discusses the strengths and limitations of the study.

Before concluding this chapter, I thought I should briefly share my own migration story to Australia as an OQN from sub-Saharan Africa.

**My Migration Journey to Australia**

The incentive for this study came from my own migrant background and experience. I went through this research journey with my own knowledge and experience as an overseas qualified nurse and midwife who participated in and experienced the process of skilled migration from Zimbabwe to Australia.

I have always loved nursing and have had the desire to advance; I always imagined myself with a PhD in nursing. However, since the year 2000, the chances of being able to study at this level were slipping away as my country, Zimbabwe, went into economic turmoil. This followed a political decision by the government to violently seize white-owned farms to resettle blacks (Meldrum, 2000). A few years later, my beautiful country was on its knees economically. There had been a depletion of resources from the country by people in power, and industrial and farming production almost ceased. Inflation was high and the local Zimbabwean currency could not compare with other foreign currencies such as the US dollar or South African rand. Inevitably, this adversely affected the day-to-day life of ordinary Zimbabweans including removing hope of a decent lifestyle and professional advancement, as the costs for external courses like PhDs spiralled. My original plan was to undertake the PhD with the University of South Africa through distance education as the program was not then available in my country. At the time, I was a midwifery educator in charge of Gwanda School of Nursing and Midwifery and also working as a part-time nurse lecturer in the Faculty of Science at the Zimbabwe Open University.
I had never seriously thought about emigrating and certainly not to Australia. To me, Australia was a country somewhere beyond the Indian Ocean that I learnt about during our early high school geography lessons; it was one of the British Commonwealth countries, like ours, whose head of state was Queen Elizabeth II. We were told there were other black people called ‘Aborigines’ living in Australia and that the country produced wool and minerals.

As the situation worsened in Zimbabwe, my colleagues, who were already in the UK and Australia, were sending me information and links to websites, suggesting that I emigrate too, but I did not take heed as I thought the situation would get better. At the time, I was living with my two adult nieces and toddler grand-niece. At one time, my young sister had also encouraged me to emigrate because it would ‘help the family’ – but I was not interested. It took me a long time to make that decision because I kept on hoping, as did many fellow nurses in my country, that things would get better. At the time, as a nurse/midwifery educator in charge of the School, I was busy processing transcripts and support letters for RNs who were trained in our institution (which offered a hospital-based RN diploma) and who were already leaving the country for various destinations. I did not give their departure much thought.

I will take you back to the day I decided to ‘pack my bag and go’. It was mid-2004 on a Sunday afternoon when I was preparing to travel by public transport from Bulawayo to Gwanda, a small town where I worked as a nurse educator. My car had broken down some time ago and there were no spare parts available. That weekend, I had visited my relatives in my hometown Bulawayo, 126 km away.

The students in Gwanda School of Nursing were writing their end-of-block session examination the following morning and I had to be in Gwanda to supervise it. Not being there was not an option for me. That weekend, there was a sudden national shortage of fuel in most petrol stations and hence no public transport. I went to the main Bulawayo-Gwanda Road to join hundreds of other commuters who were flagging down private cars going in the direction of Gwanda. A few cars came along, but it was a situation of survival of the fittest as only men were able to push through the crowd and literally ‘jump’ in. After about two to three hours of flagging – it was already dark and windy – there came an open utility truck and I managed to jump onto the back with a few other women and children. We were crowded on the back of the truck where we crouched, packed like sardines and we could not
even stretch our legs. I did not have a cardigan for the cold wind on the back of an open truck and my head was not covered. We were all at the mercy of this driver whose face we could not even see. On such journeys, you start with a prayer! He was driving fast, probably to get to the destination quickly and then come back for more customers since public transport was down. My ears were painful from the wind – and at such speed!

The following morning, I felt sick but had to invigilate the examination. From the events that had taken place the previous day, I told myself there was no way things could get better in this country! At the end of the working day, we had to queue for bread at the local supermarket as the bread supply was running short; probably, supplies could not be delivered because of the fuel shortage. That evening, there was yet another food queue for a 50 kg maize bag (staple food) from ‘the Party’ – or else, my family would starve. This was the only source of maize as none was available in the shops; only ‘the Party’ had access to the national granaries of the Grain Marketing Board. I had had enough. The following day, I downloaded the Nursing and Midwifery Board of Australia’s registration application forms from a website link which had been sent to me by a friend.

The registration process, according to my friend in Australia, went smoothly and quite fast – we could not believe it – then she linked me up with an Australian migration agent. Again, it was easy for the agent because I was already registered and had chosen Sydney as the city I wanted to work in; all they did was link me up with a Sydney hospital that was interested in sponsoring my work visa. Bankstown Hospital contacted me for a telephone interview which was conducted at 6 am Zimbabwe time. I was offered a job to work in a surgical ward. A few weeks later, the Australian Immigration Department approved my SC457 visa application. It felt so good!

I touched down at Sydney airport on Sunday night, 5 December 2004, following a 13-hour flight and was received by a Zimbabwean couple who had been contacted by my migration agent. By 7 am the following day, while suffering jetlag and functioning on adrenaline, I was receiving a patient handover report from the night nurses, together with other day staff, in a large public hospital in Bankstown, South West Sydney. I began work in Australia as an RN in a surgical ward. In the ensuing years I undertook a few short in-house courses including an adaptation course for overseas-trained midwives, offered by the NSW College of Nursing. After three years, I moved to another large public hospital to take up a clinical nurse educator post. I believe my previous nurse/midwife educator role in Zimbabwe played
a significant part in my success for this job. In 2009, I moved inland to Wagga Wagga NSW to take up a lecturer position in nursing and midwifery at Charles Sturt University.

This brief story of my migration gives an overview of how some migrant nurses come to be working in countries they never dreamed of. The unexpected socioeconomic circumstances in my country took away my dream of professional advancement and provided me with the incentive to migrate. I wanted to know how others experienced their migration to Australia. Since my migration, I have been visiting family and friends in Zimbabwe every other year. My grand-niece joined me in Australia after four years and we are now Australian citizens, living in our new-found land.

**The Interest in the Study**

I embarked on this research journey with my own knowledge and experience as an overseas qualified nurse and midwife who has participated in and experienced the process of skilled worker migration from sub-Saharan Africa to Australia, albeit to a metropolitan city. Since my arrival in Australia, I have sometimes wondered how this journey has been for other OQNs from Africa. From the brief and informal discussions I have shared with other African OQNs, during lunch breaks at work or at ‘get-together’ functions, it became apparent to me that each individual had their own story to tell and their experiences were important to understanding their need for support in making the transition to their host country. This project provided a platform for these OQNs to share their experiences. I believe their narratives have added to the historical records of international nurse migration especially during this era of unprecedented global migration.

**Conclusion**

International nurse migration occurs everywhere and it will probably continue for some time. Nurses move all the time from country to country and from continent to continent for various reasons. Chapter 1 introduced the study by discussing its context and explaining its purpose and significance to nursing. Research questions were posed which the study sought to answer. In addition, the chapter gives an overview of the organisation of the thesis indicating its adoption of a qualitative research approach which gives a deeper understanding of the migration experience from the perspective of an OQN. I also retraced my migration journey to Australia. The following second chapter of this thesis reviews literature that is relevant to international nurse migration.
Chapter 2: Literature Review

Introduction

This literature review chapter provides the context of the study. It begins with a review of the historical origins of human migration generally, and then identifies international labour migration theories. The review examines the experience of OQHPs in rural areas of various destination countries and then progresses to the global market demands for nurses and midwives. The motivations for international nurse migration are described and an analysis of the source and recipient countries worldwide is provided. The review finally examines workforce migration in Australia with a focus on OQNs. The literature review provided in this chapter will help to explain the meanings and interpretation of the themes that emerge from this study focusing on the experiences of sub-Saharan OQNs living and working in rural NSW.

Various literature search strategies were implemented as migration cannot be confined to a single-science discipline. The review process involved reviewing several electronic databases: CINAHL Plus, EBSCOhost (Health), SAGE Journals online, Scopus, ProQuest and ISI Web of Knowledge, JSTOR, MUSE, Rural and Remote Health Database (RURAL), OvidSP and ScienceDirect (Elsevier SD). Key words used included, but were not limited to, migration, international nurse migration, migration and rural areas, and rural health; as well, various terms were used to describe OQNs, migration motivation, integration and culture. The words were also combined to expand the search. Data sources included key websites, government and organisational documents/reports, textbooks and peer-reviewed articles. In addition, the reference lists of relevant articles were thoroughly examined to identify more articles and reports. The literature review process was carried out throughout the research project up to the end of the study when I wanted to access current information on migration issues.

History of Human Migration

Since historical times, migration has been one of the most natural activities human beings have engaged in. Ancient civilisations have migrated within their lands and across continents carrying with them cultures and skills that have contributed to the economic and socio-demographic development of their new countries (King, 2007). King saw human migration as reaching back to ‘the very birth of mankind’, seven million years ago when humans in the
form of *Homo erectus* and later as *Homo sapiens* took the journey from the African forests to the rest of the world (p. 15). The old testament of the Bible (Exodus 12:40–42, The Holy Bible, King James Version) describes the exile and migration of the Israelites to and from their homeland, while in China there was massive migration during the Eastern Jin dynasty (317–420 AD), the Southern dynasties and the Northern dynasties (Hu, 2010). In the 17th and 18th centuries, a period considered the darkest hour in migration history, millions of enslaved black Africans were forced to migrate across the Atlantic Ocean to America and the Caribbean to work in the sugar and tobacco plantations and to serve their masters in various other family and household chores (King, Connell, & White, 1995). Historical records also show that black Africans migrated to Australia in the 18th century, albeit under different circumstances.

**18th – 20th Century Black African Migrants in Australia**

Historical records show the arrival of black Africans in Australia with the First Fleet in 1788 (Pybus, 2006; Udo-Ekpo, 1999). The dozen or so black men on the First Fleet (and subsequent fleets) had been convicted in Britain for petty crimes like stealing food, clothing, alcohol, etc. These ‘Black Founders’, as described by Pybus (2006), were former slaves in America who had escaped slavery by going to London during the American Revolution but unfortunately they could not find employment and ended up in petty criminal activity (Pybus, 2007). More black Africans continued arriving in Australia via trade routes as seamen throughout the nineteenth century. They would disembark on the Australian coast and then disappear into the local Indigenous communities (Pybus, 2006; Zwangobani, 2008).

The 1901 ‘White Australia Policy’ Act, which did not recognise coloured populations as citizens of the new colony, is believed to have led to the Africans integrating with Indigenous communities and the African lineage disappearing into mixed marriages (Pybus, 2001). Two of these first black African men in Australia left legacies in Australian history. John Caesar (alias Black Caesar) was known as Australia’s first bushranger whose crime was to escape to the bush and subsequently to steal food; a crime he was shot and killed for following a manhunt. William ‘Billy’ Blue had been shipped to Australia following a conviction for stealing sugar in Britain (Pybus, 2007). Billy Blue was the first ferryman on Sydney Harbour and was later honoured by Blue’s Point in Sydney being named after him. Following the enactment of the 1901 Immigration Act, the early 20th century saw Australia determining which ethnicities were welcome in the country. This resulted in a reduction in the arrival of non-whites in Australia. However, the Constitutional recognition of Indigenous people in 1967 and the acceptance of other cultures by the Whitlam government in the early 1970s
opened doors once again for non-white migrants (Zwangobani, 2008). Now, just over two centuries after the arrival of the first Africans on the First Fleet, Africans have resumed their migration to Australia, this time for varied reasons that have included those displaced by wars on the African continent.

21st Century Migration

In the 21st century, people continue to leave their hometowns or their own countries voluntarily to live, work, study or reunite with their families elsewhere. Some migrate as refugees or forced migrants, fleeing persecution or intense political and/or economic unrest in their countries (Betts, Loescher, & Milner, 2012; Crock, 2015; Hayes & Mason, 2012). In Australia, migrants continue to arrive with the hope that the country will offer them economic opportunity and safety (Hayes & Mason, 2012).

During these population movements, the potential exists for the transformation of the lives of all those who have direct contact with migrants and those who are indirectly affected socially, politically and economically (Colic-Peisker, 2011; Colic-Peisker & Farquharson, 2011; Fong, Verkuyten, & Choi, 2016; International Organization for Migration [IOM], 2015). This transformation has been facilitated by the current globalisation; it changes the demographic structures and economies of cities and nations (IOM, 2015).

The IOM (2017, para 1) defines a migrant as:

Any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is.

The nurses who participated in this study are referred to as migrants. The past two to three decades have seen an increase in international migration. The IOM (2015) reports an estimated 232 million international migrants, with women making up 50% of those numbers (International Labour Organization [ILO], 2010). The ILO describes these migrants as including “seasonal workers, temporary contract workers, skilled migrant workers, students, asylum seekers and refugees, workers with irregular status and victims of trafficking and forced labour” (2010, p. 1). All countries have been affected as some have served as source countries for the migrants, some as destination countries while yet others have served as transit countries (Kingma, 2006a). This has made 21st century migration more complex with increasing diversity and more challenging for the United Nations. Cross border movements
of labour have emerged as a central issue for the international community with millions of people worldwide leaving their home countries every year in search of work (ILO, 2010). As the ILO definition above shows, these migrant workers can be a mixed group of different types of workers including victims of trafficking and forced labour. With migrant workers accounting for 90% of international migrants, the ILO was given the mandate to ensure protection, good governance and cooperation in dealing with international migrants (ILO, 2010).

This overview of human migration shows that it is not new. Migration has always been one of the most natural activities undertaken by human beings in search of food or moving away from natural disasters, violent conflicts or persecution (ILO, 2010). The majority of migrants are workers and, as current international labour migration has become more diverse and complex, several labour migration theories have been advanced in an effort to understand this phenomenon.

**Labour Migration Theories**

Horevitz (2009) emphasised the need to understand human behaviour and the social environment of people who migrate. There is no single theory of international labour migration. International migration is complex and various contemporary migration theories relate to why and how people migrate. The two broad categories are those theories that have a political and economic focus and those that focus on how labour migrants adjust to living in a new country. Theories that have a political and economic focus include, among others: i) the rational choice theory; ii) the world systems theory; and iii) the supply-and-demand theory (Kim, 2009; Massey, 2015; Massey et al., 1993; Sirojudin, 2009).

The **rational choice theory** refers to individuals who evaluate their situation regarding their best economic interest and then decide to migrate based on their rational understanding of economic costs and benefits (Sirojudin, 2009). These individuals assess the destination country in terms of its demographic structure, political and economic situation, the labour wages and also the ability to manage risk in cases of market meltdowns (Ciarniene & Kumpikaite, 2011; Massey et al., 1993). The theory leans more on personality factors in those individuals who are work-oriented and who have the motivation for higher achievement (Ciarniene & Kumpikaite, 2011). Being a migrant labourer in another country is considered a rational choice made by the individual at a personal level, hence this theory assumes that these individuals will not migrate against their will (Sirojudin, 2009).
The **world systems theory** postulates that international labour migration is related to the structure of world markets (Massey et al., 1993) where multinational firms in rich countries, like Western Europe, the USA and recently China (Ma, 2012), penetrate poorer countries aided by their neo-colonial governments in search of land, raw materials and new consumer markets to increase their profits and wealth. As these resources come under the influence and control of capitalists in these poorer countries, staple crops are substituted with cash crops and this drives small-scale farmers out of local markets. Consequently, traditional systems are destroyed as populations are socially and economically uprooted. This creates a mobile labour force that not only moves to cities in their own countries, but also is likely to migrate abroad to countries where foreign investment originated, due to the dual development of communication infrastructure facilitated by economic globalisation (Massey, 2015; Sirojudin, 2009).

The **supply-and-demand theory** refers to international geographic differences in the supply of and demand for labour resulting in international migration (Massey et al., 1993; Sirojudin, 2009; Stark & Fan, 2011). Countries with good capital and high demand for a labour force tend to pay higher wages than countries that have poor capital and a low demand for a labour force. This differential results in workers in countries with lower wages migrating to countries with higher wages (Massey et al., 1993). This theory explains the ongoing massive movement of workers from developing countries to the developed world (capital rich countries) in search of higher paying jobs.

Mejia (1978) had earlier identified a simplified version of all these theories by simply describing push/pull factors in health worker migration – a theory that has been frequently used to explain why nurses migrate. The push/pull factor theory is discussed later in this chapter under ‘Motivations for International Migration’.

Theories that have a psycho-sociological perspective focus on how migrants interact with their new social environment as they adjust to living in a new country. These modern theories have moved from the 1920’s migration concept of a one-way process of movement to a two-way process that involves movement and relationships that draw upon social networking between individuals in countries of origin and destination countries (Hernandez, 2009; Kimberlin, 2009; Lee, 2009). For example, these ‘transnational’ migrants as described by Lee (p. 741) prefer dual citizenship and send remittances or run businesses in their countries of origin (Horevitz, 2009; Kim, 2009; Lee, 2009). New migrants continue to have strong ties with their homelands regardless of their permanent settlement in a new country (Adepoju,
2011; Horevitz, 2009). This has also helped migrants maintain aspects of their culture of origin. Advances in communication technology and technological globalisation continue changing labour migration trends and have made it easy for families to communicate across distances and time zones.

**Globalisation and Health Workforce Migration Trends**

Labour migration has been facilitated by globalisation, a phenomenon described by Ritzer (2011, p. 2) as a “set of processes involving increasing liquidity and the growing multidirectional flows of people, objects, places and information as well as the structures they encounter and create”. Some of the structures encountered can hinder or facilitate these flows. Globalisation has involved increasing human mobility of not just refugees but also people visiting other countries, the result of which has increased diversity among country populations and sharing of cultures (Riggs, 2002, 2006; Satlykgylyjova, 2017). The workforce has become so globally mobile that country residents, for example, Australians, depart permanently or temporarily to seek employment in other countries (Collins, 2008). Related to this globalisation are also processes that connect individuals across geopolitical borders. For example, fast and easily available transportation and interaction between people in different countries through the World Wide Web on the Internet have facilitated international migration for workers seeking employment across country borders and maintenance of communication with their loved ones.

In recent years, health workforce migration has accelerated in both developed and developing countries as increasing numbers of nurses, midwives and doctors seek employment across borders (Brush, 2008; Dywili, Bonner, & O’Brien, 2013; Hidalgo, 2013; Li, Nie, & Li, 2014; Omaswa, 2008). Several developed countries have shown a dependence on health professionals from other countries (Goodyear-Smith & Janes, 2008; Kamalakanthan & Jackson, 2009; Samet, 2013; Schafheutle & Hassell, 2009). The negative impact of this permanent loss of knowledge and qualified labour, due to migration (brain drain), on health systems in source countries, especially developing countries, has resulted in critically low staffing levels (Afaha, 2013; Samet, 2013) and has become a worldwide concern. This has led various organisations to develop position statements to curb the negative impact on source countries.

At the 63rd World Health Assembly in May 2010, the WHO presented a code of practice (referred to here as the ‘Code’) for its member countries on the ‘International Recruitment
of Health Personnel’ (WHO, 2010a). The Code provides ethical principles which recruiting countries are encouraged to apply to their international recruitment processes. The WHO Code is founded on the principle that everyone has a right to the highest possible standard of health and everyone, including health workers, has the right to migrate to any country in search of employment. The Code encourages recruiting countries to consider the specific needs and circumstances of countries whose economies are in transition and so may be vulnerable to health workforce shortages; therefore, countries should recruit in a manner that does not weaken the health systems of developing countries (WHO, 2010a). It should be noted though that use of the Code is voluntary and member states are only encouraged to use it. This Code is also supported by the ICN.

The ICN (2006) described three patterns of nurse migration: i) migration among developed countries; ii) migration among developing countries; and iii) migration from developing countries to developed countries. While the exchange of doctors, nurses and midwives between developed countries has been happening for many decades (Lurie, 2016; Mejia, 2004), over the last 20 years there has been an increasing trend of these health professionals migrating from developing to developed countries (Brush, 2008; Kingma, 2006a; Li et al., 2014; Likupe, 2006). This loss of human resources has reduced the capacity of health systems in the developing countries because of the loss of skilled health professionals. Developing countries end up recruiting from each other or remain with no staff (Afaha, 2013; Anderson & Isaacs, 2007; Likupe, 2013) propagating the cycle of nurse shortage and international recruitment. As the global demands for nurses increase so too does international nurse migration.

**Global Market Demands for Nurses**

International nurse recruitment has increased to a level never seen before due to the ever-increasing demand for nurses. Over the past few decades, nurse migration has become more global and more complex involving governments and recruiting agencies (Kingma, 2008). New markets and new competition for nurses have emerged (Lintern, 2015; Zhou, Roscigno, & Sun, 2016). Competition for nurses is stiff; developed countries attract nurses with many employment package perks including higher salaries and better working conditions with which poorer countries cannot compete (Beaton & Walsh, 2010; Zhou et al., 2016). At the other end of the migratory axis, developing countries fail to employ their graduates because of financial constraints and those nurses who are employed feel there could be better incentives to retain them (Dywili et al., 2013). The social environment driving these forces
has provided more access to global information through the Internet and faster transport, thus easing the movement of nurses across regions (Thupayagale-Tshweneagae, 2007).

In several developed countries, such as the United Kingdom (UK), the United States of America (USA), Canada and Australia, there has been an increasing demand for nursing care while the supply of nurses from within those countries has been low (Adhikari & Melia, 2015; Calkin, 2013; Iredale, 2010; Jose, 2011; Lintern, 2014; Sederstrom, 2013). Some of the contributory factors to the undersupply of nurses in developed countries are the declining enrolment due to attractive alternative career opportunities for school leavers, the ageing workforce, poor working conditions resulting in job dissatisfaction and the generally poor nursing image (Iredale, 2010; Stankiewicz & O’Connor, 2014). Over the years, there has been an increasing demand for nurses due to population increase, an ageing population that requires more nursing care, the increasing complexity of health care due to technological developments in medical science and decreased local community healthcare activity (Humphries, Brugha, & McGee, 2008; Iredale, 2010). While several strategies have been used to increase the supply of nurses in developed countries, for example, improving nurse retention, attracting men and mature entrants, and encouraging returnees and ethnic minorities, these have not been sufficient to meet the demand (Adhikari & Melia, 2015; Hawthorne, 2010). The imbalance between demand and supply has forced developed countries to bridge the gap through active overseas nurse recruitment (Adhikari & Melia, 2015; Hawthorne, 2010; Kingma, 2006a). In the UK and Australia, for example, both the public and private healthcare sectors have used international recruitment as part of the solution to their staffing needs (Adhikari & Melia, 2015; Iredale, 2010; Stankiewicz & O’Connor, 2014). While extensive international recruitment campaigns by recruitment agencies provided opportunities for professional development and financial security for migrant nurses, they also encouraged nurse migration on an unprecedented scale attracting business entrepreneurs who saw potential in an industry that was initially operating within an unregulated environment (Kingma, 2006a). Such an environment which had no code of practice created a potential for the abuse of the system and exploitation of the migrant nurse. The whole migration process has impacted on both source and recipient countries.

Impact of Nurse Migration on Source and Recipient Countries

International migration can have a significant impact on both the source country and the recipient country. International migration trends have highlighted the loss of nurses and midwives from countries such as Africa, the Caribbean and Asia to the developed world.
Migration patterns have been predominantly from developing countries to developed countries (Afaha, 2013; Li et al., 2014; Xu & Zhang, 2005); Kingma (2006a) referred to these trends as the South-North migration where there was a one-way movement of nurses from the source to the receiving countries. Developing countries have been a cheaper and quicker source of nurses (Kingma, 2006a) with the source countries often sharing language and postcolonial ties with the recipient countries (Alonso-Garbayo & Maben, 2009; Buchan, 2004; Efendi, Chen, Nursalam, Indarwati, & Ulfiana, 2016). In addition, developed countries have had an advantage of luring overseas nurses and midwives with better economic opportunities (Dywili et al., 2013; Efendi et al., 2016; Likupe, 2013; Ohr, Parker, Jeong, & Joyce, 2010).

As overseas nurses migrate to countries with economic advantage, they deprive their own countries of a skilled human resource: a scenario that transfers the shifting of the shortage to the poorer countries (Afaha, 2013; Blake, 2010). In recognition of the impact on source countries, the ICN (2007) has condemned the unethical recruitment practices which some countries have engaged in to ‘pull’ the nurses in order to address the shortages in their own countries. The Nursing and Midwifery Board of Australia (NMBA, 2017) also decided to restrict international nurse migration by introducing very tight admission criteria which include a minimum of a Bachelor degree qualification.

In some source countries, the out-migration of nurses and midwives caused conflict between ministerial departments where, for example, the ministry of health and the international development community found their programs at risk of collapsing because of nurse and midwifery shortages while their ministries of finance preferred to ignore the problem because of overseas remittances that boosted their economy (Vasant et al., 2004). When international recruitment of nurses peaked in 2001–2002 in countries like the UK (Adhikari & Grigulis, 2014), it was reported as an area of interest at the June 2001 ICN Congress in Copenhagen and developing countries were calling for restrictions on it (Buchan, 2001). This is because the loss of nurses and midwives to migration results in fewer skilled workers and a loss of economic investment, time and money to train nurses in the source country. Migration also results in low morale/poor motivation and increased workloads and stress for the nurses who remain in the source country (Evans & Tulaney, 2011; Garner, Conroy, & Bader, 2015; Lofters, 2012). India and the Philippines are two large source countries that have capitalised on the shortage situation in the recipient countries by commercialising nurse training where nurses are trained for export as a national development strategy (Blank, 2011; Brush & Sochalski, 2007; Sparacio, 2005). The remittances that come from the Indian and
Filipino nurses working overseas are reported to constitute a noteworthy economic boost to their home countries (Buchan, 2006; Walton-Roberts, 2015).

International nurse recruitment is seen as a quick fix for staff shortages in recipient countries as these countries gain well-trained and experienced professionals at relatively no expense (Blake, 2010). Receiving countries have, however, been challenged on their ability to sustain international recruitment as this is seen as treating the symptoms without dealing with the root cause of the shortage of nurses. This delays the implementation of effective local programs aimed at addressing the real problems relating to why very few people choose nursing as their profession or why thousands of those RNs are not employed in the nursing workforce (Blake, 2010). Under-investment in the nursing profession in both recipient and source countries is a major contributory factor to nurse migration (Jellinek, Reinhardt, Ladden, & Salmon, 2015).

For the migrant nurse, moving to another country can be a dream-fulfilling journey while it can also be quite challenging as the immigration and registration procedures can be expensive, time-consuming and frustrating (Kingma, 2006a), not to mention the negative experience for some nurses on arrival in their destination countries (Blake, 2010). The ICN believes that nurses in all countries have the right to choose to migrate regardless of their motivation. The impact on the migrant nurse is discussed further in the findings chapters of this study which sought to explore the migration experiences of nurses in rural Australia.

The critical global shortage of health professionals, followed by an unprecedented high global demand for a health workforce, has resulted in increased international recruitment of health workers by developed countries from developing countries. The nursing profession has not been spared by these developments. This international nurse migration phenomenon has been facilitated by the globalisation processes taking place around the nursing profession. International nurse recruitment has impacted positively and/or negatively on both source and recipient countries. As international nurse migration continues unabated, the literature shows various factors that motivate nurses to seek work beyond their country borders.

**Motivations for International Migration**

A number of factors have been identified that contribute to an individual’s motivation to migrate. Mejia (1978) observed that there is an interplay of different forces that occurs in worker migration. These forces are situated at either end of the migratory axis. Mejia
classified these forces as ‘push’ and ‘pull’ factors (p. 210). Failure by some source countries to employ their graduates due to financial constraints was identified as a significant ‘push’ factor while failure by the recipient countries to train enough physicians and nurses served as a ‘pull’ factor. Mejia noted that the nurses and physicians who migrated at that time sought to improve themselves professionally and financially (Mejia, 1978). The motivations for current labour migration trends relate to migratory forces that include political, social, economic, legal, historical, cultural and educational factors. Whilst individual factors are described, there is also an overlap between motivations; for instance, economic factors are closely linked to political and social factors and these also impact on professional factors.

**Economic Factors as Determinants of Migration**

A large number of studies report economic factors as important determinants of nurse migration. Many nurses mentioned better remuneration in another country as a motivating factor for migration (Afaha, 2013; Beaton & Walsh, 2010; El-Jardali, Dimassi, Dumit, Jamal, & Mouro, 2009; El-Jardali, Dumit, Jamal, & Mouro, 2008; Habermann & Stagge, 2010; Perrin, Hagopian, Sales, & Huang, 2007). For many nurses, international migration is a strategy to change their lives for the better as many source countries have declining economies (Aboderin, 2007; Prescott & Nichter, 2014). Earlier in the migration peak in 2001–2002, Ross, Polsky, and Sochalski (2005) found that a higher percentage of overseas trained nurses registered in the UK came from low- and middle-income countries than from high income countries. Other studies (Ronquillo, Boschma, Wong, & Quiney, 2011; Squires & Amico, 2015; Troy, Wyness, & McAuliffe, 2007) reported that migrant nurses were driven by the desire to send money back to their countries of origin as remittance to help family members. These studies included reports of better benefit packages and earning more to improve themselves financially (Garner et al., 2015; Johnson, Green, & Maben, 2014; Perrin et al., 2007).

Findings from most of the studies supported the common theory that the incentive to migrate depended upon the prospective income to be gained from migration. However, some studies have disputed the assumption that nurses move mainly for financial reasons (Buchan, Jobanputra, Gough, & Hutt, 2006; Ohr et al., 2010), citing many other motivations. The literature shows that professional, socio-political and personal factors are commonly cited by nurse migrants.
Professional Factors as Determinants of Migration

Sometimes, nurses cross international borders in response to motivators related to the job itself (Beaton & Walsh, 2010; Brunero, Smith, & Bates, 2008; Perrin et al., 2007; Troy et al., 2007). Professional development was a frequent reason for migration as nurses in both developed and developing countries sought opportunities for employment and advancement in their careers. Younger nurses in developing countries, in particular, emigrate because of inadequate educational opportunities and lack of support for continuing education (Thupayagale-Tshweneagae, 2007). Those who have a desire to advance in the profession get demotivated when resources are diverted to other national projects like HIV/AIDS control programs (Thupayagale-Tshweneagae, 2007).

Even for those nurse migrants whose main motive was economic gain, professional advancement was an additional incentive (Aboderin, 2007). Nurses migrated because they anticipated a recognition of their profession (Aboderin, 2007; Thomas, 2006), good working conditions and societal respect (El-Jardali et al., 2008). Some migrated expecting improved job security and reduced workload (Aboderin, 2007) as well as autonomy for nurses (El-Jardali et al., 2008). Other migrant nurses were influenced by colleagues who were already abroad (Palese, Barba, Borghi, Mesaglio, & Brusaferro, 2007) and by advertised incentives from prospective employers and recruiting agencies (Beaton & Walsh, 2010; Buchan et al., 2006; Palese et al., 2007; Palese, Cristea, Mesaglio, & Stempovscaia, 2010).

Professional push factors from source countries included differences in working conditions between countries (Zander, Blümel, & Busse, 2013), such as lack of resources and lack of adequate facilities within the healthcare system and high workloads (Aboderin, 2007; Likupe, 2013), nepotism in the workplace (El-Jardali et al., 2008) and the low social status of the nursing profession (Aboderin, 2007; Thomas, 2006). Decisions by some nurses to migrate out of Lebanon were triggered by the organisational culture in hospitals where nepotism occurred or nurses not being actively involved in managerial decision making (El-Jardali et al., 2008). Thomas (2006) reported that nurses in India intended to migrate because of unfair treatment by government promotion policies which reserved training and promotion posts for certain social classes/castes. Indian nurses expressed pessimism over the profession fulfilling their ideals and this feeling was driving international migration. The nurses reported that their only option was to migrate to countries that supported equal opportunities for all (Thomas, 2006).
High workloads and inadequate equipment in Africa have been reported to be linked to the HIV/AIDS pandemic which has contributed to the loss of nursing staff and nurses’ intent to migrate (Chikanda, 2005; Kohi et al., 2010; Lynch, Lethola, & Ford, 2008). Many nurses in developing countries have succumbed to the disease and have not been replaced, resulting in high workloads for the remaining nurses. Chikanda (2005) also found that there was a very high risk of HIV exposure to Zimbabwean nurses because the majority of patients were being nursed with very little protective equipment. El-Jardali et al. (2009) showed an association between job dissatisfaction and the intent to migrate by nurses in Lebanon. El-Jardali et al. (2008) also found lack of appreciation by supervisors for work done and the existence of a blaming culture. A poor work environment, stress and exhaustion, few opportunities for advancement because of lack of support for continuing education, and limited continuing education programs all contributed to Lebanese nurses intending to migrate (El-Jardali et al., 2008).

Issues affecting nurses in their professional practice have been shown to contribute to international nurses’ migration. These include lack of respect for nursing as a profession, poor remuneration, poor working conditions that led to stress and high workloads, job insecurity and lack of appreciation by supervisors. Sometimes motivations for migration are not necessarily related to the nursing profession. Some of these professional factors are closely linked to the existing socio-political environment that has been seen to influence the emigration of nurses from their countries.

**Socio-political Factors as Determinants of Migration**

A number of socio-political factors have been put forward as determinants of nurse migration. Even without direct economic and/or professional pressures motivating nurses to migrate, several studies found nurses migrated in search of a better quality of life (Aboderin, 2007; Beaton & Walsh, 2010; Buchan et al., 2006; El-Jardali et al., 2009; Palese et al., 2010; Perrin et al., 2007; Thomas, 2006; Tregunno, Peters, Campbell, & Gordon, 2009). While often linked to economic factors, a better quality of life also included a number of social issues such as living in a better and safer environment because their present living conditions were unmanageable and a threat to their families (Thomas, 2006; Tregunno et al., 2009). Nurses also migrated to experience life in another country where their families could experience another culture (Al-Hamdan et al., 2015; Warin & Blakely, 2012), while some were encouraged by family members to migrate (Ronquillo et al., 2011; Troy et al., 2007) to open opportunities for other family members. Migration of nurses has also grown within
the European Union countries since its enlargement and some commonly stated social motivations relate to a desire for better living conditions (Galbany-Estragués & Nelson, 2016; Zander et al., 2013).

Some nurses migrated in search of security for themselves and their families; they left their countries due to political instability and violent conflict, particularly in countries like Lebanon and some of those in sub-Saharan Africa (El-Jardali et al., 2008; Kalipeni, Semu, & Mbilizi, 2012; Thomas, 2006). As already stated above, this political instability can be directly linked to a poorly performing economy. Political factors are closely aligned with social and other factors as the political situation provides the context for the social and work environment. El-Jardali et al. (2008) found that high levels of violence and crime in the country, a general sense of despondency and seeing no future motivated nurses to move. For example, Lebanese nurses wanted to raise their families in a politically safe environment that also showed signs of economic growth (El-Jardali et al., 2008).

Motivations related to social and political factors have been seen to influence international nurse migration. Some serve as push factors while others take the form of ‘pulling’ nurses to other countries. These economic, professional and socio-political factors were not the only motivations for nurses. Linked with these factors were personal reasons to migrate.

**Personal Factors as Determinants of Migration**

Personal and family reasons were other driving forces for international nurse migration. These play a major part considering that not all nurses emigrated from their countries in response to the unfavourable social and political conditions. A number of studies found that nurses were primarily motivated by individual desires and needs such as an opportunity to travel and experience something new and challenging in other countries whilst working (Beaton & Walsh, 2010; Stankiewicz & O’Connor, 2014; Troy et al., 2007; Zander et al., 2013). Some nurses migrated to accompany partners, or following divorce or family breakdown and seeking a change of lifestyle (Larsen et al., 2005). In addition, some nurses migrated because they saw it as an opportunity to visit the country of their ancestors (Larsen et al., 2005). Some migrated and chose certain countries because there were no language barriers and it was easy to have their qualifications recognised (Buchan et al., 2006; Palese et al., 2007) while others saw the nursing profession as ‘a passport to the world’ (Troy et al., 2007, p. 3).
Motivations for international nurse migration emerged from the literature as related to economic, professional, socio-political and personal factors. Economic and professional factors were those related to financial issues and working conditions, respectively. Socio-political factors described events in the broader society and how people related to each other as well as the influence of political power or government decisions that are beyond the control of the nurse. Personal factors were those related to the characteristics of nurses with their individual desires and needs. The common feature for all these nurses is a desire for change of lifestyle and security for themselves and their families. These motivations are not discrete as they tend to influence each other and there may be more than one factor operating in any decision to seek migration.

The Decision to Migrate

The motivations discussed above have suggested a link with the decision to migrate. This decision may also be influenced by pre-existing migration flows between the affected countries (Warin & Blakely, 2012). However, the final decision to migrate is a personal one. Regardless of all these push and pull factors, some nurses decide not to migrate (Freeman, Baumann, Blythe, Fisher, & Akhtar-Danesh, 2012).

According to Maslow’s hierarchy of needs (Tovey, Uren, & Sheldon, 2010), humans must meet the basic physiological needs that contribute to sustenance of life as well as security and safety needs. The other needs of belonging, self-esteem and self-actualisation will be dependent on these survival needs. Nurses, like all human beings, work because they need to. They want to provide for their families; they need food on their tables and a roof over their heads. If these needs are not met, for whatever reason, nurses will seek other ways to do so including migration.

Economic factors dominated motivations for migration. Some nurses were prepared to leave their jobs and their families and forfeit whatever savings they had accrued over time because opportunities were better elsewhere (McGillis Hall et al., 2009). In addition, recruitment agencies promised free travel tickets, subsidised accommodation and tax free salaries (Beaton & Walsh, 2010; Kingma, 2006a; Singh, Nkala, Amuah, Mehta, & Ahmad, 2003).

The literature review has shown that nurses experience basically the same motivations for migration as they did four decades ago (Mejia, 1978); it is predominantly for financial and professional reasons. However, unemployment in some source countries and nurses just leaving their jobs and seeking employment elsewhere seem also to be a trend.
Some of these migrant nurses and other health professionals find themselves working in the rural areas of their destination countries. The critical global shortage of health professionals is more evident in rural areas of both source and recipient countries (WHO, 2010b). Countries like Australia have been recruiting international health workers mainly for rural and remote health services where the shortage has been more significant (Iredale, 2010). The literature has discussed the experience of some of these migrant health workers in rural and remote areas of their destination countries.

**OQHPs in Rural Areas of Destination Countries**

The critical global shortage of health professionals in both developing and developed countries is a significant problem for healthcare delivery (National Rural Health Alliance, 2010; WHO, 2010b). Approximately half the global population live in rural areas, yet only 38% of the total nursing workforce and 24% of the medical practitioner workforce serve these areas (WHO, 2010b). OQHPs working in rural and remote areas of destination countries include doctors, nurses/midwives, dentists/dental therapists and pharmacists (Fink, Phillips, Fryer, & Koehn, 2003; Francis et al., 2008; Harding, Whitehead, Aslani, & Chen, 2006; Hopcraft et al., 2010; Wellard & Stockhausen, 2010).

Most of the research studies exploring the experience of OQHPs in rural areas involved medical practitioners; the limited research information on other health professionals showed a gap in research, particularly for migrant nurses (Dywili et al., 2012). Among the issues of note were those concerning the OQHPs’ migration expectations and the cultural diversity they brought into those communities.

**Migration Expectations**

The OQHPs were expected by the employing organisations to fill employment gaps (Thompson, Hagopian, Fordyce, & Hart, 2009) and to possess adequate clinical and interpersonal skills (Hagopian, Thompson, Kaltenbach, & Hart, 2004; Han & Humphreys, 2005). This was checked through appropriate registration assessment procedures. Some medical practitioners in Canada were expected to function beyond their previous cultural limitations, for example, male medical practitioners were now expected to attend to female clients as well (Curran, Hollett, Hann, & Bradbury, 2008).

In Australia, work colleagues expected overseas qualified medical practitioners to understand their culture stating that it was up to the medical practitioners themselves to
reduce the gap between cultures (Durey et al., 2008; Gilles, Wakeman, & Durey, 2008). One Australian study found that, although clients saw overseas qualified medical practitioners as valued members of their society and were equally satisfied with them as they were with the locally trained ones (Harding, Parajuli, Johnston, & Pilotto, 2010), they did expect communication and cultural competency (Gilles et al., 2008; Howard et al., 2006) and they perceived language as an impediment to effective communication. The OQHPs themselves expected their previous experiences to be considered by their employer (Gilles et al., 2008). They also suggested longer and more comprehensive orientation programs (Beaton & Walsh, 2010). Their expectations included recognition and respect for their culture (Durey et al., 2008) and support for their families as remote areas did not offer much for their spouses and children in terms of employment and recreation (Gilles et al., 2008; Han & Humphreys, 2005). The new culture brought by OQHPs to the rural areas created a diversity within a rural culture that tended to be uniform for everyone.

Cultural Diversity at the Workplace

Overseas qualified health workers, including nurses, travel to their destination countries carrying with them a wealth of culture and knowledge (Blake, 2010). Sometimes rural folk are reluctant to consult overseas trained medical practitioners due to perceived language barriers (Goins, Williams, Carter, Spencer, & Solovieva, 2005); this cultural difference is perceived as a barrier to healthcare access especially by Indigenous locals. In Australia, cultural differences also created tensions and misunderstandings that resulted in ineffective communication and poor relationships not only with clients, but also with co-workers (Durey et al., 2008). Recognition of cultural diversity and organisational support were identified as key to effective communication and successful professional and community integration of OQHPs into Indigenous communities (Gilles et al., 2008). Workforce migration to the rural areas of Australia has been taking place for some time now. This research study sought to explore the experience of sub-Saharan African OQNs in rural Australia.

Rural Australia and Workforce Migration

Australia has witnessed a large number of migrants since British settlement in 1788. There was a large Chinese migration to Australia during the Gold Rush in the 1850s. At the time, there was no federation so laws restricting migration differed across states and their immigration restriction laws were enacted at different times; for example, Victoria in 1857 and NSW in 1861 (Collins, 1993). The federal ‘Whites only’ Immigration Restriction Act 1901 restricted migrants to mainly those of British and Irish backgrounds and excluded
‘coloured’ migrants from entering Australia. However, the Gold Rush led to a higher and urgent demand for labour from the rest of the world because of the concurrent economic boom and the expansion of the territories.

After World War II, the government of the day pledged to increase Australia’s population by one per cent per year by embarking on a large-scale immigration program operating under the theme ‘populate or perish’ (Collins, 1993, p. 294). The policy focused on the migration and reunion of families unlike Western European countries that assisted only contract guest workers. The project, however, did not meet the expected results of more British and Irish migrants, instead these two groups constituted less than half the post-war migrants, resulting in the government accepting non-British migrants and officially abandoning the White Australia policy in 1972 (Collins, 1993). Since then, migrant workers from all over the world have been settling in Australian cities with a significant number settling in rural areas working in the farming and mining sectors.

Participants in this study migrated from sub-Saharan Africa to rural Australia. Of the 24 million plus Australian population, approximately one-third of Australians live outside major cities in regional, rural and remote areas (AIHW, 2016a). Australian rural communities tend to have small populations spread across a vast area. Such a sparse population distribution can present a challenge for provision of services and infrastructure (Pritchard & McManus, 2000).

Several classification systems have been developed to define the rural and remote areas of Australia. There are three major classifications that describe these areas – the RRMA (Rural, Remote and Metropolitan Areas) classification, the ARIA (Accessibility/Remoteness Index of Australia) classification and the ASGC (Australian Standard Geographical Classification) Remoteness Areas classification (AIHW, 2004). No one classification system addresses all the issues related to rural and remote health as each one has its own strengths and weaknesses. Rural areas tend to vary greatly hence they are difficult to define. Basically, the classifications consider population size, population density and distance factors in relation to urban centres, and then they are categorised accordingly. For the purposes of this study, rural Australia refers to those areas outside of major cities. They are made up of many diverse settlements including farming, mining and Indigenous communities; they have different social and economic determinants of health and less access to health services due to less human- and health-related infrastructure resources (AIHW, 2017).
Rural Australia has gone through some environmental and demographic changes over time. For a century, rural industries in the form of agriculture and mining had been the major export earners which symbolised what it was to be Australian (Connell & Dufty-Jones, 2014). The wool industry, in particular, was the backbone of the Australian economy in the 1950s giving the country its iconic description of ‘riding on the sheep’s back’ when it lifted Australian living standards to one of the highest in the world (Connell & Dufty-Jones, 2014). As the minerals (coal and iron ore) replaced wool as Australia’s economic future, rural farmers began to struggle to sell their wool on international markets. As a consequence, farmers felt marginalised and isolated from the cities. By the 1990s, the gap between the cities and the country was widening (Connell & Dufty-Jones, 2014). Today, rural life seems to be no longer attractive to the majority of Australians as shown by the population distribution. This has hindered service provision in rural areas, resulting in professional staff shunning working in rural areas because of hardships associated with transport, and poor health and education services. In fact, people living in rural areas do not have the same access opportunities to health, education and employment as those living in metropolitan cities and they tend to have a higher risk of disease (AIHW, 2016a). They, however, have more social cohesiveness and feel safer in their communities (Connell & Dufty-Jones, 2014).

Rural Migrant Demography

Following World War II, the Australian population, which was previously dominated by British settlers and Aboriginal people, underwent a transformation as migrants from Europe and the Middle East arrived resulting in rapid industrialisation in urban centres. Although the Chinese migrant influx had occurred earlier in the nineteenth century during the gold rush, those from Asia and sub-Saharan Africa joined the migration flow after the abolition of the White Australia policy in the 1970s (Hugo, 2014). Many of the migrants from southern Europe, such as Italy and Greece, had previously lived in rural farming areas in their countries of origin and so they started settling outside metropolitan cities along major rivers engaging in horticulture and irrigated agriculture (Hugo, 2014).

Meanwhile, the flow of internal migration in rural areas has seen younger populations migrate from rural areas to cities for better education and employment opportunities while older people prefer to move from cities to smaller rural towns at retirement to reconnect with their families, giving rural areas a larger proportion of the elderly (Davies, 2014; Davies & James, 2011). This city to rural migration by older people resulted in social isolation for some (Davies, 2014) and an increased demand for health care and social welfare facilities.
The consequence has been a greater need to increase the health staffing levels in rural areas, especially in managing chronic conditions and aged care provision.

In recent years (1995 and onwards), the migrant population has continued to increase in rural Australia partly due to the introduction of rural migration programs in response to skills shortages in rural areas (Massey & Parr, 2012). This rural migration scheme included recruitment of OQNs to fill the staffing gaps in rural health centres. Within the Australian rural population are the Indigenous people, the traditional owners of the land.

**Aboriginal Australians**

Australian Indigenous people account for three per cent of the total population and 21% of them live in rural and remote areas (AIHW, 2015). Aboriginal Australians are found in mainland Australia while Torres Strait Islanders are found north of Queensland in the Torres Strait. The two nationalities are collectively known as Indigenous Australians or the Indigenous people (Pascoe, 2012). The Indigenous people believe they have existed in Australia since time immemorial. They have traditionally been a predominantly nomadic population group who hunted and gathered for a living, moving across their vast lands in response to seasonal changes (Broome, 2010; Pascoe, 2012). The invasion of Aboriginal land in 1788 by the British and the subsequent British dominance over Aboriginal people led to strained relationships between the two nationalities. This dominance was not without resistance by the Aboriginal people; however, the British eventually prevailed due to their superior resources and sheer outnumbering of their counterparts (Broome, 2010). The subsequent dispossession and control by the British led to Europeans claiming a racial superiority over the Aboriginal people, with some viewing them not as human beings but as a “species of tail-less monkeys” (Broome, 2003, p. 95). This view supported the belief, at the time, that killing Aboriginal people was no different than shooting wild dogs.

The racism against Aboriginal people worsened in the 1840s when their legal rights were undermined; they could be arrested and held without trial. Racism in this case is defined by Berman and Paradies (2010, p. 217) as that phenomenon which “maintains or exacerbates inequality of opportunity among ethno racial groups. Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions/affect) or discrimination (racist behaviours and practices)”. In racism, there is inequality of power, resources and opportunity (Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011); racists attribute inferiority to another ethnic group (McMurray & Clendon, 2015) and then justify their unequal treatment of the group. This enshrined racism towards Aboriginal people exists to date as racial tensions
continue and they feel marginalised by the system, stigmatised and neglected and also disrespected for their culture (Durey & Thompson, 2012; Eckermann et al., 2010; Priest et al., 2011).

Aboriginal people experience disadvantage and discrimination compared to non-Indigenous Australians. The Australian Bureau of Statistics (ABS) (2014a) reports that Indigenous Australians are half as likely as non-Indigenous Australians to be employed, and they are generally in poorer health. In the remote areas, Aboriginal people survive on subsistence hunting and gathering, food aid programs and employment for a few lucky ones (Connell & Dufty-Jones, 2014). This is seen as being associated with historical dispossession at colonisation, marginalisation and oppression as well as present-day racism (Australian Indigenous HealthInfoNet, 2017; Berman & Paradies, 2010; Eckermann et al., 2010; Steffens, Jamieson, & Kapellas, 2016). Aboriginal descendants have grown up learning that their own parentage and heritage are stigmatised and looked down upon by the wider society.

From the above rural demography, it is noted that participants migrated to a diverse rural population that has experienced socio-cultural changes through the invasion of Aboriginal land, settlement of post-World War II migrants, globalisation and economic reforms. These have resulted in either loss or restructuring of rural industry and services (Connell & Dufty-Jones, 2014; Davies, 2014; Pritchard & McManus, 2000).

**OQNs in Australia**

The British settled in Australia in the 18th century (1788); by April 1868 Lucy Osburn, a Florence Nightingale trained nurse, arrived in Sydney with five other trained nurses from London’s St Thomas Hospital, marking the arrival of the first OQNs in Australia (Godden, 2006). The team later set up a nurse training school at the Sydney Infirmary, marking the beginning of professional nursing in Australia. As more nurses arrived from the UK over the years, there was no concern about migrant nurses as they shared similar educational and cultural backgrounds with those trained in Australia and English was their first language (Godden, 2006).

With the advent of globalisation and the increasing shortage of skilled workers (including nurses and midwives) in the past few decades, Australia adopted new policies of multiculturalism and focused on economic growth. Following the abolition of the White Australia policy in the 1970s, Australia opened its doors to migrants from culturally diverse communities and, as at November 2013, of the more than 24 million Australians, 32% were
born overseas (ABS, 2014b). Similarly, there has been a corresponding increase in the number of skilled workers from diverse cultural backgrounds (Brunero et al., 2008) as Australia joined other developed countries in actively recruiting nurses and midwives from overseas to meet their domestic demand for nurses. It is estimated there will be a shortfall of around 31,000 nurses by 2062 (Stankiewicz & O’Connor, 2014). Nurses in Australia continue to leave the service due to increasing workloads and high patient ratios as well as experiencing high levels of burnout resulting from their work (Holland, Allen, & Cooper, 2013; Stankiewicz & O’Connor, 2014). By 1999, RNs and midwives were listed on the Migration Occupation in Demand List by the Department of Immigration and Border Protection and, following the review of the list in 2017, they are still on the list (Department of Immigration and Border Protection, 2017). The Nursing Boards and Nursing Associations in various states embraced the recruitment of overseas qualified nurses and midwives with supportive policy statements and recruitment guidelines. The Australian Nursing and Midwifery Federation (ANMF) has been endorsing their support policy since 1998 (ANMF, 2015). By 2001, Australia had one of the highest rates of foreign-born nurses (24.8%) compared to other OECD countries (Iredale, 2010). In 2007, one in six nurses (15.5%) obtained their first nursing qualification outside Australia (AIHW, 2009). By 2015, a health workforce survey reported 18% of nurses had obtained their first qualification outside Australia (AIHW, 2016b). These OQNs included those from sub-Saharan Africa. Currently (2017), OQNs are found in almost all health sectors, including acute and critical care, and public health and aged care facilities; and they are found in both urban and rural and remote areas of Australia. The sub-Saharan African OQNs carried with them a wealth of African culture and a life philosophy that brought even more diversity to their workplace and where they lived. This concept of life is explained next as it provides the context of the sub-Saharan African OQNs.

**The African Spirit of Ubuntu**

The sub-Saharan African OQNs migrated to rural Australia introducing more cultural diversity into Australian rural communities. The settlement and experiences of these participants in rural Australia can be understood in the context of *ubuntu*, a spirit that drives the African philosophy of humaneness. Fundamental to being an African person are the interrelated concepts of family and *ubuntu*. Family, in the African context, is discussed in Chapter 9. Briefly, *ubuntu* is a philosophy of life which emphasises the humanness and interdependency of human beings (Ncube, 2010; Tutu, 2010). It is a concept of life that is referred to in different languages throughout the African continent (Gade, 2011, 2012; Metz
& Gaie, 2010). Ubuntu denotes both a state of being and one of becoming; it is an African way of being, an African worldview of life (Schreiber & Tomm-Bonde, 2015; Van der Merwe, 1996) and ubuntu is central to most traditional African cultures.

Expressed in a Xhosa phrase, umuntu ngumntu ngabantu literally means ‘a person is a person through other persons’; this African phrase can be extended to mean ‘I am who I am because of who we all are’. The statement radiates the spirit of ubuntu which encompasses respect, kindness, trust, caring, generosity, community and sharing (Mangaliso, 2001; Ncube, 2010). Life principles derived from ubuntu include interconnectedness and interdependency, collaboration and reciprocity, and the social culture of collectivism where the collective needs of the community rank above the needs of the individual (Ncube, 2010). These values are critical to African existence. A person with ubuntu is friendly, caring and compassionate. They are hospitable and generous including being physically present for other people. In African villages, people live as one big family; they greet each other and ask each other how they are, as they watch over one another. Africans operate from the premise that I cannot be myself if you are not yourself; my very existence is caught up in yours (Tutu, 2007). Nobel Peace prize recipient Desmond Tutu (2010) sees it as a fundamental law of our being; the very essence of being human. Ubuntu is a concept that should not only be found among Africans; it should be present in all human beings regardless of race or creed if it is allowed to thrive and prosper. Tutu sees human beings as existing in a delicate network of interdependence, in this bundle of belonging where “my humanity is bound up in yours, for we can only be human together” (Tutu & Tutu, 1989, p. 69). This African spirit is one where one cannot fully live unless the other fully lives.

The rationale for ubuntu is that as human beings we are essentially interconnected. Human beings are 99.9% genetically identical to each other (National Human Genome Research Institute, 2016). It is only 0.1% that makes us different. Yet, it is these tiny differences we often use to define ourselves instead of celebrating our diversity as we share our human experiences. Tutu (2007) warns that differences should not separate or alienate people, instead they should give us the opportunity to realise our need of each other. We all belong in a greater whole, one big family of humankind and, ‘I am who I am because of who we all are’.

It was on this premise that participants in this study journeyed to alien lands without fear because they believed there would be other human beings in those lands who, they expected, would be living guided by this ethic of humanness and interdependence. They migrated in
their state of being African nurses carrying with them the culture of interdependency and collectivism. A disruption in these principles could be quite significant in their migration experiences.

**Conclusion**

The literature reviewed in this chapter has illuminated the origins of human migration and how international migration has been impacted by globalisation. The historical background, the varied motivations for migration and the current trends discussed above show the complex nature of migration, especially as nurses migrated even in the absence of economic incentives. Labour migration theories were discussed including an analysis of both source and recipient countries. The worldwide demand for nurses is high and this is envisaged to continue. Source countries need to pay serious attention to push factors as a way of retaining their staff. It has been noted that effective orientation and communication, coupled with organisational support and acceptance of cultural diversity within a community, create a good environment for successful integration of OQHPs.

Despite the abundance of literature on overseas qualified medical practitioners, there was less research that has correspondingly examined the experiences of other OQHPs, especially OQNs, in rural and remote areas of destination countries. Given the continuation of recruitment and presence of OQNs in rural and remote areas of many countries, including Australia, there is a need to explore the experience of these nurses in their destination countries, particularly nurses from sub-Saharan Africa, who have not been widely studied. The following chapter discusses the philosophy and methodology that informed the study.
Chapter 3: Methodology

Introduction

This study is based on a phenomenological theoretical framework informed by hermeneutic philosophy and methodology. In this chapter, the philosophical movement and underpinnings of phenomenology are discussed. The works of great philosophers in the paradigm of phenomenology such as Edmund Husserl, Martin Heidegger and Hans-Georg Gadamer are discussed for their influences on the development of modern hermeneutic phenomenology. Their ideas underpin the philosophical foundation of this study. The chapter also includes a discussion of the use of hermeneutic phenomenological frameworks in nursing and midwifery research.

Epistemology and Ontology

Research seeks to examine and expand knowledge and understanding of phenomena. This research process is guided by the concepts of epistemology and ontology (Schneider, Whitehead, & Elliott, 2007). Epistemology is the branch of philosophy that studies the nature of knowledge (Dupré, 2007). It is derived from the Greek term, episteme (knowledge and science) (Dupré, 2007). Epistemology addresses questions such as: What is knowledge and how is it acquired? “What do people know and how do we know that we know?” (Morse, 1994, p. 118). Raadschelders (2011, p. 918) further asked: “What are the sources of knowledge? What is the relation between the object of knowledge and the researcher?” Answers to these questions underpin the aims and methods of the research process as explained in the methods section. Husserl (1970) saw these questions needing answers through rational insight.

Ontology, on the other hand, refers to a branch of metaphysics that is concerned with matters of existence and the relationships between them (Tsagdis, 2002). It is about things, about groups of people and individuals. Ontology addresses questions such as: “What is being?” (Morse, 1994). The ontological concept looks at social reality which becomes meaningful through social interaction between individuals (Porter, 1996). Gadamer (1975) saw language as the linchpin in all of human experience. As groups share experiences within their communities, phenomena are understood. However, these social realities can be influenced by culture and language (Lawler, 1998). These two concepts are relevant to my research as
it is concerned with acquiring knowledge about the experiences of migrant nurses and midwives and their social reality as they interact with other individuals.

**Philosophical Foundation of Phenomenology**

The word ‘philosophy’ has its origins in the Greek language – *philo* meaning ‘love’ and *sophia* meaning ‘wisdom or knowledge’, thus meaning ‘love of wisdom’ (Stumpf, 1986, p. 2). Philosophy originated from early Greek philosophers like Socrates (470–399 BC), Plato (428–354 BC) (who was Socrates’ student) and Aristotle (384–322 BC). Socrates was one of the first qualitative researchers into human meanings when he wanted to find out the moral belief systems of the philosophers in Athens who claimed to have wisdom (Wakefield, 1995). Plato was considered the father of dialogic teaching through his philosophy of listening (Haroutunian-Gordon, 2011). Of course, where there is listening there is talking as its counterpart and this contributes significantly to human knowledge. This philosophy of dialoguing is significant in phenomenological inquiry and for the methods that will be used in this study.

**Historical Development of Phenomenology**

Phenomenology was first used as a concept by a German philosopher, Kant (1724–1804), in the 18th century (Cohen, 1987). Hinchman and Hinchman (1984, p. 186) described Kant as a philosopher who “… helped set the stage for phenomenology” when he distinguished between noumenal reality, ‘things in themselves’ which can never be known, and phenomenal reality which is ‘the appearance of things’ as perceived and interpreted. Phenomenologists challenged this concept of noumenal reality arguing that the event or object becomes a phenomenon the moment it is observed (FitzGerald, 1995) or experienced. The philosophy of phenomenology is the discipline of knowledge and it is a system that acknowledges the independent existence of the object. As described by Husserl (1931), philosophy itself is entirely a ‘science a priori’ and in phenomenology the aim is to reach and describe the *essence* (ultimate structure) of the phenomena/conscious activity, not just a description of the everyday world. Thus, phenomenology can determine the *essence* of an event or phenomenon. For example, a phenomenological approach can discover what it means to experience migration from one country to another; it is through phenomenology that the core of experience can be uncovered. In phenomenology, the philosophical assumption is that reality is not independent of human consciousness; it consists of events and experiences as they are perceived or understood in human consciousness (Heidegger, 1962). Over the years, phenomenologists have sought to discover how the person
understands their real world, and there have been philosophical differences influenced by
different philosophers as phenomenology moved through three distinct phases: the
preparatory, the German and the French. These phases were identified by the historian
Spiegelberg (1994) who described them as the ‘phenomenological movement’.

The preparatory phase of phenomenology, pioneered by Franz Brentano (1838–1917) and
Carl Stumpf (1848–1936), distinguished between the natural sciences which explore
physical phenomena, and human sciences which investigate mental phenomena such as
perception and memory (Crotty, 1996; Moustakas, 1994). The philosopher Kant challenged
this thinking and explanation of the fundamental nature of reality and helped create a
foundation for phenomenology when he made a distinction between the two forms of reality,
as already mentioned earlier. Phenomenology started as a philosophy in Germany before
World War I and has maintained its prominent position in modern philosophy (Dowling,
2007). The German phase was dominated by Edmund Husserl (1859–1938) and Martin
Heidegger (1889–1976) and, later, by Hans-Georg Gadamer (1900–2002). They criticised
positivism and they (particularly Husserl) were concerned about the scientific worldview of
philosophy taken by Descartes (Benner, 1994). Their focus was on the nature and origin of
all knowledge asserting that phenomena and experience cannot be separated. Phenomena
can only be understood through descriptions by those experiencing the phenomena
(Heidegger, 1962). During World War II, phenomenology became popular in France and
developments in psychology and psychiatry greatly influenced the French philosophers of
the era. The dominating philosophers were Marcel (1889–1973), Jean-Paul Sartre (1905–
1980), Maurice Merleau-Ponty (1908–1961) and, later, Paul Ricoeur (1913–2005)
(Spiegelberg, 1994). Their works will not be discussed in this chapter as they have not had
a significant influence on this study.

For the purposes of this chapter, the works of the philosophers of the German phase (Husserl,
Heidegger and Gadamer) will be described. Husserl, who is generally acknowledged as the
‘father’ of phenomenology, was influenced by Brentano (Stumpf, 1989). Husserl taught and
mentored Heidegger who, in turn, influenced Gadamer.

**Husserl (1859–1938)**

Edmund Husserl, a German philosopher, was born in Prossnitz and educated in Vienna and
Berlin, first in mathematics and later in philosophy (Russell, 2006). He later wrote and taught
philosophy in Germany. He was influenced by the Descartian (1596–1650) concept of body
and mind which suggested that human beings should be divided into ‘body’ to be studied by
science, and ‘mind’ and ‘soul’ to be studied by philosophy and religion (Helman, 2000). Husserl’s main philosophical focus was on the nature and origin of all knowledge. He sought an alternative to positivism and first described the concept of phenomenology (Heidegger & Brock, 1956; Spiegelberg, 1994). Husserl (1931, p. 40) saw a science of ‘essential being’, which was a real world of experience that could not be ignored. Based on this lived experience, Husserl postulated a philosophical descriptive approach to research where questions should be asked to gain knowledge through the conscious awareness of objects (Koch, 1995; Schneider et al., 2007). The suggestion was that phenomena could be understood through the descriptions by those experiencing the phenomena (Dinkel, 2005) and should be studied as they appear through the consciousness (Koch, 1995). Husserl (1970) argued that the ‘lifeworld’ (Lebenswelt) should be understood as what the people who have experienced it describe before any reflections or interpretations are made. For Husserl, the aim of phenomenology was to study things as they appear in a rigorous and unbiased manner in order to arrive at an essential understanding of human consciousness and experience (Dowling, 2007). He suggested that phenomena could not be separated from the experience itself; phenomena can best be understood through descriptions by those experiencing the phenomena and Husserl defined this as ‘being of the world’ (Husserl, 1970). Husserl regarded experience as the fundamental source of knowledge (Racher & Robinson, 2003) and set out on a mission to reinstate the discipline of philosophy to its former importance as leader of the disciplines. Husserl wanted to ‘get back to the things themselves’, as he took a fresh look at reality (Crotty, 1996, p. 30).

As part of the phenomenological process, Husserl sought to refine his thinking against positivists. Husserl described phenomenological reduction or bracketing as a means to reduce subjectivity and facilitate the emergence of the essence of the phenomena. Bracketing refers to the necessity of researchers to suspend their beliefs or preconceived ideas about the phenomenon under study (Crotty, 1996; Denzin & Lincoln, 2005). Reduction is further described as literally meaning that the person “reduces the world as it is considered in the natural attitude to a world of pure phenomena or, more poetically, to a purely phenomenal realm” (Valle, King, & Halling, 1989, p. 11). In this context, phenomenological reduction is considered necessary for rigorous foundations in research (Paley, 1997) and researchers put on hold every assumption that is normally made, including logical and common-sense beliefs they may have. Researchers examine and bracket out their attitudes and prejudices in an effort to remove them from influencing the research. At the heart of this phenomenological reduction and the understanding of the essences of the phenomenon is
what Spiegelberg (1994) identified as phenomenological intuiting. This is an accurate or eidetic understanding of what is meant in the description of the phenomenon (Streubert & Carpenter, 2011).

Husserl’s work has been acknowledged and accepted by other philosophers and human scientists. Some, including Colaizzi (1973) and Giorgi (1985), developed their phenomenological methods from Husserl’s work. Despite Husserl’s immense contribution to human sciences, there has been criticism of his concept of phenomenological reduction (Luft, 2004). Husserl’s philosophical assumption was that human beings can only know the reality of what they experience by ignoring anything outside their immediate experience. Husserl proposed that the outside world and individual biases must be bracketed out for anyone to successfully achieve understanding of the ‘essence’ of a phenomenon (Laverty, 2003). Consequently, Husserl’s ontological neutrality and belief that human beings can isolate themselves from their own experiences did not fit well with my study of the experiences of OQNs. I am an overseas qualified nurse and midwife and I bring my preconceptions and beliefs to the research process. It is because of my experience that I can ask questions. Husserl’s phenomenological philosophy was later expanded to a more interpretive form by Martin Heidegger and Hans-Georg Gadamer.

Of note among Husserl’s critics was his own student and colleague, Martin Heidegger, who acknowledged Husserl’s influence on his work (Heidegger et al., 1956). Heidegger’s phenomenological focus was also based on human experience as it is lived, but he disagreed with Husserl on the issue of bracketing. The fundamental difference between Husserl and Heidegger was that Heidegger’s focus was on ‘being’ rather than knowing. Heidegger defined his philosophy as a ‘fundamental ontology’ (Gadamer, 1976). He differed from Husserl in how these lived experiences should be explored. Heidegger placed importance on the ‘understanding’ of the phenomenon instead of just on the ‘description’ of the phenomenon, as suggested by Husserl (Racher & Robinson, 2003). He advocated the use of hermeneutics as a research method based on the ontological view that the lived experience is an interpretive process (Racher & Robinson, 2003). Thus, Heidegger’s philosophical focus moved from description to interpretation as he was concerned with the meaning of being, suggesting that the study of phenomena made sense when analysed in context (Allen, 1985; Cohen & Omery, 1994). The next section looks at hermeneutics and the description of the two prominent hermeneutical philosophers, Heidegger and Gadamer.
Hermeneutic Interpretive Phenomenology

The term ‘hermeneutics’ is derived from Hermes, the Greek mythology messenger who possessed knowledge and understanding between the gods and the dead (Crotty, 1998). The Greek term, *hermeneuein*, means ‘to interpret’ or ‘to understand’. This term has been considered the science of biblical interpretation and, by the 17th century, the term ‘hermeneutics’ was associated with the interpretation of text, especially in theology (Crotty, 1998, p. 88). Since then, theologians and philosophers have come up with different types of hermeneutic philosophy and methodologies (Schleiermacher & Kimmerle, 1977). Although hermeneutics was originally associated with biblical interpretation and ancient texts (FitzGerald, 1995), it has now been applied to current disciplines such as anthropology, nursing and feminist studies (Benner, 1994; Thompson, 1990). Interpretation is now broadly defined and has been understood, by some, as the first point of human inquiry (Dreyfus, 1991; Heidegger, 1962). Gadamer (1975) suggested that all phenomena, regardless of their nature or origin, are primarily subject to interpretation. Gadamer went further to extend the goal of interpretation from representation of the original author’s meaning to the ‘fusion’ of the horizons of the author and the interpreter. This will be discussed later in this chapter.

Heidegger (1889–1976)

Martin Heidegger was also a German philosopher like his teacher and mentor, Husserl. Heidegger was regarded as an accomplished academic and philosopher when he became Husserl’s assistant in 1922 (Stassen, 2003). His hermeneutic phenomenology was also concerned with human experience as it is lived.

Heidegger was born to a Catholic family and his parents wanted him to become a priest (Stassen, 2003). In his early days, he studied theology but later left the course due to ill health. His theological background in Catholicism is believed to have had a significant influence on his philosophical ideas when he studied philosophy and mathematics later in life (Stassen, 2003). Following his attainment of a PhD in philosophy (Dreyfus & Hall, 1992), Heidegger was appointed Husserl’s assistant at the University of Freiburg, Germany. This was not for long though as Heidegger later fundamentally disagreed with Husserl’s phenomenology, advocating instead that hermeneutics is a philosophy founded on the ontological view that lived experience is an interpretive process (Racher & Robinson, 2003).
Heidegger’s Hermeneutic Phenomenology

In this section I will describe Heidegger’s important concepts that transformed the Western philosophical world and informed my study.

Heidegger’s early work, *Being and Time*, first published in 1927, advanced an argument for an existential adjustment to Husserl’s writings, proposing that consciousness cannot be separated from human existence (Heidegger, 1962). He agreed with Husserl in defining phenomenology as ‘the things themselves’, clarifying that phenomena are “the totality of what lies in the light of day or can be brought to the light of day … they are that which shows itself, the manifest” (Heidegger, 1962, p. 51). Heidegger added that the meaning of ‘being’ was the main focus of phenomenology (Heidegger et al., 1956). He rejected Husserl’s emphasis on the description of experiences arguing that it was impossible to bracket one’s ‘being-in-the-world’; phenomenology involved interpreting as well (Bradbury-Jones, Irvine, & Sambrook, 2010). Heidegger saw understanding as incomplete without interpretation. Descriptive phenomenology gave the impression of a detached researcher. Heidegger further argued that one cannot separate the observer from the world (Bradbury-Jones et al., 2010) and therefore presuppositions cannot be eliminated or suspended. He thus moved away from Husserl’s epistemological viewpoint to emphasise the ontological foundations of understanding which can be reached through ‘being-in-the-world’ and proposed a hermeneutic-interpretive phenomenology where he saw people as aware of their own existence and being capable of interpreting their own world differently compared to others (Heidegger et al., 1956; Schneider et al., 2007). Heidegger preferred *Dasein* as the method of seeking understanding (Dreyfus, 1991). In his concept of *Dasein* (meaning ‘existence’ in German), Heidegger saw a person and the world as co-constituted (Heidegger, 1962; Koch, 1995) and, hence, humans make sense of their world from within their existence and not while detached from it. He argued that it is our presuppositions and prior knowledge of phenomena that enable us to understand our situations and our ‘being-in-the-world’ (Heidegger et al., 1956). Instead of detaching ourselves from the phenomenon under study, the researcher should align their perspective of the phenomenon with that of the participants (Heidegger, 1962, p. 151).

Significant as his contribution might have been to the understanding of ‘being’, Heidegger’s controversial involvement with the Nazi party and his linkage with anti-humanist ideology during World War II were often criticised (Holmes, 1996; Sembera, 2008). After the war, he was consequently removed from the position of chair in the department of philosophy.
and also forbidden to teach until 1951. He, however, continued with his writings until his death in 1976. Heidegger’s work, together with that of Husserl, influenced Hans-Georg Gadamer when he was a student of philosophy in the 1920s (Laverty, 2003). Greater detail will be given to Gadamer’s philosophy as my study resonates well with his philosophy.

**Gadamer (1900–2002)**

Hans-Georg Gadamer, one of the prominent German philosophers of the 20th century, studied under Husserl and Heidegger and, at one time, worked as Heidegger’s assistant (Grondin, 2003). Gadamer was born on 11 February 1900, in Marburg, Germany. His father was a pharmaceutical chemistry professor who suggested Gadamer study natural sciences. However, Gadamer became more interested in the humanities with a special attraction to literature, poetry and drama (Grondin, 2003; Van Niekerk, 2002b). He studied philosophy under the guidance of Richard Höningswald and the Neo-Kantian philosophers Paul Natorp and Nicolai Hartmann. Gadamer did not serve in the world wars because of ill health as he had suffered polio at the age of 22 years. During his nine-month confinement to bed, Gadamer read several scripts he was given by Paul Natorp; one manuscript that fascinated him most was authored by Heidegger entitled: *Phenomenological Interpretations of Aristotle – Indication of the Situation in Hermeneutics*. Gadamer had a feeling that he had “found in Heidegger what he had been looking for for a long time” (Grondin, 2003, p. 6). He later attended no less than five of Heidegger’s seminars which further attracted him towards his philosophical ideologies and he later became his assistant at Marburg University. Gadamer had high praise for Heidegger whom he saw as having had a tremendous effect not only in Germany but also worldwide (Gadamer, 1976). It was Heidegger’s influence that led Gadamer away from the earlier Neo-Kantian influences. Gadamer’s book, *Truth and Method*, which was published in 1960 when he was already 60 years old, gave him international fame that involved international travel and great influence (Van Niekerk, 2002a).

Contrary to Heidegger, Gadamer was anti-Nazi and never joined the Party. This compromised his career mobility during the Nazi era until, following the end of the war and undergoing a thorough screening by the American occupation forces (Grondin, 2003), he was appointed rector of Leipzig University in 1946. He worked as a professor at the Universities of Frankfurt and Heidelberg until his retirement in 1968. After this, he was invited to facilitate courses and conferences throughout the world, including the USA and Italy, and South Africa in 1980. He died in 2002 aged 102 years (Schmidt, 2002).
Gadamerian Hermeneutics

The work of Gadamer has been recognised as pivotal to the evolution of hermeneutic phenomenology. Following Heidegger, Gadamer (1975) saw understanding and interpretation as inseparable. He also drew on the works of Dilthey who had a keen interest in methodological studies that related to the nature and history of the humanities. Gadamer (1975) extended Dilthey’s phenomenological stance, arguing that hermeneutics had developed beyond the disciplines of theology and become the basis of all human sciences. In his works, Gadamer aimed at elaborating on the concept of ‘philosophical hermeneutics’ which Heidegger had already initiated. Gadamer agreed with Heidegger that a hermeneutical question is the most fundamental philosophical question that needs to be identified. He saw hermeneutics as a “universal aspect of philosophy, and not just the methodological basis of the so-called human sciences” (Gadamer, 1975, p. 433). In his writings in *Truth and Method*, Gadamer (1975) asked how understanding was possible. Referring to Heidegger’s temporal analytics of human existence (*Dasein*), Gadamer saw hermeneutics as not just understanding one of the behaviours of the subject, but as a term denoting the understanding of its whole experience of the world.

Gadamer wanted *Truth and Method* to describe what is always done when things are interpreted: “My real concern was and is philosophic: not what we do or what we ought to do, but what happens to us over and above our wanting and doing” (Gadamer, 1975, p. xvi). Gadamer identified key philosophical principles in understanding phenomena and for successful interpretation to take place. These included prior understanding/prejudice, historicity, dialogue, fusion of horizons and the hermeneutic circle. Gadamer saw the purpose of hermeneutics as explaining the conditions in which understanding takes place. From Gadamer’s perspective, prejudices are seen in a positive light and he argued that they should not be eliminated as they are the means by which we encounter the world and they assist us to understand our experiences (Annells, 1996; Gadamer, 1975; Koch, 1996).

**Historicity and Prejudice in Understanding**

Gadamer’s historicity and prejudice were developed from Heidegger’s notion of fore-meanings (Gadamer, 1975; Annells, 1996). These are ideas and beliefs that one has before they encounter a phenomenon and these can influence understanding of the phenomenon. Gadamer emphasised the notion of historical awareness/consciousness and considered it a positive condition for knowledge and understanding (Fleming, Gaidys, & Robb, 2003). According to Gadamer, we are all part of history and it is therefore impossible to step outside
of history and be objective about the past. Our historical and cultural traditions affect the way we place value on issues, that is, our prejudgments, which in turn affect the way we understand (FitzGerald, 1995). Although the term ‘prejudice’ is usually used with a negative connotation, Gadamer interpreted prejudice in a positive manner and as an inevitable aspect of understanding. He reacted strongly to the Enlightenment’s ‘prejudice against prejudice’ (Gadamer, 1975), pointing out that before any interpretation can be made the phenomenon must be conceived of ‘as something’ and that something is a function of our preconceived idea about the phenomenon. Prejudice does not restrict our understanding, instead, ‘by our prejudice, the world opens up to us’ (Gadamer, 1975). He further explained that we can only understand others according to our own prejudices as it is impossible to understand other people the way they understand themselves. Gadamer believed that understanding is only possible on the basis of “what we are, what we already believe, what we expect, and where we find ourselves in history” (Van Niekerk, 2002a, p. 222).

Researchers do take prejudices with them into a research process and these, according to Gadamer (1975), help with understanding. The challenge is not to suppress them but to be open and receptive to them. In this study, the aim is not to remove all prejudice and preconceptions but to utilise the prejudices that I have concerning the migration of overseas qualified nurses and midwives to Australia in order to better understand the migration experience phenomenon. My historicity and prejudices concerning the migration experiences of nurses and midwives from sub-Saharan Africa will help in the study. The challenge for me is to stay open to new understanding and possible transformation as I analyse the data; this will help me to see things differently, thus enriching my horizons. Within the understanding of historicity and prejudice is the notion of language and dialogue between the participants and those seeking understanding.

**Language and Text/Dialogue**

Gadamer (1975) placed strong emphasis on language and described it as the medium of all hermeneutic experience. He saw language as not just an instrument for communication, but as a fundamental mode of operation of our being-in-the-world (Gadamer, 1975) and, as Pillay (2002) elaborates, a vehicle of thought and tradition. All interpretation takes place in the medium of a language and this allows the phenomenon to be understood in words (Gadamer, 1975). Language becomes the medium through which meanings are shared in a culture. Language, in this instance, also includes dialoguing with the text. During the interaction/dialogue between the researcher and the participant, there is openness and active
listening, resulting in socio-cultural understanding of each other (Koch, 1999). Participants
tell their stories that are recorded and transcribed; and it is these transcriptions in the form
of texts that the researcher works with. To Gadamer, understanding is not just a reproduction
of knowledge, as in stating what the participant or author meant, but, it should include
understanding oneself in some kind of dialogue with the text. Text brings understanding
when what is said in the text can be expressed in the interpreter’s own language.

For Gadamer, the dialogic nature of understanding does not happen independently. As the
process of understanding continues through pre-understandings and dialogue, prejudices
will contribute to a personal horizon. It will be important that I allow new points of view to
challenge my prejudices in this study and see new meanings as I interview participants and
analyse the data. Our dialogue may fail if I do not regard their expressions as worthwhile in
their own right.

Understanding as Fusion of Horizons

Gadamer (1975) explained the notion of a ‘horizon’ as the breadth of vision that the person
who seeks understanding must have. This is the prejudice of fore-knowledge which can be
used as the first horizon of understanding. This requires looking well beyond what is close,
in order to view the phenomenon better and within a broader picture (Gadamer, 1975).

Gadamer warns that horizons are only temporary and they are always in motion, not fixed.
Our own history will, in turn, influence our horizons. Gadamer (1975) went on to explain
that a fusion of the historical horizon with the horizon of the present then occurs, resulting
in personal understanding of the concepts. For the participants, this would be their historical
and cultural horizons. Fusion is the coming together of different vantage points (Annells,
1996), in this case the horizons, as a result of a willingness to open oneself to the standpoint
of the other person so as to allow their standpoint to speak to you. The data from the
participants are fused with the experience of the researcher, and this connection, through a
“common human consciousness”, makes understanding easier (Dowling, 2007, p. 134). The
Gadamerian hermeneutic process becomes a dialogue where the horizon of the interpreter
and the phenomenon that is being studied are combined and every activity is interpreted
(Koch, 1999).

In this study, I should be open to critical reflection and be able to allow my own horizons to
fuse with those of the participants, as reflected in the texts. Where we remain open to each
other’s horizons, our prejudices can be negotiated and fused into a new horizon of
understanding.
The Hermeneutic Circle

The notion of the hermeneutic circle is central to hermeneutic understanding (Heidegger, 1962). Traditionally, the hermeneutic circle signified a methodological process or condition of understanding where understanding the meaning of the whole of a text and understanding its parts were always interdependent activities. Heidegger further explained that interpreting the meaning of the whole meant making sense of its parts, and comprehending the meaning of the parts depended on having some sense of the whole. For Heidegger and Gadamer, the circular form of interpretation was not just a simple methodological process but a critical feature of all knowledge and understanding; every interpretation relied on other interpretations (Gadamer, 1975). It is how the everyday person understands their world. Gadamer describes the circle of understanding as not a methodological circle but one that describes an ontological structure of understanding. Schwandt (2007) added that there is no experience or meaning that is independent of interpretation or more basic to it such that one can escape the hermeneutic circle.

According to Heidegger (1962), the hermeneutic circle is a way of expressing fore-structures or preconceptions from which understanding is derived and these can be historical, personal and cultural in nature. Heidegger refers to it as the flow of understanding that takes place through being-in-the-world (Mackey, 2005). Gadamer (1975) and Thompson (1990) describe the hermeneutic circle as involving moving backwards and forwards between the experience of the individual living-in-the-world and the background of the shared meanings which may constitute common language, history and beliefs/traditions. FitzGerald (1995) gives an analogy of learning a foreign language where, in order to understand a conversation, one has to learn the individual words; whereas to understand the meaning of the words, they need to be related to the whole conversation. This hermeneutic circle is distinguished by Kinsella (2006) from the vicious circle, representing constant representation that may be erroneous, in that the hermeneutic circle is constantly renewed with new information as we move forwards and backwards within the circle. According to Gadamer (1975), the whole is forever developing and it is through the hermeneutic circle that we continue to search for meanings.

The discussion above shows that Heidegger and Gadamer’s theoretical positions were tree and branch. Both of them were inspired by Edmund Husserl. They had an interest in hermeneutics as they both believed that phenomenology without hermeneutics would be shallow (Todres & Wheeler, 2001). For both theorists, understanding can be recognised
through interplay of the hermeneutic circle. Heidegger, with his work ‘Being-in-the-world’ laid the foundation for phenomenological hermeneutics arguing that understanding is a reciprocal activity (Heidegger, 1962; Koch, 1996) while Gadamer, with his work ‘Truth and Method’, extended Heidegger’s work by positing philosophical hermeneutics (Gadamer, 1975; Dowling, 2007). Gadamer supplemented the hermeneutic circle with the concept of dialogue (Warnke, 2011) which is characterised by openness and listening to each other. Gadamer advanced the concepts of prejudgement/ prejedices and the fusion of horizon which are part of our linguistic experience that makes understanding possible (Dowling, 2007; Gadamer, 1976). They differ where Heidegger’s ontological inquiry postulates that one can interpret reality without background, meaning that every object is out there to be experienced and no one needs any background to interpret them, while Gadamer argues that one cannot interpret reality without presupposition or background (Gadamer, 1975). According to Gadamer’s version of phenomenology the researcher can derive understanding through personal involvement in a reciprocal process of interpretation. Thus, research using Gadamarian hermeneutics uses dialogue and, the interpretation permeates every activity where ‘social, cultural and gender implications’ are considered (Koch, 1999, p. 32).

The circular and dynamic nature of hermeneutics was applicable to this study throughout the whole research process. Hermeneutics was important for my fore-structure of understanding throughout the research process and, in its final form, how it resonated with the reader and structures of understanding. Participants’ stories were not linear, instead, they moved back and forth, between the whole and the parts, describing what happened to them and their families or friends. The same applied to data analysis as I immersed myself in the data, moving forwards and backwards constantly deepening understanding.

Although Gadamer was a phenomenological philosopher who offered valuable explanations on how to develop deep understanding of language and text, he did not develop a methodology or a research method to do so. From the discussion above, it can be seen that he did not actually come up with procedures or methods with which to apply his hermeneutic principles. His work was utilised, however, as an inspiration and philosophical foundation for my research.
Hermeneutic Phenomenology in Nursing and Midwifery

Over the years, phenomenology has been found to be a useful investigative approach to the disciplines of nursing and midwifery. Todres and Wheeler (2001) report widespread use of phenomenology by the 1980s. As nurses and midwives sought to understand the experiences of phenomena that were related to health and illness and the subsequent care given, they embraced phenomenology as a research framework (Schneider et al., 2007).

As the study of lived experiences (Van Manen, 1997), phenomenological research allows nurses and midwives to study the experiences of people and this is critical to providing individualised holistic care. Van Manen (1997) actually describes hermeneutic phenomenology as a research methodology that is relevant to human science. With nursing/midwifery viewed as an art as well as a science, phenomenological studies are popular among researchers. Nurses and midwives are involved in the human side of illness and healing and spend time with people in healthcare situations, talking to them and listening to their stories, feelings and thoughts. Consequently, phenomenology appeals to nursing and midwifery because it allows questions to be explored and reflects the participants’ values and beliefs as they tell their stories.

The early works on phenomenology in nursing research included that of nursing scholars such as Benner (1994) whose ideas were influenced by Heidegger and Gadamer. She saw an increase in the utilisation of phenomenological approaches in nursing research by those who sought to investigate experience. The distinction between the descriptive (Husserlian) and interpretive (Heideggerian and Gadamerian) phenomenology has been addressed in detail by nursing scholars such as Thompson (1990) and Koch (1995) who have also documented the relevance and application of hermeneutic inquiry in nursing and midwifery. Thompson (1990) refers to well-known research applications of hermeneutic philosophy by Patricia Benner in her descriptions of expert practice, and Nancy Diekelmann in her discussions of curriculum reform for the National League for Nursing in New York.

Hermeneutic inquiry is applicable to my research study as it sought a deep understanding and knowledge of the working and social experiences of OQNs who migrated to rural Australia. The intent was to explore how the OQNs give meaning to and make sense of their daily working and social lives. Although my study may not be focusing on clinical practice per se, the experiences of OQNs in Australia have a bearing on their clinical performance. Hermeneutic philosophy helped me to better understand myself and to better understand the decisions I made in this research process as the philosophy emphasises the “social, political
and ethical dimensions of each and every step of the research process …” (Thompson, 1990, p. 228).

**Summary of the Main Points of the Philosophical Framework**

In summary, the main points of the hermeneutic philosophical framework relating to this study and which have informed it are the concepts of understanding suggested by two German philosophers, Heidegger and Gadamer. Hermeneutic phenomenology seeks understanding and creates meaning from our experience of everyday life.

Heidegger’s hermeneutic phenomenology is concerned with the ontological interpretation of what it means for something to be, more specifically, what it means to be a human being. He emphasised the ontological foundations of understanding which can be reached through ‘being-in-the-world’ and proposed a hermeneutic-interpretive phenomenology where he saw people as aware of their own existence and being capable of interpreting their own world differently. In his concept of *Dasein*, he saw humans making sense of their world from within their existence and not while detached from it. According to Heidegger, all understanding is circular and, therefore, the interpretive process is through a hermeneutic circle. Our history is part of who we are and it helps us understand ourselves and the world.

Gadamer identified key philosophical principles in understanding phenomena. He identified prior understanding/prejudice, historicity, fusion of horizons, dialogue and the hermeneutic circle as principles necessary for successful understanding to take place. Gadamer claimed that the fusion of horizons occurs when our horizon of the past and historicity fuses with the horizon of the present which constitutes our prejudices and assumptions. Gadamer’s hermeneutic phenomenology also placed a strong emphasis on language, describing it as the medium of all hermeneutic experience and central to our being-in-the-world. All interpretation takes place through dialogue in the medium of a language and this allows the phenomenon to be understood in words. Like Heidegger, Gadamer saw the notion of the hermeneutic circle as central to hermeneutic understanding. This circular form of interpretation postulates that meaning from a whole can only be understood by making sense of its parts just as the meaning of the parts can only be comprehended by making some sense of the whole. Gadamer described the hermeneutic circle as an ontological circle of understanding where all human life takes place through every human experience. According to Gadamer, the whole is forever developing and it is through the hermeneutic circle that we continue to search for meanings.
Implications of the Theoretical Framework for this Study

Hermeneutic phenomenology was a suitable framework and methodology for this study. The study sought a deep understanding of the experiences by listening to stories being told and identifying the themes that emerged. Listening to, dialoguing and valuing the OQNs’ stories was the lynchpin of the methodology. The approach acknowledged and placed value on the meaning I ascribed to the experiences of the OQNs (Roberts & Taylor, 2002). Within this interpretive paradigm, it was important to identify research methods that were consistent with this selected hermeneutic philosophical framework. The methods that are used to generate meaningful dialogue are discussed in the next chapter.

Conclusion

This chapter has explored the philosophy and historical movement of phenomenology. Key ideas from Husserl’s transcendental phenomenology, through to Heidegger’s and Gadamer’s hermeneutic phenomenology were discussed. Gadamer explained how one can converse with the texts, how we can be open to them being aware of our own viewpoint and at the same time try to understand another person’s viewpoint as they relate their stories. Phenomenology has gained increasing recognition among the human science disciplines, including nursing. Hence, this research study adopted a hermeneutic phenomenological approach in order to deal with the interpretations of the meaning of being an OQN in rural Australia. For example, hermeneutics will search for meanings of textual interpretation within the context of OQN experiences. Hermeneutic phenomenology examines a whole system of beliefs and facts promoting the view that each part must be fully understood and related to the whole. The following chapter describes how hermeneutical phenomenology formed the foundation of the methods used to carry out the research study.
Chapter 4: Methods

Introduction

Chapter 4 discusses the phenomenological research process that informs this project. It provides an overview of the research design and describes my position as a researcher in this project. Participant information and data collection and preparation are also outlined followed by ethical considerations and data analysis.

Hermeneutic phenomenological philosophy underpins the methodology and methods used in this study. Phenomenology is described by Dowling (2007) as a philosophy, a methodological approach and a research method. There is no standard phenomenological research method in hermeneutic phenomenology. Richards and Rodgers (1986) argue that within one methodology there can be many methods that utilise different approaches. Hermeneutics is one such phenomenological research method as well as methodology.

Hermeneutic Phenomenology as a Research Method

Hermeneutic phenomenological research designs afford the opportunity to explore phenomena in-depth and they have been previously used in nursing and midwifery research (Carr, Hicks-Moore, & Montgomery, 2011; Kociszewski, 2003; Sommerseth & Sundby, 2010). Hermeneutic phenomenology provides insights that assist nurses to holistically understand the experiences of participants who are living a particular phenomenon. Phenomenology as a research method describes particular phenomena in their contexts as lived experience (Streubert & Carpenter, 2011); it allows for focus on conscious experience and it is important in the search for the meaning of lived experiences (Crotty, 1996; Giorgi, 2000). In this particular study, the hermeneutic inquiry allowed the exploration of the experiences of the OQNs in rural Australia. It is my belief that the migration experience and its associated complexities can be adequately explored by thematic inquiry that can ensure an in-depth analysis of events.

My Position as a Researcher

Corbin and Strauss (2008) acknowledge that researchers bring with them significant background and knowledge to an inquiry. I believe my experiences as an OQN who migrated to Australia and my professional achievements in Australia have influenced the way I
understand and interpret my research questions, the methods I use and the way I have analysed the data.

In this hermeneutic phenomenological study, I was part of the research process. I entered the hermeneutic circle with my own migration experiences and pre-understandings. My historicity and prejudices concerning the migration experiences of nurses from sub-Saharan Africa helped me to better understand the phenomenon of migration. The challenge for me was to stay open and not impose my ‘expertise’ on new understanding and possible transformation as I analysed the data; this helped me to see things differently and, thus, enrich my horizons.

**The Participants**

Participants in this study were RNs working in rural NSW whose original qualifications were from sub-Saharan Africa. These sub-Saharan OQNs were selected because the literature search showed that there were limited studies on nurse migrants from the African continent, particularly those working in rural areas of their destination countries. Participants migrated to Australia through skilled migration visas, that is, solely as skilled professional workers. Their selection in this study was based on their firsthand experience with the migration process. Polit and Beck (2010) suggest that, in interpretive studies, all participants should not only have experienced the phenomenon, but also should be able to explain what it was like to have lived it. Eighteen participants were purposively recruited (Kvale & Brinkmann, 2009) for the study through advertisements and the snowballing technique. This number of participants was manageable and, in hermeneutic research, it is the richness of the collected data that is important more than the number of participants (Polit & Beck, 2010; Schneider et al., 2007).

Purposive sampling is described by Streubert and Carpenter (2011) as a method that selects participants based on their knowledge of a particular phenomenon with the purpose of sharing that knowledge. Thus, the information given was key to the purpose of the research. A discussion of the principles of participant selection and their application to this research study follows.

**Recruitment Procedures**

The study recruited participants working in rural areas of Australia. These rural areas vary considerably in terms of geographical, environmental and socio-demographic characteristics
and it has been generally acknowledged that they are difficult to define (Kulig et al., 2008; McKenzie, 2011; Wakeman, 2004). In most literature, the term ‘rural’ is understood as “everything that does not include the capital cities and major metropolitan centres of Australia” (Blue & Wilkinson, 2002, p. 2). As identified earlier in Chapter 2, three classification systems can be used to define rural and remote areas, that is, the RRMA, ARIA and ASGC classifications (AIHW, 2004). Although some of these classifications are an improvement on others, there are still some differences in the issues they address (AIHW, 2004; Francis et al., 2008; Gilles et al., 2008).

Participants were recruited from rural and remote areas as classified by the Australian Statistical Geography Standard (ASGS) remoteness area classification (ABS, 2016). This classification was selected as it is used by several peak bodies, including the Australian Institute of Health and Welfare and the Australian Bureau of Statistics. For the purposes of this study, the term ‘rural’ is used as an umbrella term to incorporate regional, rural and remote areas of NSW.

The participants were contacted through a variety of recruitment methods. Firstly, participants were invited through an advertisement that was posted in local newspapers (Appendix A). There were no respondents to newspaper advertisements. I then approached a few participants directly at African cultural functions and various organisations frequented by people from African communities. This initial contact was to provide information about the study and to provide contact details, should they wish to participate. More participants were recruited through the snowballing technique by requesting the initially identified OQNs to refer other prospective participants. Participants were approached directly; I did not access them through hospitals nor their Area Health Services (AHS).

**Inclusion and Exclusion Criteria**

Participants had to meet certain criteria in order to participate in the study (see Table 1).
Table 1: Inclusion and Exclusion Criteria

<table>
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<tr>
<th>Inclusion Criteria</th>
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<tr>
<td>• OQNs from sub-Saharan Africa currently working in rural Australia as RNs.</td>
<td>• OQNs who did not come via the General Skilled Migration visa.</td>
</tr>
<tr>
<td>• OQNs who migrated to Australia through the General Skilled Migration visa.</td>
<td>• OQNs who came to Australia via other countries.</td>
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Participants who met the criteria were requested to contact me, in person, through a telephone call or email. They were sent a letter of invitation which included information about myself, the researcher, and the nature and purpose of the study so they could think and reflect on their experiences in their own time and decide what experiences they would like to share with me, should they consent to participate (Appendix B). Potential participants were then contacted by phone or email to check if they still wished to participate in the study so we could make arrangements for the interview. Together with the invitation was a consent document for those who met the criteria (Appendix C). The signed consent forms were collected before the interviews started. Focus group discussions (FGDs), which would come after individual interviews, were arranged for areas where higher concentrations of OQNs worked and where the participants were willing to engage in FGDs. As RNs, all participants were competent communicating in the English language.

The Setting for Data Collection

I collected the data myself during the interviews and the FGDs, and participants were reassured that their interview transcripts would only be available to my PhD supervisors and myself. The interviews were conducted at quiet, non-distracting places and at a convenient date and time for the participants and myself. I informed someone of my arrival and departure to the interview venue for safety reasons. For the FGDs, participants were requested not to reveal any information related to a specific person and not to reveal sensitive information outside the group. In addition, the FGD participants were advised that confidentiality could not be guaranteed, due to the nature of the group discussions.
Data Collection and Preparation

Interviews

One of the significant features in Gadamerian hermeneutics is the use of language in questions and answers (Weinsheimer, 1985). The assumption in Gadamerian hermeneutics is that human beings experience the world through language and the language provides both knowledge and understanding (Byrne, 2001). Hence, this study used semi-structured, face-to-face interviews that were guided by the participants’ stories with prompts used when required. Hermeneutic interviews use open conversational questions that focus on the phenomenon being studied (Van Manen, 1997) and, as the topic is explored, they allow for probing of further thoughts and reflections. Such conversation allows the researcher immersion into the subject matter in order to gain a deeper understanding of the experiences (Fleming et al., 2003). For this reason, I conducted the interviews, transcribed the interviews verbatim, and analysed the data myself in order to allow for better understanding of the experiences. Guided by a Gadamerian hermeneutic approach and the concept of ‘fusion of horizons’, this process facilitated interpretation of participant experiences allowing for dialogue that brought a new horizon between those of the researcher and participants (Gadamer, 1975). My own familiarity with migration processes enhanced the quality of questioning during interviews.

The participants were encouraged to talk freely about their experiences, that is, to tell their story. Open-ended questions allowed me to follow the participants’ lead with minimal interruptions except where clarification and/or probing were required. Streubert and Carpenter (2011) advise against researchers leading the discussion; instead, they should encourage the participants to describe their lived experiences. Each interview session was recorded using a digital recorder and then I transcribed it verbatim, as soon as possible. Recorded interviews are important in phenomenological research as the inquiry usually starts with an exploration of the experience as lived by the individual (Madjar & Walton, 1999), followed later by a deep analysis of the transcribed data. Transcribing qualitative data was an important step as I needed to print out the interviews and actually put my hands on the data (O’Leary, 2010; Polit & Beck, 2010).

During the interview, I strengthened internal validation by repeating and paraphrasing the issues that were generated during the discussion. Lincoln and Guba (1985) advocate for member-checking where findings are returned to participants for validation. In contrast, McConnell-Henry, Chapman, and Francis (2011) argue that the potential problem with this
kind of transcription validation is that participants may want to change the data even if it was accurately transcribed. However, in this study, participants were given the option to request transcripts if they wished; none of them did. Capture of the direct quotes given by the participants increased the credibility of the study. I kept a personal reflective journal of the events of the research process and contemporaneous field notes to capture the non-verbal communication expressed by the participants and my own general impression during the interviews. This included participants’ facial and bodily expressions and the atmosphere of the conversation. Transcripts do not capture non-verbal communication (Kvale & Brinkmann, 2009), hence, the need for field notes. The information from the field notes was inserted into the transcript during or soon after the transcription. This included whatever extra information participants told me, off the tape, and my own observations about the visit. The post-interview reflections in my personal journal served to clarify my pre-understandings of the topic and related issues.

Focus Group Discussion

One rural town had a larger number of OQNs living in close proximity. An FGD was held in addition to the one-to-one interviews in order to enable participants to reflect and listen to the experiences and opinions of others regarding migrating to rural Australia (Paterson & Higgs, 2005). These participants were not the same ones who provided one-to-one interviews. The FGD session was digitally recorded and then I transcribed it, verbatim, soon after it was held.

The advantage of focus groups is that the group dynamics that develop may be synergistic in bringing out information that may not have surfaced during one-to-one interviews, especially in relation to sensitive issues (Kitzinger, 1995; Manoranjitham & Jacob, 2007; Morse, 1994). Participants have an opportunity to discuss a topic with each other and these collective interactions may result in spontaneous expressions and views (Kitzinger, 1995; Kvale & Brinkmann, 2009). Focus group interviews are stimulating and assist in the recall of information (Streubert & Carpenter, 2011). The FGD was particularly useful in this study as it gave more background information on the research topic and this information assisted with the interpretation of data collected from the one-to-one interviews (Streubert & Carpenter, 2011). FGDs also give the researcher data on the shared perception of migration issues relating to Australia. FGDs do, however, have disadvantages.

FGDs can allow individuals to dominate and influence the thinking and verbalisation of other members. However, an observant and articulate moderator can prevent that. There can
also be problems associated with recording, taking field notes and transcribing when people talk at the same time (Mansell, Bennett, Northway, Mead, & Moseley, 2004). Critics such as Webb and Kervern (2001) have questioned the use of focus group interviews in phenomenology. The argument advanced is that a phenomenological approach seeks the core of the lived experience and the never-changing characteristics of the phenomena from an individual who describes their experiences in a way that has not been contaminated (p. 800). Focus group interviews involve interaction within a group of participants and this makes them incompatible with phenomenological research, Webb and Kervern (2001) claim. However, hermeneutic phenomenology seeks understanding of experiences; hence, focus groups have the potential to deepen meaning by expanding one’s understanding of the phenomena.

I believed that participants, by virtue of their cultural orientation, would welcome FGDs as these are seen as culturally congruent with the African way of dealing with issues that concern life. African gatherings are traditionally known as *indaba*; this is an expression of African culture where people get together to discuss problems that affect them all and where everyone has a voice in an attempt to find a common mind or solution that everyone can tell to others. It is a way of listening, engaging and understanding issues that affect their communities (Nesbitt, 2017). These gatherings symbolise African oral literature where meaningful conversations are held and information is passed on from generation to generation. The gathering together of participants in this study fitted in well with Gadamer’s view of dialogue and fusion of horizons in sharing understandings among and between participants and the researcher.

In Africa, these group gatherings can take place in village meetings, by the rivers, in open markets and wherever people meet and talk. An FGD was appropriate for the OQNs as they could meet as a group to discuss the common phenomenon they shared in their lives. Group processes resulting from an FGD help ease the sensitivity of the issue and also elicit participants’ beliefs and feelings (Freeman, 2006).

The integration of both focus group and individual interviews enriched the understanding of the experience of OQNs from sub-Saharan Africa. Both methods drew on open-ended questioning followed by inductive probing of responses. Focus group discussions expanded on some issues discussed during individual interviews thus, complementing each other as they enriched the understanding of participant experiences.
Ethical Considerations

Ethical approval was obtained from the Charles Sturt University Human Research Ethics Committee before fieldwork was conducted (Appendix D). Ethical issues that needed to be considered included issues of informed consent, maintaining confidentiality and privacy, and balancing the risks and benefits of the study (Liamputtong, 2007). Although the study carried the benefit of giving participants a platform to verbalise their experiences and have their experiences acknowledged as important, there were possible risks associated with participation.

Avoiding Harm to Participants

It is acknowledged that the participants are a minority group within the Australian workforce and so may be considered marginalised and vulnerable. The literature has reported discrimination and racial conflicts with nurse migrants in other countries (Aboderin, 2007; DiCicco-Bloom, 2004; Jones, Bifulco, & Gabe, 2009). As a researcher, I gave participants the opportunity to accept or refuse participation; no one was pressured to participate in the study. I was also aware that they could become emotionally distressed as they relived some of their experiences that could have been traumatic. Participants did not show any exacerbation of home sickness in the interviews even though some of their family members were still living overseas. I needed to be sensitive to their vulnerability throughout the research process. Most of the time, I needed to fit myself into their time schedules as I was aware that participants were giving of their time and energy. They were in employment, balancing shift work and family chores, so I appreciated their finding time to accommodate being interviewed in their busy schedules.

The study approach was centred on treating participants with dignity and respect, causing no harm to the participants, and giving adequate information on the purpose and aims of the study, confidentiality issues and potential risks so they could make informed decisions to participate. Only one participant showed signs of emotional stress during the interview but she stated she was alright and did not need to terminate the interview nor did she want any follow-up counselling. During interviews, I was aware of and ensured that I did not mistakenly move from my investigative role to that of counsellor or therapist, as warned by Streubert and Carpenter (2011).
Informed Consent

All participants were above the age of 18 years and capable of giving consent. Although they were coming from culturally and linguistically diverse backgrounds, English was the language of communication. OQNs working in Australia are registered with the Nurses and Midwives Board which assesses them on English proficiency; therefore, I did not anticipate language problems. It is appreciated that participants sometimes used particular African expressions during interviews; these were viewed with a Gadamerian lens through which participant experiences were interpreted and understood. The information sheet conveyed information on the research process, for example, recording of interviews, description of the risks and benefits of the study, and how confidentiality and privacy of the participants were guaranteed. The participants were made aware that the findings of the study would be disseminated through publication, reporting and conference presentations but confidentiality would be maintained. Participants were required to give consent to participate; they were also free to withdraw from the study without any reprimand/penalty.

Confidentiality and Privacy

Participants were also informed that, during the research, their contact details would be kept in a password-protected computer and their consent forms kept in a locked cabinet, separate from other data, to avoid inadvertent identification. They were informed that identifying information would be kept separate from the recordings and transcriptions, to maintain confidentiality. Participants were assured that their names or any other identifying information would not be used for reporting or publication purposes. Instead, fictitious names would be used when referring to their comments in the research report. Streubert and Carpenter (2011) advise that the more comfortable the participants, the more likely they are to share their experiences. During the interview and FGD, I addressed participants as agreed and then, later, used pseudonyms during data analysis.

Data were, at all times, securely stored in a password-protected computer and a lockable cupboard that could only be accessed by myself and supervisors, when required. During the data analysis and presentation, pseudonyms were used to avoid participant identification. Audio recordings and all data relating to the study will be destroyed five years after the completion of the study.
Data Analysis

Van Manen (1997, p. 27) indicates that a good phenomenological description is “collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience”.

Soon after data collection, I dated the data and used the selected pseudonyms for the purposes of confidentiality and keeping track of the data. Tarling and Crofts (2002) advise that the transcripts, recordings and diary notes should be dated for easy data management and to avoid the risk of not knowing, later, who said what and when. Data were organised into transcript files and memo/field note files – these were stored electronically in password-protected computer folders.

Streubert and Carpenter (2011) describe data analysis as a hands-on process where the researcher is deeply immersed in the data and committed fully to the process, in order to understand what the data convey. It entails searching for common patterns shared by participants in their experiences as nurse migrants and the identification of essential themes that emerge (Polit & Beck, 2010). Qualitative researchers immerse themselves in the data by repeatedly reading their transcripts and listening to recordings so as to ‘hear what the data say’ (Tarling & Crofts, 2002, p. 172).

According to Heidegger (1962) and Gadamer (1975), the hermeneutic circle is a mode of understanding and refers to the circular nature of hermeneutic analysis. In this hermeneutic study, I was moving back and forth between the written text and the emerging interpretations as I sought to understand and interpret the accounts of experiences given by the OQNs. The circular backward and forward movement from the details to the whole, and from the whole to the details, is congruent with hermeneutics. I sought depth and detail in an effort to ensure rigour and trustworthiness of the study (Parsons, 2010). According to Gadamer (1975) though, there is no method in phenomenology and hermeneutics. I drew upon Streubert’s steps and Spiegelberg’s essentials in phenomenological investigations (Dinkel, 2005; Spiegelberg, 1994) for the data analysis process. Spiegelberg (1994) described phenomenological intuiting, analysis and description as the critical phases in investigating phenomena while the interpretation of the hidden meanings in these phenomena becomes the final step of the phenomenological method. These were essential processes for my study. Polit and Beck (2010) describe these processes as closely related, but distinct, and as occurring simultaneously. I remained open to the meanings attributed to the migration
process by the OQNs; I made sense of the meanings of their experiences through thematic analysis and then described these experiences through the use of language. Gadamer (1975) did not see hermeneutics as a notion of defining a specific method but, rather, as a way of gathering knowledge and truth.

I utilised the NVivo 10 software package in order to organise and manage my data efficiently and for easy understanding. NVivo 10 software basically does all that can be done, manually, for a large data set, but it just does it more efficiently (O’Leary, 2010). The application can store interview recordings and allows the researcher to identify patterns or themes in the data (Hoover & Koerber, 2011). A diagrammatic view of the process is illustrated in Appendix E.

The data analysis involved repeated listening to the audio-taped interviews, and reading and re-reading the transcripts which allowed engagement with the data (Priest, 2002). The process of bracketing as suggested by positivists was omitted in this study as it had no place in Gadamerian hermeneutics, as explained in the previous chapter. Underpinning qualitative data collection and analysis is the demonstration of the trustworthiness of the study.

**Trustworthiness**

Holloway (2005) advised that the researcher must be able to account for the data by displaying a visible trail of the decision-making process that will strengthen the credibility and validity of the findings. This involves clear methodological descriptions and rationales throughout the study, the purpose of which, as explained by Streubert and Carpenter (2011), is to give an accurate representation of the participants’ experiences. Processes that contribute to rigour in qualitative research have been identified by Lincoln and Guba (1985, pp. 289–331) as credibility, dependability/auditability, confirmability and transferability/fittingness.

**Credibility**

Credibility in this study referred to the ‘believability’ of the findings of the experiences of the participants engaged in this study (Morse, 1994, p. 105). This was established by identifying the participants who experienced the phenomenon through purposive selection and investing enough time to engage with the participants. I explored my own personal feelings and experiences about the phenomenon; any personal distortions about the phenomenon were not allowed to interfere with the findings. I challenged my own
assumptions and remained open to different perceptions. I included verbatim sections of participant stories in the findings to allow the surfacing of issues voiced by participants. Participants were interviewed at times convenient to them and myself, meaning data were collected at different times of the day and different times of the year, as the process was lengthy. One-to-one interviews and an FGD were used to gain a deep understanding of the migration experiences.

**Dependability**

Dependability refers to the ‘stability’ and auditability of the data (Polit & Beck, 2010). Dependability requires documentation of the process of inquiry which demonstrates how interpretations were made. This should be evident in the way the interpretation is reflected in the report. Gadamer viewed an awareness of historically informed prejudices as forming a basis for understanding phenomena (Gadamer, 1975). True to Gadamer’s philosophical approach, my previous migration experiences influenced interpretation and the way meaning was constructed. Nevertheless, the research methods are clear and transparent with a detailed presentation of findings that included participant narrative accounts. I kept a study diary to explain the research methods as a way of ensuring dependability. Holloway (2005) added that a diary helps capture events like the participants’ reactions and comments. Data were critical to the conclusions I made. The research study supervisors were also overseeing the study process through their review comments in order to maintain the rigour and trustworthiness of the study.

**Confirmability**

Through notes and diaries, I clearly illustrated the events that took place and how the conclusions were reached. The interpretations and conclusions came directly from the data reflecting the participants’ voices (Polit & Beck, 2010) and not from my own biases and motivations. Confirmability was also established by checking with the participants during the interviews if what was understood as having been seen or heard during the interviews was correct. Repeated affirmations from the participants established confirmability. According to Morse (1994), the establishment of confirmability should be easier in the presence of credibility and dependability.
Transferability/Fittingness

This refers to the probability that the findings have meaning to other settings/groups (Polit & Beck, 2010). This form of rigour is achieved when interpretations of the research findings can fit contexts that are different from the study situation. The goal of qualitative research is to seek a deep understanding of a phenomenon under investigation. I explained in detail the research methodology used so that the research consumer can determine if the information is applicable to their context or not.

Writing as Research Activity

Van Manen (2006) challenged qualitative phenomenological researchers on the place and meaning of writing in research analysis. He described human science research as a form of writing, stating that phenomenological inquiry and the practice of writing cannot be separated (Van Manen, 1997, 2006). He argued that writing is essential to all philosophic reflection as there is a relationship between phenomenology in general and writing. Van Manen (2006) added that insights emerge in the process of reading and writing; the research data are collected and interpreted in the process of writing and it is through texts that phenomenological knowledge is produced. Writing in the form of text becomes a word representation of the phenomena under study. Therefore, in phenomenological research, writing does not wait until the end of the research process. Writing started early in this study; it continued during interviews when I took field notes, during the transcription of the recorded data as they were converted to text and through to the end of the research process. It is through writing that I was able to analyse and better understand the experiences of OQNs.

Conclusion

This chapter has given an overview of the research design justifying the selection of hermeneutic phenomenology as a research method. In addition, the chapter outlined the recruitment of participants, the data collection setting and procedures and ethical issues that were considered. The chapter also described how data were analysed. The next chapter introduces the participants who took part in the study.
Chapter 5: Introducing the Participants

Introduction

This chapter introduces the 18 participants, together with a brief overview of their migration journey. Participants were RNs – some with postgraduate midwifery and paediatric nursing qualifications – who came from sub-Saharan African countries. All participants interviewed came directly to Australia as skilled migrants through the SC457 Temporary Work (skilled) visa which was sponsored by their new employers. The temporary visa allowed the holder to work for their sponsor in the nominated occupation (‘nursing’ in this case) for up to four years. The visa holders could also migrate with their families. For all but two participants, the migration process involved securing a job first, before departing from their countries. Most participants did this with the assistance of Australian migration agencies. Participants would go through two interviews; firstly, by the recruiting agent and then by the employing hospital. So, the majority of these participants did not start looking for employment on arrival; they were ready to start work. Of note is that all participants were in nursing employment as RNs in their own countries and had to resign from their employment when they migrated to Australia. Participants had between 2–21 years of nursing experience with some having relinquished senior positions (e.g., clinical nurse educators and district nursing officers) in their home countries. All participants initially travelled to Australia alone leaving their families behind, for them to follow a few months later. At the time of their interviews, their stay in Australia ranged from three to 11 years. Six were permanent residents of Australia while 11 had attained Australian citizenship; only one participant still had a temporary visa.

It was not my intention to have only black African nurses from sub-Saharan Africa as participants in the study; however, those were the participants who responded to the invitation. They may have been the predominant migrant group at the time of interviews or this may have been due to the snowballing method of recruitment where participants probably contacted those they were close to. All participants came from areas that were formerly British colonies where English is an official language in addition to their traditional languages. Therefore, language and communication did not pose a challenge for participants during interviews and as they transitioned to their new country, Australia; except for adjustment to some informal ‘Aussie’ terminology and accent and the trade names of medications that were commonly used.
The Participants

All the participants came as skilled migrants (SC457 visa). Even those who underwent an NMBA-approved bridging program first before registration had to get the same visa to work in Australia. These were participants who migrated from Africa to Australia between 2003 and 2010. Their first qualification in nursing was a hospital-based diploma in nursing leading to them being RNs.

Participants are introduced in the order in which they were interviewed. In these descriptions, I have included information from the notes I made during the interview process. Table 2 provides a summary of participant demographics.

Table 2: Demographics of Participants at Time of Interviews

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age range</th>
<th>Professional experience (years)</th>
<th>Duration of stay in Australia (years)</th>
<th>Working as:</th>
<th>Migration status Australian citizenship/residency status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noma</td>
<td>Female</td>
<td>41–50</td>
<td>15</td>
<td>5</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Citizen</td>
</tr>
<tr>
<td>Lili</td>
<td>Female</td>
<td>31–40</td>
<td>12</td>
<td>4</td>
<td>RN</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Betty</td>
<td>Female</td>
<td>41–50</td>
<td>26</td>
<td>11</td>
<td>RN</td>
<td>Citizen</td>
</tr>
<tr>
<td>Mimi</td>
<td>Female</td>
<td>51–60</td>
<td>32</td>
<td>11</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Citizen</td>
</tr>
<tr>
<td>Mpilo</td>
<td>Female</td>
<td>31–40</td>
<td>15</td>
<td>10</td>
<td>RN &amp; registered midwife</td>
<td>Citizen</td>
</tr>
<tr>
<td>Linda</td>
<td>Female</td>
<td>31–40</td>
<td>8</td>
<td>5</td>
<td>RN</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Farai</td>
<td>Female</td>
<td>41–50</td>
<td>13</td>
<td>5</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Simba</td>
<td>Female</td>
<td>31–40</td>
<td>11</td>
<td>3</td>
<td>RN</td>
<td>Temporary visa</td>
</tr>
<tr>
<td>Thabo</td>
<td>Male</td>
<td>31–40</td>
<td>10</td>
<td>8</td>
<td>RN</td>
<td>Citizen</td>
</tr>
<tr>
<td>Bongani</td>
<td>Female</td>
<td>41–50</td>
<td>22</td>
<td>9</td>
<td>RN</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Sindi</td>
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<td>10</td>
<td>4</td>
<td>RN</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Ola</td>
<td>Female</td>
<td>41–50</td>
<td>19</td>
<td>3</td>
<td>RN</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>Mary</td>
<td>Female</td>
<td>41–50</td>
<td>20</td>
<td>11</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Citizen</td>
</tr>
<tr>
<td>Focus Group Discussion Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>-------------------------------</td>
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<tr>
<td>14</td>
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</tr>
<tr>
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<td>4</td>
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<td>Citizen</td>
</tr>
<tr>
<td>16</td>
<td>Female</td>
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<td>23</td>
<td>10</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Citizen</td>
</tr>
<tr>
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<td>Citizen</td>
</tr>
<tr>
<td>18</td>
<td>Female</td>
<td>51–60</td>
<td>27</td>
<td>10</td>
<td>RN (with overseas midwifery qualification)</td>
<td>Citizen</td>
</tr>
</tbody>
</table>

Noma

Noma was the first participant in my study. She was married with three daughters: teenage twins and their younger sister. When I arrived at her home she was alone waiting for me. Her husband was at work and her daughters were at school. Her motivations to migrate included obtaining a good education for her children, good living conditions in Australia, good working environment and lots of learning opportunities. She applied directly to the hospital (without the help of a migration agent) and was offered employment. Like most OQNs, Noma had left her family behind and waited for them to join her six months later. Noma had 15 years of professional experience as an RN, ten of which were in Africa. She was also a non-practising midwife with an overseas midwifery qualification; she had not made up her mind whether to apply for the NMBA-approved bridging program for midwifery or not. Noma was the first and only black African nurse in her rural hospital and her work involved being in charge of shifts. This professional responsibility motivated her to advance herself professionally. At the time of interview, she had already completed a First Line Emergency Care Course (FLECC) and was enrolled with the College of Nursing, studying acute care nursing. She had been in Australia for five years and had already attained Australian citizenship. The family had been back to Africa visiting relatives and friends once, a trip that the children enjoyed.

Lili

Lili had been in Australia for almost five years and was a permanent resident of Australia. She had moved from a metropolitan city to a rural town where she was living when I interviewed her. She was married with two children, a son and a daughter who were of primary school age. Her main motivation for migration was education for her children; she
wanted to give them the best she could. Lili had 12 years of nursing experience and was working in operating theatres at a local rural referral hospital. She was one of a few participants who did not work in an aged care facility. After six months of remaining overseas without her, Lili’s family followed.

Lili owned a clothing shop in the town centre and that is where the interview was conducted. She was at her shop that morning waiting for the interview with me. After that, she went for an afternoon shift at the local hospital while her husband took over at the shop. Lili had no plans to advance in nursing; instead, she wanted to take up sonography. The family had not yet been back to Africa because of the family business commitment; however, Lili had plans in place to take the children to visit their grandparents. Lili was happy to be in Australia stating that she made the right decision. However, she planned a return migration once her children finished their education and were settled wherever they wanted.

**Betty**

I found Betty home alone. She was married with four children, two boys and two girls. The first born, a son, was a second-year university student while the last born, a daughter, was at high school. The children were at school and her husband was away on one of his ‘fly in, fly out’ work trips. Betty was well prepared for this interview. She had arranged the sitting area in the lounge room with some snacks and juice on the table. She had some ‘notes’ with issues she wanted to discuss with me and had also scribbled quite a few items on the information sheet I had sent her.

This was not Betty’s first time in Australia. She had been before, in 1992, to another state where her husband had been an international student. After his studies, they returned to Africa, but not to their country of origin. They went to a neighbouring African country where her husband was offered a ‘good’ job and they lived there for seven years. As the years went by, Betty became worried about the high crime rate in that country. Security for her family was the major motivation for her emigration from Africa. She wanted protection for her family and a better future for her children. So, Betty migrated in 2002 to Sydney, Australia, where she worked in the medical and surgical wards of a private hospital. After five months, Betty briefly returned to Africa to check on her family because she could not stand the loneliness without them; she was also worried about her children. Her family joined her eight months later. Three years afterwards, the family moved from Sydney to a regional town; this is where I had the opportunity to interview her. Betty worked in the intensive care unit of the local rural referral hospital; she had 26 years of nursing experience, 15 of which were
gained overseas. She completed a course on intensive care nursing and was studying for her Master’s degree in the same specialty. Betty had been in NSW, Australia, for 11 years. She was an Australian citizen. Despite some occasional work frustrations, Betty was happy to be in Australia.

**Mimi**

Mimi’s interview was held at her home in the morning, about three hours after the end of her night shift, a time she confirmed was best for her. She was alone at home at the time with her husband at work and her last born child at high school. She was married with three children, two of whom were now adults and no longer living with their parents. Mimi came via a migration agent with four other RNs from her country. Her main migration motivation was a better future for her children and her own professional advancement. Mimi brought with her 21 years of nursing and midwifery experience; however, she was not practising midwifery in Australia. Mimi had been working in rural Australia for 11 years. The rest of the family joined her three months after her arrival. At the time of interview, the family had moved from a smaller town to a larger town with a rural referral hospital within the same AHS, because they wanted to enhance the job prospects of their adult children. By then, Mimi had attained Australian citizenship. She was happy with her professional achievements in Australia as she had attained a Master’s degree in mental health. She had been back to Africa several times visiting friends and relatives.

**Mpilo**

Mpilo came to Australia in 2003 as a single mother of two, following separation from her first husband in Africa. She remarried in Australia and had a third child, a toddler at the time of interview. Her first born daughter was studying at university and her second born son was at high school. Mpilo migrated to Australia because life was ‘getting a bit difficult’ economically for her family. Although most of her colleagues were migrating to the UK, Mpilo chose Australia because she had a friend who was already in Australia. For Mpilo, the whole application process took less than six months – thanks to her friend who was guiding her and supplying her with the paperwork/application forms. Her agent provided the air ticket from Africa to Sydney. She proceeded to her rural base by bus, disembarking at a local railway station. At some time during the bus journey, Mpilo became a bit apprehensive asking herself where she was going when the bus kept going on and on, inland in NSW, passing through small towns and farming country. Mpilo was one of the first African OQNs in the region and stated her health institution had never had an OQN before. She had five
years’ nursing experience when she migrated. She initially worked at a local aged care facility before training as a midwife and working at a local maternity hospital. Mpilo was the only participant in this study who was a practising midwife, having obtained her Australian postgraduate midwifery qualification from a regional university, not far from her place of work. Mpilo and her family had been back to Africa visiting family and friends. She had no regrets migrating to Australia and she was an Australian citizen.

Linda

I found Linda all ready for me in her house. We had arranged for a morning interview as she would later go for an afternoon shift at a local aged care facility. I felt humbled by her accommodation of me before going to work. Linda came to Australia in 2008, mainly because she could no longer care for her family financially and she was worried about her child’s future. Her family (husband and daughter) joined her four months after she arrived in Australia. It took her husband approximately four months to find a job and a full year for the family to finally settle and realise the benefits of their migration. At the time of interview, Linda had a teenage daughter and a toddler son who was born in Australia. Sadly, for Linda, almost two years previously, she lost her husband in a motor vehicle accident in her home country when they had been visiting their families; she was pregnant with their son at the time of the tragedy. She described the sudden loss of her husband as a big setback in her life.

Linda was one of those participants who found it hard to supervise their teams in aged care facilities because their supervisees would not take instructions from them. Linda had come to Australia with three years’ nursing experience (one of the lowest among the participants) and had been in Australia five years. She had plans to commence a midwifery course the following year. Linda was generally happy with her migration to Australia and for her children; by then, they had attained their permanent residency in Australia.

Farai

Farai offered to participate in the study after hearing about it from a friend. She described her migration motivation as the ‘political situation’ in her country; she did not elaborate. Farai was in the older age range (41–50 years) and had eight years of nursing experience when she migrated to Australia. She was an overseas qualified midwife but was not practising midwifery in Australia; she was working in an aged care facility. As a midwife, she felt she was a ‘wasted resource’ working in an aged care facility. Farai had been in Australia five years at the time of interview. She was married with two adult sons with whom
she had migrated; they were no longer living with her; they wanted to live in larger cities. Farai was one of those participants who attended Australian migration agency recruitment interviews in a neighbouring country because of political insecurity in her own country. She stated that these recruitment interviews were carried out daily and there were ten candidates from her country in her group that day.

After registration with the NMBA in 2004, Farai did not leave for Australia until 2008; she just could not make up her mind. Her friends in Australia kept renewing her registration for her, year after year. Even after acceptance of Australian employment, Farai struggled with her decision to leave her family until ten months later when she finally left for Australia. She was offered the job in January 2008 but only migrated in November of that year. She kept postponing the starting date as she could not imagine herself in Australia without her husband and ‘two boys’ who were already in their twenties at the time. Once she arrived in rural Australia, Farai was happy and had no regrets about her migration to Australia. At the time of interview, she was a permanent resident of Australia and was intending to pursue her midwifery specialty. Every year she visited her family in Africa.

Simba

Simba was one of two nurses who came from a country where they had to undergo an NMBA-approved bridging program for RNs before registration and securing employment in Australia. Simba migrated to Australia with eight years of nursing experience and a specialty in paediatric nursing. She was married with two daughters, one of whom was born in Australia. Simba’s husband and their first born primary school aged daughter followed a year later. Simba found this family separation an enormous source of stress for her. Like most participants, her major motivation for migration was a better future for her children as well as a desire for change. She wanted to experience other people’s cultures and also to “expand my scope of practice”. Simba was one of the few participants lucky enough to work in their specialty areas, unlike others who often found themselves working in aged care facilities. Simba found the three-month long bridging course very expensive (A$10,000), but useful, as it gave her confidence and ensured a smooth transition to the Australian health system. She had to obtain a loan and borrow from friends and family to raise the fees and other associated costs of the program. She had a higher postgraduate diploma in paediatrics and child health and had worked as a paediatric emergency nurse educator overseas. Coming to Australia was not a shock for Simba as she had done some African regional and international travelling before, to undertake postgraduate courses. At the time of interview,
she had been in Australia three years and was still on the temporary SC457 visa. Simba was happy to be in Australia and was intending to stay longer. She had not been back to Africa since she migrated. Simba saw her migration as a huge move and was happy to be given a platform to share her experiences.

**Thabo**

Thabo was the only male participant in the study. His partner was also a RN who kindly took part in the FGD. They had doubts about migration; it took them five years from their first application to finally make the first move. After long deliberation, the family decided to migrate separately as they had fears and doubts about the whole migration process. The wife migrated first in 2005, leaving Thabo and their toddler daughter behind. The motivation for migration in their case was the poor economic conditions in their country (they had hoped things would improve) which did not allow them to provide adequately for their children and other family members who needed support. They also had a desire ‘to discover the world’. Their decision to finally move was in response to an Australian recruiting agent who gave a face-to-face slide presentation in the town where Thabo worked. The agent was showing how beautiful a country Australia was and how their lives would be changed if they migrated. The couple was attracted by the fortnightly payment of wages, owning a house at 35 years of age and the low crime rate in Australia. So, Thabo’s wife migrated first. There was even further separation for Thabo and his daughter as they were living separately while waiting to join his wife in Australia. This was because the little girl moved to live with her grandparents in the city while Thabo continued working as an RN out of town. Thabo described this period of family members living in three different places as very stressful for the family. Fortunately, within four months, they were together as a family once again when they joined his wife in Australia. At the time of interview, they had a second child, a son, who was born in Australia. Thabo had been in Australia eight years and was an Australian citizen at the time of interview. He brought two years of nursing experience with him – the lowest among the participants. He was intending to study mental health nursing as a specialty. Thabo felt he made the right decision to migrate, describing the journey as one of excitement, self-discovery and personal growth.

**Bongani**

Bongani migrated to Australia in December 2004, mainly for personal reasons. She had lost her husband in an accident in 1998. Her mother became very sick and Bongani cared for her until she died in 2003. Bongani became ‘very depressed’ following these losses. Her friends
who were already in Australia and the USA convinced her to migrate and change her environment for a while so she could recover from the trauma she had suffered. She had two teenage children, a son and a daughter, who were only toddlers when their father died. Bongani had migrated with 13 years of nursing experience and had been in Australia nine years working in an aged care facility and, later, in a high dependency unit of a local hospital. She was a permanent resident of Australia. Her children ‘did not like Australia’ and so did not stay long, preferring to go back to Africa to finish their studies and seek work there. Although she was a permanent resident, Bongani had no intention of staying permanently in Australia and so did not seek citizenship. She had visited her children and family in Africa several times in the previous nine years. At the time of interview, Bongani was already planning her return migration within the next two to three years; a move she was looking forward to. Bongani was happy that she had had time out to reflect on the sad events in her life and family. However, she did not think she had achieved much professionally as she could not complete her chosen intensive care nursing course due to what she perceived as racial discrimination to prevent her professional advancement.

**Sindi**

Sindi was happy to be given the opportunity to share her experiences as an OQN. Sindi had a very good, well-paying job in her home country where she was employed as an RN in a paediatric unit by an international non-government organisation. She was married with two young children. The economic decline in her country adversely affected her husband’s business which was failing. At her daughter’s school, the teachers were leaving for other countries because of the poor economic environment; the remaining few were not motivated to teach, leaving school children to spend most of their days playing in the school grounds. This left Sindi and her husband wondering what the future held for their young family; hence, the thought of emigration. The UK and the USA were their top destination countries as they had friends and relatives there; however, Sindi teamed up with workplace colleagues (approximately 10 of them) to respond to a recruiting agent in Australia. When she migrated, Sindi left behind her primary school aged daughter and toddler son which stressed her a lot. Her husband remained living with their son whilst their daughter moved to be with an aunt in another town so she could continue with her education in another school. They joined Sindi in Australia four months later. At the time of interview, Sindi had been in Australia four years and had come with six years of nursing experience. She was a permanent resident who was intending to stay longer in Australia as her children were still very young. Sindi was studying an acute care nursing course at graduate certificate level with the intention of
continuing on to Master’s degree level. She and the children had not yet been back to Africa but her husband had been several times to check on his business.

**Ola**

At interview, Ola had been in Australia three years and brought with her 16 years of nursing experience. She was one of the two participants who went through the NMBA-approved bridging program before registration. Otherwise, she was a paediatric nurse by specialty.

Ola’s journey had been a long and very expensive one. She did not engage the services of a migration agent. She completed her bridging program in Queensland and then searched for employment after registering with the Queensland Nurses Council. Ola had difficulty finding employment despite applying for positions. Hers turned out to be a lengthy process because most prospective employers in Queensland would tell her, “We wish you were from the UK”. Such statements distressed Ola. Regardless of such discrimination, Ola remained hopeful. When her international student visa expired she was required to return to Africa and apply anew for employment. Luckily, at the time of her registration, the nursing registration boards in all states had recently amalgamated and so she could look for employment anywhere in Australia; she finally settled in rural NSW. Ola was married with two teenage sons. Her family had not yet (at the time of interview) joined her to live in Australia although they had visited her once. The migration visa application process for her family took a long time. After almost two years of waiting for the visas, Ola’s sons were about to complete their high school education; Ola felt their education would be disrupted if they moved to Australia at that stage. She and her husband decided to let their sons complete their high school education in her home country before migrating to Australia.

Her main motivation for migration was a better future for her children; so, when her sons could not be with her in Australia, Ola was not happy with her migration. The whole migration journey was expensive and did not yield the results she wanted. This was worsened by the continued loneliness of living without her family for three years. Although she and her family had attained permanent residency status, Ola was not sure if she would continue living in Australia. She had been back to Africa several times visiting family. Ola had some regrets about her migration to Australia; however, in the meantime, she would do her best to work and support her family and parents in Africa as she was getting better pay in Australia.
Mary
Mary left her country mainly because of the declining economy in her country. She could no longer afford the basic needs for her family and, when she did, the availability of basic commodities was erratic. She wanted a better life. Mary migrated through a migration agency together with four other OQN’s recruited by the same agency. Mary was a softly spoken participant who was married with a teenage son attending high school. Her family joined her a year after she migrated; a waiting period that caused a lot of stress and loneliness for Mary. At the time of interview, she had lived in Australia 11 years. Mary brought with her nine years of nursing and midwifery experience. She was one of the few lucky ones who had two weeks’ orientation at her new hospital and she was happy with that. When she moved to a larger town, Mary worked for an agency, a job which, to her delight, gave her the opportunity to travel Australia wide, working in other states such as Queensland and Victoria.

Although Mary completed the bridging course for her midwifery qualification at the Royal College of Nursing in Sydney and practised as a midwife at her original place of work, once she left that hospital to work for the agency, she no longer practised as a midwife, preferring medical/surgical nursing. Mary and her family had been back to Africa to visit family members and were now Australian citizens. Mary had no regrets; she thought she made a good decision by migrating to Australia.

The Focus Group
The FGD was the last data collection event. It was held in a town that had a number of OQN’s from sub-Saharan Africa. There were five participants in the group, incidentally, all from one country. Two prospective participants from other countries cancelled at the last minute. It was a vocal and cheerful group discussion in a relaxed atmosphere. Participants in the group were not identified as individuals; their responses were taken as a group response. All of these participants used migration agents. Some of the participants had been promised work in hospitals when they were offered jobs, but on arrival in Australia they were sent to work in aged care facilities. Participants in the FGD had nursing experience ranging from 6 to 17 years when they migrated to Australia. All but one worked in an aged care facility when they first arrived in rural Australia; but now, they had moved to a larger town and were working at a rural referral hospital with some working in their specialty nursing areas. Some participants were working extra shifts in local aged care facilities as casuals for extra income. The group felt their country had lost experienced professional staff but that they could not
help but leave because the economy could not sustain them. The duration of their stay in Australia ranged from 4 to 10 years and they had all attained Australian citizenship. All but one participant in this group had been to Africa with their families to visit relatives since migrating to Australia.

**Conclusion**

This chapter provided an overview of the participants’ families, their years of nursing experience and how they made their migration decisions based on the motivations they had. The descriptions of the participants give the context of international migration, especially from the African continent. These were nurses who had tremendous nursing experience but had to leave their politically and/or economically unstable countries in search of a better life for their families.

The participant findings are presented in the following three chapters that reflect the themes that emerged. Chapter 6, *The Move Across the Indian Ocean*, presents the first theme as participants described their experiences as they left their countries and arrived in Australia. Chapter 7 describes *New Life in an Alien Land* as perceived by participants as they negotiated the Australian workplace and way of life. Finally, Chapter 8 presents the third and final theme, *Developing a Sense of Belonging and Moving On*. The findings are then discussed and interpreted together in Chapter 9. The first of these themes follows in the next chapter.
Chapter 6: The Move Across the Indian Ocean

*It was a huge move* (Simba)

**Introduction**

Chapter 6 is the first of three chapters that present findings. Before the stories of the participants unfold in the next few chapters, it needs to be noted that the participants had mixed migration experiences, particularly soon after their arrival in Australia. Responses from participants in the focus group discussion were representative of the group response, not just the ideas of a single dominant group member. There were both positive and negative experiences as will be shown in these findings. Together these findings present the sociological background and events of each participant’s lived experience. Each chapter represents a major theme that was identified from the data. Overall phenomenological analysis is presented in Chapter 9: Understanding the experiences of OQNs.

Chapter 6 begins by exploring the participants’ decision-making process as they contemplated emigration including the motivators for their migration and why they chose Australia as their country of destination. Their arrival experience is also described. The first theme, *The Move Across the Indian Ocean*, consists of two sub-themes: ‘Making the Decision to Migrate’ and ‘Arriving in Australia’.

The sub-theme ‘Making the Decision to Migrate’ explores the participants’ experiences as they initiated the move to migrate to Australia. This sub-theme discusses the motivators that pushed or pulled participants to rural Australia; it describes participants’ experiences of selecting Australia as a country of choice and the difficulty in making the decision to leave their country. Participants took a long journey across the Indian Ocean to a land they knew little about but of which they had much hope. They took a leap of faith journeying to a land that was alien to them. Only one of the participants had ever been to Australia before and most of them had never been out of Africa. It took considerable motivation for these participants to embark on this journey of over 10,000 km. The second sub-theme, ‘Arriving in Australia’, explores how participants experienced both hope and trepidation as they landed on Australian soil and prepared for settlement. First to be discussed are participants’ experiences regarding their decision to migrate.
Making the Decision to Migrate

It was the most difficult decision I made in my life (Farai)

Participants described various factors that determined their decision to emigrate, and to Australia in particular. Their decisions were affected by socioeconomic and professional factors. They saw Australia as a family-friendly country compared to other countries. After they made the final decision to migrate, participants described experiencing doubt, fear and scepticism. They worried about coming to an unknown land with its unknown people and culture; some also worried about being turned back at Australian airports if they did not meet visa requirements. It was an apprehensive time for participants. However, the motivation to migrate had the upper hand in their final decision making.

Motivation to Migrate

Motivators to migrate included socioeconomic factors, family reasons and professional advancement. These factors tend to overlap as family reasons may be related to socioeconomic factors while at the same time they may also be linked to the political environment of a country. The common thread in all participant descriptions was their desire for a new lifestyle that would provide security and a better future for themselves and their loved ones. Each participant described several motivating factors. They described their concerns about the deteriorating economies in their countries and how these were pushing them out of their countries. This was further facilitated by the attractive success stories of those who had been overseas. Participants wanted better lives.

As much as I really loved working at home,¹ economically, it wasn’t sustaining me. So, there was no point, that’s why I had to come here ... I never had the intention to come to Australia at all ... but because of the economic instability in my country, I had been pushed to come. And seeing other people going out, not just nurses, but doctors, pharmacists and engineers; they were leaving the country ... and it was sort of attractive because each time they were coming back, they were managing to buy houses and mansions and everything. So, it was one of those push factors that made me think, “No, I need to go out of the country”. (FGD)

Participants in the focus group described the economic instability in their countries as a pushing factor for them leaving. They loved their countries but, because of poorly performing

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¹ Home in this context refers to home country.
economies, participants found it difficult to make ends meet. The better economic situation in other countries was pulling them out. They were attracted by the possibility of improving their lifestyles once they secured jobs overseas. Mpilo’s sentiments resonated with those expressed by participants in the focus group:

*Just the economic hardships really, because I have two kids. It’s like we were getting into a state where even if you were a registered nurse you were not able to send your kids to a proper school and they wouldn’t have a better future. Because of the kids you think, “I need to do something about this, I need to make sure that I’ve got a better future for them”. They would still maybe end up not getting any jobs. I didn’t want that for my kids. So, it’s the kids, it’s the main thing that got me here.*  

(Mpilo)

Mpilo was worried about the deteriorating economic situation in her home country and she did not want her children to end up unemployed. Participants knew that as parents they had to intervene for their children as their prospects for the future were poor. The economic hardship of the country impacted on family income, employment and education. The same was echoed by Sindi. She realised that the poor economy in her country was not getting any better and it was adversely affecting their family income and the education of her children:

*My husband was not happy, his business was not doing well and so we thought about the future of our kids. Kids would go to school and come back in the afternoon with very dirty uniforms showing that they had been playing throughout the day, and my daughter would tell me, “Mum we didn’t learn anything, the teacher was not there” ... You would get feedback from the teachers like, “Why should we work; we are not getting paid enough, we’re just getting peanuts”. Time is money and, we thought, if we leave our kids in such an environment, their future would be doomed.*  

(Sindi)

Sindi described her husband’s failing business and teachers who were demoralised and no longer performing their expected teaching functions because they were earning very low salaries. She realised this adversely impacted on the education of her daughter and would result in poor outcomes for her children’s futures if she did not rectify the situation. Sindi, like most participants, could not allow such a situation to prevail and deny their family, especially children, a better future. Her way out of this situation for her children lay in migrating to Australia. All but one participant described their desire for a better economic environment for their children’s future as providing enough reason to consider migration.

Participants wanted better lives for their families and children; they did not see this happening while they worked in their home countries. They were worried for their families. Some participants had friends who had left the country before them and were sending back
information which depicted Australia as a land of opportunities, especially for the younger generation. Noma was one such participant:

_The situation wasn’t very good at home and I had kids. My friends who were already here were talking of the good education; yeah, so I thought my kids will get a good education there [in Australia] and learn as much as they like._ (Noma)

Noma desired better educational prospects for her children, hence the move. Similarly, Mimi migrated after she and her husband considered the future of their children and realised that, if they continued living in their home country, their children would not get a good education and, therefore, stood very little chance of employment:

_It was hard to send children to good schools in [home country] and the children’s prospects afterwards didn’t look all that good because of the high unemployment rate, so that was our first motivation._ (Mimi)

Betty was more concerned about security for her children. The environment in her country did not provide protection for her children:

_My main reason for coming to Australia was to have a better future for my children and also because some parts in [home country] have a high crime rate so I was coming here to protect my children._ (Betty)

Mimi and Betty, like other participants, had concerns for their children. They wanted them to achieve their potential academically while living in a safe environment. To Mimi and Betty, it was paramount that they secured a better future for the children. The high unemployment rate that is linked to poorly performing economies resulted in unsafe communities due to high crime rates. Participants perceived environmental safety as critical for their children, hence, the decision to migrate. Besides the worry over their children’s future, participants described other factors that also facilitated their decision to migrate. Some participants were drawn to Australia in order to position themselves to support their extended family.

Participants assessed their family situations and saw migration as a way of improving their financial position so they could better assist members of their extended family. They saw this as part of their family role to assist those family members in need; migration was of benefit to others, not merely themselves. For many participants, this act of helping extended family members came naturally. Linda and Thabo explained their situations where their extended families needed help in one form or another.
I'm the first born in a family of four; so, I had my young sisters and brothers who were still at school. My mum and dad separated and my dad is in another country ... so I have to make sure that I help my mum [financially] to look after these young ones. (Linda)

I would also be in a position [if I migrated] to assist my family and assist my parents. And you do realise that if you’re in a better financial position a lot of people benefit as well. (Thabo)

While some participants sought to help their immediate as well as extended families by migrating to Australia, there were those who expressed a desire to advance themselves professionally. This desire contributed significantly to their migration decisions as they saw no professional future in their countries. They saw Australia as a land that would give them that opportunity. Participants had attained many years of nursing experience in their home countries. They felt the need to experience nursing in other parts of the world; they wanted to discover the world. They expressed a desire to find out what it was like to provide nursing care in a different environment, outside their countries. They were yearning for a change in their nursing experience as well as opportunities to develop themselves further in their chosen career.

Simba wanted to experience nursing in a different environment and to increase her opportunities for professional advancement. She felt she needed a change and was frustrated by having to improvise nursing procedures in her country due to lack of appropriate equipment:

Actually, my motivation to come to Australia was basically the need for a change ... It was basically wanting a better life and trying to improve my skills in nursing and experiencing other people’s cultures and sharing my culture; just a need for a change. Most of the time as a RN [in previous country] you had to improvise and work with very little resources to provide care to clients and that frustrated me ... that was another reason why I wanted to get out of the country. (Simba)

Similarly for Noma, she was attracted by Australia’s opportunities for career advancement as well as the conducive working environment that would give her a chance to study while working:

Good working environment and lots of learning opportunities, so I got attracted to it and started the application process. (Noma)

Participants saw learning opportunities that would advance their careers by migrating to Australia. They would also gain nursing experience in a different country with different cultural practices. This was significant for participants like Noma and Simba. The other
attraction was the good working environment that Australia offered. These served as pulling factors while participants were being pushed out of their countries, mainly by socioeconomic factors. Expanding on the attractions that were pulling them, participants described the reasons why they preferred Australia to other countries.

**Family-friendly Australia**

For most participants, Australia was their first-choice country for migration. A few participants selected Australia after failing to migrate to the UK. Participants described Australia as a country that was peaceful and politically stable. For Farai, Australia was the first choice mainly because of the peace that prevailed in the country:

*I thought Australia was better than other countries and I had more friends here ... it’s a stable country. I haven’t heard anything like what is happening in the United States where they are shooting each other. Australia is a peaceful country, that’s what I thought. That counts in life; we like to stay in a peaceful country ... This is what life is.* (Farai)

Farai was drawn to Australia by the stability and peace that she saw existing in the country. Farai valued peace and, therefore, such an environment would be ideal for her family. The presence of people who she knew also seemed to help her in her choice of Australia as they confirmed the peace that she valued in life. Besides the peace that prevailed in Australia, other participants also described other factors making Australia their country of choice. Mimi was encouraged by friends who described Australia as a friendly country with better migration conditions:

*I had always wanted to go overseas and I had thought I would go to Britain, but then things didn’t go that way as it was becoming more complicated for nurses from [my country] to go to Britain. A friend told us that Australia was quite a friendly place and had much easier conditions for nurses, at the time. It seemed too good to be true at that time because it was like, yeah, registration wasn’t very expensive, there was no adaptation, and you were going to be provided with an air ticket, accommodation, everything [laughs]. I was sceptical at first ... I just filled the forms in and said let me see what happens.* (Mimi)

Mimi was attracted by the migration perks that Australia offered which excluded the need for adaptation courses required by other countries. Although she initially had doubts about the whole migration package, she took the plunge anyway. Ola’s choice of Australia was based on the tropical weather which Australia shared with her country:

*I had looked at a few countries; I looked at the UK, I looked at Ireland but I think I picked Australia because I thought,
weatherwise, it was not extreme; it’s tropical, just like where we come from and I thought it would be good for my family and my children who were asthmatic when they were young. (Ola)

Following a critical analysis of possible countries, Ola thought the Australian weather would work in her children’s favour because, as stated earlier, it was all about children. Thabo had an opportunity to attend a face-to-face presentation by an Australian migration agent who was recruiting nurses in Thabo’s home country:

He told us that Australia is a beautiful country. He had slides and he showed us houses saying, “Look, there are no fences, what do you think about the level of crime there?” Zero! He told us ... that most people own their houses at 35 years of age ... Yeah that got us interested. He talked about crime ... and I can say, at that time, I rarely heard about Australia from the media. So, I just said, “Oh, this is a good country, there’s no war, there’s nothing”. But, of course, when you get here you know there are areas which you should avoid. To us ‘owning’ [a house] was outright ownership; but I guess he was talking about mortgage [laughs]. (Thabo)

Thabo saw the physical presence of a migration agent advertising Australia as a country with ‘zero’ crime rate as something that attracted him to Australia as a destination country. Seeing a migration agent coming all the way from Australia to advertise Australian nursing jobs in his country made Thabo feel wanted by Australia and that increased his motivation to migrate. Participants were attracted by the beauty, security and peace that prevailed in Australia. Other participants chose Australia because they saw it as a family-friendly country:

For me, the thing that I like about Australia is the family friendliness. I was really so impressed by that one, because I had heard people say in the UK you cannot process all visas and everything; but Australia made sure that you came with your family. That was the most important thing because even after the stress that I would go through [at work] in the nursing home, I would come home and talk to my husband and he would say, “Oh, don’t worry about it”, or something. (FGD)

Regardless of the pressures that were pushing participants out of their countries, most of them chose their destination country based on limited knowledge. However, Australia seemed to compare positively to other countries. For most participants, Australia was an undisputed choice because there was no requirement for an adaptation course before registration with the Australian Health Practitioner Regulation Agency (AHPRA); they would be able to start work very soon after arrival. Australia was not only receiving them as individual skilled workers, but also making provision to include their families as well, during the visa application process. This was critical to participants who were coming from an
African culture that emphasised strong family relations and a communal lifestyle. Being with family was very important to these participants; and Australia provided for that. They perceived it as a friendly place with good migration conditions and opportunities for property ownership and, most importantly, they would be with their families. However, despite all the hardships they were facing in their home countries and the attractions that Australia was offering, participants still experienced difficulty in making the final decision to move.

**A Hard Decision to Make**

Participants described how hard it was to make the final decision to move. They were worried about coming to an unknown land. What was initially an exciting time following the issuing of the work visa, would sometimes turn into periods of worry and stress. A lot was going on in their minds with some participants describing apprehension and anxiety. This involved contemplating whether to go ahead with the migration plan or not, with concerns about what kind of people lived in Australia; how Australia would receive them; and fears of being deported at the airport. For most participants, it was the first time they would leave Africa. Noma was one participant who had many concerns:

*I was thinking, “How am I going to see Australia? What kind of people am I going to meet there? And, at work, am I going to manage to nurse [people of] different nationalities? I don’t know; I will just see when I get there”. It wasn’t easy though because I was thinking of lots of things.* (Noma)

Noma experienced fear of the unknown. She worried about the type of people living in Australia and what they would think of her. She was beginning to doubt her capability of nursing patients of different nationalities. However, she went ahead with her decision to migrate. Similarly, Sindi also found the process of making her decision difficult as she was concerned about going to a continent that was totally different, culturally and otherwise:

*For me it was really a hard decision to make. We did all the preparations; it was a stressful time because I didn’t know what I would get, coming from Africa to a totally different continent and I didn’t know what the culture would be like.* (Sindi)

Sindi had gone through all the preparations for her move to Australia; however, she still felt the stress of the whole decision-making process and facing the unknown. Africa was a different continent culturally, especially when compared to developed countries. Thabo also experienced mixed emotions not knowing whether to go or not. Thabo’s major challenge in his decision making related to feelings of guilt and patriotism towards his country:

*I was thinking, “Should I go, [or] should I stay?” You go through a lot of emotions, mixed emotions, yeah, you just feel that, “OK, I’m*
going, but is it the right decision; am I helping my country or am I being unhelpful by getting an education here and then leaving?” ... You also think, “If I go, when I come back will I fit in?” Yes, you think about all those things. (Thabo)

Thabo experienced conflicting thoughts as he pondered whether he should go or not. He wanted to go, but at the same time he felt the need to support his home country that had given him his education. Like most participants, Mimi, who migrated at the same time with four other OQNs through the same agency, was worried about being sent back at the airport and how they would be received by patients and the community:

I couldn’t [sell my stuff] before I left because we were not sure ... we could be returned at the airport; we’d heard so many stories of people going overseas and returned at airports. We were going so far away and thinking, “How will the community accept us, will the patients accept us?” ... but anyway, because it was necessary that we go, we forged ahead with our preparation and plans. (Mimi)

Like most participants, Mimi had concerns about her impending journey with regards to her entry at the Australian immigration borders and also being accepted by the Australian community. Regardless of these concerns, participants wanted a better life for themselves and their families; based on this premise, they were prepared to pack their bags and leave their countries.

To participants, Australia was a faraway, unknown land and that resulted in many questions and doubts. The migration decision-making process was described by participants as an experience based on various motivations which included socioeconomic factors that were seen as pushing them out of their countries and affecting their desire to be able to provide for their loved ones and advance themselves professionally. The difficult economic situation had impacted on their families as well as on their children’s education. They saw Australia as the country of choice because of its warm climate, family-friendliness and its prevailing stability and peace. These were seen as pulling factors by participants. Some participants voiced indecision though, regarding their eventual move to Australia. Regardless of these push and pull factors, participants in this study described feeling ambivalent about their migration as they struggled with the final decision to migrate. Besides the external factors, they also had internal push and pull factors and some emotional turmoil related to uncertainty about Australia and leaving their families behind.

Concerns for participants related to leaving their families behind and how they would be accepted by Australian communities. As African nurses coming from communal lifestyle cultures, they saw acceptance by the local community as significant to their successful move
to Australia. Even those who had made the decision and whose preparations were at an advanced stage still had conflicting thoughts and fear of this unknown land and its people. Regardless of all this emotional turmoil, participants ‘forged ahead’ with their plans and took a leap of faith, arriving in Australia to start a new life.

Arriving in Australia

The way management was friendly to me made a big difference; I even told my mother. If someone came to Australia from my country, I don’t think I would have done that for them; but they did, which was very good. (Mpilo)

All participants described their arrival at Australian airports as welcoming and exciting. All had someone receiving them at the airport, with some describing how good it felt to see placards with their names lifted high by the employers or agencies who had come to collect them. Some employers and agencies had even purchased the air tickets for participants. They provided accommodation and some made sure participants had enough provisions at least for the first week or so. Employers and migration agents went out of their way to provide for a smooth arrival process for participants. Although most participants started off with recruitment agencies, by the time they arrived in Australia they were already AHS or aged care facility employees.

Participants experienced a welcoming reception from their employers at Australian airports and railway stations. For Bongani, it was a moment of joy when she saw her name being held up by the people who were picking her up at the airport:

At the airport, the hospital manager and my manager were holding my name; they were there with MY name! [In the house] I had everything; a small fridge which was filled up, that was nice ... air con, TV ... The following day they took me to the bank to open a bank account. They were driving me around showing me the town; and that was nice. (Bongani)

Bongani appreciated the reception by the managers and the preparations they had made for her, including provisions to start her off and showing her around the town. This made her feel welcomed and accepted by her employers who were ready for her. Mary, who had been assigned to a small rural community hospital with two other OQNs, was very appreciative of the way the AHS had prepared for them:

The AHS bosses met us at the airport. They really welcomed us nicely and one of the bosses there, was a former [home country] nurse ... They had prepared the house, with provisions available; we
were really surprised, yeah. There was new bed linen, beds already made up; all we could do was, “Ah, my bedroom is this one and that one” [laughs]. Yeah ... I remember the Nurse Manager telling us, “I was told to prepare, I didn’t even know what to buy; we were asking each other, what could they be eating?” [laughs]. We really appreciated it. Thinking of coming from Africa where you have to source everything, buy everything, and then come here and there was everything! ... Ahh! That really lifted our spirits. (Mary)

The experience of so much kindness from the AHS managers left Mary holding her breath in awe. She could not believe how well the situation had turned out for them. Even though the Director of Nursing (DON) and the Nurse Manager did not know what exactly to prepare for them, it was a positive experience for Mary and her friends. They felt that this would not have happened in their home countries. In this way, Mary started off in her new country in high spirits. Other participants shared similar experiences as described by Mpilo:

> When I arrived at the train station, they were really nice; there were four of them waiting for me. It was so beautiful and they had flowers and a bottle of wine; unfortunately, I don’t drink ... a little bit of groceries so that you know where to start with the basic stuff. The DON and management staff were really nice and they tried to make sure that I settled really well. (Mpilo)

Mpilo described her joy from the welcoming reception by her friendly managers, indicating that welcoming is one of those powerful tools human beings can utilise in building good relationships and making other people feel at home. For some participants, the arrival experience extended to involving members of the wider local community. Mimi, with her fellow OQNs, experienced a warm welcome by their employer and local community:

> The Area DON and the District Nurse Educator made us feel very welcome ... Yeah, they were all ready for us ... The [reception] was good; people were quite willing to help us ... There was a newspaper article on us; a reporter came and took our photos and wrote our story; so even the community was prepared to help us. Vinnies [St Vincent de Paul, a charity organisation selling second-hand goods] saved our lives, [laughs] because I don’t think I would have managed to get everything ready for my family in three months ... the lady there knew what we were looking for and she kept stuff for us all ... There were some farmers from [home country] who had left the country [for Australia] during the [political] problems that we had, yeah, they were also welcoming to us. (Mimi)

Like other participants, Mimi experienced a welcoming reception from her management team. She was also impressed by the positive community response to their arrival and the news item that was placed in the local newspaper. It meant a lot to Mimi to appear in a local newspaper article of a country to which she had just migrated. Mimi experienced very good
support from her supervisors and the local population. She also noted that, ironically, members of the community who welcomed her included farmers who had earlier been driven out of her country for political reasons. Mimi felt humbled by the farmers’ positive actions towards them as OQNs regardless of what her home country government did to those farmers.

Participants described their arrival experience as welcoming. They were happy as they felt that employers and agencies had prepared for their arrival. People who were assigned to receive them were waiting at the various airports and railway stations. Accommodation with some provisions were supplied to them. In some instances, local communities rallied together to receive the OQNs in their regions. Participants felt honoured and they were very appreciative of their reception in rural Australia. This showed the power of welcoming.

**Conclusion**

This chapter explored the beginnings of the phenomenon of migrating to Australia by OQNs from sub-Saharan Africa. In this theme, *The Move Across the Indian Ocean*, participants started by making the decision to migrate. The chapter examined the key issues that were influential in their migration decision making. For most participants, the motivation for migration was fuelled by the failing economies in their countries which created difficulties in sustaining themselves and financially assisting their loved ones who included their immediate as well as extended families. Their decisions were also determined by the pulling effect of the efficient migration agents who not only advertised Australia as a potential opportunity for migration but also travelled to Africa to recruit on the ground. As they described the factors that motivated them to leave their countries, participants included socioeconomic factors, family reasons and their desire for professional advancement. They also saw Australia as a generally family-friendly country that offered peace and opportunity for professional advancement and a better life for their children. For most participants, it was a hard decision to make as they wondered what lay ahead of them in this faraway land. Participants included their arrival experience as part of their early migration journey to Australia. Contrary to the fears participants had before departure from Africa, they experienced a welcome and acceptance from the Australian institutional managers who were receiving them. Participants were received by management or their migration agents at international airports and, in most cases, hospital accommodation had been prepared for them. This helped participants to settle in smoothly. The managers had travelled long distances from rural hospitals and aged care facilities to the big cities to welcome the
participants. The welcome by the employers laid the foundation for participants to have courage and the drive to go on, even when they later felt they were not so welcomed by their work colleagues and patients. Their employers had gone out of their way to receive the participants with a warm welcome to Australia and also provided for their physical needs. Experiences that occurred in the weeks and months immediately following arrival are discussed in the next theme. Participants were starting a new life in an alien land.
Chapter 7: New Life in an Alien Land

It’s a different world (Thabo)

Introduction

Chapter 7 is the second chapter that presents findings. The story of the participants continues as this chapter focuses on the second theme, New Life in an Alien Land, which describes the participants’ experiences as they settled in to a new life in rural Australia. Participants left their African home countries for Australia, to start a new life in a land they did not know much about. They found the lifestyle quite different from what they were accustomed to.

Four sub-themes were identified as depicting part of their new life. The chapter begins by exploring the first sub-theme, ‘Separation From Family’, where participants described their experiences of starting a new life in Australia without their families. This sub-theme explores what led to family separation before demonstrating how it adversely affected participants as they settled in to rural Australia. Participants suffered loneliness and stress and experienced feelings of guilt and self-blame as they thought of their loved ones, particularly children, who they had left behind. Although participants knew they would have to leave their families behind for a while, they did not expect to feel such extreme loneliness and guilt.

The second sub-theme, ‘Being Oriented at Work’, describes the participants’ experiences of orientation to their new workplace. The third sub-theme, ‘Racial Discrimination: Being Visibly Different in the Workplace’, outlines the participants’ experiences that led to their perception of being alienated through discrimination and disadvantage as they negotiated their place within the Australian health workforce. There were times when they felt unwelcomed, undervalued and not trusted by their colleagues and patients. The chapter ends with the fourth and last sub-theme, ‘Being Culturally Different: Living Between Two Cultures’. Participants encountered cultural differences that sometimes resulted in cultural shock as they settled in to rural NSW and their workplaces. The findings are presented and illustrated by the participants’ voices as they describe their experiences of beginning a new life in Australia. Participants’ experiences of family separation will be discussed first.

Separation From Family

Yeah, it wasn’t easy for me; it wasn’t easy, no, it wasn’t (Noma)

All the participants interviewed came to Australia as skilled migrants. Their migration process involved the work visa holder (the participant) coming to Australia alone, leaving
their loved ones behind to follow at a later date. Participants described their experience of
this family separation; how it resulted in them being lonely and stressed as well as feeling
guilty and blaming themselves for leaving their families, particularly children, behind.
Participants described how employers were desperate to fill vacancies and could not wait
until immigration papers for all family members were sorted out:

I stayed for a while before my family joined me here; that was four
months later. This was because my employer felt it would be better
if I came first as they wanted me urgently. (Linda)

It’s like you were expected to come here on your own and then start
the process to bring your kids and everyone else here. The whole
process took about six months, I think. I had to first apply for their
visas and then put some money aside to go back to get the kids ... it
was very hard. (Mpilo)

I wanted to come at the same time with my family but the agency
said, “No, you need to come by yourself”. I think they were afraid of
the costs. So, I came by myself. (Sindi)

I came alone and was here for six months, while my husband and
kids were waiting for their visas ... The hospital offered me [only]
the airfare plus the accommodation for four weeks. (Noma)

Employers assisted the visa holder only with travel expenses and the participants then
needed to pay for the travel of their families. This meant working for some months to raise
money for family air tickets and to get accommodation suitable for a family. Some
participants initially lived in shared facility accommodation with other staff. They expected
that the process of settling in to the new country would not take long and the family would
reunite within a short time. However, the separation period for participants ranged from three
to six months. This long separation created disruption within the family unit which,
participants indicated, was unanticipated and difficult to bear. In the early experiences of
their migration, while waiting for the rest of the family to join them, participants felt very
lonely and distressed. They worried for their children and families; this led to feelings of
guilt and blaming themselves for leaving their families behind. The experience of loneliness
and stress is discussed first.

Being Lonely and Stressed

Participants described their experiences of loneliness and stress following their arrival in
rural Australia. Participants had known they were leaving their families behind but they did
not anticipate such a degree of loneliness and stress. They described this experience as due
to being in a new country without their families. For most participants, the physical
separation from their networks back home resulted in noticeable loneliness. After work and
during their days off, their Australian colleagues would go home to their families while the
participants went home to empty houses where they could only communicate with their
families through telephone calls or emails. Mpilo described how difficult the separation was
and how she missed her children in her first few months in Australia:

[I was] very miserable. It was very traumatic. It’s like, for the 12-year-old, you could communicate with her on the phone but for the
two-year-old, I couldn’t say much over the phone ... it was terrible; it was! (Mpilo)

Mpilo described how she would phone her young children overseas as she tried to deal with
the misery of loneliness and to keep in touch with her family. Participants kept in touch with
families overseas in various ways including a virtual presence through telephone calls and
Skype™ (video chat service) or sending presents/gifts for special occasions.

Participants would remit money to families overseas for various functions like birthdays,
weddings, holiday celebrations or even funerals. However, participants indicated that it was
not the same as being there and sharing the moment. This absence from family gatherings
worsened the feelings of loneliness, as expressed by Mary:

I remember my first Christmas here; I was supposed to work, [but]
I didn’t go to work because I was just thinking, like, we used to be
together on Christmas days ... Then I talked to them over the phone,
they were all there, it was me missing out. It made me sick; I had a
terrible headache. (Mary)

Christmas time is generally seen as family time because family members come together to
celebrate. That did not happen for Mary who felt so lonely that she could not even attend
work on the day. Her family was still overseas and she was alone on Christmas day; this
made her miss them even more. Although there were other sources of stress, most
participants identified separation from family as the major cause of the stress they
experienced. Simba, who had to attend a three-month adaptation program before registering
with AHPRA, saw this family separation as a constant source of stress:

It wasn’t a very good experience. To begin with, I had to leave my
daughter and my husband behind. And it was almost one full year
before they could join me because I had to find a job, find a house
and settle down before they would come. So that was a constant
source of stress for me; you know, as a mother, you’ll always be
worried. And, of course, the separation from your family, I haven’t
been able to go back home and I definitely want to go home soon to
visit; so it’s quite a challenge. You know those are some of the
Simba was one of two participants whose overseas nursing qualifications required them to go through an adaptation course before they could register with AHPRA. Following her registration, Simba had to look for a job. The transition program and the search for a job caused a lot of stress for her which was made worse by the absence of her family. Similarly for Ola, she recalled how separation from her family affected her psychologically:

*It’s also that you’ve left your family back home, you’ve got so much going on in your mind, and there were those times you just felt like you wanted to break down.* (Ola)

The first few days were quite hard for these participants, almost amounting to psychological trauma as they worried about the welfare of their families back in Africa. Betty’s situation was similar as she described below:

*It was very stressful ... and I used to cry all the time and I used to phone four times [a day] back home asking my husband “Are the kids alright, what are they doing?” ... and I went back home after five months [because] I couldn’t stay any longer, going back home just to check on them.* (Betty)

This experience of stress after leaving their families behind, especially young children, was echoed by most participants. Sindi found the separation from her very young son hard and painful. She would come home from work and, alone in her apartment, would start crying:

*It’s a hard thing for a woman, leaving your family there. My son was only two years when I left him there. So, I was crying every day; I would look at myself in the bathroom mirror and start screaming, “Why am I here? What am I doing here, I left my family there” ... When I saw my son crying [on departure day] ohh! It just felt so painful to leave them behind and he wouldn’t let go, I was holding him. We had to force him ... [pause] ... that was really painful!* (Sindi)

Sindi had left her two-year-old son and was having difficulty coping without her children. Most participants found the period they were separated from their families stressful and painful even though they knew it was just for a while. Participants also experienced feelings of guilt and self-blame during their first few months in Australia. These feelings were largely related to separation from their families and their inability to care for and protect their families who had remained behind.
Feelings of Guilt and Self-blame

On departure for Australia, some participants had to leave their children with their partners or extended family members. Others had to separate their children and leave them in the care of different family members. This created a lot of anxiety and feelings of guilt among participants as they blamed themselves for this situation. Participants worried for their children who remained overseas when they first left for Australia. Betty had left her children with her husband and was living in hospital accommodation which overlooked a playground:

I was just saying to myself, “Am I a good mother, what am I doing here; is it because of money that my children are all by themselves?” … it was very painful as well because my last one [child] was attending Year One. I should have been there to orientate and to settle her down. During that period, I was blaming myself whether I had done the right thing because my room was just opposite a playground where children were playing and I always blamed myself, “Did I do the right thing”, because I had left my kids [overseas] … As a mother, I didn’t feel good thinking that if my child, my girl, got raped then people will say, “Oh! You were after money”. (Betty)

For Betty, seeing other children led to her thinking of her own children who were thousands of kilometres away and without the care of their mother. Betty blamed herself for not having been there when her daughter started school. She questioned her migration decision to come to Australia and was worried people would see her as a mother who did not love her children enough. This undoubtedly brought intense emotions of guilt and self-blame. Some participants had left their children with different members of their extended families. Sindi was one such participant; she also worried about her children:

He was two and she was eight. I had to leave them at different places. I left my son in [rural area] with the maid and his father; and my girl had to go to [another city] for her studies and live with her auntie there. So, it was very difficult; and when communicating I would need to ring my husband and talk to him and my son and then ring this other one; so, it was just bad … It was a struggle and I spent a lot of money calling them. (Sindi)

Sindi worried about separating her children and found it even more difficult to communicate with her family as they were in different places. This was experienced by other participants who also found it difficult to communicate with their overseas families if children were left in different places. It was very important to participants that they communicated with their loved ones. Participants would worry and feel guilty if they did not talk to their loved ones. For some participants, their feelings of guilt emanated from a realisation they were living a better life and eating good food in Australia when their other family members were barely
eating, overseas. In the words of Mimi:

> It was an experience, and it was hard to eat because most of us had left kids at home, you know; you just say, “Do I really have to eat ... if I eat this, what are they eating [back home]?” ... because we knew the state that was back home. (Mimi)

Mimi had left behind her husband and three children. So, instead of enjoying themselves, she and other participants felt more stress and guilt for having advantages over other members of their families. Participants also described missing out on family functions as increasing their sense of guilt.

Mpilo was worried about being absent from family funerals and weddings. Although she thought migration was a necessity as it would have a positive financial impact on her family generally, she still experienced a sense of loneliness and guilt as she did not attend some important family gatherings:

> You miss home, you miss the family, you miss your friends ... Yeah, and sometimes you have to make sacrifices. You can’t have everything; you weigh – which one weighs more. I can’t be with my family, I’m missing out on weddings and funerals of family members, like my uncles and people that passed away because I can’t be there for everyone. Yeah, there are some things you wish you were able to do but you can’t because you are here. (Mpilo)

Mpilo missed her family and all her loved ones: she wished she could attend family functions overseas. Like Mpilo, participants felt guilty because of the physical separation from their families and their inability to fulfil their obligations to care for their children on a day-to-day basis; hence, they were worried about possible negative comments from their communities in their home countries.

The other source of their feelings of guilt was their enjoying a comfortable life which their families could not experience in their home countries. Participants felt they had an advantage over their loved ones and this made them feel guilty. Participants felt this guilt and the moral obligation to be with their families. They saw it as not only morally correct for a woman to be physically present and look after her family and children, it was also an expectation of the society they grew up in.

For participants, the migration journey to Australia meant initially leaving their families behind for about four to six months on average. This period of family separation turned out to be a lonely and stressful time for participants. They would cry, worrying about their children and partners. They would phone overseas, sometimes several times a day, in order
to keep in contact with their loved ones. As participants reflected on their loved ones who were still overseas, they developed feelings of guilt and blamed themselves for having left their families overseas, even if it was just for a short period. Whilst participants were grappling with the impact of family separation as they started a new life in rural Australia, they were also expected to start work immediately. Participants described their orientation experience in the first few days of starting work. They had expected familiarisation with or some kind of training on various aspects of their new roles within the health services, such as organisational procedures and policies, job expectation and responsibilities as well as health and safety at their workplaces.

**Being Oriented at Work**

*When you don’t have orientation, you take longer to fit into the system and when you take longer you don’t make people happy* (Ola)

Participants were recruited at a time when Australia was experiencing a critical shortage of nursing staff and struggling to fill those posts, as already discussed in Chapter 2. Participants discussed various experiences of work orientation when they started work in rural Australia. There were positive and negative work orientation experiences in both acute care hospitals and aged care facilities. Participant perception of their orientation experience varied greatly mainly because of the different strategies adopted by the various institutions.

Some participants thought the orientation was good and adequate. It is noted, though, that all participants who were happy with the orientation were based in hospitals. They were happy with the duration which ranged from three days of supernumerary status to a full month working with a mentor. Included in the orientation was assistance with computer systems, the health system programs and other activities usually included in mandatory training for all staff. Mimi recalled her orientation experience:

*We were taken to the AHS headquarters where we had our orientation for two weeks after which we were then transferred to our different stations. It was mostly mandatory kind of stuff like Occupational Health and Safety, Infection Control and all that. It wasn’t really specific to us, we joined the groups that were having mandatory training. At our hospital, we spent the first week with the educator. We were actually doing stuff on the ward ... seeing patients with him, ECGs and so on. I think they did their best and we did the best as well because eventually we just integrated with everybody else.* (Mimi)

Mimi was obviously satisfied with the way she and her colleagues had undergone orientation at the AHS headquarters as well as at their designated hospitals. There were five of them
going to that AHS. It was a similar experience for some members of the focus group who were also happy with the orientation they had:

\[ \text{I was lucky when I went to the orthopaedic ward where the NUM [Nurse Unit Manager] was very supportive. She said, “I want to make sure that you’re orientated for a month, so that you know what to do”. I was thinking to myself maybe it’s too much but I realised that it was good to work with somebody for one month. (FGD)} \]

The mentoring was most appreciated by this participant. The support from the NUM also made a difference in the participant orientation experience. This NUM was prepared and had an orientation program in place for her new recruit. Similarly, Linda, who was a permanent employee at an aged care facility but doing casual shifts at the local hospital, found the hospital orientation process helpful and well organised:

\[ \text{Support at the hospital is beautiful. You’ve got the DON, you’ve got the NUMs, you’ve got your peers and, honestly, they do everything by the book ... The orientation was just beautiful ... They’ve got a lot of experience in getting foreign nurses to settle here ... Their [recruitment] experience is broad so I think that’s how they get really good. (Linda)} \]

These participants were happy with the orientation they had and this helped them settle quickly in to their workplaces. However, quite a few participants were not as happy with the work orientation they received. They felt it was inadequate, if they had any at all.

Participants, mainly those working in aged care facilities, reported inadequate orientation to the workplace. They attributed this to a shortage of staff at these institutions resulting in them being guided by enrolled nurses (ENs) and assistants in nursing (AINs) and in some cases agency nurses who did not know much about organisational structures and policies. Despite this, these OQNs were expected to be team leaders so they felt they needed extensive orientation over time. However, this was not so for Sindi:

\[ \text{There were no permanent RNs for that place. So, when I got there the agency nurse orientated me; the second day it was another agency nurse because they keep changing and, on the third day, it was an EEN [endorsed enrolled nurse]. So, that’s just three days of orientation in a specialty where you’ve never worked. After the third orientation day they told me, “You’re in charge of the nursing home”. Unfortunately, on my third day of orientation with that EEN, a resident fell and I didn’t know the protocols ... Even up to now I think twice about working in a nursing home. It was a tough one ... it was so stressful for me. (Sindi)} \]

Sindi viewed aged care nursing as a specialty because she had not nursed elderly people in residential facilities. The stress experienced by Sindi working in this unfamiliar environment
was echoed by Linda who was not happy with her orientation at an aged care facility either. Linda began working in an aged care facility on arrival in rural Australia, before taking a second job as a casual in a nearby hospital:

*That nursing home I went to was so short staffed ... I was the first RN there to be permanent, the other ones were just part-time and so I just did one orientation day because whoever was supposed to orientate me got sick and so I was on the floor already. It was terrible. When you're going to supervise people, you need to know what you're doing. I knew my job as an RN but this was with different resources which are more advanced compared to ours. I needed someone to show me. Obviously, inadequate orientation didn't give me that confidence that I have to have at work, it took a while. Also, it was the first time for my manager to have a foreign nurse ... so it was a 'hit and miss' situation. I would imagine they didn't do enough research, yeah ... It didn't bode well for me but, yeah, I did survive.*

(Linda)

Similar sentiments were expressed by participants in the focus group:

*What I was expected to do was completely different and, you know, when you don't have nursing home experience you really struggle; there was basically no support at all because I just had two supernumerary shifts ... everything was just different ... it's not safe.*

(FGD)

Sindi and Linda, like most participants, found rural aged care facilities were hardly functioning because of staff shortages. They expressed their dismay at the inadequate orientation they received; this created a lot of anxiety for them as they struggled to cope with their new roles with very little guidance. This undermined their confidence, sometimes making them feel less of a nurse. As Mpilo explained:

*It was a little hard to start with; there was no proper orientation. The first day on the ward, you feel like you haven't been a nurse; you feel as if you've just been picked up from the community and thrown into a ward because, it's like, you don't know the expectations.*

(Mpilo)

The first days were difficult for Mpilo as she wanted to know what the expectations were for her new role so she could set her goals within that framework. It was a new environment with different expectations for participants. Mpilo felt helpless as though she was losing control of her professional nursing identity. Similarly, Simba and other participants described how their colleagues were quick to judge their performance rather than help them:

*People were more willing to criticise that you're not able to do this rather than tell you, “This is how we do it”. So that was just a bit of a challenge that I experienced.*

(Simba)
The other problem was that there are some staff, instead of supporting, they are just there to keep an eye on you and report you, which sort of puts you down because those are the people who are supposed to be helping you so that you get settled on the job. (FGD)

This response of their colleagues may have been due to the frustration of having to orientate the OQN when they had their own patient workloads to attend to. Participants felt that, although they were experienced RNs, they still needed adequate orientation in the workplace in order to facilitate their integration. They argued that this was a new environment with new roles as aged care workers, where things were different and done differently. Participants stated they felt their confidence was undermined and felt disadvantaged. The limited orientation added to the stress already experienced due to their family separation.

From the participant experiences noted above, it is clear that work orientation was not consistent. As nurses who had migrated from overseas to a new environment, participants felt adequate work orientation was critical for them to keep up with job expectations. Participant experiences show better support was provided in the hospitals than in aged care facilities. Unlike in the aged care facilities – where participants were the only RNs on a shift and were expected to be in charge – in hospitals, participants worked with colleagues who could show them how things were done or, at least, they were there for participants to observe some procedures. It seems the orientation processes were not standard as the duration ranged from two supernumerary days in aged care facilities to a month of mentorship in hospitals. Mentors in aged care facilities were anyone on a shift on the day ranging from ENs to casual agency RNs and sometimes facility managers. AINs also helped in orientating participants. It was hard for participants particularly since some of them had worked as midwives or paediatric nurses in their previous roles, only to get to rural Australia and work in aged care facilities. Participants gave a few suggestions that could improve the orientation of OQNs and these are discussed in Chapter 10. Participants also described moments when they felt discriminated against, especially in the workplace. Participants felt this was based on their race.

**Racial discrimination: Being Visibly Different in the Workplace**

*It’s like, they just think you’re from Africa, so you don’t know anything* (FGD)

Participants described experiences where they were acutely aware they were different from the mainstream population in their newly adopted country. These differences were in their
language, accent, culture, skin colour and social interactions. Participants spoke English with a different accent and also spoke another language. They had a darker skin and had a different cultural orientation. In short, they were visibly different. This was who they were and had always been.

However, it was the responses of some colleagues and patients to these differences that led to participants feeling alienated and discriminated against. First were the experiences of feeling unwelcome due to the behaviour of some of their colleagues and patients. Participants also described experiences of being undervalued and not trusted as professionals. They felt they were not trusted by patients and colleagues and were not being recognised for the nursing skills and experience they brought with them. They further described how discrimination and disadvantage impacted on them, the ward environment and patient care. Participants also described the coping strategies they used to deal with the experience of being seen differently. First to be discussed are the participants’ experiences of feeling unwelcome in their workplaces.

**Feeling Unwelcome in the Workplace**

For most participants, it was when they entered the workplace that they realised they were not welcomed by everyone. These experiences were mainly related to inter-professional interactions, mainly nurse-to-nurse, but also interactions with staff from other disciplines and nurse-to-patient interactions. Some of these experiences continued for years although they were more pronounced in the first few months after their arrival. Participants described experiences where some colleagues, patients and their relatives, and Indigenous communities were not welcoming.

*Sometimes you just feel that you are not sure of what you’re going to expect … When you see a group of people just standing, talking and then when you approach them, they stop talking you think that maybe they are talking about you, because why should they stop talking? Or they just disappear into different directions. Is it because they don’t want you to associate with them?* (Betty)

*At times, you feel like your plans are just shattered because so and so doesn’t like me; at work, I can’t thrive because I’m black; I can’t be supported because of who I am … So, in order for me to get there [pointing up] I will need to be strong enough to push through the doors, the closed doors that are supported by this racism thing. They don’t say it out, but they display it, you can just feel it … even if they don’t say that you’re black and things like that, you can feel it.* (FGD)
Betty experienced confusion as to what was happening in her workplace. She felt uneasy that other staff would move away each time she approached them. She felt unwelcome due to this behaviour of her colleagues. Some participants in the FGD shared the same sentiments. Farai described a typical day at work in those first few months after her arrival. She sometimes felt unwelcome on the ward as people did not seem to want to interact with her at break times:

You could see there were staff who didn’t want to see you ... there were racists among the staff ... some of them didn’t even want you to touch their cup. Even if you went to the staff room sometimes you were isolated. They didn’t even want to associate with you. (Farai)

The lack of association with colleagues gave Farai a perception of not being welcome in her workplace. This isolated her and worsened her feelings of loneliness. Farai attributed this behaviour to racism. Sindi also reflected on her encounters with colleagues. A wardsman entered an IIMS (incident information management system) report about her when Sindi had called for assistance one night. The claim was that Sindi was nowhere to be found and the wardsman ended up doing Sindi’s work. Apparently, at the time they were looking for her, Sindi was showering a patient who had soiled himself to such an extent he needed a full shower in the middle of the night.

You know it was hard for me to explain what had happened. I just broke down and cried because I just thought, “No, this is just racism at its worst, it’s nothing other than that”. So, I cried and cried ... anyway, I managed to tell the NUM what happened so that she could fill in the portion where she had to investigate. (Sindi)

Sindi was hurt by this incident and felt she was unfairly treated by her colleague. She saw this act as discriminatory based on her being black and it resulted in her breaking down, crying. Fortunately for Sindi, the NUM did not support the allegation. The NUM removed the report from the system after realising that the incident did not meet the IIMS criteria; she stated the wardsman should have informed the person-in-charge on that particular night if they had a complaint about Sindi. Other participants mentioned episodes of blatant racism from patients’ relatives, as was recalled by a participant in the FGD:

It was painful ... I was the person in charge and I had a new grad. The new grad wanted help so she called me to help her. She was admitting this new patient and the [patient’s] daughter said, “Excuse me sister”, she was addressing me, “Don’t worry about what I’m going to say, I’m talking to this nurse here”. So, I thought, well, she’s talking to the nurse. Then she said to the nurse, “Excuse me nurse, I don’t want my mother to be nursed by a black person ... yeah, I don’t want my mother to be nursed by a black person; in our family we don’t do that. We don’t associate with them”. I was there!!
But because we had a supportive NUM she said, “We don’t tolerate that, no other nurse is going to look after your mother except that nurse”. The NUM made sure that I kept on looking after the mother until the relative ended up liking me. (FGD)

The participant’s description of the response by the visitor indicates a relative who had no desire for her loved one to be cared for by this nurse due to her skin colour. The statement was boldly said in the presence of the OQN and in the presence of other people in the room. This caused a lot of pain to the participant, as stated in her narrative. Participants also felt they were seen as being different by patients who they described as not being comfortable with black nurses:

There is also the issue of working with patients who have never been exposed to blacks ... I was on night shift and I remember a patient who screamed when I went to her room; she said, “Yeoew!!” ... I said, “It’s only me, I’m just checking on you”. Then, when I went back the second time, she screamed, “Aaaaahhh!” I said, “Oh, why?” she said, “It’s you”. “What have I done?” “I’m scared of you”. “What’s wrong?” “Because you’re black”. (FGD)

It was a scary moment for the patient to wake up in the middle of the night and see a black nurse. The nurse looked different to the ones the patient was used to. The nurse interpreted it as due to lack of exposure to ‘blacks’.

Similarly, and perhaps surprisingly, some participants described Indigenous people responding negatively to their presence. Mary described her encounter with a rowdy group of local Indigenous people. It was a rather violent incident that scared her family:

They [Indigenous people] are the very people who didn’t like us more because they were saying, “You’re working with the white people”, so it was as if we were enemies to them, I don’t know ... probably they didn’t want us to associate with the white people ... There was a time at night when they came to our house and they kicked the door open and burst in. Yes! We were sleeping and the police had to come ... it wasn’t like they wanted to rob us; they kicked the door and it broke, yeah. We never understood what they were shouting, but they were shouting and shouting, and they left. (Mary)

Mary stated that her family did not expect such resentment from the Indigenous locals and they least expected a physical attack that required the attention of the police. The incident suggested to Mary and her family that they were not welcome in that community. It was a frightening moment for Mary. Bongani also had an Indigenous patient who was rejecting her care and she thought this was because she was a black nurse from Africa:
With the Indigenous people, I think they don’t know if someone who is not white can be a nurse. Yes, they can be very nasty because they said, “There’s never been anyone from Africa; someone from Africa cannot be a nurse” ... There was this Aboriginal patient who just started to be mean and chasing me away, “Go away, go, go away, I don’t want you, I want the nurse”. So, I got someone white. “Is this the one you want?” He said, “Yes, yes, I want this one”. Luckily, that nurse didn’t entertain what was said by this patient. She told him, “This one is the nurse who’s going to look after you, I am looking after that patient. She is a nurse as well; if you don’t want to be nursed by her no one is going to nurse you”. He apologised and I told him, “It’s OK, I’m going to take care of you”. I think they thought that we’re going to poison them or give them something wrong because we are black. They’ve got that thing that everyone from Africa is here because of hunger, yes, so when you come to Australia you’re just here to be fed. I don’t blame them because it was the first time for them to see black nurses. Yeah, they haven’t seen their own people being nurses, either, and then they see us being nurses, so they think it can’t be. (Bongani)

Bongani believed that the patient’s negative response to her was due to ignorance. She thought the patient refused her care because he had never seen a black nurse before and probably believed that there could never be one. This made Bongani feel rejected and unwelcome.

Some participants described how, soon after arrival, they were asked when they would go back to their own countries. Betty described why she did not like the question:

> When you come [to Australia] you just want to be appreciated and also want to be treated the same as any other Australian, not to be asked, “Oh, when are you going back home?” It’s not nice to be asked, “When are you going back?” (Betty)

Such a question left participants with feelings of being unwelcome or unwanted. Betty wanted her presence to be appreciated and to feel welcome instead of people asking her when she was going to leave Australia.

The narratives above show that participants encountered some colleagues who were not welcoming. Some patients and patients’ relatives were also seen as not being welcoming as they were refusing the care offered by participants. Participants saw those responses as being discriminatory. For some, it was exclusion from associating with others and inappropriate reporting to supervisors. For others, it was blatant racist remarks and becoming more physical with a house break-in. Although these unwelcoming encounters were hurtful and difficult for participants, the NUMs responded swiftly to such incidents in support of the OQNs. They would not tolerate such behaviour from anyone; hence, they helped in Sindi’s
situation as well as the participant’s who was being racially abused by a relative who did not want her mother cared for by a black nurse.

Participants also cited situations where they felt discriminated against on professional grounds. These concerned their qualifications and professional experience which were poorly recognised and the perception that they were not trusted by their patients and colleagues.

**Being Undervalued and Not Trusted as Professionals**

In addition to feeling unwelcome because of their differences, participants also experienced discriminatory situations where they felt they were not trusted as RNs by both patients and staff. Some patients did not trust the OQNs, refusing to take medications from them. Participants also felt they were not trusted and valued by their colleagues as they described the hindrances they encountered in relation to opportunities for promotion and professional advancement. As stated in earlier chapters, some of these participants had vast nursing experience that could have been capitalised upon by both employers and colleagues. Participants felt they were not trusted.

The issues of mistrust in the workplace were expressed by many participants; this was linked to their being black and coming from Africa. Mpilo told of her initial encounter with residents in an aged care facility:

> *When we were new here and doing the medication round, let’s say a patient has been prescribed a new medication and you go to give this medication as an African nurse and it’s the first time the patient has had that medication ... they don’t take the medication, they will put it aside in the drawer and then when an Australian girl passes through they will ask her if they should take that medication and then they take it. These were the first few months, they would not trust us, maybe they thought we were going to kill them [laughs] or something? ... You won’t know until the local nurse came to you and said, “I gave Mr X his medication because he didn’t take it, he had it in his drawer”. And the nurse wouldn’t go into details but obviously you knew that they didn’t take the medication because they didn’t trust you.* (Mpilo)

Mpilo was not trusted by some residents in her facility and she attributed this to her being an African nurse. Residents based their acceptance of nursing care on skin colour. They would trust anyone white with their medications, regardless of their professional qualifications. Other participants described similar experiences with their patients who needed much convincing they were giving them correct medications. Farai describes her
experience with some residents in her facility:

Even some of the residents didn’t want to be touched by an African, yes, and they would compare their skin colour to say, “... your skin is dark, look at mine”. Then I’d say, “It’s just the difference of the skin but I can do whatever anyone else with a white skin can do; I can do that”. Like in aged care, you are the RN, you give them medications and then they will call an AIN to ask them if they are the correct medications; it was really very bad. (Farai)

Participants described having to seek assistance from other staff such as ENs and AINs to convince residents they were getting correct medications. Participants interpreted these responses from their patients/residents as bordering on racism and showing lack of trust in them as RNs. Since some of the participants stated they were the first black nurses to work in those institutions, it may have been a cultural shock for residents/patients to be nursed by a black nurse, hence their response.

Similarly, participants felt that their nursing colleagues, too, did not trust them and did not recognise or value their qualifications and experience. Participants would be checked by their Australian counterparts in most of the nursing care they provided. This was expressed by Betty when she related incidents where she also felt patient privacy was being breached during nursing procedures:

The other thing we encounter is that when you’re doing a procedure behind the curtains, people are always checking on you and peeping through the curtains. It’s not a good thing because you don’t trust me that I’m doing a correct procedure and, at the same time, you’re exposing the privacy of the patient. Of course, if I don’t know, I ask, but not someone coming and peeping through the curtain. Why can’t they just say, “Oh excuse me, can I come in?”, or “Betty are you there?” Something like that. (Betty)

Betty wanted her nursing colleagues to, at least, seek permission before entering the screened-off area as a sign of trust and respect for her and her patients. She perceived such behaviour by colleagues as taking away the privacy and confidentiality that must be upheld in patient care. The mistrust also caused doubts and suspicion between participants and colleagues resulting in gossip and ‘dobbing in’. Some participants lamented inappropriate reporting to managers by their colleagues that occurred in their first few months of working. Thabo recalled his experience:

There was a lot of ‘dobbing in’ as they call it, people going to the office ... yes, yet you’re new and you are still learning. And then there were those, of course, who were looking for errors in everything that you did. Yeah, yeah, but anyway we soldiered on. (Thabo)
The same sentiments of mistrust were expressed during the FGD, where participants felt they were not trusted by some members of other health disciplines as well and they attributed this to racism:

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\text{It [racism] will always be there, it will never end, it’s there forever ... and those issues don’t just come from patients, but our colleagues as well. Because I remember the time when I was in charge at [hospital], the doctors would come and talk to my juniors, then those juniors would come and give me the orders; until I started saying, “I’m not taking any orders from anyone. If the doctors want to tell me anything they can come and talk to me, I do understand English”. That’s when it stopped. Otherwise, it was just someone talking to someone else and then me. (FGD)}
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Participants felt they were discriminated against by their patients and colleagues based on their race. They thought the racism that existed at work would always be there. Similarly, Linda was not happy with the way the after hours DONs at the hospital where she worked as a casual would conduct their routine ward checks on seriously ill patients while she was in charge of shifts, as they differed from their practices with other staff. Supervisors would check with other white nursing staff on the ward but ignore her. It was as if Linda was invisible and the managers were just seeing through her. She interpreted all this as racism:

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\text{Some of them [the relatives] were racists and some of the staff [too] ... Some of them [still] are now and I don’t think you can ever stop racism totally; but it becomes better as people get used to you and get to know who you are. We had to put up with such things ... The white Australians think they are superior; so, they think you can’t tell them a thing. It’s unfortunate that even the relatives will be knowing that you are the in-charge but if something happens they don’t come to you, they will go to an AIN ... I don’t know whether they think you don’t know or because they are white so they would rather be talking to another white person; ... because, like I said, they [supervisors] usually come every shift to get a report of who is very ill and what you’re doing about it ... You’d be surprised, sometimes, when you see some of them asking a person who is not in charge. So yeah, it does happen. (Linda)}
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Participants expressed concern over the way relatives would ignore them for AINs when seeking clarification on care issues. Linda was not happy that some relatives and supervisors in her unit would not check the patients’ condition with her as the in-charge of the shift. She confirmed that relatives in aged care facilities knew who was in charge as they are given this information on admission of their loved one to the facility. She felt supervisors did not trust her or value her leadership skills as they tended to check with other white nurses. Although this annoyed participants, Linda noted that some people’s perceptions were changing for the better over time and participants welcomed this change.
Some of the mistrust among staff deteriorated to near insubordination when the facility wards persons and AINs would not take delegation from the participants. They did not view the participants as RNs in positions of authority, nor did they accord them the respect they deserved:

And also being a black person, being someone from a foreign country, and you’re leading AINs and most of them were Australians, some of them looked down upon you. They didn’t want to take orders from you ... [shaking her head] ... Sometimes you could delegate to the staff and the staff wouldn’t do it, you ended up doing it yourself. They didn’t expect an African to be educated and come in and work as their team leader. And like some of them, they didn’t even want it. You come in and then you tell them what to do, you could see by the non-verbal cues that they are really not happy if you ask them to do something. I remember when I asked one of the cleaners to come and clean in the office because the bin was spilling over, there were papers all over and then she said, “Do you think you can tell me what to do?” (Farai)

Farai felt this response was due to her being black and from Africa. Her staff would not take delegation from her regardless of her supervisory position. Participants felt this mistrust went hand-in-hand with their professional skills not being valued. Lili (who had 12 years of nursing experience) noted a similar thing in her rural hospital, particularly in relation to her diverse nursing experience not being valued. She thought she was being looked down upon:

I noticed that in the rural settings people haven’t had much mixing with people from overseas so they sort of, like, looked down upon the people from overseas ... Workwise, they don’t really have that expectation that you can perform to standard, or even more than they do [because], from my personal experience, I can say I am much more experienced than them. I’ve been exposed to Africa, to African conditions, to African diseases and I came here and I worked in an urban setup. I’ve been exposed to Australian conditions that are mostly prevalent in urban setups and I’m now here, also in a rural area of which I think I’m much more exposed than them. So, they sort of, like, find it hard to accept that this person knows more than they do. (Lili)

With the diverse nursing experience that Lili had, she felt her colleagues could have expected her to perform to a suitable standard, even if she was overseas qualified. The participants also thought their experiences of being treated as different and not being valued as nursing professionals were impacting on their promotion and professional advancement endeavours as they strove to integrate and upgrade themselves professionally. This was expressed mainly by those working in hospital environments where they sometimes felt discriminated against. After working in an Australian hospital for three years, Sindi was not happy with the way professional development information was disseminated in her unit. She felt such
information was intentionally kept away from her in order to block her professional aspirations:

To some [extent] though, I still feel, at times, I’m alienated [from] education, you feel that people are hiding information. They know that you don’t know where to get things. Instead of them showing you, step by step, and encouraging you to gain your potential, they’ll just try and sideline you and pull you down ... they just hide things to such an extent that it’s taken me so long to start a grad cert – I started my Graduate Certificate in Acute Care last week. I had told my nurse educator that I wanted to do a wound management course; and the next thing, the nurse educator is the one who was doing wound management. They were telling me, “Oh, the Local Health District wants you to first do this step, then you do that”, until it was closed. So, I was so let down. I don’t want them to pull me down, I don’t want them to. (Sindi)

Sindi, like most participants, felt she was disadvantaged at work because she did not know where to get information. Participants needed information regarding their career paths. They needed information on courses that were available for them to improve their nursing skills, more so now that they were functioning in a new environment. Sindi missed out on the course she wanted to undertake and started the other one late due to this lack of knowledge and this made her feel alienated. The same sentiments about the struggle for professional development opportunities were expressed by participants in the FGD:

Even our juniors, you see them doing things ... They get priority to information before we do. Even with this College of Nursing, there are courses that can be sponsored by the hospital ... I said, “OK, I’ll put in an application”. My colleague had told me about it. We didn’t even get a response ... They [also] didn’t want me to go [for the venepuncture course] and I said, “I’m going!” ... I phoned and they said, “No, it’s full, it’s full.” ... I decided to check with another person, then he said, “Aw, the class is full, but have you downloaded the papers?” I said, “I’ve downloaded the papers and I’ve read them”. He said, “OK, I will include you”. So, I did the venepuncture [course]. (FGD)

The above expressions of hindrances for professional development were once again interpreted as discriminatory by participants and some felt let down by their colleagues. They had to find ways of dealing with such situations in order to achieve their professional development goals. In some instances, it took perseverance and searching for information for participants to be admitted to a course. Some participants, especially those working in hospitals, thought they had been in Australia long enough (3–11 years) to be considered for promotion into senior roles in their hospitals. Their expectations were high for promotional opportunities as they came with many years of experience, and some had relinquished senior
positions before they migrated to Australia. However, this, for some, was not to be. Betty was eight years into her migration to Australia and she expressed frustration in being sidelined for promotion as if she did not belong:

As RNs, they should also give us chances to be promoted as well because we have also done the same thing and we are registered on the same register. Why are they taking so long to promote us? It is very annoying because we also want those promotions. For example, I was in the intensive care unit teaching other people how to do ventilation and, after a few months, you see those people who you have been teaching are the ones who are now supervising you; it’s quite frustrating, yeah ... because, if you are teaching someone, it means they’ve [supervisors] got faith in you to teach that particular student. I’m worried why things are not explained that, “No, you lack this and that and that, can you do this, so that you’re also in this same position”. When you ask why am I not being promoted they tell you, “Oh! It’s because we’re still trying to see how much you can do”. How much can I do, when I’ve been mentoring the person that has been promoted? When you go for a [performance] appraisal every box is ticked, so you wonder why. (Betty)

Betty was not happy that she had not yet been promoted in her department regardless of her experience. It was even more annoying for her when her supervisors could not give her acceptable reasons for her lack of promotion when her mentees were being promoted.

Participants had a desire to be trusted and to have their professional experience and aspirations valued and recognised. The above participant narratives show that there were feelings of mistrust between participants and patients as well as other staff. Participants felt their professional knowledge and experience could have been valued more and they could have been trusted more by their patients and colleagues. They related experiences where some were looked down upon by colleagues and patients and some had their supervisory roles challenged, regardless of their qualifications and experience. Participants also narrated encounters they had with patients and staff where they felt they were not trusted. Participants linked these responses to being seen as different from other nurses in the units where they worked. They felt they had limited opportunities for promotion or further education by sometimes being excluded from information dissemination. Some participants went on to describe the impact these experiences had on them and their patients and how they coped.

**Coping With Being Seen Differently**

Participants described these racially based experiences of feeling unwelcome and not trusted as having a negative impact on patient care and causing divisions in the teams they were working in. Participants in the FGD described situations where shift ‘floaters’ would choose
who they wanted to assist with heavy patient loads based on skin colour rather than on the workload:

In our ward, it’s each man for himself and God for us all. No one will be willing to help you with heavy loads. It’s your patient, it’s your problem; you have to deal with it, no matter how heavy [your load is]. In our ward, there’s a ‘float’ person but the floating part of it is selective … They choose the ‘white area’ [where the white nurses are working]. Yeah, they go to the ‘white area’ and leave the ‘black area’ … and you just suffer by yourself. But now I also do that too: when I’ve got my black ones, I go to the ‘black area’ to help with heavy patients. What can you do? Once you point it out, “You don’t help so and so, or you don’t help us”, you’re labelled. At the end of the day you just say to yourself, “I came here to help patients and I’m capable of looking after my five patients, no matter how heavy the load is; I just do it.” (FGD)

The ‘float’ person is expected to help in areas that are heavier during the shift. However, according to participants, this help is offered selectively based on the colour of the nurse thus adversely affecting not only patient care but also the affected nurse as this stresses them physically and mentally.

Participants described various ways of coping in these situations where they felt ostracised and hindered in their efforts to settle within their workplaces. Some participants tried to brush off these responses telling themselves that racism will always be there and it will never end. They spoke of using avoidance strategies to cope with the situation where they would remind themselves of their reasons for coming to Australia, as was stated during the FGD:

It’s like, we knew why we came here, we were economic migrants as well as political migrants, so you know, you can’t go back because of those situations and you also want your children to have a better life here, to have a better education; so, you sort of … [pause] … humble yourself; I can say accept, telling yourself you’re just here to work and you just do, yes, you do your work and then go home [at the end of the shift]. (FGD)

While some participants accepted the situation and justified their coping strategy, others did not give in like that. Some narratives above showed that they were persistent and determined to resist such behaviour in order to achieve their goals. Sindi had her way of dealing with such situations:

Sometimes you find clients who are racist as well and I would say, “OK, if you don’t want me to look after you I will find someone else to look after you because I can’t change who I am”. So yeah, it’s unfortunate really. I have seen it even with the Indians, they are having a hard time to such an extent that I thought my next move
Sindi had seen that this racism was inflicted on OQNs from India as well, to the extent that she now has a long-term goal of advancing and positioning herself within the system where she could help other OQNs. Participants described encountering discriminatory responses from some staff and patients as they interacted with them on a day-to-day basis. Some of these were based on ‘race’ or the colour of their skin and this was distressing to participants. They described how they felt discriminated against and unwelcome in the workplace in comparison to the positive welcome they experienced when they arrived in the country. They also felt undervalued and not trusted as professionals. Participants described the impact all this had on them and their patients, as well as the coping strategies they adopted when such situations arose. Participants also experienced differences between the Australian and African cultures; they found themselves living between two cultures.

**Being Culturally Different: Living Between Two Cultures**
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*I still feel separated from my family. At least my nuclear family is here with me, but I left my whole life behind* (Simba)

Participants came to Australia from a very different community where everyone spoke the same language and had very similar cultural values and practices. In Australia, participants had cultural encounters that exposed them to different values and beliefs. Their cultural experience in Australia included identifying the existence of cultural diversity within the communities they settled into, seeing Australians as keeping to themselves, and participants trying to hold onto their own culture.

Some of these experiences came as a shock and sometimes called for some personal and cultural transformation on the part of participants as they learnt more about the local culture. Sometimes participants saw themselves as negotiating two worlds where they wanted to cling to their own traditional culture whilst trying to embrace the new one. Of particular note was the participants’ experience of living next to neighbours who kept to themselves and the participants’ desire for their children to appreciate their African heritage. The cultural diversity that existed in their localities was an interesting revelation for participants.

**Cultural Diversity**

The Australian environment also presented participants with several cultural differences in day-to-day communication and interaction. Participants discovered how diverse cultures can
be and how difficult it can sometimes be to adapt. Participants found a less formal society in Australia where people could invite you out and expect you to pay for yourself, women could smoke and children could easily place their elderly parents in nursing homes if they felt they could not look after them. Some participants, such as Mimi, could not believe that if you were invited out for dinner you would be expected to pay for yourself:

*In Africa if you invite someone out for dinner you pay, but when we got here we were expected to pay for ourselves; that was a culture shock.* (Mimi)

Thabo and Farai noted a smoking culture, particularly among women, as something which was new to them:

*It was strange at first but I think it’s something that we quickly got used to. Staff taking frequent smoke breaks ... everyone is smoking, the young staff, old ladies smoking, so it was sort of a culture shock, yeah.* (Thabo)

*Seeing lots of women smoking cigarettes – we were really surprised that women smoke cigarettes, I had never seen it in Africa. It was very interesting.* (Farai)

Although participants eventually became used to these cultural practices they could not forget the shock they experienced when they first encountered them. Participants found these cultural practices interesting. Simba found Australians, as a people, readily shared their personal lives with strangers; however as participants noted, Australians, as neighbours, generally tended to keep to themselves.

*To start with, I found Australians are a very open-minded people. They are more open about their personal life than in my culture. Like, you would meet somebody and within 10 minutes you will know everything about their lives and they would wonder when you don’t say anything about your life ... in my culture, you don’t talk anything personal with anyone until you know them very well ... you don’t say those things at work.* (Simba)

While these cultural differences were a revelation to participants, they also noted another culture shock in relation to care of the elderly. The Australian culture of caring for the elderly in nursing homes was in contrast to the participants’ African culture where family members look after their elderly within the family setting. Farai expressed her shock:

*It was the first time for me to see aged people living in one environment, in an institution; like I was really shocked and I said, “How am I going to manage, I think I’ve made a wrong decision to migrate to Australia”.* (Farai)

In addition to these experiences in the general population, participants also noted a different
work culture in Australia which sometimes made them feel uncomfortable. They found a less formal work environment where the use of first names to address colleagues and patients was the norm. The use of first names was alien to participants whose culture would never allow them to call an adult person by their first name. A few, like Mimi and Farai, were still struggling with this many years later:

*I found it strange to call older people by their first names. I felt a bit uncomfortable at first ... I just cringed ... Yeah, this first name thing is so ingrained in me; it's one thing that I'm still struggling with.* (Mimi)

*When I came, I was really shocked because back home we address people by their surnames ... It was really hard for me to call my manager ‘Joyce’. You dare not call someone adult by name; in most cases, you don’t even know it. I knew my mum’s name when I was maybe in year four or so, when I was able to read.* (Farai)

Participants were accustomed to addressing an adult person or work colleague by their surname or other traditional African terms which, for example, describe a relationship like auntie/uncle or ‘mother of …’. While participants struggled with the use of first names, they also had to contend with the unusual language that was used by some local nurses when addressing colleagues or patients:

*Like, you go to a clinical area and everybody was saying, “Hi darling, how are you today; honey, what can I do for you?” and I’m like, “This is crazy!” You don’t just call somebody ‘darling’ unless you have an intimate relationship with them. ‘Darling’ is your husband, your boyfriend ... I still struggle with this language of ‘darling’, ‘sweetheart’ and ‘honey’.* (Simba)

Participants had reservations about being addressed by such commonly used terms. This was due to the different meanings attached to the language. The mixing of male and female patients in one ward, and sometimes in one room, was another shocking revelation to participants:

*The culture is different ... they mix their patients, men and women, it doesn’t matter; and the men can just move around the corridors with undies on and to them it’s normal because they are used to moving around on beaches. Embarrassing!! I said, Lord!! I couldn’t even face them, I would look aside!* (FGD)

The above participant experiences show cultural diversity in day-to-day life events between Australia and Africa. Participants also noted some characteristics in the Australian population that they seemed to embrace. They saw Australians as a people who were assertive in demanding what was rightfully theirs, especially from health services. Simba was one such participant:
There is a lot of accountability expected of you as an RN ... there’s more demand in being a nurse in Australia because you’re dealing with a more informed population who hold you accountable for your actions. They seem to be knowing what they want and they will not stop at anything in getting what they want; whereas where I worked before you were the answer to everything the client needed; what I felt the client was entitled to, that’s all they thought they could get. So, they did not question practice, but here you get challenged at work every day in everything that you do. So that was a bit of a change in the culture and the way that I was expected to do things.

(Simba)

This revelation of a population that demanded quality nursing care helped Simba realise how important it was for clients to demand what was rightfully theirs and for staff to involve clients in their care and to keep abreast with information. Participants also noted the differences in the culture of delivering nursing care in Australia compared to their home countries. They had admiration for the models of care used in Australia, particularly the autonomy of the nursing profession:

There is that difference where here it’s total patient care. You do everything for the patient from start of shift to the end of your shift. I think it is good because we were moving from being task orientated to patient orientated ... Yes, I think it is a good model, so you can understand the patient and know exactly what is going on and the plan of care. (Thabo)

It’s the autonomy nurses have here; they own nursing; there is accountability. I desire to change such things back home. (Bongani)

The differences in the type of population they nursed in Australia and the way nursing services were delivered were interesting revelations to the participants. Participants noted differences in the way Australians communicated generally and the way the nurses delivered their services. Sometimes, participants felt confused and uncomfortable with some of the cultural norms they identified; this reaction may have been informed by their own cultural norms from Africa. Participants also noted that Australians generally kept to themselves, unlike in Africa where generally neighbours make your life their business.

**Australians Seen as Keeping to Themselves**

It was noticeable to participants that Australians kept to themselves in their neighbourhoods. Participants described experiences of not knowing their neighbours or even getting an opportunity to greet them. Some participants continued being lonely even after their nuclear families arrived in Australia, as interaction with their neighbours remained minimal compared to their previous experience. Some participants and their families found it difficult
to establish social ties within their local community. They found that Australian neighbours hardly talked to each other:

>You live with your neighbour for three years and you don’t know their name, you don’t talk to each other. If you are lucky, they can just wave from afar like when they open their gate or so, but they never say a word ... you don’t hear them speak to you, you don’t know how their voice sounds. That’s Australia! And I wouldn’t say they do it to me because I’m a foreigner, that’s how they were nurtured ... they do it to each other as well ... everyone is just minding their own business, nobody cares about the next person. (Lili)

Lili took note of this culture where people can live next to each other for several years without talking. She interpreted this as affecting the locals as well, feeling that people were too busy with their lives and hardly cared about their fellow human beings. This experience was echoed by Thabo who expressed shock at the individual way of life in Australia which sometimes left people to die alone:

>We also realised that the neighbours don’t, sort of, necessarily have to talk to you ... I think people are learning now that it’s a different world [here]. It’s different socially, there’s a lot of individualisation, there’s more emphasis on the individual than emphasis on the extended family, yeah, something like that ... it’s a shock to hear of people like, dying in their house [alone] and there is no-one [with them], which would be unheard of in [our country]. (Thabo)

Thabo and Lili described being lonely despite being with their families because of the individualistic lifestyles in Australia where people seemed preoccupied with themselves, hardly talking to or appearing to care about the person next door. This was unusual for participants coming from a communal and open African lifestyle where your next-door neighbour became your business. Participants wanted to know and be known by their neighbours. They experienced a yearning for the social life they had in Africa where they would greet neighbours or passers-by with raised voices:

> [I’m] just missing this social life, like going to Ruwadzano [women’s church groups]. We used to go on Fridays for those meetings and we used to go camping [as] different churches or things like that. Not just that; [I’m] yearning to say, “How are you?” [raising her voice and waving her hand] to your neighbour; I walk around but I’ve never seen them ... [pause] ... we miss that. (FGD)

Participants missed talking freely to and sharing jokes with neighbours, as they would do in Africa. This worsened their feeling of loneliness as described in the previous sub-theme. Even after the arrival of their nuclear families, some participants experienced loneliness as they could not easily interact with the neighbours in their communities. Participants
described Australians walking around, usually alone, for exercise purposes but not to greet and talk to neighbours in their community. Linda had similar experiences and she could not understand the need for booking visits to her relatives, especially her own mother as she heard Australians did:

Our cultures are different and ... I’m telling you that Australians keep to themselves. In my country if my mother–in-law wants to visit me or if I want to visit her or my mother, I don’t call the family to tell them I’m coming over; yet here they do that, that’s their culture. (Linda)

Linda acknowledged that the two cultures were different. She noted that, in the Australian culture, it would be an expectation to call first, before visiting. This is contrary to her culture where people visit one another anytime they feel like it; they do not see the need to inform the person prior to the visit. Similarly, participants noted that social customs were more formalised in Australia where one notifies neighbours or relatives before visiting them.

This culture of formalised social life was no more evident than when participants confronted the way that loss and death of loved ones was managed in the Australian community. This was expressed in the FGD:

When I was less than a year [in Australia] my brother passed away back home, and I told my NUM, “No, I can’t come to work, I’ve lost my brother”. I think I stayed at home for a week and then, when I got back, no one said a thing. Then I asked her [NUM], “No one has said anything, including yourself; no one came to see me”. And she’s like, “You didn’t invite us” ... That was one of the culture shocks. “You wait for me to tell you, ‘Can you please come to my place and pay your condolences?’” ... In our culture when you hear that so and so has lost their loved one, we just flock there in our numbers. (FGD)

Participants experienced a different cultural understanding of mourning a loved one. They expressed shock that the bereaved are expected to invite mourners to come at a predetermined time to express their condolences. In the African culture, people come to pay their respects uninvited; it is an expectation that they attend to and support the bereaved. Friends and neighbours will be with the bereaved all the time until their loved one is buried. A similar incident was described by another member of the focus group:

Our NUM lost her son; so, I thought, “It’s a death, I’ll just go”. I went and got there with my [condolence] card, and, “Oh, I’ve come because I heard you lost a son, it’s just to pass my condolences”. “Oh, that’s very kind of you; I will send an invitation in the paper for you to come”. Yes, at the door! [said with emphasis]. [Shocked silence in the room]. (FGD)
The other participants in the focus group could not believe what they were hearing from their colleague and fell silent, staring at her with open mouths. They were shocked. The participant was attended to at the door and was not invited to enter the house. It was not clear if she managed to give her NUM the card or not. In Africa, people paying their condolences can visit the bereaved at any time and they are allowed into the house even if it is for a brief period because their act of visiting is seen as an honour to the grieving family. In fact, the grieving person would not even be the one attending at the door as there would be other people in the house supporting them. It is seen as an honour to have people coming to pay their condolences. Participants also expressed shock at the way Australians sometimes responded to a death in their own families. Mpilo described how her Australian colleague went shopping while her deceased father was still in the morgue. The colleague did not have anyone with her for psychological support:

*I've got a friend at work that lost her father and when I went there [friend’s place] I didn’t find anyone there, they were busy shopping and the father was not yet buried. And there was no one at their place and then I rang her and said, “Where are you, I’m at your place, I’m waiting for you, I just came to say hello”. And she said, “Oh, you can wait, I won’t be long”; then she came, on her own, we just sat and talked. I found that very uncomfortable. I don’t know what they do, I wish someone could tell me what they do like, “This is what we do when someone dies, one, two, three” … you don’t know what to say when you go there. At the same time, you can’t just wait until they come back to work.* (Mpilo)

Mpilo found it difficult to console her friend. Although they sat and talked, Mpilo felt uncomfortable as she did not know what was appropriate to say or do in this new culture. She could not understand why and how her colleague could go shopping at this sad time in her life. Neither could Mpilo understand why there were no other family members or friends supporting her at home. She wished someone could explain to her what is expected of friends and colleagues in Australia when someone loses their loved one.

Participants noted that Australian neighbours tended to keep to themselves. Even after the arrival of their nuclear families, some participants continued to experience loneliness as they could not easily interact with the neighbours in their communities. Consequently, participants tended to be confined to their homes, feeling lonely and isolated due to reduced interpersonal interaction. This was hard for participants as this new lifestyle worsened their loneliness and resulted in them missing their loved ones in Africa even more. In the presence of this cultural diversity, participants also described how they wanted to hold onto their traditional culture and conserve it through their children whilst living in Australia. They
wanted to preserve their own cultural practices by holding onto them for as long as they could.

**Holding on to African Culture**

Participants described how they were integrating into Australian society and culture, but at the same time holding on to their own culture that they hoped their children would embrace. Some participants were worried about their young children growing up in the Australian culture as this could prevent them from learning their African culture. Lili had a desire for her children to uphold the African culture of valuing the extended family:

> I wish my kids would grow up with the African lifestyle because in Africa there is the extended family issue; I don’t want it to die. I always want them to care for the person next to them. Yeah, we’ve integrated into the Australian way of life, but there are some values that you don’t want to let go. (Lili)

Lili did not want her cultural value of extended family to die and it was her wish to pass this on to her children. Participants came from an African culture where extended families are key to family structure. Extended families provide support and security for their members and also help to pass on family traditions to younger generations. Participants embraced their integration into the Australian lifestyle, but they did not want to lose all of the values from their own culture. Similarly, Linda noted the cultural differences that existed and she experienced the challenges of trying to accommodate both cultures in raising her children:

> Here, they tend to give kids more freedom; the kids tend to make their own choices. We don’t [do that] with our kids. So, with those cultural differences, I can’t really say that if I’ve got a problem with my child I would discuss it with an Australian. I have to be honest with you; because they will tell me something different from what I’ve been raised to believe … So, I’ve learnt not to let my country culture clash with the Australian culture. Yes, it can be [confusing for the children], but I also take them home periodically … we want them to embrace our culture. So, if it’s something that I feel is correct in the Australian culture, they’ll adopt that; and if there is something that I’m worried about in our culture also, because our culture can’t be perfect, I’ll [leave it]. So, I’ll sort of embrace both and teach my kids the way I feel. (Linda)

Linda noted some cultural differences in her new environment, differences that would affect her decisions in raising her children. She was worried because she needed to keep a good balance between the two cultures. Participants periodically visited family in their home countries whenever they could, in an effort to maintain their African culture and to pass it on to their children. This helped their young children to understand their traditional culture.
and hopefully embrace it. Like most participants, Linda also believed such visits would help keep the balance as they lived between these two cultures. Similarly, Thabo has had the opportunity to take his children for a visit to his home country so that they learn both cultures:

ʻYes, they did [go back home], it was an exciting time for them. To go to the rural areas and see the fires, the cows, yeah, it becomes a different world to them. That was a bit confusing, but you know now they’ve got a bit of both worlds. It’s a struggle when you come here as an adult you know, you try to hold on to your culture while you try to get into the new culture. I think it’s going to be a lifelong challenge for us, but not for the children. (Thabo)ʻ

Thabo also noted the challenges he was facing personally, having come to Australia as an adult. He anticipated some difficulty as he tried to negotiate the two worlds, but he wanted to hold on to his culture whilst trying to fit into the new Australian culture. Mpilo described teaching her 12-year-old son some cultural practices related to respecting elders:

ʻIt’s the 12-year-old I’m most worried about. He came when he was two years old, so he doesn’t remember anything about the African culture; so, you have to keep reminding them. I’ve got my mother at home at the moment [visiting Australia] and he [my son] walks right through in front of her; and I said, “Go back, go back and come the right way”. It’s like you have to tell them, all the time. I said, “That’s the way you respect your elders, you can’t just walk in front of mum like that, you need to respect them”. So, he is learning. (Mpilo)ʻ

Mpilo saw the issue of respecting elders as very important for her children as it was a core aspect of her African culture. She has taken it upon herself to teach them her African culture and to keep on reminding them of its importance. She took advantage of the presence of her mother who was visiting from overseas and she saw the visit as a teaching opportunity for her children.

Participants described experiencing cultural differences in the way Australians kept to themselves in their neighbourhoods and the way they conducted family functions like funerals. This was in contrast to the ‘open’ lifestyle they were used to in Africa where they did not have to book a visit to a family member or someone grieving. Participants were worried about the loss of their culture, especially among their children; they saw these traditional cultural values as critical to the future of their children. If the children lost these cultural practices they would lose their identity as Africans and end up getting lost in other societies. Parents did not want to take the blame for that loss. So, they planned regular family visits back to Africa so the children could connect with that culture. Participants also indicated feelings of guilt for taking the children out of their cultural environment and away
from their grandparents. Hence, they felt the need to maintain contact with Africa by taking their children for regular family visits in Africa or inviting their parents to their new Australian homes.

**Conclusion**

This chapter described the experiences of participants as they entered the Australian health workforce and started a new life in Australia. Participants described their experiences of loneliness and stress as well as feelings of guilt and self-blame, due to separation from their families who had initially remained in Africa for a few months. The separation from their families turned out to be difficult to bear. When participants entered the workplace, they encountered responses that were different from the positive welcome they initially experienced on arrival in Australia. The perceptions of participants were those of being unwelcome by their colleagues, by patients and by patients’ relatives. Many participants felt they were not initially welcome and some felt they had largely been mistrusted and had not been valued and treated as fellow colleagues. Participants also described experiences where their professional skills and experience were undervalued as they were not trusted to function like other RNs. In some cases, participants interpreted such responses as discrimination based on their black skin colour and their race. Some of these alienating and discriminatory responses, as well as the cultural differences that existed socially, led to distress and feelings of loneliness for participants. Even when participants were not really isolated as such (i.e., in the workplace), they felt lonely in the presence of other people. They found it difficult to make new friendships in their neighbourhood or at work. This had a negative impact on teamwork, on the participants themselves, as well as on patient care. The findings also showed that participants developed various coping strategies to deal with being seen differently. These included some participants brushing off such behaviour, telling themselves that racism will always be there, but others did report a few incidents to their immediate supervisors who indicated intolerance for such behaviour. Participants also experienced cultural differences that sometimes confused them and led them to take action to preserve their own culture.

It should be noted though that some of these negative experiences changed over time. A few participants mentioned positive responses by some colleagues and patients as they became more familiar with having OQNs and black nurses in the workplace, acknowledging their professional knowledge and experience. Participants welcomed the positive changes that occurred at their places of work. Participants have continued with their migration journey;
some have now developed a sense of belonging and have planned for a future life in Australia. They are moving on with their lives. These experiences are discussed in the next chapter.
Chapter 8: Developing a Sense of Belonging and Moving On

**It’s only the skin colour, otherwise we are all people** (Noma)

Introduction

Chapter 8 is the third and last chapter that presents the findings from this study. The chapter focuses on the theme, *Developing a Sense of Belonging and Moving On*. It describes the participants’ experiences as they continued living and working in rural Australia. Following a difficult start at the workplace due to their negative experiences, participants noted that the responses from some patients and colleagues were changing over time. Some participants described a turnaround to positive responses by colleagues and patients as they got used to having OQNs and black nurses around. This gave participants confidence and a sense of belonging, offering them the opportunity to stay on and plan for their future in Australia.

The chapter discusses three sub-themes that are part of this theme. The first sub-theme, ‘Positive Change Over Time: Being Seen Beyond the Dark Skin’, describes the experiences of participants as their patients and Australian work colleagues warmed up to their presence. Skin colour did not matter anymore. The second sub-theme, ‘Seeing Australia as a Land of Opportunity’, describes the participants’ experiences and how they planned for their future stay in Australia. The majority have moved from aged care facilities to acute care settings giving them greater opportunities to engage in professional advancement programs. The positive workplace environment that developed and the experience of a sense of belonging gave participants the confidence to change their migration status from temporary to permanent residence and for some to obtain citizenship. The third sub-theme, ‘Embracing Cultural Diversity’, addresses how participants saw themselves as integrating into Australian society and becoming part of the community. The chapter then concludes by describing the final sub-theme, ‘Moving On’; the focal aspects here include being resilient and persistent with achieving their goals and voicing their thoughts about the future as they reflect on their migration journey. The sub-theme ‘Positive Change Over Time: Being Seen Beyond the Dark Skin’ will be discussed first.
Positive Change Over Time: Being Seen Beyond the Dark Skin

Now I laugh at those people who used to treat me like a dumb person (Sindi)

Over a period of time, some participants noticed a change in the behaviour of some of those patients and colleagues who had initially not welcomed or trusted them. They described a change from negative to positive responses by some colleagues and patients as they got used to having OQNs and black nurses around. These positive changes came, over time, taking up to two years for some participants. The positive changes opened doors for friendliness among nurses and respect and trust that OQNs could do the job equally well. Colleagues and patients were now seeing beyond the dark skin, as described by Farai:

But now, as time progresses, there’s so much respect these days, so much respect. And some of them are used to me now; they miss me when I’m off … They are now seeing beyond the dark skin. Even the management has now come to realise that I’m a very good asset at the workplace. Even the staff themselves know it; new RNs come through me as I orientate them. (Farai)

Farai noted the respect with which she was now being treated by her colleagues. She was happy that she was now seen as Farai a qualified RN who, given the chance, could do the job equally well. Participants were happy now that people realised the difference that existed between them was only skin deep. Similar changes were noted among the Indigenous people as well. Mary noted that relationships with the local Indigenous people improved, over time, as she explained:

But later when they [Indigenous people] got to know us after about two years, that’s when they were … [pause, opening her arms]. I remember this other one really shouting at us at work, but then, after some time, when she got to know us better, she was friendly, inviting us to come to the bar and this ‘n’ that. (Mary)

Like Farai and Mary, Sindi was one of those participants who noted a change of heart among those colleagues who were initially sceptical about her performance as an RN:

They now ask things like, “Sindi how do you do this, how do we do that?” and I laugh and say, “Ahh, these people” … they treated me like trash when I started here, I used to be so stressed with the way things were going on; I would cry. Now they respect me. (Sindi)

Sindi was happy with the way things turned out. Instead of looking down upon her, colleagues were now respecting her and giving her the opportunity to share her nursing
knowledge and experience with them. For Linda, the positive change was a two-way process:

This is a small town, you get used to everyone. You know, you get used to the residents, you get used to the relatives, and you get used to the community, yeah. In the bank you walk in there, the bank teller knows you’re looking after their mum [at the aged care facility]. With time, it’s OK, I’m not complaining and I’ve developed also. (Linda)

Linda realised that at the end, really, it just takes getting used to each other. She described her experiences of getting used to the people at her workplace and her small town as they also got used to her. She acknowledged that she had also developed in this process of positive change.

The above comments by participants indicate that some colleagues and patients had a change of heart as they continued working with OQNs. The frustrations and pain initially experienced by participants grew less as time passed. Time was a great healer for them and they were developing a sense of belonging. Participants were now being seen beyond their dark skin. The trust that was developing meant that participants were now becoming part of the institution and culture that they had come into and OQNs could even take part in mentoring or orientating new staff. Participants welcomed this positive move as they saw it creating a friendly and less stressful atmosphere. As participants saw the change in how they were being accepted, they also saw Australia as a land of opportunity and gained confidence in planning for their future in Australia.

**Seeing Australia as a Land of Opportunity**

I’m hoping to pursue further education and expand my scope of practice; to probably get into mentorship … It’s something I enjoyed doing and I would love to utilise those skills without letting them go to waste. I came to look for opportunities. (Simba)

This sub-theme of seeing Australia as a land of opportunity has two focal aspects: moving from initial placement, and professional development and advancement. These resulted from the confidence participants developed as they felt more secure and accepted in the communities they lived in.

As previously noted, all participants came to Australia through the SC457 Temporary Work (skilled) visa. At the time of the interviews, only one participant was still holding a temporary visa. Of the other participants, six had moved on to become permanent Australian residents while 11 were already Australian citizens. This permanent migration status gave
participants the opportunity to change employers and their places of work if they wished to; a move most participants welcomed as some of them had already moved from aged care facilities to acute care nursing in nearby hospitals. It should be remembered that these OQNs had never worked in aged care facilities in their home countries and so they were waiting for an opportunity to leave these facilities. Only two participants were still working in aged care facilities, their original workplace; they were also planning to leave. Some participants had moved from smaller towns to larger hospitals in larger rural towns. Participants also took this opportunity to advance themselves professionally.

**Moving From Initial Workplace**

As participants were getting to know the Australian health sector better, and as their temporary migration status was changing to permanent residence and citizenship, quite a few found themselves moving, once again. They were moving from smaller towns to larger rural towns. Mimi described her motivation to move from a smaller town. She was looking to the future and making arrangements for her children:

> The major reason for moving was so that [our] kids could have better education, to be exposed to much more, because you know, once they finish their year 12 there in [small rural town] there wasn’t much that they would do ... And also more employment opportunities for my husband because he was employed in the farming industry over there but because of the drought they were scaling down, so that was [an issue for us]. (Mimi)

The small rural town where she was originally offered work did not offer tertiary education or employment opportunities for Mimi’s family. It was difficult for participants to stay long in the smaller towns; they wanted larger towns that had more opportunity options for their families. Therefore, Mimi, like other participants, had to move in order to take advantage of such opportunities for her family. Similarly, after six years of working for her original employer, Mary described feeling the need for a change in her employment. She moved to agency work:

> Yeah, I really enjoyed there because staying there for six years shows that I liked the place. I just needed a change and, you know, with agency, you do just three months and then you’re sponsored to go somewhere different and with free food and accommodation. And the salary is better, yeah ... I left [the rural hospital] in 2009 at the beginning of the year. I did agency work the whole of 2009. Then ... I came to [the base hospital]. (Mary)

Mary had no complaints about her previous employer, she just wanted something different and, hence, joined an agency. Mary was one of those participants who wanted some
adventure while working and travelling around Australia. She had the opportunity to work in several rural healthcare facilities interstate. It was different, though, for Sindi who also left an aged care facility:

I didn’t really like [continuing to work] in that nursing home; my registration was at risk because I didn’t really quite understand the whole thing and how I was supposed to work. My scope of practice was totally different; I needed to study and understand what it was; so, I thought my registration was not protected there. When the HR manager wanted to promote me, I said, “No way, you can’t promote me, I don’t know anything. If you give me a higher position I won’t be able to function” ... I wasn’t comfortable. I got my permanent residency [with their help] but I didn’t want to stay there for another two years. (Sindi)

Sindi was worried about losing her AHPRA registration if she continued working in aged care. As already determined, participants had never worked in aged care before and they did not like it, as evidenced by their move from those facilities to acute care settings.

Thabo, together with his OQN wife, left an aged care facility in a small rural community for a larger referral hospital in a nearby rural town because it was larger. The move was also due to some frustrations they experienced at work:

I worked in a small rural town, about 100 km from here. It [the move] was from a nursing home to a hospital. It was all different ... This town was a bigger town with more options and a bit more multicultural. And also, workwise, we felt that the nursing home thought, like, they brought you here [to Australia] and so they owned you ... So yes, out of some frustration at work, we wanted to move to a bigger town. (Thabo)

Like other participants, Thabo did not want to be taken advantage of by his employers just because they assisted him to get to Australia. He found the larger town more multicultural and with more options. Participants in the FGD had also moved from their original employers for various reasons. Where there were hindrances from employers, participants sought the assistance of the NSW Nurses and Midwives’ Association:

When they [employer] started saying, “Oh, you can’t leave”, I had to ring the union. The union said, “No, as long as you are in NSW, there is nothing like that”. They were trying to intimidate me saying, “Hey, you can’t leave, you have to stay here for four years”. (FGD)

The union’s reassuring response gave participants confidence to stand their ground when their employers refused them a move to larger health facilities within rural NSW. One participant described her move as a result of her husband’s job and because of the higher
respect for nurses who worked in hospitals rather than nursing homes within the Australian community:

   I started in a nursing home at [local remote town] for two years, and then I’ve been at [the base hospital] for almost eight years now. When my husband came [from overseas to join me] he got a job here at [the local university], so I had to move. So that’s when I went into a hospital setup. In the nursing homes, when you say you sometimes work at the hospital [as a casual], the relatives have more respect for you and they want to talk to you as an RN who has got hospital experience. They don’t really respect those nurses that work only at the nursing home. (FGD)

The participants did not like being looked down upon just because they worked in aged care facilities. This was regardless of the many years of hospital nursing experience they brought with them from overseas. Participants also wanted to leave aged care facilities for hospitals as they were not familiar with this specialty area which required autonomous function at a time when they were finding their feet in the Australian healthcare system; some were even worried about losing their nurses’ registration because of their limited knowledge in the area. In the African culture, the elderly are generally looked after by their extended family members, hence, participants were not used to residential aged care and had difficulty in understanding it, as Farai pointed out:

   In my country, we don’t have aged care facilities, it was the first time for me to see aged people living in one environment in an institution; ... I was really shocked. (Farai)

As participants found their way out of aged care facilities to hospitals in the surrounding areas, they took the opportunity to advance themselves professionally by engaging in short postgraduate courses.

**Professional Development and Advancement**

Most participants were initially educated overseas to the general nurse diploma level and, therefore, saw a need to advance themselves to higher university nursing qualifications. Although the participants had met challenges at the beginning of their migration, as their situation improved, they utilised whatever opportunities they had to advance themselves in the nursing profession. It should be noted that professional advancement was one of the reasons some participants migrated to Australia. Many had already completed a few courses while others had advanced plans concerning future studies:

   Now I’m doing my Master’s degree. I’ve done the intensive care nursing course, I’ve done the cardiac nursing course and I’ve been
doing other courses in between, like in-services. I’m doing this Master’s degree which, hopefully, I will finish next year. (Betty)

Some participants had moved into other departments/units in order to position themselves more appropriately for the courses they wanted to undertake. Mpilo and Mimi explain:

*When I came, I was just an RN and I did my midwifery course here at [local university] in 2006–2007. So, I moved from a medical ward to maternity.* (Mpilo)

*I did an outback nursing course when I was out there in the outback, an immunisation course for nurses with the College of Nursing, a postgraduate diploma in mental health nursing and a master in mental health nursing. But, for now, I’m taking a break from academia; we have a life to live [laughs] ... Also, I feel that I’m well appreciated in my department for the achievements that I’ve done because every little course that I’ve done has sort of been credited to the next course.* (Mimi)

Mimi was happy with her achievements and she felt encouraged by the appreciation for her academic achievements. Unlike her, Noma described her experience of being in charge of shifts most of the time which was why she felt she needed to increase her nursing knowledge:

*I’m working in a country hospital where there are no doctors on site most of the time. I did the first line emergency care course (FLECC), which is good. Now I’m doing this acute care nursing course ... I wish to advance as much as I can. If I finish this I’m planning to do the masters maybe in acute care nursing. I’m doing this course because [as an in-charge of shift] I think I have to know more [laughs].* (Noma)

The desire to advance as much as she could and to also keep up with the demands of her job motivated Noma to take up studies. It was a new work environment for her and this was a new role as nurse leader. Some participants, like Simba, had not undertaken any courses but had plans in place for further professional development:

*I feel that I’ve had enough time to settle into the system here. I’m hoping to pursue further education and expand my scope of practice; to probably get into mentorship and participate in education and planning for other RNs, and students ... It’s something I enjoyed doing and I would love to utilise those skills without letting them go to waste. I came to look for opportunities.* (Simba)

Simba previously taught nursing in her home country and she thought engaging in further education would revive her skills and prepare her for a similar position in Australia. Some participants saw working in aged care facilities as non-stimulating and limiting their desires to advance professionally, hence, they moved to other institutions in order to position themselves for advancement opportunities. According to Linda, her experience in an aged
care facility had not helped her to advance in her career and she was seeing no career pathway, hence, her desire to leave the aged care facility for acute care nursing, such as midwifery:

*I’m only young and I’ve still got a lot to learn, so by staying in a nursing home really, I don’t have much to further my career on; there is not much to experience there. I’ve got a lot of things [on my mind]; midwifery is what I’m hoping to do next year. Yeah, after five years of being an RN here, I feel career wise I should be knowing a lot more than what I know … I’m at that point really where I just feel like, “You know what, I need to go to school”. At home I’m happy, my kids are keeping me busy; but career wise, I need to do something.* (Linda)

Linda’s thoughts were echoed by Sindi who saw nursing as a dynamic profession that required her and all nurses to keep upgrading themselves:

*There are a lot of nurses who’ve been here for quite some time … and are just comfortable with sitting. They’re not ready to face the challenges that this nursing is going into. It’s a dynamic profession, we need to keep upgrading ourselves; but some people are just happy with working three jobs and four jobs and not studying. I told my husband that when I’m celebrating my 40th birthday, I should be having my Masters and then moving on to a PhD.* (Sindi)

Sindi indicated that she was enrolled in a distance education course that would give her credit towards her Master’s degree. She had her professional development plan in place.

The above participant narratives show that participants were seizing the opportunities that were offered to them by their new country to develop themselves professionally. As they sensed less resistance and more acceptance, participants developed a sense of belonging; this gave them the confidence to stay longer in Australia and plan for their future as they considered their professional career pathways. Most of them undertook further nursing studies to keep themselves abreast of new developments within the profession as they moved on with their lives in Australia. Participants also described themselves as integrating well into the Australian workplace and society, and as embracing the Australian culture.

**Embracing Cultural Diversity**

*We want our kids to embrace the African culture. If there’s something that I feel is right in the Australian culture we’ll adopt that too. I’ll sort of embrace both and teach my kids the way I feel.*

(Linda)

This sub-theme of embracing cultural diversity focuses on participants accepting differences in cultures as they sought to become part of their local communities. As participants were
settling in to rural Australia, they experienced the need to be part of their communities and
to embrace the cultures of those communities. Most participants described themselves as
integrating well and were starting to feel a sense of belonging; they were becoming part of
their communities.

**Becoming Part of the Community**

Participants felt they were integrating well into their local communities and workplace. They
realised the significance of being part of their community and they sought ways of becoming
more involved with it. They started seeing themselves as part of the communities they were
living in and even took up positions at local organisations like churches. Mpilo, who had
been in Australia for ten years, was aware of the consequences of not becoming part of the
community:

*After ten years, you have to [integrate], otherwise life will be
miserable for you. I feel like I’m part of everyone now, because we
socialise together with everyone at work and I feel like I’m part of
the team and I feel like I’m part of them too, yeah, which is good ...
Yes, we are one community and we go to church and it’s like we’re
involved in everything in church activities. We’ve even got positions
at church, so I think we’re part of the Australian community.* (Mpilo)

Considering their open and communal African lifestyle, it was going to be difficult, if not
impossible, for participants to adopt an individualistic lifestyle in Australia. For Mpilo, it
was important that she became part of the community otherwise she would be miserable.
She was happy that she was now part of the local church leadership. Sindi also described
herself as integrating well into Australian society:

*As I get used to the Australian language and the Australian culture
and as I’m embracing that, I’m finding myself integrating well in the
society. The other thing is, if you can’t change it you have to accept
it. I’m here in Australia and I’m sure I’ll be here for quite some time
as my kids are still too young.* (Sindi)

Similar to Mpilo, Sindi felt she was integrating well. Since she was intending to stay in
Australia for some time to raise her children, she had resolved to integrate and embrace the
Australian culture as it was. This was important for their children as they were growing up
in Australia. Noma, who lived in a small rural town, saw the situation the same way:

*Yes, I’m the only black person here; then I said what can I do, I just
have to be part of these people. It’s only the skin colour otherwise
we are all people. When we went home to [country of origin] I just
informed my neighbours [here] ... and they were coming here
regularly watering our garden.* (Noma)
Noma described her family as the only ‘black’ one in her small community. She experienced the desire to be part of the community even if they looked different. She felt that the help from her neighbours indicated that we are all people, the difference is only skin deep. She felt accepted in Australia particularly by her neighbours and that was important to her. Mimi, too, felt that she was accepted in the Australian community as she had neighbours and work colleagues attending her husband’s birthday party:

*I think we are integrated although I suppose we socialise mostly with fellow countrymen] when there are parties and all that, that’s important. Last time when my husband had a birthday party, neighbours came. All one, two, three neighbours [pointing outside through the window] came and people from the nursing home where I work came. In a way, yeah … we are not really in a very strange land. Yes, we go to shows, we are members of the club downtown. We are members of the church … I vote and I follow politics very, very closely. I have to know and at work, some people are not interested in politics, and so they ask, “How do you know that?” because I would have said, “Do you know what the PM said, do you know what the Opposition Leader has just done?” I do follow politics.* (Mimi)

As time passed, Mimi realised she was not in a strange land after all; she was an accepted member of the community who was also interested in local activities and politics. It was a similar experience for Betty as she became accustomed to working in the Australian health system and also grew accustomed to the Australian accent:

*With time, you get used to the people, you get used to your workload … now I’m getting used to the accent of the people and the routine in the ward which makes life very easy. Yeah, at work, when we’re having our breaks, we usually talk about our cultures, things we’ve been doing back home and they also talk about theirs and we now laugh about it … yeah, having all those similarities and differences.* (Betty)

Participants were happy with the positive changes that were taking place. Such an atmosphere gave participants and their colleagues the opportunity to share the beauty of diversity. This made life easier for Betty as she could now comfortably hold conversations with other staff and even share her own culture with colleagues. It was otherwise going to be a missed opportunity. Also, on a lighter note, Farai turned out to be quite popular in her small town where it seemed ‘everyone’ knew her:

*I think I have integrated very well. This town is a very small town so wherever I go it’s, “Hi Farai!” everywhere … My friend visited from Melbourne and we went to the town centre; a lot of people were saying, “Farai!”, “Farai!” She jokingly said, “Farai, are you going to be the Mayor of [this town]?” [laughs].* (Farai)
Participants were now getting to be known by their communities and it felt good. They believed they were integrating and they acknowledged the need to become part of their communities. In fact, participants saw it as significant that they became part of their communities especially as their cultural background valued this greatly. As participants interacted more and more with people and took part in local events, Australia turned out not to be a ‘very strange land’ after all. Participants also described their experience as they reflected on their migration journey to Australia which saw them encounter obstacles but continue to focus on achieving their migration goals. They chose to focus on the positives and what the future held for them as they developed more and more a sense of belonging and were moving on with their lives.

**Moving On**

This sub-theme, ‘Moving On’, discusses two focal aspects: participants being resilient and persistent in seeking to achieve their goals; and their thoughts about the future as they reflected on their migration journey. Participants reflected on how they overcame initial challenges through resilience and persistence as they also pondered on their plans for the future. Participants’ continued stay in rural Australia, regardless of the challenges they encountered, showed their ability to be resilient and persistent.

**Being Resilient and Persistent**

Participants described their overall experience as positive regardless of the initial challenges they experienced when they first migrated to Australia. Participants acknowledged that life has its challenges; it is more a matter of how you respond to these challenges than that they exist. Participants acknowledged that “racism will always be there, it will never end; it’s there forever” (FGD); these participants indicated a need to look on the brighter side of life. They showed resilience and persistence in achieving what they set out to do. Linda chose to focus more on positive experiences:

> Generally, life here is fine, I’m not complaining; life is good. To be honest with you if the negatives were more than the positives I would be home now, yeah. The positives outweigh the negatives ... You just need to be ready for challenges, just like anything else in life; there is nothing that is going to be just easy flow. Challenges will always be there; it just depends on what kind of challenges, but, in the long run, as I was saying, you settle with your family, you get your job, you get paid well and you work with others, yeah. (Linda)
Mpilo initially had no intention of staying longer than the four years her temporary visa allowed, but on reflection she was glad she did:

> When I came, I didn’t think I was going to be here for ten years. I thought I was going to come for four years, work very hard and have some earnings and then go back home to buy a house, buy basics ... But that didn’t happen because the situation back home didn’t improve. I didn’t come here planning to be a citizen of Australia, but circumstances forced me to ... Australia is a good country. Of course, you will still come across people who are racists; that happens everywhere; it’s everywhere, but Australia is a good country to locate to. (Mpilo)

Mary shared similar sentiments to Linda and Mpilo. She had no regrets, either, for the migration decision she made; more so when she considered the economic situation still prevailing in her home country:

> Yes [I'm happy], it’s now 11 years; if I wasn’t happy I could have gone back a long time ago. I really don’t have regrets considering the socioeconomic issues happening back home, yeah. At [previous company], people have stayed with no salaries for more than a year now ... The other thing [my son’s] schooling was just easy for him here. Now he is at university. Back home, for someone to really go to university, it’s huge sums of money and a really big effort; yeah, it’s really hard for someone to go to uni back home. (Mary)

Mary explained that she was happy to be in Australia, particularly as her son has managed to go to university here which would have been significantly more difficult for him to do in her home country. During the FGD session, participants also expressed that there was no regret for their migration to Australia:

> I don’t regret coming to Australia because I didn’t drive a car back home. Now, I bought my own car, I bought my own house ... so I don’t really regret coming, that’s for sure. For me, one of the main positives is being able to support my family back home. I’ve got enough for myself and a little bit to share with my family back home compared to what it was prior. So, I appreciate the fact that I moved to Australia and now I’m trying to improve their quality of life as well. And the other thing, I can see a future for my kids. I know that even if they can go to TAFE they’ll find a better job; ... and they can go to Centrelink! [laughter by the whole group]. Centrelink is functional here unlike social welfare services back home ... here, they have an opportunity to afford a better quality of life. The fact that I can afford them that quality of life is a positive. (FGD)

For Bongani, it was a reflection on how coming to Australia helped her recover from the loss of her husband:
I think for me, coming over here helped me to forget about that [loss of husband] because I think if I was home I was going to have depression. Looking at the same house, same room, the door, thinking he would come in through the door. So, for me to be out of that, it’s helped me a lot. (Bongani)

Bongani felt strengthened by her migration to Australia; it gave her the opportunity to reflect and recover. Living and working in a new environment provided a different focus, away from thoughts of loss. The reflections discussed above by participants indicate that they were happy with their decisions to migrate to Australia; they had no regrets. Participants described experiencing a change for the better in their lives, regardless of the challenges they had when they first migrated. Some acknowledged the continued existence of racism and the fact that there will always be challenges in life; however, the overall experience was positive. They identified benefits, for example, the ability to purchase items such as cars and houses and the ability to financially assist their loved ones overseas, things they could not do while in Africa. They also saw a brighter future for their children in Australia.

Regardless of the challenges they came across, participants would recommend Australia as a migration destination to their friends or colleagues. As they explained, the positives outweighed the negatives. They also had tips for would-be migrants:

I would still recommend them to pursue their [migration] goal. It’s a positive experience; it has its challenges but if you are after change I would still recommend somebody to come, because, as I said, there are lots of resources. There’s better infrastructure, a more organised public system and all those things. It’s something that I would recommend to anybody who wants to do it. You just have to have [pause]; you have to be very resilient as we just said. If you’re not determined you can’t ... As long as you are persistent you can do it. I would recommend it to anybody. (Simba)

Simba was recalling the determination she had to achieve her goals of migrating to Australia. The journey needed resilience and persistence. Like most participants, Simba was aware of the challenges brought by her migration to Australia, but would still recommend Australia as a destination country for anyone who cared to ask her about it. Simba’s tip was the need for determination and resilience if anyone wanted to succeed in their goal of migration. Mimi had her ‘whinges’ about Australia, but she would also recommend it to friends and colleagues who were considering migrating:

Yeah, I would recommend Australia ... I’ve got some whinges though, but that’s different. I think everything is fair here because you go to the bank, nobody looks at who you are; you get served just like the next person there ... Yeah, you don’t have to know someone or pay anybody for anything, that’s why I’m saying it’s fair. (Mimi)
Mimi saw her overall experience in Australia as positive. Participants were happy with the egalitarian approach with which Australians conducted their business, treating everyone equally. Other than discovering that Australia had its challenges after all, Sindi would recommend it with a tough warning:

*We say life is greener on the other side; but once you get there you realise that there are benefits and challenges at the same time. So, as a foreigner, you just need to toughen up, because if you let people ride over you, you will be the doormat where everyone will just dust off their feet and do whatever they like and you won’t achieve anything. I would advise someone to work hard to achieve their potential and not let anything stop them, be it family, be it workplace issues … they need to keep focused.* (Sindi)

 Participants described how they would recommend Australia to their overseas colleagues and friends. However, they would warn them that, although it is generally a positive experience, it is not all ‘green’. They also had tips for their friends in case they expected a life without challenges in Australia; they would need to be persistent in their endeavours. Generally, participants embraced the Australian culture and they were happy their colleagues and patients were also starting to appreciate cultural diversity by accepting OQN in their communities and workplace. Participants had the opportunity to reflect on their migration journey and ponder on their future migration plans.

**Reflecting on the Migration Journey and Thoughts for the Future**

As participants reflected on their migration journey to Australia, they also discussed their future plans regarding migration. They were moving on with their plans for a future life in Australia. Some participants were quite positive about their plans for return migration while others were still pondering whether they would go back to live in Africa again. Lili had her mind made up:

*As soon as my kids finish school and uni, I will go back home; that’s the plan because I miss Africa. I miss it, yes, and I’m planning to go back, one day. As for the children, that’s going to be their decision.* (Lili)

Lili had no doubts about going back to Africa once her children finished their formal education. After all, securing their future was the main reason Lili migrated to Australia. She was planning to go back once her objective was achieved. Bongani was already in the process of preparing for her return migration at the time of interview:

*I’m just waiting for an immigration response about my pension, that’s what I’m worried about. I am going home … I planned to be
Bongani saw her future in her home country where her family lived. Therefore, she was already preparing to go back as she had not planned to live permanently in Australia. For some participants going back was conditional:

*If the country gets back to normal I’m going home. What will I do at home? Should I be specialising in something that I think I will utilise at home? If I specialise in this ‘acute care’ how will it help me back home? I end up getting confused, not knowing what to do. Time is just moving and by the end of the year I still don’t have anything.*

For some participants, returning ‘home’ overseas was dependent on the situation in those home countries. They were keen to return, but only if the situation had changed for the better. In the meantime, they were taking up courses they hoped would be useful when they got back to their home countries. This sometimes resulted in confusion about the choice of courses to undertake as they wanted to do something that would be relevant back in their home countries, but the majority of courses offered in Australia were designed for the Australian environment. Like some participants, Sindi had thought about the future of her migration but was still undecided:

*I’m not so sure because at times I’m thinking, “I need to retire and go home”. But who will look after my grandkids if ever I have them? So, it’s quite a dilemma; you don’t know. So, when I get to that point I say, “OK, we will cross that bridge when we get to it”. But we’re still developing our things back home. My husband is doing some projects back home so we still have two lives; we’re living here and we’re living in Africa and it’s a bit difficult to manage, yeah.*

Sindi had mixed thoughts about her migration. She wanted to go back to Africa after retirement; however, the thought of her future grandchildren growing up in Australia without their grandmother presented her with a dilemma. Sindi considered the welfare of her future grandchildren very important; she was already thinking of her future extended family. At the time of interview, she was still living ‘two lives’ on two continents. As stated previously, participants had come from African families that valued extended families. Hence, it was difficult for some of them to imagine a future life without their grandchildren nearby. Despite initially planning a four-year stay in Australia, Mpiolo noted the other family benefits of coming to Australia, hence, she was not planning to go home soon:

*At the moment, it’s better to be here than to be home. They [relatives] are getting our support. They don’t have all the financial stuff that they need back home and so we are there for them.*
assist whenever we can. So, we are grateful that we are here, too, because if we were not here I don’t know what was going to happen ... I think they [relatives] are happy, too, that we are here. (Mpio)

Participants expressed varied plans for their future in relation to their migration to Australia, a country whose culture they were embracing. There were no regrets about their decision to migrate and the choice of Australia as their destination. Very few intended return migration, unless the situation changed in their home countries. Participants still considered the push factors that had pushed them out of their countries. The migration future of some participants depended on the achievements of their children, while other participants were content with remaining indefinitely in Australia for as long as they were able to assist their overseas extended families through remittance.

Conclusion

This last chapter of findings continued to describe experiences of participants as they lived and worked in rural Australia. The main theme described in this chapter was that of participants developing a sense of belonging and moving on with their lives. Participants described their experience of positive responses that occurred over time from some of their colleagues, patients and, to some extent, some neighbours. It had been a long journey for participants – a journey that called upon their spirit of determination, resilience and persistence. They were happy that they were now being seen as people, beyond their dark skin, with colleagues and patients realising their professional worth. More people were now responding positively to their presence. It was a special feeling for participants that they belonged; they would feel more at home. This gave participants confidence in planning their future stay in Australia. Many changed their temporary migration status (SC457 visa) to a more permanent one and often moved from aged care facilities to nearby hospitals, and from small towns to larger communities as they availed themselves of greater opportunities. The findings also showed that participants were seeing themselves as integrating and becoming part of the communities they lived in. Participants also showed determination in planning for their future be it in Australia or back in Africa and they shared experiences of resilience and persistence in achieving what they set out to do.

In summary of the overall findings, participants embarked on this long migration journey which started with their response to the push and pull factors in their countries. The move saw them cross the Indian Ocean to rural Australia where they experienced a warm arrival and welcome to the country. However, they soon experienced feelings of loneliness, guilt and self-blame due to separation from their families. Participants described their negotiation
of cultural differences as they settled into a new life in rural Australia. They had to also contend with the negative responses of some of their colleagues and patients in the workplace; this led to participants’ perception of being alienated in the workplace through discrimination and disadvantage based on race. With time, participants saw a positive change among some of their colleagues. This was a welcome change for the participants as it gave them opportunities to plan for their future life in Australia.

The following chapter discusses the findings from the previous chapters. This discussion is integrated with the existing literature and, in keeping with the study’s methodology, is informed by Gadamerian hermeneutic phenomenological thought as it seeks to interpret the participants’ experiences. It demonstrates how the findings presented in this study add to current knowledge about the experience of OQNs in their destination countries.
Chapter 9: Understanding the Experiences of OQNs

Introduction

Chapter 9 presents a discussion of the findings. The previous findings chapters presented and illustrated the participants’ voices as they shared experiences of their migration journey from Africa to Australia. They described various push and pull factors that played a part in their move to Australia and how hard it was to make that final decision to migrate. The positive reception by their employers on arrival was in contrast to some of their subsequent unfavourable experiences as they lived and worked in rural Australia. These experiences included loneliness, due to family separation, racial discrimination and disadvantage, and cultural conflicts in the workplace. Over time, participants identified a more welcoming response from their work colleagues and patients. The participants contributed to and embraced the cultural diversity that exists in Australia and, overall, they saw Australia as a land of opportunity for their professional development and the wellbeing of their families.

In keeping with the study’s methodology that is informed by Gadamerian hermeneutic phenomenological thought, this chapter seeks to interpret the participants’ migration experiences. Gadamer’s hermeneutic philosophy was applied to this study to offer an in-depth understanding of the migration experiences of sub-Saharan OQNs. Gadamer’s hermeneutic philosophy of understanding ‘the whole in terms of the detail’ (Gadamer, 1975, p. 291) provides a theoretical framework through which the different experiences of participants informed the study. Gadamer’s fusion of horizons theory (Gadamer, 1976) creates a clearer understanding of the life world of OQNs.

This chapter seeks to review their experience within the context of the existing literature and knowledge about international nurse migration. The findings are synthesised and interpreted in relation to the research questions. As is characteristic of research conducted within a qualitative interpretive paradigm, the findings apply to the participants who took part in the study. The discussion is supported by the relevant literature and informed by hermeneutic phenomenology as it seeks to interpret the participants’ lived experiences.

The purpose of this phenomenological study was to gain an understanding of the experiences of OQNs following their migration from sub-Saharan Africa to work in rural Australia. This study sought to answer the following three questions:
1. What was the experience of sub-Saharan African OQNs as they migrated from their countries to rural Australia?

2. What is the experience of sub-Saharan African OQNs as they lived and worked in rural Australia?

3. From the sub-Saharan African OQN perspective, what does it mean to be a registered nurse living and working in rural Australia?

My interpretation of the migration experiences described by participants shows that arriving in a new country and becoming part of that community is a way of ‘being-in-the-world’. Similarly, being a black migrant nurse in rural Australia was their state of being and living in their newly adopted part of the world.

The experience of these sub-Saharan African nurses undertaking migration to Australia was discussed in the previous chapters as: *The Move Across the Indian Ocean; New Life in an Alien Land*; and *Developing a Sense of Belonging and Moving On*. This chapter provides further understanding by discussing four major aspects of the experience: ‘Taking the Plunge’; ‘New Beginnings in a New Environment’; ‘Culture, Race and Colour’; and ‘Developing a Sense of Belonging’. Findings are discussed in light of understanding the African culture and previous migration studies and other literature. These interpretations of the experience cannot be seen as discrete entities. They are aspects of the whole experience and, hence, impact on each other.

Before proceeding with the findings, it is important to discuss family in the context of the African participants. What the participants experienced had a bearing on their families and was linked with their African philosophy of family.

**The African Family**

All over the world each society is structured around family units, units that form the foundation of society. Family becomes the building block of society. Golash-Boza and Menjivar (2012) describe family as a natural and fundamental unit of society. The family is there to nurture its members by providing physical and psychological security through love and meeting basic needs (Barnes & Rowe, 2013). When an individual is loved and appreciated within their family, they feel wanted by the world and so will tend to strive to be the best they can be (Schrodt, 2009). Families also teach members rules and values within the context of their culture.
Family is defined in different ways by different institutions. Wright and Leahey (2000, p. 70) define family as “whoever the family says they are”. In the Western world, for example, Australia, a contemporary family would consist mainly of immediate family members usually resident in the same household (ABS, 2015), with little interaction with other relatives except on special occasions such as birthdays or wedding celebrations. However, with Australia’s open policy to multiculturalism it is acknowledged that there is more than one concept of family. This definition of family has been changing to accommodate other cultural perspectives of family. In contrast, the concept of family among African people differs from that of people from the Western culture. The African family unit is structured as an extended family where both immediate and extended family members share many day-to-day life experiences. The definition of family among African people goes beyond the nuclear family. From an African context, family is a way of life (Turnbull, 1962). African people feel they cannot exist in isolation from other human beings, especially their relatives. African people have a strong sense of family spirit, embracing the concept of communal living across extended families and the village community. This bond between family members and community creates a sense of belonging and security among members (Nguyen, Chatters, & Taylor, 2016). These family relationships are further strengthened by loyalty and the notion of reciprocity where family members can rely on each other, especially in times of need and crisis (Nguyen et al., 2016). Hence, African people value family loyalty as a way of preserving family unity and strength and for overcoming family challenges. It is therefore not surprising that the participants had difficulty in making the final migration decision which would involve them leaving their family and resulting in feelings of loneliness, stress, guilt and self-blame from family separation.

Taking the Plunge

Taking the plunge discusses the participants’ decision making regarding migration and their initial arrival experience where they were welcomed and supported by management. International nurse migration to Australia as a destination country has been happening for many years now (Brunero et al., 2008). In recent years, this has been made easier through the technological advancements in communication and travel within the ever-growing global migration (Bhavnagri, 2001; Kingma, 2006b; Shaffer, Bakhshi, Dutka, & Phillips, 2016). Sub-Saharan African nurses taking part in the study advanced various reasons for migrating from sub-Saharan Africa to Australia. Similar to findings in other parts of the world (Aboderin, 2007; Beaton & Walsh, 2010; Dywili et al., 2013; El-Jardali et al., 2009; El-
Jardali et al., 2008; Perrin et al., 2007), these included socioeconomic, political, family and professional reasons. Overall, participants wanted a better life for themselves and their families. They were concerned for their children and so were prepared to pack their bags and leave their countries. Attractive pulling factors participants identified in Australia, such as a good working environment and learning opportunities, also motivated them. This was similar to what Mejia (1978) identified as part of the push and pull factors in the international migration of workers. McCann, Poot, and Sanderson (2010) observed that when a decision was made to migrate it was always an active response to a negative or positive factor.

It is important to acknowledge the complexity of the motivation to migrate; it cannot be reduced to a simple dichotomy of push and pull factors. From the difficulties expressed by participants in making the final decision to migrate, it shows that migration is more complex than the simple push and pull theory by Mejia (1978). The participants were struggling with conflicting thoughts and ultimately had to take the plunge into the unknown. They wanted to go to Australia but they were worried about leaving their loved ones behind. Being with family meant a lot to them; hence, the difficulty for them to simply pack their bags and leave, even though they had been assured of a job overseas. The desire to remain with their families was seen as compatible with the African philosophy of family and communal living.

The Welcome and Support with Settlement

As participants in this study shared their migration experience, they noted the good spirit with which they were received in rural Australia. Migration literature, whether on refugees or skilled migrants, has long identified the importance of welcoming people to their new country (Camozzi, 2011; Hyunjoo, 2014; IOM, 2015; Prilleltensky, 2008; Refugee Council of Australia [RCA], 2015). Arriving at a new place in a different country brings about anxiety and fear of the unknown. This is in addition to the fear of fleeing a war zone or leaving your loved ones behind. Various voluntary organisations in new countries welcome migrants and offer them a range of practical and psychological support services (Camozzi, 2011). Without doubt, welcoming new people in any setting is a great step to making them feel at home. Australia as a country has policies committed to welcoming newcomers through multicultural groups and the Refugee Council of Australia (RCA, 2015). As a country, Australia also has policies committed to welcoming newcomers and encouraging cultural diversity (Lobo, 2015, p. 3; McGuire & Canales, 2010). The Australian government also “accepts and respects the right of all Australians to express and share their individual
cultural heritage within an overriding commitment to Australia and the basic structures and values of Australian democracy” (Department of Social Services, 2014, para 2).

It is important to welcome others because it is the right thing to do. In a welcoming community, everyone is involved at different levels and aspects of life. A welcoming gesture is a tool that can have a significant impact on the life of a migrant as they settle into a new country (Welcome to Australia, 2016). People do better in a community where they are welcome. The welcome helps to remove barriers and for the migrant to feel they belong and are valued. It was important for the OQNs to feel welcome on arrival because their continued stay in rural Australia partly depended on it. Föbker, Temme, and Wiegandt (2014) saw a welcoming work culture as important in attracting and retaining highly skilled migrants. This was important for participants as they were starting a new life at a new workplace. Participants were shown the spirit of giving from another dimension. Their employers received them with open arms. This welcoming spirit ties in with the African spirit of ubuntu as discussed previously in Chapter 2.

As participants started a new life in rural Australia, it did not take them long to encounter challenges, some of which were unexpected. Participants experienced loneliness and stress and episodes of racial discrimination in the workplace. They also found themselves negotiating two cultures as they sought meaning in the Australian culture. It was evident from the participants’ experiences that they also saw positives in their migration to Australia and they did not regret the move.

**New Beginnings in a New Environment**

The start of a new life in a new environment was marked by emotional vulnerability. Not long after arrival in Australia, participants experienced feelings of loneliness, stress, guilt and self-blame; this was during their transition period as they were settling in to their new country. Their loneliness and stress were largely related to separation from their families who remained overseas. The racial discrimination they encountered in the workplace and the cultural differences that existed socially also contributed to this loneliness and stress. This racial discrimination is discussed later in the chapter.

**Loneliness and Stress**

Migration literature has long identified that migration, for whatever reason or circumstance, can lead to loneliness (Barrett & Mosca, 2013; Jose, 2011; Van Tilburg & Fokkema, 2015;
Victor, Burholt, & Martin, 2012). This loneliness occurs in many migrant groups including nurse migrants. The loneliness felt by these African OQNs was profound. As discussed above, African people have a strong connection with members of the family unit (Horsford, Parra-Cardona, Post, & Schiamberg, 2010). They also have a strong sense of community where family and neighbours form support networks for individuals by providing safety, social support and a sense of belonging. Participants felt lonely during family separation as these support structures and networks were absent. These findings were supported by Babatunde-Sowole, Jackson, Davidson, and Power (2016) who also found that African women migrants tended to feel isolated and lonely because of the absence of the communal lifestyle they are accustomed to in their countries of origin. In the Western world, they found an individualistic lifestyle that was incongruent with their previous lifestyle and, hence, suffered isolation and feelings of loneliness and stress. The individualistic Australian lifestyle where there was very little interaction, if any at all, with their neighbours was contrary to their open cultural orientation and made their loneliness worse.

These study findings shed light on the cultural understanding of loneliness from the perspectives of sub-Saharan African OQNs. An understanding of the context of the communal way of life that the OQNs experienced in Africa better explains their experience of loneliness in Australia. In a communal lifestyle, there is sharing of joyous and difficult moments between immediate and extended family members and even neighbours. The OQNs had expected a communal life experience, at least with their neighbours. However, this tended not to happen. The unexpected loneliness from family separation and the absence from family gatherings was increased by the Australian culture of keeping to themselves in the neighbourhood. The Australian philosophy of individualism added to these feelings of loneliness, through lack of social contacts and participation in local social activities. Participants had limited social networks as they did not know many people; there could have been cultural barriers as well. This lack of community interaction made them vulnerable as they were used to the African lifestyle of relying on each other. On the other hand, the locals probably did not know what to do since it was probably the first time for them, too, to work or live with African people.

The perception of loneliness as a result of family separation came through strongly in the stories of participants as they described how much they missed their children. At times of family gatherings overseas, feelings of loneliness and homesickness among participants were triggered. These feelings were not unique to them. Wheeler, Foster, and Hepburn (2013) echoed these feelings of loneliness by OQNs in their American study in which
participants expressed feeling culturally isolated in the smaller towns where they worked. Some felt professionally isolated as they could not establish relationships with their colleagues because of the overwhelming demands of their new jobs as they tried to settle in; also racial discrimination was an issue for some participants. Similar to the findings in this study, West African women migrants in Australia felt lonely and isolated when they realised that social customs were more formalised in Australia where one usually notifies neighbours before visiting them (Ogunsiji, Wilkes, Jackson, & Peters, 2012).

To deal with their experience of loneliness, participants had frequent telephone contact with their extended families and friends overseas and were keen to find other African families living in nearby towns. This is similar to the findings by Van Tilburg and Fokkema (2015) where Turkish and Moroccan migrants in the Netherlands frequently contacted their overseas families in order to reduce loneliness. For the participants, it was as if they were living with two hearts, aptly described by Hondagneu-Sotelo and Avila (1997, p. 548) as “I’m here but I’m there”.

Participants’ descriptions of how they felt unwelcome by some of their colleagues because of racial discrimination (Farai and Betty) resulted in them feeling lonely, even in the presence of their colleagues. Dahlberg (2007) stated that loneliness can occur if a person is not acknowledged by the other people they are with; the feeling is deeper when the person is not with their loved ones. Participants were lonely because their families were not with them. Dahlberg (2007, p. 197) explains further that those who encounter discrimination at work experience what he calls ‘loneliness with others’. Feeling socially isolated can result in social pain which, as Cacioppo, Hawkley, Norman, and Berntson (2011) explain, motivates one to take action to reduce this unpleasant sensation. Cacioppo, Fowler, and Christakis (2009) found loneliness as much a morbidity and mortality risk factor as smoking, obesity and high blood pressure.

Loneliness has been associated with several medical conditions, both physical and psychological (Cacioppo et al., 2011). Stress resulting from international migration can be a significant factor in loneliness (Gouin, Zhou, & Fitzpatrick, 2015; Weishaar, 2008). Human beings are meant to interact; a life with no social inclusion compromises one’s physical and mental health. This was evident among the participants as they also experienced moments of stress.
Participants also described emotions of pain and stress during their move from sub-Saharan Africa and separation from their families. Some participants had a long journey from Africa with barely any rest before their first shift. They experienced fear and uncertainty about what lay in store for them and, on arrival, many things were new to them. These included work challenges, like working in the unfamiliar environment of a new country or being in charge of shifts at aged care facilities when they had never worked in such facilities before. Many also considered their job orientation as inadequate, resulting in loss of self-confidence as they did not feel safe to practise independently; consequently, they took additional time to settle in. Some encountered racial discrimination and disadvantage in their workplace. This stressful period presented a potential for the disruption of their mental and physical health.

Participants in this study echoed Falicov’s (2007) assertion that the process of migration where there is transnational family separation can be a stressful event in one’s life. This is further supported by Bhugra (2015) and Kingma (2006a), who stated that the first two years in a new country are the most difficult. Svášek (2008, p. 216) added that the period is often characterised by contradiction, where people are not able to be physically present with their loved ones in their home countries and, at the same time, they need to find a way to settle and attach to their new homeland. In the USA, Yi and Jezewski (2000) found psychological stress to be the most significant challenge for Korean nurses adjusting to working in acute care hospitals. This was also the case for some participants in this current study. Contrary to the sub-Saharan African nurses who migrated to the USA, mainly because of family ties (Wheeler et al., 2013), participants in this study were mostly recruited through migration agents and had no family networks in Australia. It is therefore no wonder their loneliness was intense as there was no local social support from family members or friends.

Participants suffered stress in the workplace because most of them were working in aged care facilities which were an unfamiliar environment to them. Participants were socially and professionally unaccustomed to the Western culture of nursing the elderly in a care facility. The orientation to the job was reported by many as inadequate adding yet more stress to the participants. The ICN position statement (ICN, 2007) on international nurse recruitment considers this unethical; it “… denounces unethical recruitment practices that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience” (para 4). Participants may have been qualified as RNs with specialties in other fields of nursing, but they had little, if any, experience in aged care. They felt disadvantaged as they were expected to perform safely, regardless of their lack of experience in an area participants saw as a speciality area. This
constituted a risk to the care of residents as well as a threat to participant confidence and self-esteem.

**Guilt and Self-blame**

Participants also described moments where they experienced feelings of guilt and self-blame especially during the period of family separation. This was not unique to the participants as the concept of self-blame among migrants also featured in other studies in the UK and Australia, albeit for different reasons (Alexis, Vydelingum, & Robbins, 2007; Baldassar, 2015; Ward & Styles, 2012). Participants felt guilty for leaving their loved ones behind, particularly children, and for not attending important family functions such as weddings and funerals. Although they assisted financially, they still felt the desire for a physical presence, something considered significant in African communities. Vermot (2015, p. 141) explained that this kind of guilt expressed by participants may be seen as a reaction to social disapproval when women move away from their socially assigned roles of being a “good mother”, “good sister” or “good daughter”. Due to migration, participants could not practise their mothering role of being physically present for their families. Baldassar (2015) explains a guilt feeling that takes the form of an obligation to be present with the family. Participants experienced these guilt feelings for leaving their families overseas, especially their children.

Similar outcomes were described by Ward and Styles (2012) when they found intense and long-lasting feelings of guilt among migrant women going from the UK to Australia. These women felt guilty for leaving their parents and also for disrupting the relationship bond between grandparents and grandchildren. Participants felt this traditional family obligation and responsibility for each other in the form of reciprocity. With reference to the traditional African family and the experiences of participants, the loyalty among family members is very strong such that any gain of an individual outside the family circle would cause one extreme grief or guilt as they would be seeing themselves as having an advantage over the others (Baldassar, 2015).

Baumeister, Stillwell, and Heatherton (1994) take an interpersonal approach to explaining the guilt phenomenon. Interpersonal guilt commonly occurs in communal relationships where there are expectations of mutual concern for the welfare of others, in a reciprocal manner. This was the case with the participants and is common in African family relationships where reciprocity and sharing of obligations are highly valued. Baldassar (2015) added that in such relationships members give without measuring what they give but expect that gift to be returned to them. It could be giving of yourself or of your time. This
may explain why participants felt guilty for not being there for their families when family members probably assisted in their educational and professional success. Also, participants felt guilty for living a better life and eating good food when other family members, overseas, were barely eating. However, participants looked at the positives of their migration; at least they were contributing financially for those family activities to take place and for their loved ones to have food on their tables. This was all relevant to the participants who felt guilty because of the physical separation from their families and their inability to fulfil their obligations to care for their children on a day-to-day basis.

Participants developed coping mechanisms to deal with the stress and feelings of loneliness and self-blame. They made arrangements to bring their immediate families to Australia as quickly as they could; some worked extra shifts not only to purchase air tickets but to also keep themselves busy and distracted from their loneliness. They maintained regular communication with loved ones overseas so as to sustain family relationships. They used various forms of communication which included mainly telephone and Skype™ conversations as well as electronic mail. These forms of communication provided a virtual presence which helped strengthen emotional interaction with their families and also demonstrated their loyalty to them. This helped reduce the negative impact of distance as they endeavoured to care and support their loved ones overseas. Wilding (2006) also identified that similar methods were used by what she calls ‘transnational families’ in her literature search on studies conducted in various countries including Australia. Further, Ward and Styles (2005, p. 423) found that migrants in Western Australia would seek more information about their new country and also engage in local social activities like community clubs in order to cope with their stress due to ‘exposure to a new culture’.

Some participants in this study identified a few fellow African people within their locality and surrounding towns and they would socialise together. At the time of interview, almost all participants had been back to Africa to visit family. These were important visits as they assisted in physical interaction with loved ones. Family gatherings and communal living were part of the participants’ cultural lifestyle; interacting with their family was very important to them. Fumanti and Werbner (2010) noted that many African migrants in Europe maintain contact through transnational networking with their home countries and live in the hope of returning to Africa when the political and economic situations improve. Participants in this study also worried about taking their children out of their cultural environment and away from their grandparents in Africa. Hence, they felt the need to maintain contact with Africa by taking their children for regular family visits to Africa or inviting parents to their
new homes. Participants also encountered cultural differences and issues relating to their African race.

**Culture, Race and Colour**

Managing cultural difference challenged the participants both socially and professionally. This section addresses differences in work and social culture and the challenge of negotiating between two cultures. Additionally, the section discusses the discrimination and disadvantage participants encountered based on their race and skin colour.

Participants were shocked by the cultural differences they experienced as they started settling in to rural Australia. The cultural diversity that participants encountered included differences in lifestyle and language compared to their traditional lifestyles in Africa as well as a different scope of practice in the workplace. Kreitz (2008, p. 102) defined diversity as “any significant difference that distinguishes one individual from another”, covering obvious and non-obvious factors. Some of these factors relate to culture. For participants in this study, there were differences in the social and work cultural practices. Most notable in the participants’ experience was the workplace culture shock which included the informal way colleagues and patients communicated within the Australian health system, as well as cultural practices relating to the lifestyle in the population generally. It was a new world for them where things looked and were done differently. Ward and Styles (2005) described this culture shock as typical among migrants and usually transient in nature. As already noted, however, not only were these participants African, they were also black, coming from a black African cultural background migrating to a predominantly Western society. It should be noted, too, that some of the local nurses and patients were also probably experiencing cultural shock in working with and being cared for by African nurses for the first time.

**Different Work Culture**

A number of studies have indicated that OQNs encounter culture shock in their new countries (Al-Hamdan et al., 2015; Alexis, 2013; Baldassar, 2015; Jose, 2011; Okougha & Tilki, 2010). As they enter an unfamiliar world, especially their new workplaces, they experience a different culture; a culture for which they usually are ill-prepared. Generally, people accept that differences exist among different nationalities in the way things are understood and done based on the cultural and traditional backgrounds of individuals; after all, that is what defines who we are. What seems to shock people is the impact these differences may have on an individual experiencing them, especially on foreign land. Dealing with these cultural differences can once again be stressful for migrants. As echoed
by Mirdal (1984), the process of migration where participants are confronted by an unfamiliar culture can be a stressful event in one’s life with the potential to negatively affect one’s mental and physical health. Eckermann et al. (2010, p. 5) define cultural shock as:

That feeling of uneasiness, anxiety, and stress that arises when suddenly all our familiar cues, language, interpersonal relationships, tastes and actions appear to be out of place, suspect or even inappropriate, and we must reassess our behaviour in the light of foreign expectations.

This definition would relate to the differences and difficulties that OQNs experienced as they transitioned into Australian nursing practice. For most participants, Australia was a completely new and different environment. On a few occasions, participants were anxious, stressed and confused as they experienced different ways of doing things, some of which were challenging. Ward, Bochner, and Furnham (2001) described four progressive stages of culture shock that people go through. These stages are 1) the ‘honeymoon phase’ depicting the initial phase of excitement, euphoria and enthusiasm; 2) the crisis phase characterised by anxiety, anger and feelings of frustration; 3) the crisis resolution phase characterised by recovery and learning of the new culture; and 4) the adjustment phase where the person develops functional competence in the culture and enjoys it. Participant experiences seemed to have identified with these phases. Initially, the participants were excited on arrival to Australia and later were frustrated and anxious about living in a society where they rarely interacted with their neighbours. The paragraphs below will also show how the participants have adjusted to the Australian culture.

Adjustment to a predominantly Western culture was not easy for participants in this study. Participants expressed a desire to hold on to their culture for as long as they could. However, they also embraced local cultural practices which they found preferable to their own. Although they appreciated and embraced some practices, there were those that participants had difficulty in understanding and felt uncomfortable in embracing. Some of these related to addressing a colleague or a patient using first names. Similar findings were reported by Okougha and Tilki (2010) among the UK migrant nurses from Ghana and the Philippines when they reported their discomfort in addressing adult patients by first names. This was because first names are not used to address older people in the community or family in their country of origin.

It was important for participants to maintain their traditional culture and identity. That is what made sense to them. Although they wanted to integrate and be part of the society, they
were conflicted, wanting to hold on to their own culture as well. Berry (2008) refers to this cultural position as acculturation. He explains it as a phenomenon in which individuals from different cultural sides may change in their original cultural patterns.

**Australians Seen as Keeping to Themselves**

Participants noted that Australians tended to keep to themselves. This lifestyle worried participants because it worsened their loneliness and stress as they were used to an open lifestyle where people communicated freely with neighbours. Participants came from communal and collectivist cultures. They were missing that free open lifestyle where you know and are known by everyone in your local community; where you can talk loudly over the fence to your neighbours and your neighbour’s business becomes yours. It is like watching each other’s backs. This communal cultural orientation to life is described by Jensen and Gaie (2010) as African communalism versus that of Westerners who view life from an individualistic worldview. Triandis, McCusker, and Hui (1990) assert that affluent countries (including Australia) tend to adopt a cultural orientation of individualism where individuals regard themselves as being autonomous and independent from the norms of their in-groups (such as family, community or tribe) and tend to give priority to their personal goals. In such situations, these individuals keep to themselves and may not realise the needs of other members in their communities. On the other hand, participants in this study were from a more communal orientation which Triandis (2001) refers to as collectivist. In this cultural orientation, people are interdependent within their in-groups, they share the same goals and are mainly concerned with maintaining relationships with each other. In communalism, even if you run short of salt in your house you will still have food with salt because your neighbour will provide it. Triandis (2001) goes further, though, to warn that not everyone in these two cultural orientations will show the same characteristics as the group.

Participants interpreted the Australian way of keeping to themselves as a local culture where people minded ‘their own business’ and were not concerned about the health of their neighbours. These expressions by participants resonate with the experiences of Oromo migrants in Melbourne (Gow, 2002) who could not believe that anyone could die and be alone for three days in their home without anyone knowing. This interpretation by participants may have been true in their initial exposure to the locals due to cultural and age differences, however, it could have changed with time as they integrated more and more into the society.
Negotiating the Cultures of Two Worlds

Participants from this study found themselves negotiating between two cultures where they wanted to hold on to their own culture while also trying to fit into the new culture. They were also in a new work environment (mostly aged care facilities) that required a new set of skills. The literature shows a tendency for OQNs to be placed in areas outside their usual scope of practice (Brunero et al., 2008; Francis et al., 2008; Jose, 2011). Jose (2011) attributes this to institutions that recruit according to their needs without regard for the nurse. Just like any nurse who would need orientation in a new work environment, participants felt it was critical to be orientated in a supernumerary position to their new scope of practice. However, the orientation programs were ad hoc and not the same for all participants. From the varied responses regarding orientation, it seems institutions delivered orientation programs whichever way they saw fit. It must have been hard for managers as well since it was a first for most of them to have OQNs in their institutions. However, these were nurses who needed longer and well-planned orientation programs that would include cultural orientation and mentorship to assist them to settle in. These findings on inadequate orientation and the expressed need by participants for longer orientation sessions were supported by Francis et al. (2008) and Cheng and Liou (2011) for OQNs in Australia, and Asian nurses in the US, respectively. They emphasised the need for preparation to adapt to the cultural diversity. Jose (2011) also reported that OQNs in the US also requested greater orientation regarding the country’s social systems. All of these studies indicated participants could have been better prepared for cultural diversity with a resultant smoother adaptation to the work environment.

In this study, participants wanted to maintain their own cultural identity while trying to fit into a new culture. They had a desire to belong and identify with the locals without losing their own cultural identity. Despite so much cultural confrontation, they were still expected to perform their workplace duties like everyone else: administering medications, bathing patients and giving handover reports. Participants also experienced discrimination at work that was based on race and the colour of their skin.

Racial Discrimination and Disadvantage

Most of the participants started work at their new workplaces within a day or two of arriving in Australia. They had already secured jobs before leaving their home countries and,
therefore, were ready to start immediately. Excited and at the same time a bit apprehensive about their ‘new jobs’, participants were seeing their dreams being fulfilled.

It should be noted that the recent arrival of African nurses in rural Australia is comparatively new (Mapedzahama, Rudge, West, & Perron, 2012). African people are now arriving as skilled professional migrants and this has caused an observable shift in the composition of the nursing workforce. Their presence is changing the face of the Australian nursing workforce in healthcare facilities. This is because people with black skin colouring do not walk around unnoticed – they are ‘visibly different’ for all to see (Colic-Peisker & Tilbury, 2007, p. 59). This is due to their observable skin colour.

One of the challenges African nurses faced was that of perceived racial discrimination as they interacted with patients and colleagues. Participants interpreted these experiences as being caused by their skin colour and being from Africa. Participants expected to be welcomed by their colleagues; they wanted to be accepted as professionals like everyone else. Participants were generally welcomed at organisational and managerial level and were regarded as an asset to the organisation. There were a few reports of discriminatory issues levelled against some unit managers which mainly involved managers not recognising the value of OQNs in the health system; they were seen as blocking participants from career advancement. By policy and law, Australian health institutions do not tolerate discrimination at work due to the Anti-Discrimination Act 1977 and other legal statutes and policies which discourage racism (Hunt, 2013). However, ‘on the floor’ at work, things were different; participants felt excluded. It was what Essed (1991) called ‘everyday racism’ where racism is integrated into everyday practices, becoming part of the expected behaviour without questioning, and this may be seen as normal by the dominant group. Although Essed (1991) initially distinguished the cognitive (prejudice) component of racism from the behavioural (discrimination) component, she is quick to explain that it is actually hard to separate the two as they are “mixed and operate synchronically as part of the same process” (p. 50). The general view is that everyday thinking cannot be separated from everyday behaviour. Essed (1991) goes further to warn that “when racist notions and actions infiltrate everyday life and become part of the reproduction of the system, the system reproduces everyday racism” (p. 50). For participants, it was some of these little things that happened in everyday interactions that hurt the most.

Studies of overseas qualified migrant nurses or OQNs report discrimination based on racism (DiCicco-Bloom, 2004; Hagey et al., 2001; Larsen, 2007; Mapedzahama et al., 2012; Omeri
& Atkins, 2002; Xu, 2007, 2008). It is not a new phenomenon for black Africans to be unwelcomed and excluded, as was the case with these black African nurses in rural Australia. Africans have been excluded not only in societies where they are the minority, but they have been treated as outsiders even in their own homeland, Africa, which was colonised by Western powers and other nations (Novak, 2012; Williams et al., 2008). Black Africans are not only seen as different, but they are sometimes seen as backward, inferior and less socially acceptable (Deitch et al., 2003). At worst, they are undesirables. It does not matter how good they may be at what they do. Several decades ago, Turnbull (1962, p. 16) observed that “the African has been taught to abandon his old ways, yet he is not accepted in the new world even when he has mastered its ways”. Shulevitz (2013, p. 25) added that people who feel discriminated against and are perceived as ‘different’ are more likely to experience loneliness and feel rejected. Alexis (2015) found, in another UK study, that nurses from Africa perceived more discrimination and received less support than other migrant nurses; hence, their support needs would be greater in the workplace. Participants in this study felt that they did not belong, they felt like outsiders who were being alienated in a land they had entered with so much hope.

Previous studies have shown that racism, especially in the form of exclusion of darker skinned groups, exists within the nursing profession. In an international study conducted in the UK by Larsen (2007), it emerged that OQNs from Africa experienced discrimination and professional exclusion by colleagues. A workplace experience shared in a study of African physicians and nurse migrants in their destination countries by Wojczewski et al. (2015, p. 13) reported that the issue is “not only about being a foreigner, it is about being black”. There is a heightened visibility of black migrant nurses, probably because they are in the minority and are relatively new among the skilled migrant groups in Australia (Mapedzahama et al., 2012). The introduction of this new and different group could be responsible for the racial response from colleagues. The fact that these nurses were black cannot be denied – it is a fact. The visibility of the black nurse in the Australian health workforce was also described by Mapedzahama et al. (2012) who identified nurse-to-nurse racism and racial prejudice against black nurses in Australia.

Other studies that have identified similar challenges for darker skinned OQNs (not only black Africans) include those by Omeri and Atkins (2002, p. 500) where the nurses mostly felt unhappy and experienced a feeling of ‘otherness’. Indian nurses in the USA (DiCicco-Bloom, 2004, p. 32) felt ‘marginalised’. The findings from the current study are also similar to what Magnusdottir (2005) found in her Icelandic study on experiences of foreign nurses,
which included Asians. The Asian nurses felt they were outsiders and not accepted by their colleagues. Also noted in Magnusdottir’s (2005) findings was the same rejection of non-white nurses by patients; this was consistent with what was expressed by participants in this study.

These findings also showed an element of silence regarding this everyday racism; that is, silence by the participants themselves by not reporting all incidents and silence by the organisation. Even when incidents of racism were reported to management, participants felt they were not taken seriously as they did not see any investigations being undertaken. This may indicate a denial of the existence of racism as well as downplaying such incidents. Indeed, institutional management declares no tolerance for racism, however, the incidents were treated as having no serious consequences. These current findings confirm that everyday racism and the silence regarding it still exist in the workplace, as previously stated by Essed (1991), Jayasuriya (2002) and Mapedzahama et al. (2012).

Deitch et al. (2003) asserted that as blatant racism becomes less prevalent among dominant group members, subtle, everyday discrimination may become even more common, resulting in what Essed (1991) refers to as the ‘lived experience’ of being black. It is a hidden form of racism that is intertwined with the day-to-day interactions of people. Essed contends that ‘everyday racism’ constitutes familiar everyday encounters with prejudice where the affected are devalued in various ways. Overt racism has been replaced by less overt forms such as ‘ambivalent racism’ (Katz & Hass, 1988, p. 893) and ‘subtle racism’ (Deitch et al., 2003; Mapedzahama et al., 2012). In these forms of racism, individuals do not view themselves as ‘racists’, as they do not engage in, for example, racial slurs; but they engage in more subtle discriminatory behaviour, such as ‘avoidance of blacks’ or failure to provide help where needed. It is the casual, everyday insensitivities which sometimes may not even be intended to hurt but participants perceive these incidents as racism. George and Chaze (2014) explained this ‘systemic’ form of discrimination as also existing when practices are aimed at limiting the opportunities for certain groups of people to succeed.

Participants wanted to succeed in their work and to integrate into the nursing workforce without any limitations or exclusion. Sindi felt disadvantaged and that people were conspiring against her professional development and trying to limit her, professionally, instead of guiding her career development. Participants felt they were treated as though their expertise was invisible. They did not think they had equal opportunities for professional advancement. Similar findings were reported by Alexis, Vydelingum, and Robbins (2007).
in the UK where overseas nurses (including Africans) would be excluded by nursing teams and from promotional opportunities. They would even be bypassed by patients and their relatives who were seeking nursing care. In this study, participants would, at times, seek assistance from other staff to convince patients they were getting the correct medication. In the case of the participant whose care was rejected by the patient’s relative, the issue had nothing to do with the nurse’s competence. The relative had not talked to the OQN and would not have known where the nurse was educated. This study described situations where patients’ and relatives’ reactions were based on the sight of these black nurses. This study also shows that vulnerability to discrimination and exclusion undermined the participants’ self-esteem and beliefs in their capabilities, which is supported by Omeri and Atkins (2002).

Migration and adjusting to a new workplace can be demanding regardless of one’s racial background; however, exposure to everyday racial discrimination and rejection is especially stressful. Participants in the study suffered the stress of not only being new in a country, but also of being black skinned and discriminated against. The participants migrated with their traditional background life philosophy of ubuntu where people live together as one community and respect each other, realising they cannot be the best they can be unless they all are. Racial discrimination has no place in the philosophy of ubuntu. As participants negotiated their way despite discriminatory practices within the nursing workforce, they faced the added task of identifying themselves as professionals in their own right. Teamwork and strong nurse–patient relationships are built on trust and on showing appreciation of the contribution of team members. Managers did not tolerate racism in their departments, however, more could have been done proactively to avert racist intolerance.

**Being Undervalued and Not Trusted as Professionals**

Closely related to the experience of being identified as different due to skin colour was the issue of not being trusted and valued by colleagues and patients. Trust is one of the important aspects of teamwork among members and it is an essential component of interpersonal relationships in health care. Participant narratives showed there were feelings of mistrust between participants and patients as well as other staff. Participants felt patients did not trust their skills in providing quality nursing care; they also felt uncomfortable due to being under scrutiny by their colleagues. They felt their professional knowledge and experience could have been valued more, and their supervisors could have trusted them and believed in their potential to attain professional advancement. While feeling that their actions were under scrutiny and their work was not trusted, participants expressed concern that not ‘getting
things explained’ inhibited them from knowing where they could improve. Participants were also unable to identify who to go to for professional support and advice. This has implications for mentoring new staff, especially OQNs. Benefits of mentoring have been recognised in the nursing literature (Allan, 2010; McCloughen, O’Brien, & Jackson, 2006, 2014) as it ensures personal growth, skills development and advancement in nursing careers. For some participants, career progression was their main reason for migrating to Australia and they had a desire to attain that professional goal. Instead, they had their aspirations and confidence undermined by the racial discrimination and disadvantage they were subjected to by some colleagues and patients. A well-structured ongoing mentoring program would have helped develop positive relationships and allowed participants to objectively assess their potential against set criteria.

Similar findings have been reported in other studies. Alexis et al. (2007) and Alexis and Vydelingum (2004, 2009) reported on OQNs in the UK, especially black nurses, who were not recruited into managerial positions. These black nurses had migrated to the UK expecting equal opportunity based on merit and not on skin colour. Mapedzahama et al. (2012) also reported on black OQNs in Australia whose nursing experience was not trusted by their colleagues and immediate supervisors. Issues of mistrust and high scrutiny of OQNs’ performance of tasks based on racial discrimination have been raised in several countries as shown by studies in the UK (Larsen, 2007; O’Brien, 2007), USA (Xu, Gutierrez, & Kim, 2008) and Canada (Tregunno et al., 2009). For participants in this study, the issues of being trusted and valued at the workplace were considered critical as these are part of the core of the nursing profession. Participants sought to be recognised and their nursing experience acknowledged in order for them to advance in their chosen career. Interpersonal relationships based on trust help to deliver quality patient care and effective organisational function (Bosch & Mansell, 2015; O’Toole, 2012).

Trust as a concept involves an element of expectation or a belief about the future behaviour of others (Brien, 1998; Ferrin, Bligh, & Kohles, 2007). To trust someone is to have certain expectations that they will act as expected and not harm the one who is trusting them (Brien, 1998). In the concept of trust there is a trustor and a trustee. Ferrin, Dirks, and Shah (2006) explain that the trustor holds an expectation of trust while the trustee responds to an expectation of trust. These roles can be reversed as the relationship develops. Mechanic and Schlesinger (1996, p. 1693) describe trust as referring to the expectations “that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and not inappropriately defer to others (control), and
that they will make patients’ welfare their highest priority (agency)” Iacono (2007) adds that these attributes that define trust need to be fulfilled in a trusting relationship.

Patients trust nurses based on expectations that they will be cared for and protected from harm (Iacono, 2007). In this trust, there is an expectation of competence (Baier, 1986; Bell & Duffy, 2009; Mechanic & Schlesinger, 1996); a belief that nurses have the ability to perform their roles competently. In trusting, there is a belief in the goodwill of others, that they have the motivation to do well (Baier, 1986; Rousseau, Sitkin, Burt, & Camerer, 1998). Baier elaborates further that the trusted may offer the trustee the opportunity to cause harm but believe that they will not. Therefore, trust involves risk, putting oneself in a vulnerable position. There would be no need to trust if there was no risk of losing something (Lewis & Weigert, 1985; Rousseau et al., 1998). Based on this goodwill, the patient gives the nurse or doctor some control over their care. As patients give up this control over their care, because of their trust in nurses, there is an element of risk; this may leave the patient in a vulnerable position as aptly noted by Rousseau et al. (1998). Rousseau et al. (p. 395) further see trust as comprising one’s intention to accept vulnerability based on the positive expectations of the actions of the trusted person.

Iacono (2007) states that people will trust nurses when they first meet them. In this study, employers trusted participants to perform up to the expected nursing standards. However, some patients and colleagues did not. Patients were not willing to place themselves in a position of vulnerability by accepting medications from a black nurse who they thought was probably not qualified enough to handle medications. There is no record of mistrust in this study concerning their hygiene-related needs like assistance with showering, toileting or feeding; but patients would not accept medications from participants. Some doctors would not conduct ward rounds and discuss patient care with a black nurse, preferring rather to do it via white nurses regardless of their position in the profession. Research studies have suggested that several cues influence judgments regarding the ability and competence of other people (Holtz, 2013). People make inferences regarding the trustworthiness of others by basing these on biological signs such as age, gender, disability and race (Hekman et al., 2010; Nguyen & Ryan, 2008) and sociocultural cues such as clothing and socioeconomic status (Holtz, 2013). Some of these factors may have played a part in the judgment of the participants by their patients and colleagues. They were black and from Africa, a continent that is generally of low socioeconomic status. Participants interpreted this search by doctors and patients for third party assistance to interact with black nurses as racism. Ferrin et al. (2006) state that sometimes in situations of mistrust, a trustor and trustee may be linked to
each other via third parties. This is shown in this study by patients double checking their medications with other nurses and the doctors giving patient care instructions to the nurse in charge via other nurses.

In addition, when only conditional trust exists in the workplace, the team will not share the same values and common goals (Jones & George, 1998). Colleagues will not cooperate, instead, they will seek to achieve their own individual goals, sometimes at the expense of others. This explains the gossip and ‘dobbing in’ described by participants as they were trying to find their place within the workforce. They were not trusted and were treated as outsiders, regardless of their efforts to be part of the existing workplace teams. In contrast, where trust exists, a group becomes a team, and team members contribute to the common goal which, in this case, is quality patient care. Trust would have enabled these migrant participants to develop a positive relationship with other staff and to also feel valued as part of the Australian healthcare system.

For many patients in rural Australia, it may have been the first time for them to be nursed by a black nurse. The facilitated international nurse recruitment by agencies brought many migrant nurses to rural communities as Australia wrestled with a rural nursing shortage (Blake, 2010). This was probably a culture shock for rural communities who are generally closely knit and have a complexity of their own compared to metropolitan communities. Patient mistrust manifested mainly during higher level care such as medication administration and clinical decision-making moments. Although that may have taken away whatever confidence and faith participants had in their practice, it should be acknowledged that there appeared to be a high level of anxiety displayed by elderly residents. They were not just mistrusting but were anxious about the difference. The problems reported related mainly to higher level nursing duties like medication administration but patients/residents did not mind their lower level personal care being provided by black nurses.

Some participants did not see themselves winning this battle for recognition. It is these little everyday incidents that can have an impact on the individual (Williams, 2001), resulting in feelings of hopelessness and resignation. This is consistent with Turnbull’s assertion (1962, p. 204) that “the African cannot be expected to have any great faith in a way of life that has done its best to exclude him, obstructing him with or without intent at almost every turn”.

Participants directly experienced situations where they needed to be trusted and valued by their patients and colleagues for their contribution in the workplace. An environment of trust
strengthens feelings of belonging and identity, which is what participants desired as they settled in. Trust binds the team together and also strengthens the relationship between the nurse and the patient. Lewis and Weigert (1985) assert that it is through trust among team members that there can be acceptance of each other. The cooperation and collaboration that are built on trust among health team members can then help achieve quality patient care. Some participants, however, did not find this happening following their arrival in rural Australia. Another dimension that troubled participants was the unexpected and unwelcoming response of the Australian Indigenous people towards the black African presence in rural Australia.

**Beyond the Black versus White Differences**

Participants did not understand why they could not be accepted by their ‘cousins’. Such reactions were more complex and multilayered beyond the *black versus white* differences described earlier. As discussed in Chapter 2, the Indigenous people of Australia are an oppressed group (Broome, 2010). They have lost power and recognition as a people and so will trust no one as they protect their territory. As an oppressed group, they feel threatened by anything new in their communities. They feel they have been severely dealt with as they observe migrants being imported and given good quality Australian jobs while they, the Indigenous people, experience unemployment problems, generation after generation. In addition, the oppression and marginalisation they suffered at the hands of their colonisers impacted on their confidence and self-esteem in such a way that they cannot imagine a black person achieving professional status as these participants have done (Broome, 2010; Durey & Thompson, 2012). The negative response of Indigenous people to other blacks in their communities seems quite complex and beyond the aim of this study, however, the experience of this negative response confused and impacted participants in this study. It is an issue that can be taken up for further study.

Participants in this study, were determined to counter racism and would report racial discrimination incidents to management; in most cases, management responded positively to deal with the situation. However, some incidents were not reported because some of the participants just resigned themselves to the discrimination, believing that they could not do anything about it and accepting that racism will always be there. With regards to human ethos, human beings are meant to interact together; it is a good thing to live well with people as beautifully described by the Wiradjuri phrase: *yindyamarra winhanganha* – ‘the wisdom of respectfully knowing how to live well in a world worth living in’ (Grant & Rudder, 2010).
People need to live and work well with other people and make this world worth living in. This is significant in nursing where everyone should be treated with respect, regardless of colour, creed or race.

Discrimination based on race is a sad reality in the nursing workforce. When the ‘white policy’ was overturned in 1973 turning Australia into a land of equality (Pybus, 2006), some people did not recognise it, as there are still elements of racism within the society. Just changing the policy was not enough to change society. Racial discrimination is unlikely to start in the workplace. Racists are people, luckily few in number, who are short-sighted and ignorant of the beauty of diversity. Discrimination based on the colour of skin is not acceptable, especially in the nursing profession. Such behaviour is not congruent with the spirit of multiculturalism, that Australia is known for, and the concept of ubuntu which is the spirit that drives the African philosophy of humaneness encompassing respect, kindness, trust, caring, generosity, community and sharing (Gade, 2012).

**Developing a Sense of Belonging**

Despite some of these negative migration experiences described by participants as they travelled along their migration journey, participants had to find coping strategies to deal with them. Participants showed resilience and persistence in their desire to develop a sense of belonging and to become part of the community. Their future migration plans indicated their pleasure in developing a sense of belonging to their communities.

**Resilience and Persistence**

The other feature that came out of this study related to the resilience and persistence these participants showed during their migration experience. As already seen in previous chapters, international migration can be quite costly financially, physically and socially; sometimes many dreams do not come true for these migrant nurses. Participants showed great adaptive skills and seemed determined to stay and achieve their migration goals, regardless of the obstacles they met. For them, there was no going back.

Resilience has been noted among international migrants in other countries, especially the refugee population, as they employ various strategies to cope with the demands of immigration processes (Shishehgar, Gholizadeh, DiGiacomo, Green, & Davidson, 2016; Simich & Andermann, 2014). The concept of resilience has been studied in the literature with various definitions advanced, and authors seem to agree that resilience is context
dependent. Masten and Powell (2003, p. 4) defined resilience as referring to “patterns of positive adaptation in the context of significant risk or adversity”. This implies that there must first be a demonstrable threat or risk to one’s endeavours for one to be considered resilient (Masten, 2001). Individuals would need the capacity to navigate and negotiate opportunities in life and this can be done in culturally meaningful ways in the presence of risk (Ungar, 2008). Resilience becomes a coping resource that helps individuals overcome significant risk and disadvantage (Aroian & Norris, 2000). Aroian and Norris (2000) studied the relationship between resilience and immigration demands and asserted that the two were negatively correlated. The literature search studying experiences of migrant care workers in developed countries by Ho and Chiang (2015) identified resilience among migrant workers that included nurses. Resilience to adapt to new migration challenges was noted among female Indian migrant nurses working in the US (DiCicco-Bloom, 2004) and those working in Canada (Sochan & Singh, 2007), just to mention two.

From an ethical perspective, OQNs in this study were considered a vulnerable group as they were a minority group in a foreign land. Gallopin (2006) identified a relationship between vulnerability, resilience and adaptive capacity. Gallopin identified resilience as the ability for an individual to cope with external stresses due to changes in their environment. Individuals adapt to such environments, a process where they develop the capacity to at least maintain or even improve their quality of life in response to changes in their environment.

Participants in this study were exposed to significant psychological adversity and had to develop the capacity to recover from the difficulties they experienced, especially in the workplace. Participants were determined to stay in Australia to achieve their migration goals. They showed resilience and persistence to overcome non-acceptance in the workplace by colleagues and patients simply because they were black, as well as to advance their new professional roles for those working in aged care facilities. They needed to remain optimistic as they employed different coping strategies; they had to call upon their individual tenacity to overcome these obstacles. Colleagues and patients did not trust them, regardless of their approved qualifications as RNs. Management was on their side and were not tolerating any discrimination of participants by staff or patients. Participants were resilient and persistent as they showed positive outcomes in spite of the discriminatory responses they faced towards adapting to their workplaces in rural NSW.

Mansouri and Lobo (2011) add that events like racism can make the targeted individual stronger and more resilient. Individuals develop these coping strategies to buffer themselves
against the negative outcomes of racism. However, these may not be sufficient to protect one from isolation and feelings of stress and loneliness. Through resilience, participants developed a new professional identity of working in aged care facilities, although many later left for acute care hospitals; and they developed the ability to adapt and embrace cultural differences. As individuals, they grew stronger; they also identified and took advantage of professional development opportunities that came their way. Participants saw progress over time and that encouraged them to overcome the obstacles they encountered.

In sharing their migration experiences, participants told stories that demonstrated difficult work and cultural negotiations and that called upon their sense of persistence to succeed. Ironically, during the FGD, participants viewed their migration journey with a sense of humour as they joked and laughed about some of the barriers they encountered, indicating they felt a sense of victory. This sense of victory set the tone as participants sought to become part of their communities.

**Becoming Part of the Community**

Over a period of time, most participants noticed a change of heart in those patients and colleagues who had initially not welcomed or trusted them. Participants described how the initial challenges of discrimination and disadvantage as well as cultural shock were gradually disappearing. As one participant stated, they were now being ‘seen beyond the dark skin’. Participants felt that both they and their colleagues were now embracing the diversity that existed in their communities. Time was the healer for all involved. As the reception of the participants began to be more positive, the participants themselves also responded more positively; it was a synergistic process. For participants, that feeling of belonging was necessary in order to make their migration move a success. This gave participants a sense of belonging where they could now integrate into the society and express themselves at work and in the communities they lived in. This opened doorways for participants to feel part of their communities. This is what participants had longed for. That is what living and working in rural Australia meant to participants. Berry (1997, p. 10) stated that integration can occur when the “dominant culture has an open and inclusive orientation toward cultural diversity”. Participants described resistance to diversity as weakening and the local nurses and patients becoming more accepting.

According to Ward et al. (2001), the third stage of culture shock includes recovery and resolution of the issue. Participants described recovering from culture shock and learning a new culture, socially, and in the workplace. Participants learned some new cultural norms,
the ‘Australian language’ and started taking part in local cultural activities. However, these participants, like most migrants elsewhere (Joarder, Harris, & Dockery, 2016), occasionally described some dilemma about how much to retain of their culture of origin and to what extent to embrace Australia’s cultural norms. They wondered if they would have to give up their spirituality in order to adopt the Western culture. They related this to their children who were being raised in a new Australian culture and who might not embrace their original culture as they may not really relate to it. Hence, participants saw the need to make some adaptations to this different culture in order to fit in. For Africans, belonging is part of the state of being as propounded by Heidegger (1962) and links well with the African philosophy of ubuntu, as discussed earlier. Africans transfer and share knowledge through human relationships, and these relationships are protected within the philosophy of ubuntu because everyone is recognised and respected, no matter what. As Archbishop Desmond Tutu said, “we all exist in a bundle of belonging” (Mackay, 2014, p. vi).

Participants felt that it was very important to belong to rural Australian communities. They sought to belong and be part of the communities. Belonging to a community was so much part of their cultural being and they felt they were culturally bound to this; it was part of their heritage. They valued a state of belonging where they would even look forward to going to work. They obviously found this most difficult when they first arrived but they worked hard at being part of the community. Having come from a background of communal living, participants would find it difficult to continue living in Australia without becoming part of the community. That explains the first few months of intense loneliness and stress and their search for networks with other Africans from surrounding towns and states in order to identify themselves in this new environment and to also belong. In a comparative study of migrants in Australia and Canada, Sommerfeld (2011) found that social acceptance of migrants was significant in developing their sense of belonging in their new countries. This is supported by Indiyanto (2012) and Grant and Hogg (2012) who further add that self-identity and acceptance in a group are important for social integration. The study findings are also supported by Ogunsiji et al. (2012) where West African migrant women in Australia expressed how a greeting from their neighbours gave them that sense of belonging and made them happy.

The Future

On arrival in rural NSW, the majority of participants were working in aged care facilities; however, they were not comfortable with their placement in such facilities. At interview, the
majority had moved to acute care settings. The only two participants who were still working in aged care facilities were also working as casual staff members in nearby public hospitals with the intention of leaving the aged care facilities when positions became available in the hospitals. It was not surprising that the participants left the aged care facilities for acute care positions. Firstly, they felt they did not possess adequate skills in the specialty as aged care facilities are not common in Africa and, secondly, it is not congruent with the African culture to care for the elderly/senior citizens in such facilities. This was incongruent with their culture of an extended family structure where families look after their elderly members. Otherwise, participants have embraced their new country and they have had the opportunity to develop and grow personally, as well as professionally, through the process of migration. The majority of participants planned to stay and work in Australia until they retired, especially now that they had positions in their areas of interest. These same participants were, however, not willing to be buried in Australia when the time came; they wanted to be taken back ‘home’ for burial and thus maintain that cultural link with their motherland. It did not matter that they were already Australian citizens. Those who had made up their mind about going back to Africa at the end of their working years were, however, worried for their future grandchildren because, culturally, they felt the obligation to look after them. Their children were planning to settle in Australia and may not want to return to Africa as they do not have such a strong connection to their motherland. In this context, it seems it may take generations to create a new ‘home’ in a new country.

The Link with the Framework

This chapter has sought deeper meanings of this phenomenon of being a nurse migrant in rural Australia. The study is informed by hermeneutic phenomenology as guided by Heidegger’s (1962) and Gadamer’s (1975) work related to the state of being. For participants, the lived experience of being a migrant nurse in rural Australia was their state of being. This state of being incorporated their being visibly different (physically and culturally) and also becoming part of the community as they settled in their new land. Being nurse migrants in rural Australia was their form of being-in-the-world. Participants sought to belong and were determined to be part of their communities. It was culturally difficult for participants to deal with the generally individualistic Australian lifestyle; this is because becoming part of the community, as guided by the African philosophy of ubuntu, was a way of being for them; being with others. Ubuntu is a philosophy of life which emphasises the humanness and interdependency of human beings based on respect for and reciprocity with each other (Gade, 2012). Human beings find themselves in communities and it is within
these communities that they are protected and nurtured (Metz, 2012). This philosophical orientation was embedded in their cultural histories. As the cultural values clashed on this aspect, participants sought to understand the local practices and find ways of becoming part of their communities. The hermeneutics of both Heidegger and Gadamer take understanding as a mode of being and Gadamer describes it as “that intermediate place or being in between what was their familiar culture and what was strange to them” (Gadamer, 1975, p. 263).

Gadamer goes further to expand on the concept of understanding phenomena by relating it to the concept of dialogue and fusion of horizons (Gadamer, 1975). For the participants, it was the positive change by their colleagues and patients towards their presence in the workplace that was showing understanding and acceptance of cultural diversity. They were now being seen beyond their dark skin and the horizons of understanding were fusing. Different perspectives were merging and a common/mutual understanding was developing. The truth was the outcome of the fusion which entailed respect and acknowledging each other for their expertise.

This concept of understanding has also helped me to understand the issues relating to migration of sub-Saharan OQNs to Australia. Gadamer’s view is that when dialogue has been successful there is a fusion of horizons (Gadamer, 1975; Vessey, 2009). Participants have told their stories using language and I have had dialogue with the text from the interviews. The result has been a fusion of horizons, an understanding of the migration phenomenon from the point of view of participants. This understanding has been facilitated through a process of moving in a circular process within the ‘hermeneutic circle’, as explained by Gadamer’s hermeneutics. I started with an understanding of my own migration experience. My ‘pre-understanding’ was necessary for me to understand what the participants were currently experiencing. As I interpreted the participant experiences, I was constantly moving from a “whole to the individual parts and then from the individual parts to the whole” through the hermeneutic circle (Debesay, Nåden, & Slettebø, 2008, p. 58). I was analysing what the participants said and then interpreted it by referring to the broader picture for a clearer understanding.

**Conclusion**

This chapter has discussed the main aspects of the experience that were raised by participants at interview. These were issues relating to their motivation and decision to migrate to Australia, the new beginnings in a new environment, and those issues relating to cultural differences and the racial discrimination they encountered (and sometimes still encounter).
as they settled in. The other aspect related to developing a sense of belonging. The decision to migrate was not just weighing push and pull factors on a scale; it was highly complex and very emotional. Participants were coming from a communal cultural background into an individualistic one. Participants have moved on to embrace diversity and so have local Australians who they interact with, as evidenced by the positive changes that participants described. It has also been noted that the positive support of participants by managers influenced their stay in rural Australia as they felt a sense of belonging and the desire to be part of their communities. The next chapter discusses the conclusions and recommendations from the findings.
Chapter 10: Implications, Recommendations and Concluding Thoughts

Introduction

This phenomenological study explored the experiences of OQNs from sub-Saharan Africa in rural NSW. The study sought to understand their experiences as they migrated to Australia and as they lived and worked in rural NSW. This concluding chapter provides a synopsis of the findings, describes the success of migration and outlines the implications of the findings. These implications relate to clinical practice and education. The chapter also explains the value of the methodology to the study and the limitations of the study. Finally, the chapter provides recommendations as informed by the findings and then draws concluding thoughts from these findings.

Synopsis of the Findings

The Move Across the Indian Ocean showed how the participants made their decisions to emigrate. Participants described economic, family and professional reasons for migrating to Australia, a country they saw as family-friendly and full of opportunities for a better life. It was hard for some participants to make the final decision to move as they were leaving their families behind. They were also anxious, fearing the unknown in a land whose culture they did not know. However, this anxiety quickly disappeared when work management received participants with a warm welcome.

New Life in an Alien Land explored the experiences of participants as they described the loneliness, guilt and stress they felt in their first few months after arrival due to family separation. They also felt they were discriminated against at work based on their darker skin. They felt unwelcomed and undervalued by their colleagues and patients whilst in some instances they felt hindered from professional advancement by their management. Often, an inadequate orientation put them at a disadvantage from the beginning and reduced their confidence, especially in aged care facilities where they had little experience of working as RNs. Participants also noted the cultural diversity that existed; they saw a society where people would address each other informally and tended to keep to themselves. Some cultural practices were found to be in contrast to what participants expected, causing cultural shock in some instances, as in cases of death in a family. In response to these cultural differences, participants tended to hold onto their own cultural practices, adopting just a few of the
Australian practices. However, participants welcomed the autonomous culture of nursing care in Australia and the patient-oriented model of nursing care. Similar to Gadamerian hermeneutics (Gadamer, 1975) and through their experiences, participants constructed meaning of their migration by being in the world, the new alien land in this case. They created their world from understandings and experiences in this new world as they related to it.

*Developing a Sense of Belonging and Moving On* discussed how participants experienced a positive change, over time, as some of their colleagues and patients were now accepting them and seeing them beyond their dark skin. This acceptance gave participants confidence in their work and a feeling that they belonged. They also embraced the Australian culture and sought to advance themselves, professionally, when opportunities arose. Their desire to be part of their communities was coming to fruition and this was significant to participants who had come from a background of communal living, driven by the philosophy of *ubuntu*.

**The Success of Migration**

Notwithstanding the migration challenges that they encountered, the overarching message from participants was that migration to Australia was a positive experience. This was helped by support from their employers and supervisors. Participants did not forget that in all this there were many local community members and work colleagues who received them with open arms and went out of their way to assist them in their time of need. This was a time of transition for participants as they were adapting to a different culture in a new environment. In line with the final stage of culture shock, as described by Ward et al. (2001), participants described themselves as being happy in Australia, embracing their newly found home with most of them taking up citizenship. As they reflected, participants expressed no migration regrets; in fact, Australia changed their lives. Participants have grown, they have learnt a lot and have transformed through the experience of migration. Living and working in a multicultural environment has transformed participants’ lives in terms of their personal, professional and social networks in their new country.

These participants were persistent, resilient and determined; they had an inner toughness that saw them through this sometimes rocky journey. They could not afford to come all the way from Africa only to fail in their endeavours. It seemed there was no going back for them. Returning to Africa could be seen as failure by their former colleagues, families and communities in Africa. As loyal members of their families, they had to be exemplary because
they were not doing this just for themselves but for the whole family, if not their community, back in Africa. The African sense of reciprocity, that mutual obligation to each other as family members, was at play here and is the African philosophy of life. So, being a sub-Saharan African nurse with this cultural obligation was an asset for the nurses themselves. The migration of these OQNs was successful for Australia as well, particularly the nursing profession, to have gained people with such a determined mindset. So the benefit was mutual. These were nurses who had an orientation towards the future; they were very strategic, right from an early age: setting goals, being educated in their home countries, becoming migrants, getting a job and settling in Australia. They had a purpose in life. They have completed quite a few postgraduate courses since coming to Australia and are moving on with their desires to achieve more by strategically positioning themselves for opportunities in the workforce. These experienced OQNs should be seen as adding value to the Australian health service. Institutions could not ask for more in an employee.

In addition, by virtue of being OQNs, they brought with them many years of nursing experience and problem-solving skills. The participants possessed tremendous problem-solving skills which they applied to so many migration challenges they encountered such as arranging for their children as they left their countries and working in discriminatory conditions. Australia is a multicultural society where we should all be strengthened by diversity. While participants have enriched the Australian multicultural rainbow, they have also added to the challenge of cultural competence in the nursing profession. Australia houses the world’s longest surviving culture and has the world’s richest cultural history (Broome, 2010). The worldwide trend now is for everyone to be culturally competent in health care (Dreachslin, Gilbert, & Malone, 2013). Therefore, the OQNs are giving Australians a real lived opportunity to be culturally aware, culturally sensitive and culturally competent.

Participants offered a few suggestions to help OQNs settle smoothly in to their workplaces. Although they were aware of the expenses involved in the adaptation program, participants felt an adaptation pathway could have given them a head start and the confidence they needed to work in unfamiliar aged care environments. For aged care facilities, they suggested a well-organised orientation program that appreciates the cultural background of OQNs who have had very little, if any, experience in aged care. For acute care hospitals, participants suggested a formal standardised orientation approach that operates under the guidance of a hospital committee created to address the needs of migrant nurses. Migrant nurses are likely to have personal and social challenges that may affect their work.
performance; therefore, more support needs to be provided through the orientation program. The orientation itself would benefit from being at least two weeks in duration and conducted by designated people. This orientation should include information not just about the Indigenous culture but the general Australian culture as well. Participants thought that this lack of cultural knowledge affected their performance and the way they related to other staff as well as patients.

Implications of the Findings

Firstly, the implications are for policy makers in African source countries who need to retain their nursing staff, a much-needed resource in those countries. The findings, supported by the literature (Buchan et al., 2006; De Veer, Den Ouden, & Francke, 2004; McCann et al., 2010), have shown that it is not only economic incentives that drove the nurses out of their countries. These source countries need to also improve working conditions and social security in their countries. They could invest more resources in their health systems and, thus, improve working environments for nurses to perform their duties in safe environments that also provide opportunities for professional development. Nurse managers in these countries should advocate for nurses by promoting opportunities for professional development. This might motivate nurses to stay in their countries. There are also implications for recipient countries that need to put in place effective strategies to address cultural, discrimination and orientation issues raised by participants.

Clinical Practice and Education

The study findings have implications for clinical practice and education and these can be used to develop specific programs for African nurses. The findings also have implications for the management of international nurse recruitment and orientation programs for African nurses in rural NSW.

Considering their cultural background and the need for workers in aged care facilities at the time, these African nurses needed an orientation program that was specific to them with a different approach to their support needs as this was not a familiar environment for them. Kirkcaldy et al. (2005) found that different groups of migrants generally required different forms of support to help with their different coping strategies. Support for these OQNs should have been ongoing; negative experiences could have been avoided had there been a standardised orientation program for these nurses in rural Australia. The orientation programs need to include information on the Australian culture generally, not just the
Indigenous culture. Participants seemed to struggle with understanding the general Australian culture. Sometimes these cultural issues are generally taken for granted to be understood until someone notices the differences.

To the recruiters, be it agents or employers directly recruiting, the findings of this study show that African nurses require more support and effective intervention planning in general to assist them with settling and integration, particularly in the workplace. They needed support due to the discrimination identified in the workplace.

The findings also showed a lack of understanding of cultural diversity by some people in the general and health professional population in rural Australia. Australia is widely known as a multicultural country; it would help for the citizens of the country to be more culturally accommodating and open to cultural diversity. Cultural diversity enriches the workplace through multiculturalism. More public and professional training on cultural diversity could help.

The study findings raised interesting issues/questions related to the experience of OQNs with Indigenous Australians and aged care nursing in rural Australia.

**Indigenous Community Consultation**

The reaction of Indigenous people to participants brought a dimension that could relate to possible communication issues in rural communities. Indigenous people were either not informed about skilled worker migration to their areas, leading to a feeling of being invaded once more or, if they were aware, the communication system was probably not working very well. A possible question for further research would relate to what communication there is between local councils or local health authorities and Indigenous communities and how these rural local authorities consult with Indigenous leadership. Could it be that these authorities focused on just filling vacant posts without thinking of the possible ramifications of their decision making in terms of impact of sub-Saharan African OQNs on the community?

**Aged Care Nursing**

Although this study was not focused on aged care, the findings demonstrated an interesting dimension related to aged care in rural NSW. The literature has shown that rural health services are the worst affected by staff shortages and aged care facilities suffer high turnover rates (Gao, Tilse, Wilson, Tuckett, & Newcombe, 2015). Participants found aged care facilities had very few, if any, RNs on the staff; in some cases, there were agency nurses
who were not permanent. Aged care, especially in rural areas, seems to be shunned by nurses generally. The implication here could relate to the low status accorded to aged care (Algoso, Peters, Ramjan, & East, 2016) as it is generally not considered a nursing specialty, due to the notion that it is different from acute care nursing that saves lives. It is noted that these facilities were understaffed and so OQNs were recruited to fill those vacancies. However, the findings show that aged care nursing fell out of favour among participants as most of them had moved to acute care nursing at the time of interview. This was not surprising as these were OQNs from sub-Saharan Africa where residential aged care is not the norm. The adequate presence of local nurses in aged care facilities could have helped to properly orientate the OQNs in order to develop an adequate understanding of this aspect of nursing and possibly yield positive outcomes from the implementation of this rural migration scheme.

The Value of the Methodology to This Study

Hermeneutic phenomenology, as guided by Heidegger (1962) and Gadamer (1975), provided the framework to explore the experiences of sub-Saharan African OQNs. The methodology gave participants the opportunity to narrate their migration stories as they lived and worked in rural Australia. They described their ‘state of being’ in rural Australia based on their personal understanding of their experiences as migrants, particularly as well-qualified black migrants working in health. As the researcher, I transcribed the narratives to text and interpreted them with the help of the participants’ understanding and my own understanding and experiences of international nurse migration. The resultant product from the fusion of our horizons gave a clearer understanding and meaning of what it is to be a sub-Saharan African OQN living and working in rural Australia.

The hermeneutic phenomenological approach was a strength to this study as it sought to explore the lived experiences of the participants; these experiences were described as understood by the participants themselves. The study gave knowledge and insight into the experiences of African nurses, and this should contribute significantly to the current body of knowledge on nursing and international nurse migration. Use of an FGD was a particular strength to the study of participants of African origin, considering it was their cultural way of storytelling; this gave participants the opportunity to freely express themselves.
Limitations

The limitations of this study included the geographical African country imbalance as there were no participants from West and Central Africa and the Horn of Africa. Participants were mainly from East and Southern Africa. This may have been due to the East and Southern African countries being former British colonies with English as their other medium of communication. Their nurse training had British origins and was similar to the Australian system, hence, participant qualifications from these Southern countries were acceptable to Australia. Although the study was open to all sub-Saharan African nurses, participants were all black nurses, depriving the study of experiences of sub-Saharan African nurses from other races.

Recommendations

International nurse migration can be challenging for both migrant nurses and recipient health institutions. The recommendations that follow arise directly from the findings of the study and are not exhaustive. Some of these recommendations were suggested by the participants themselves during interviews. Recommendations discussed in this section include those related to workplace orientation of participants and issues relating to equal opportunity and cultural diversity. As well, recommendations for further research are made.

Orientation

It is appreciated that a lot may have been done to improve the orientation of OQNs generally, since the active recruitment of OQNs by Australia two decades ago (Australian Nursing & Midwifery Federation, 2015); however, there are specific cultural needs of new African nurse migrants.

There is a need for an orderly and standardised orientation program for all nurses from sub-Saharan Africa. Having the same orientation as Australian nurses from other AHSs with nothing more for the African recruits is insufficient due to the substantial differences in culture and technological advancement. Participants need a more detailed and organised form of orientation especially if they work in a different work environment; this was particularly apparent in aged care facilities as these are rare in sub-Saharan Africa. Participants wished there were appropriately trained and designated people to conduct orientation programs. Ongoing mentorship at ward level could be strengthened by at least nominating someone the OQNs can go to as they settle in their workplace.
Recruiting organisations could provide more pre-departure information in relation to the Australian social and work culture. Some participants found it difficult to settle in the wards and aged care facilities they were working in, as they hardly had any orientation to Australian policies and procedures that could guide them. Recruiting organisations can assist with the transition of these nurses to the Australian healthcare system by first understanding the migration and cultural experiences of these African nurses and then by tailoring their information packages accordingly. OQNs need information about their new country and their new work environment and the culture in both. The findings from this study will expand that knowledge and assist the transition and integration of these nurses.

**Equal Opportunity**

There is a need for a review of workplace equal opportunity policies, especially in acute care facilities, in response to the OQNs who perceived they were sidelined from advancement opportunities in their work units because of their African background. This could indicate that the current policies are ineffective in ensuring equal opportunity for all. A review and further implementation of such policies might assist.

**Cultural Diversity**

With international nurse migration continuing to increase (Stankiewicz & O’Connor, 2014), so will diversity in health organisations. There should be early identification and acceptance by all of diversity including its appropriate management. There was an expectation for staff to show a professional and welcoming behaviour towards participants, but that cannot be relied upon. Employers should train their staff on cultural diversity and the significance of tolerance in cases of differences as difficult subtle behaviour usually occurs in the absence of managers. Health employers should make it clear to their staff, patients and visitors that racial discrimination will not be tolerated. Employers of OQNs, particularly black African OQNs, should ensure a psychologically safe work environment for these nurses to increase their acceptance in the workplace by both patients and staff. A positive work environment could have increased participants’ confidence and job satisfaction as supported by the ICN (2007, p. 59), “We believe patients and the public have the right to the highest performance from nurses and other healthcare professionals. This can only be achieved in a workplace that enables and sustains a motivated, well-prepared workforce”. The starting point could be the orientation of existing staff on cultural diversity before the OQNs arrive and show how this helps individuals grow and also helps build organisations. Participants added diversity
to the nursing workforce in rural NSW. Workplace diversity should be celebrated because it can be an advantage to organisations as they respond to a society that is increasingly becoming culturally diverse. Staff in the healthcare sectors need more knowledge on cultural diversity and to learn to accommodate OQNs and treat them as colleagues.

**Further Research**

A recommendation for further research would include an investigation comparing the lived experiences of OQNs from different cultural backgrounds in rural Australia. This will add more knowledge to the body of understanding international nurse migration, especially to rural areas. Another recommendation would be the investigation of the lived experiences of Australian nurses who have worked with OQNs from sub-Saharan Africa, especially those who have mentored them. They may give a different perspective of the experiences and the challenges they may have faced working with these OQNs. The study may clarify the impact that this has, overall, on workplace culture and how African nurses are accepted. Information from both sides may help in planning orientation and staff development programs in healthcare settings. In addition, a study on the experiences of local rural Australians, including Indigenous populations, to the presence of OQNs in their localities would probably also shed light on how they have changed, if at all, from their original cultural understanding and patterns.

**Concluding Thoughts**

The lived experience of participants as they migrated and lived in rural NSW formed the basis of this study. The hermeneutic phenomenological concept of state-of-being as propounded by Heidegger (1962) and expanded by Gadamer (1975) framed the methodology. Being nurse migrants in rural Australia was the participants’ form of being-in-the-world. Participant stories revealed the experience of the African nurse in rural Australia. They recalled their varied migration motivations and the amazing welcome they received from their Australian employers, only to feel discriminated against by their colleagues and patients as they entered their workplaces. Participants felt this was based on racial as well as cultural differences. Colleagues did not recognise the value of the nursing experience that participants brought with them; yet they could have gained from that experience and the cultural diversity that was provided by these African nurses. This can be considered a missed opportunity for all. Colleagues doubted the participants’ competence and goodwill in performing their nursing duties. In all this, participants endeavoured to maintain their integrity as professional nurses as best they could.
The main message from their migration experience was not so much the beginning part when they had difficulty in deciding whether or not to migrate because that can happen to anybody going to a new country; it was when participants got to rural Australia that cultural differences and racism became major issues, coupled with participants’ efforts to belong to their rural communities. Even when participants moved or changed employers, they still remained in rural Australia showing their commitment to the region. It is the hope of the author that the reader will listen to the voices of these African nurses as they recount their navigation of the Australian healthcare system and the Australian rural society at large.

It is my belief that participants have contributed to a sustainable and competent health workforce in rural Australia as they migrated to relieve a critical nursing shortage in the country and have shown their intention to stay longer in rural Australia.

The experience described by participants in this study emphasises the need to acknowledge each other, as found in the philosophy of ubuntu. If only all the staff at the workplace, including the black nurses themselves, would live and work by this philosophy, rural Australian health institutions would be better places to work in. Due to being discriminated against, marginalised and not trusted, participants went through much stress and often felt lonely. Indigenous Australians have challenged us to live well in a world that is worth living in (Grant & Rudder, 2010).

Given that Australia will continue recruiting OQNs for some time to come, there is a need to appreciate their significant contribution to the Australian healthcare system and the beauty of cultural diversity in the workplace. The study provided a platform for participants to voice their experiences; their participation in the study was based on the premise expressed by one of the participants:

*Yeah, I’m happy if we’re doing interviews like these, maybe the authorities can try and address these issues that happen every day.*

(Linda)
References


Mansouri, F., & Lobo, M. (Eds.). (2011). *Migration, citizenship, and intercultural relations: Looking through the lens of social inclusion (Studies in migration and diaspora)*. Farnham, United Kingdom: Ashgate.


Xu, Y., & Zhang, J. (2005). One size doesn’t fit all: Ethics of international nurse recruitment from the conceptual framework of stakeholder interests. *Nursing Ethics, 12*(6), 571–581. doi:10.1191/096973305ne827oa


Appendix A: Study Advertisement

An invitation to overseas-qualified nurses to participate in a Research Study

Are you:
- An overseas-qualified nurse (OQN),
- Whose 1st nursing qualification was obtained in sub-Saharan Africa, and
- Who is working in rural NSW?

If you have answered ‘YES’ to all questions above, you are invited to participate in a study that seeks to explore the migration experiences of OQNs from sub-Saharan Africa to Australia. This will be done through an interview and/or focus group discussion for about 1-2 hours at a place of your convenience.

LET YOUR VOICE BE HEARD!

For more information please contact Sophia Dywili (PhD Student at Charles Sturt University) on:

Email: sdywili@csu.edu.au
Mobile: 0400 429 756
Work: 02 6933 2452

http://www.123rf.com/photo_880571_globe-plan.html
Appendix B: Participant Information Sheet

My name is Sophia Dwyer and I am a Registered Nurse, Registered Midwife and a lecturer at Charles Sturt University where I am undertaking PhD studies.


I am contacting you because you are an Overseas Qualified Nurse (OQN) from sub-Saharan Africa. I am requesting your formal consent for participation in an interview that will be carried out at a place and time convenient for you.

The Project: The purpose of the research is to gain an understanding of the experiences of OQNs following their migration from sub-Saharan Africa to work in rural Australia. This study will give you an opportunity to share your migration experiences and what it is like for you to live and work in Australia. The results of this study could have implications for the development of orientation and integration programs for OQNs working in rural NSW and VIC.

Your participation will involve attending a 1 – 2 hour face-to-face individual interview and/or a focus group discussion (FGD) with open-ended questions that will allow you to tell your story as you know it and give a broader and deeper understanding of the experiences. Below is a list of broad areas you may wish to include as you share your experiences. The interview will be held at a quiet place and time convenient for you and I – this could be your home or a quiet public spot for the FGD. Should you recall uncomfortable/upsetting negative experiences during the interview, you will be free to stop the interview, arrange for another day or even withdraw from the study if you wish.

In addition you will be encouraged to contact the employment assistance program (EAP) at your place of work if needed be. To keep an accurate record, the interview will be tape recorded and then transcribed (typed) for easy analysis. During the research your contact details will be kept in a password-protected computer and your consent form kept in a locked cabinet. Although I will know who you are during the interviews, all data collected from the interviews will be kept confidential and your name or any other identifying information will not be used for publication. A fictitious name will be used (if needed) when referring to your comments in the research report.

Access to data: Data collected in this research study will only be available to me and my PhD supervisors Elaine Dietrich, Louise O'Brien and Judith Anderson. However, as I have a duty of care, I will be required to report any disclosed incidents that constitute illegal or unprofessional conduct. You will be provided with a copy of the transcript if you wish and a summary of the findings will be available to you. There is a possibility that the findings of this study will be presented at academic conferences as well as in journal articles and in the PhD thesis. The tape recordings and transcripts will be kept by the CSU at a safe and secure place and then destroyed after 5 years.

www.csu.edu.au

CRICOS Provider Numbers for Charles Sturt University are 00005F (NSW), 01387G (VIC) and 00210N (ACT). ABN 42 828 708 651

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I am asking you to agree to participate by reading and signing (at interview time) the attached Consent form. Your participation in this study is voluntary. There are no penalties if you refuse to take part or should you decide to withdraw from the study.

Please feel free to contact me if you have any questions about this research project.

**Contact Details**

**Principal Investigator**
Sophia Dywill (PhD student)
Charles Sturt University, School of Nursing, Midwifery & Indigenous Health
Wagga Wagga Campus, Locked Bag 588, NSW, 2678
Telephone (Work): 02 6933 2452  Telephone (Home): 02 6971 7769  Mobile: 0400429756
Email: sdywill@csu.edu.au

<table>
<thead>
<tr>
<th>Principal Supervisor</th>
<th>Co-Supervisor 1</th>
<th>Co-Supervisor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Elaine Detlich</td>
<td>Prof. Louise O’Brian</td>
<td>Dr. Judith Anderson</td>
</tr>
<tr>
<td>Associate Professor of Midwifery</td>
<td>Professor of Nursing (Mental Health)</td>
<td>Lecturer, Charles Sturt University</td>
</tr>
<tr>
<td>Charles Sturt University</td>
<td>University of Newcastle</td>
<td>Phone: 02 6338 4640</td>
</tr>
<tr>
<td>Phone: 02 6933 2762</td>
<td>Phone: 02 6338 4630</td>
<td>Email: <a href="mailto:iandersson@csu.edu.au">iandersson@csu.edu.au</a></td>
</tr>
<tr>
<td>Email: <a href="mailto:edetlich@csu.edu.au">edetlich@csu.edu.au</a></td>
<td>Email: <a href="mailto:lobrien@newcastle.edu.au">lobrien@newcastle.edu.au</a></td>
<td></td>
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</tbody>
</table>

**NOTE:** Charles Sturt University’s Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Office of Academic Governance
Charles Sturt University
Panorama Avenue, Bathurst NSW 2795
Tel: (02) 6338 4628
Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Thank you for taking the time to read this Information sheet.

***********************************************************************

**www.csu.edu.au**

CRICOS Provider Numbers for Charles Sturt University are 00005F (NSW), 01597G (VIC) and 04990B (ACT). ABN: 85 678 708 551.
Appendix C: Consent Form

CONSENT FORM


Name of Principal Investigator (PhD student):
SOPHIA DYWILI, School of Nursing, Midwifery & Indigenous Health, Charles Sturt University, Wagga Wagga, Private Bag 588, NSW, 2678

I have read and understood the information sheet given to me explaining the purpose of the research and the potential risks associated with participating in the research project. I have also been given the opportunity to ask questions about the research.

I understand that I am free to withdraw my participation in the research at any time, and that if I do, the information I provided will be destroyed (excluding the information I would have provided in a focus group discussion) and I will not be subjected to any penalty or discriminatory treatment. I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published. I understand that interviews will be individual and/or part of a focus group and will be audio taped. I permit the investigator to tape record and publish information from my interview (that does not identify me or any place) as part of this research.

I understand that if I have any complaints or concerns about this research I can contact:

The Executive Officer: Human Research Ethics Committee
Office of Academic Governance
Charles Sturt University
Panorama Avenue
Bathurst, NSW, 2796
Phone: (02) 6338 4628 Email: ethics@csu.edu.au

Signed: ____________________________ Print name: ____________________________ Date: ____________________________
Address: ____________________________________________________________________________

__________________________________________________________________________________

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Appendix D: Ethics Approval Letter

12 November 2012

Ms Sophia Dywili
School of Nursing, Midwifery &
Indigenous Health
WAGGA CAMPUS

Dear Ms Dywili,

Thank you for the additional information forwarded in response to a request from the Human Research Ethics Committee (HREC).

The CSU HREC reviews projects in accordance with the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Research Involving Humans*.

I am pleased to advise that your project entitled “The Experiences Of Sub-Saharan African Overseas-Qualified Nurses And Midwives Working In Rural Australia: A Hermeneutic Phenomenological Study” meets the requirements of the *National Statement*, and ethical approval for this research is granted for a twelve-month period from 12 November 2012.

The protocol number issued with respect to this project is 2012/191. Please be sure to quote this number when responding to any request made by the Committee.

Please note the following conditions of approval:

- all Consent Forms and Information Sheets are to be printed on Charles Sturt University letterhead. Students should liaise with their Supervisor to arrange to have these documents printed;
- you must notify the Committee immediately in writing should your research differ in any way from that proposed. Forms are available at: http://www.csu.edu.au/__data/assets/word_doc/0010/176833/ehrcrep.doc;
- you must notify the Committee immediately if any serious and/or unexpected adverse events or outcomes occur associated with your research, that might affect the participants and therefore ethical acceptability of the project. An Adverse Incident form is available from the website as above;
- amendments to the research design must be reviewed and approved by the Human Research Ethics Committee before commencement. Forms are available at the website above;

Version 3

FIA

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CRICOS Provider Numbers for Charles Sturt University are 00009F (NSW), 01047G (VIC) and 602900 (ACT). ABN: 83 878 739 851

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• if an extension of the approval period is required, a request must be submitted to the Human Research Ethics Committee. Forms are available at the website above;
• you are required to complete a Progress Report form, which can be downloaded as above, by 12 November 2013 if your research has not been completed by that date;
• you are required to submit a final report, the form is available from the website above.

YOU ARE REMINDED THAT AN APPROVAL LETTER FROM THE CSU HREC CONSTITUTES ETHICAL APPROVAL ONLY.

If your research involves the use of radiation, biological materials, chemicals or animals a separate approval is required from the appropriate University Committee.

The Committee wishes you well in your research and please do not hesitate to contact the Executive Officer on telephone (02) 6338 4628 or email ethics@csu.edu.au If you have any enquiries.

Yours sincerely

Julie Hiels
Executive Officer
Human Research Ethics Committee
Direct Telephone: (02) 6338 4628
Email: ethics@csu.edu.au

Cc: Associate Professor Liona Dierick Professor Louise O’Helen Dr Judith Andersen
Appendix E: Sample of NVivo Code Development

Theme: New Life in an Alien Land

- Separation from Family
- Racial Discrimination: Being Visibly Different in the Workplace
- Being Culturally Different
- Feeling Unwelcome in the Workplace
- Being Undervalued and not trusted as Professionals
- Coping with being Different

- Doctors relaying information to me through junior staff
- Patients checking with AIN if I gave correct medications
- So you find they will give managerial positions to the white people
- I don’t want my mother to be nursed by a black person....
- They didn’t expect an African to be educated and come in and work as their team leader