

A PHENOMENOLOGICAL STUDY OF SOUTH AFRICAN NURSE MIGRATION AND WORKPLACE REINTEGRATION UPON RETURN

A RESEARCH REPORT

By

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Declaration

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Abstract

Return migration is becoming more popular as more countries with developing economies realise the potential of returnees, with encouragement of participation in improving the country.

This study investigates the push and pull factors influencing nurse migration from South Africa (SA), as well as return migration in relation to the ease with which workplace reintegration takes place.

The methodology applied in this study is that of descriptive (Husserlian) phenomenology within a qualitative approach. Purposive and snowball (network) sampling was done to obtain candidates with experience about the phenomenon. Ethical approval was granted by the Health Research Ethics Committee of Stellenbosch University for the study and approval to participate was obtained from the ten participants by way of their written informed consent.

A pilot interview was conducted, followed by data collection via semi-structured interviews. These interviews were audio-recorded and then transcribed verbatim. Transcriptions were analysed, emerging themes identified, and the data coded accordingly. Member checking was done throughout, to ensure that the true meaning of the situation was portrayed: Interviewees were engaged with several times to clarify statements and information given regarding the status quo at the time of migration and return to ensure that the lived experiences of the participants were captured as fully as possible. The results were discussed in detail to portray the full extent of the experiences of the participants. Anonymity was maintained throughout the process to prevent exposure of the participants and to encourage true opinions. Trustworthiness was ensured with special attention paid to credibility, transferability, dependability and confirmability.

The findings of this study show that the majority of participants migrated for economic reasons, since the remuneration in the SA healthcare sector is inadequate to make ends meet. However, once the main goals were attained, the majority returned to SA to fulfil

their parenting role. Furthermore, workplace reintegration was found to be an individualised journey with negative and positive experiences along the way. It appears that successful sustainable workplace reintegration in SA depends mainly on two factors: current SA workplace issues that need to be addressed on management level, and the ability and the willingness of the individual to adapt to SA circumstances on return.

In conclusion, the phenomenological approach used to obtain return migrant nurses lived experiences during their reintegration in the SA workplace allowed the researcher a deeper understanding of how they perceived this work environment, following international nursing exposure.

Key words: Keywords used during the search: migrant nurse, brain drain, migrant health workers, return migrant nurses, brain gain, reintegration of return migrants

Opsomming

Migrasie terug na die land van herkoms raak al hoe gewilder in lande met ontwikkelende ekonomieë. Dit gaan gepaard met erkenning van die potensiaal van diegene wat terugkeer en aanmoediging van hul deelname aan die ontwikkeling van die land.

Die studie ondersoek die faktore (druk na buite en trek terug na SA) wat verpleegmigrasie uit Suid Afrika (SA) beïnvloed, sowel as die terugkeer en gemak waarmee herintegrasie in die werkkplek plaasvind.

Beskrywende (ook bekend as Husserliaanse) fenomenologiese kwalitatiewe navorsingsontwerp is in hierdie studie toegepas. Doelgerigte en sneeubalproefneming is gedoen om deelnemers se ervaring van die verskynsel te bepaal. Etiese goedkeuring vir die studie is van die Gesondheidsnavorsingsetiekkomitee van die Universiteit Stellenbosch verkry en die deelnemers het skriftelike, ingeligte toestemming gegee.

'n Loodsonderhoud is gevoer, gevolg deur data-insameling deur gebruik te maak van semi-gestruktureerde onderhoude. Dit is opgeneem en daarna woordeliks getranskribeer. Die transkripsies is ontleed, ontluikende temas geïdentifiseer en die data ooreenkomstig gekodeer. Deelnemerkontrole is deurentyd gedoen om te verseker dat die

ware betekenis van die situasie weergee is. Deelnemers is verskeie kere geraadpleeg om stellings te verduidelik en inligting te gee met betrekking tot die status quo ten tyde van migrasie en terugkeer. Dit het verseker dat die ondervindinge soos beleef deur die deelnemers so volledig moontlik vasgelê is. Gedetailleerde besprekings van die resultate het gevolg om sodoende die volle omvang van die deelnemers se ondervindinge uit te beeld. Anonimiteit is regdeur die proses gehandhaaf om blootstelling van die deelnemers te voorkom en om verkryging van ware opinies aan te moedig. Betroubaarheid is verseker deur spesiale aandag aan geloofwaardigheid, oordraagbaarheid, betroubaarheid en bevestigbaarheid te gee.

Die bevindinge van hierdie studie wys dat die meerderheid van deelnemers om ekonomiese redes migreer, omdat die vergoeding in die SA gesondheidssektor onvoldoende is om van te leef. Wanneer hoofdoelwitte egter bereik is, het die meerderheid na SA teruggekeer om hul ouerlike rol te vervul. Verder is daar bevind dat werkplekherintegrasie 'n geïndividualiseerde reis met negatiewe en positiewe ervarings onderweg is. Dit blyk dat suksesvolle, volhoubare werkplekherintegrasie in SA van hoofsaaklik twee faktore afhang: die huidige SA werkplekkwessies wat op bestuursvlak aangespreek moet word, en die gewilligheid van die individu om met terugkeer by SA omstandighede aan te pas.

Ten slotte het die navorser die fenomenologiese benadering gebruik om die ervarings van terugkerende migrerende verpleekkundiges – soos beleef en weergegee tydens werkplekherintegrasie – te ondersoek. Dit het die navorser in staat gestel om dieper insig te kry in hoe hul die werksomgewing na internasionale verpleegblootstelling ervaar.

Slutelwoorde: Migrerende verpleegkundiges, breindrein, migrerende gesondheidswerkers, breinwinnings, herintegrasie van terugkerende migrerende verpleegkundiges

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Abbreviations

BLS	Basic Life Support
ICU	Intensive Care Unit
KSA	Kingdom of Saudi Arabia
P	Participant
RN	Registered Nurse
R425	Diploma in Nursing (General, Psychiatry and Community) and midwifery
SA	South Africa
UAE	United Arab Emirates
UK	United Kingdom
US	United States of America
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO STUDY

1.1 Introduction

Temporary versus permanent migration became a new game-changer in the dynamic mobile labour market, and Kingma (2007:2) mentions that it was bound to attract its fair share of attention.

Further, the global migration pattern has changed considerably from unskilled to highly skilled workers through the years, with this phenomenon often referred to as 'brain drain', according to Clemens (2014:1). Oladeji and Gureje (2016:61) add that the migration flow is often from developing countries to more developed countries. South Africa and other sub-Saharan countries are no exception to this pattern. However, authors such as George, Atujuna and Gow (2012:14) recognise the negative impact migration of health workers has on the already constrained health system, adversely affecting delivery of health services to the neediest African populations.

The individual's motivation for migration is complex (Biondo, Pluchino & Rapisarda, 2012:1), with the process of migration being driven by push and pull factors (Lee, 1966:48). Temporary migrant workers are more likely to return to their country of origin after working for a predefined time (Kingma, 2007:2). This is due to pull factors for return migration, such as strong family ties, goal attainment and policy changes such as economic improvement in country of origin (Haour-Knipe & Davies, 2008:9). Sometimes conditions in the host country are not what they were envisioned to be when they migrated, as reported by South African nurses who returned from the United Kingdom (UK). Economic downturn and political pushes within the host country may also be behind the return of migrant nurses (Haour-Knipe & Davies, 2008:9). Some host countries are developing their own workforce, as demonstrated by the process of Saudiasation to increase the workforce of Saudi nationals in Saudi Arabia to 30% by 2020. Dr Al Yamany (2015:1), during an interview, mentioned that the establishment of King Fahad Medical City (a hospital in Saudi Arabia's capital) is in line with this goal. If successful, it could

generate a higher return of migrant nurses from Saudi Arabia to return to their countries of origin, serving as a push factor.

The focus of this study was on the return of migrant nurses and the reintegration process into the workplace in South Africa. When migrant nurses return to South Africa to join the healthcare system, they come with new skills acquired abroad. They have often been exposed to the latest technology while working elsewhere. They often do not return in large enough numbers to alleviate the staff shortage, and because of poor reintegration, tend to look for work abroad again. The duration of return migration rests mainly on the individuals' preparedness towards reintegration. With this research, the researcher endeavoured to identify reasons why South African nurses are likely to migrate in search of employment, and to explore workplace reintegration experiences upon return to South Africa.

1.2 Significance of problem

Many developing countries are currently facing the consequences of a brain drain to developed countries. This manpower loss to another country exacerbates the skill shortage and increases the workload for non-migrants, negatively affecting equity in healthcare distribution (Organization for Economic Co-operation and Development (OECD), 2010:1).

Skilled workers are wanted back in their home country, and some governments such as China (Battistella, 2014:3) and South African have amended their policies to encourage a reverse brain-drain with salary and benefits increments. The impact of brain gain via reintegration of those returning migrants should by implication have a positive impact on their country of origin.

There is a dearth of literature internationally and nationally regarding return migrant nurses and reintegration in the workplace. There is a need to improve research on return nurse migration and its effects on the delivery of nursing care in country of origin (Haour-Knipe & Davies, 2008:3; 9).

Understanding of the reintegration process may shed light on possible difficulties and how to cope with them, for retention in the workforce in the home country to take place. Further, it could assist in relevant policy-making and improved practice.

1.3. Rationale

The permanent or even transient return of migrant nurses may have a positive effect on alleviating the shortage of nursing staff, and help towards sharing of knowledge and skills acquired abroad. Records and statistics on return migration are scant and inaccurate as many countries of origin do not keep record of outward migration of skilled workers, while destination countries employ different criteria to collect data, increasing the complexity surrounding the phenomenon (Haour-Knipe & Davies, 2008:8).

Battistella (2014:25) bemoans the fact that appropriate attention is not paid to the return of nursing staff from abroad, resulting in a lack of knowledge and research and subsequently little if any legislation is formulated or enforced to obtain details of the returning migrants. Four studies have been found regarding the return of migrant nurses of which Brown (1997) focused on Jamaican nurses returning from the United States, Battistella (2014:25) researched Filipino nurses returning from different destinations, Haour-Knipe & Davies (2008:23) together with Breier, Wildschut and Mqgqolozana (2009:58) studied South African nurses' return from the UK and Efendi, Purwaningsih, Qur'aniati, Kurnaiti, Singka *et al.* (2013:151) looked at the return migration of Indonesian nurses.

In developing countries, great initiative has to be taken to engage any available and returning qualified nursing staff to become re-employed in the country's health care system. Developed countries have the funds to promote ongoing education and on-job training whereas developing countries' lack of funds restrict some mandatory activities. Returning nurses' exposure towards these opportunities would prove to be invaluable (Haour-Knipe & Davies, 2008:14) for gaining more knowledge and improving nursing practices in country of origin (Li, Nie & Li, 2014:316) and, ultimately, the health system

(Efendi *et al.*, 2013:158). Exposure to a newly acquired skill set should be an advantage to any potential employer keen to encourage fresh ideas and transformational leadership in the 21st century.

1.4 Research problem

According to Makhubu (2016) South Africa's healthcare sector and nursing profession is in deep crisis partly because many South African nurses are migrating abroad in search of better employment conditions. Thus, the effects of professional nurse migration have a negative impact on the disadvantaged population.

Return migration of nurses is an understudied phenomenon, can have positive effects in the country of origin (Haour-Knipe & Davies, 2008:24). Despite the valuable knowledge and newly learnt skills obtained by South African migrant nurses while working abroad, on return they are often faced with challenges during reintegration in the workplace. Based on the researchers' experience, many returnee migrant nurses seem to seek employment abroad again after only a short period in their home country, without proper reintegration into their South African workplace environment. This is indicative of problems with reintegration. A private health company known as Netcare used the 'homecoming revolution' to lure skilled migrant workers to address the shortage of nurses and assist them in returning and reintegrating in SA (Breier *et al.*, 2009:58). However, re-migration intention indicates that returnees doubt how welcome and needed they really are.

1.5 Research questions

What are the push-pull factors influencing the decisions of South African nurses to migrate internationally?

What are the push-pull factors influencing the decisions of South African nurses working abroad to return to their homeland?

What are the experiences of returnee migrant nurses regarding reintegration in the workplace in South Africa?

What could possibly influence returnee migrant nurses to seek employment abroad again?

1.6 Research aim

The aim of this study was to identify the factors that influenced South African nurses to migrate internationally for employment and return to homeland, in order to explore, describe and gain an understanding of the reintegration experiences of migrant nurses in the workplace on return to South Africa.

1.7 Research objectives

The objectives of this research study were to explore the following:

- The push/pull factors that motivate South African nurses to migrate as well as return to the SA workforce.
- Experiences of returning South African migrant nurses regarding reintegration in the SA workforce and how they cope.
- The factors that motivate migrant nurses to reapply for employment abroad or to remain as part of the workforce in South Africa.

1.8 Theoretical framework

The researcher applied the push and pull factors of Lee's theory to develop a logical understanding of and explanation for the research. Levine's theory of conservation was then combined with Lee's theory to explain reintegration in the workplace and to guide the progression of the study. The adapted theoretical framework is given in Figure 1.1 below.

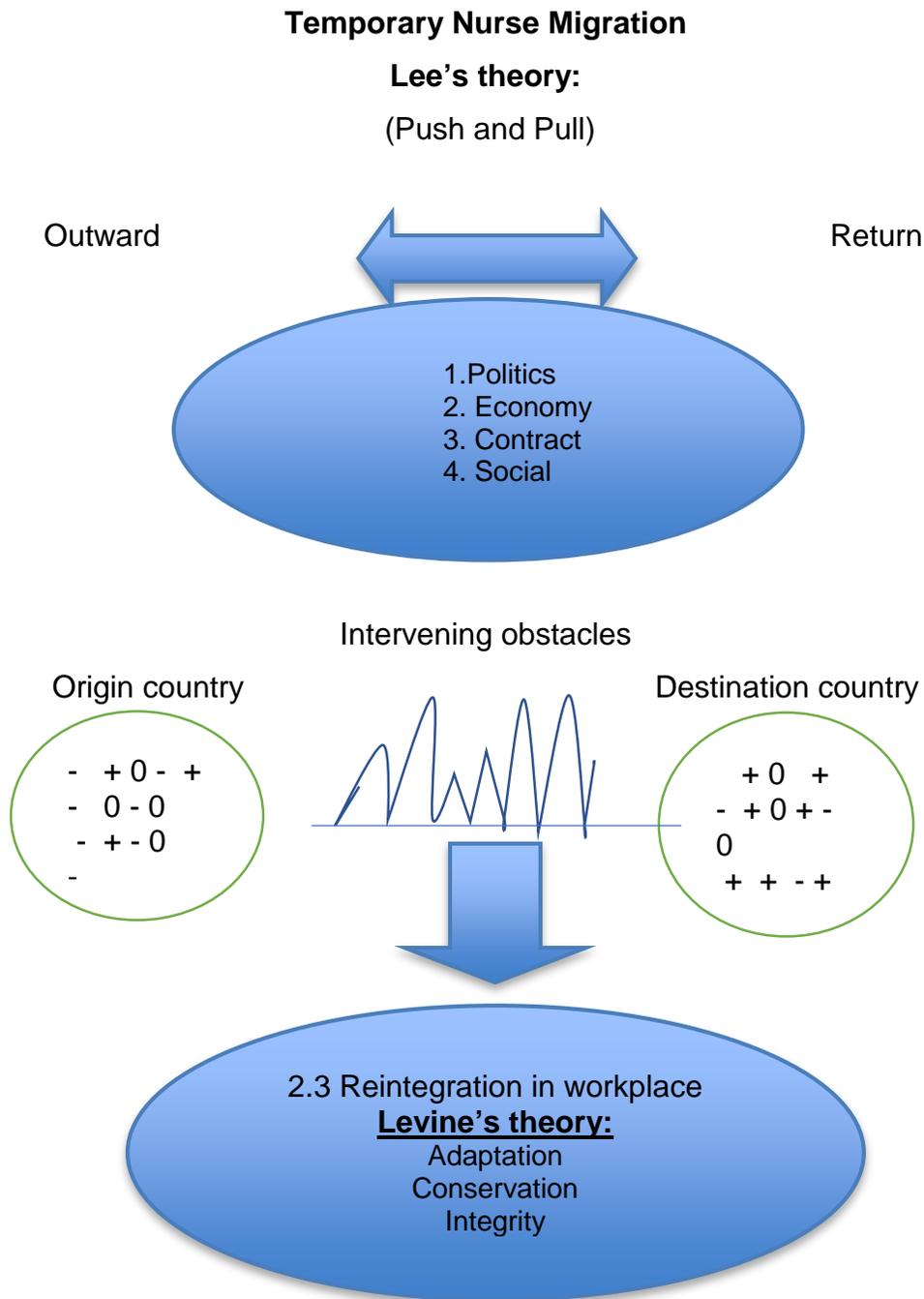


Figure 1.1 Push and pull factors of Lee's theory (1966:48) combined with Levine's theory of conservation (George, 2014:235) applied to workplace reintegration

1.8.1 Lee's theory of push and pull

In order to gain an understanding of the reintegration of returnee SA migrant nurses into the workplace, Lee's theory of push and pull was applied to explore the factors at play.

Individuals have different reasons that influence their decision to migrate from their countries of origin to wealthier countries. Such reasons include political differences, economic realities, employment opportunities, and contracts within the employment situation at home or abroad (Biondo *et al.*, 2012:2).

Lee's push and pull theory states that there is a relationship between push factors in country of origin and the pull factors in the destination country (Lee, 1966:48) and vice versa. These factors are contrary to each other. That which would pull persons to apply for employment abroad is often the result of a factor that pushes them to resign from employment in the home country. An example is poor remuneration for services in the home country, with the attraction of better salary and benefits abroad. Push and pull factors can influence individual migrant nurses' decisions to return to their home country. Should the working conditions and, most importantly, remuneration in the home country improve, migrant nurses may consider returning home.

An intervening obstacle, according to Lee (1966:48), is a third factor (added to push and pull) that plays a pivotal role in facilitating the move from source to host country and also determines the success of the integration process upon arrival in a destination country. No place is perfect and even attractive destination places have positive and negative aspects (Lee, 1966:48), with the former outweighing the latter in the eyes of the migrant, resulting in the push and pull factor dichotomy. The 'squiggles' in Figure 1.1 above represent the intervening obstacles.

According to Lee (1966:48), plusses and minuses respectively represent possible positive and negative attributes in country of origin as well as the destination country. When the plusses in country of origin are less than those of the destination country, the individual

is likely to migrate owing to the strong pull power represented by the plusses. The limited opportunities for professional growth in country of origin (fewer plusses) as opposed to numerous opportunities to advance one's career in the destination country (more plusses) may entice the individual (strong pull factor) (Efendi, Mackey, Huang & Chen, 2016:2). More negative attributes in country of origin (such as crime) as opposed to fewer negatives (low crime rate) in the destination country serve as a push factor from country of origin. The zeros represent attributes that are neutral and will not affect the individual negatively or positively and are present in both countries.

Intervening obstacles may occur at any time during a migration cycle, with negative consequences for the individual. Intervening obstacles in the country of origin during reintegration in the workplace environment force nurses to seek employment abroad again with new factors acting as push or pull back to the home country, such as expiry of a contract abroad, or needs of the family at home (King, Black, Collyer, Fielding, & Skeldon, 2010:91).

1.8.2 Levine's adaptation theory

Upon return to the home country, adaptation to the work environment is necessary for the successful reintegration process and ultimate retention of staff. Adaptation, according to Levine's theory, depends on characteristics that are specific to the individuals' past experiences (George, 2014: 233) and his internal coping mechanisms. Levine considers conservation as being part of adaptation and indicates that conservation protects the system (individual's) integrity by regulating the ability to approach and deal with environmental deviation swiftly to maintain its (the individual's) uniqueness (George, 2014:234).

The act of conserving personal integrity helps the person to self-actualise, which is the highest human need on Maslow's hierarchy. According to George (2014:235), Levine likens the awareness of self to independence. If the person cannot conserve his personal integrity and an acceptable sense of self-awareness in the new work environment at home, he will not be independent and not be able to reach self-actualisation, and thus he

will not have social integrity. Conservation of social integrity goes beyond the participant and is necessary for the human being to be a whole unit.

In the study under review, the researcher paid special attention to the conservation of the social integrity of participants, in relation to reintegration into the workplace upon return to country of origin. The process of such reintegration determines whether the return migrant nurse remains in South Africa or becomes a circular migrant nurse.

1.9 Research methodology

Methodology describes the design and specific procedures implemented to conduct a study. Polit and Beck (2012:56) describe a research design as the rules in action and strategies intended to obtain answers for stipulated questions whilst Grove, Gray and Burns (2015:43) as well as Grove, Burns and Gray (2013:502) maintain that it is a calculated plan to ensure maximum control over factors that could interfere with the accuracy of the study findings.

1.9.1 Research design

Phenomenology is an approach to qualitative research and is considered to be a philosophy that directs the study of experience (Dowling & Cooney, 2012:21). Descriptive (also known as Husserlian) phenomenology is concerned about the individual's experiences as they are lived, and requires the researcher to analyse data without biased ideas (Grove *et al.*, 2015:69). The central endeavour of this study was to obtain transcendental subjectivity; therefore, processes in this study were frequently reviewed and biases as well as pre-suppositions kept in abeyance (Lopez & Willis, 2004:726).

The researcher intended to identify the similarities of the lived experiences of the return migrant nurses as well as to uncover and discover the return migrant nurses' experiences in the context of their own world (LoBiondo-Wood & Haber, 2014:112; Bultas, 2012:463).

1.9.2 Study setting

The study was conducted mainly in the Gauteng province, one of the nine provinces of South Africa, due to proximity to the researcher. Furthermore, Skype interviews were conducted with return migrant nurses who were not easily accessible. This included interviewees from two other provinces in South Africa namely, Western Cape and KwaZulu-Natal, as well as with nurses who were re-employed overseas.

1.9.3. Population and sampling

A population is a specific group of individuals that meet the assigned set of inclusive criteria established by a researcher (Grove *et al.*, 2015:250; Grove *et al.*, 2013:44). The target population is described as the overall group of individuals with characteristics in the researchers' inclusion criteria (Grove *et al.*, 2015:251). The sample consisted of a small percentage of the target population that the researcher studied (Grove *et al.*, 2013). Specifically, this population comprised of nurses who had worked abroad for more than a year and had returned home to South Africa and joined the workforce. Participants were purposively selected according to their knowledge and experiences as return migrant nurses back in South Africa. Snowballing or network sampling was used by requesting from the participants to suggest any potential participants who may meet the criteria.

1.9.3.1 Inclusion criteria

The study sample included migrant nurses who had worked abroad and returned to South Africa to rejoin the healthcare workplace.

1.9.4 Data collection tool

Data collection is the precise, systematic collection of relevant information to answer the research aim or the specific research questions (Grove *et al.*, 2013: 45). According to Knox and Burkard (2009:14), "to a large extent, the interview is a planned conversation to collect data and is intended to be carried out in a similar manner with all participants". The questions in the interview were open-ended, based on the central focus of the study and prepared prior to data collection (Knox & Burkard, 2009:3).

1.9.5 Pilot study

A pilot study, which is a smaller version of the study, was carried out to obtain information that would assist to improve the questionnaire where needed and to assess the feasibility of the study (Polit & Beck, 2012:195). The participant in the pilot study was similar to those in the main study and was selected accordingly. The data collection and analysis methods used were also similar (Grove *et al.*, 2015:45), but the results from that pilot study were not included in the final study to exclude bias, since the participant was the supervisor. Conducting the pilot study assisted in identifying problems with the semi-structured questions and in refining them as needed (LoBiondo-Wood & Haber 2014:284; Polit & Beck, 2012:642). The questions were considered by the supervisor and adjusted as advised. Furthermore, the pilot study gave the researcher the opportunity to practice interviewing skills. The interview was recorded (thus testing equipment and technology used) and a transcription was made of the pilot interview to the satisfaction of the supervisor.

1.9.6 Trustworthiness

Trustworthiness of the qualitative study was established, based on credibility, transferability, dependability and confirmability, as described by Guba (1981), as rigour has to be ensured via these concepts to allay critics' fears of a study not being trustworthy (Shenton, 2004:63).

1.9.7 Data collection

Data was collected through face-to-face and Skype interviews. Semi-structured interviews, which refers to a set of fixed questions (Grove *et al.*, 2015:90), were conducted. The interviews were recorded and transcribed and detailed notes were written soon after every interview.

1.9.8 Data analysis

Following data collection, the interviews were transcribed verbatim to ensure they reflected the real recorded experiences. Data collected during interviews were analysed through application of Colaizzi's seven steps' strategy (Polit & Beck 2012:540) to induce

a comprehensive description of the phenomenon. The strategy assisted in obtaining, organising and interpreting the data. The formulated meaning was clustered into themes. Themes were referred back to the original descriptions to ensure validation.

1.10. Ethical considerations

Human rights are moral principles that need to be adhered to, as they are rightfully due to all human beings. According to Grove *et al.* (2015:105), the ethical responsibility to protect the rights of the participants' rests with the researcher.

The Helsinki Declaration as amended over the years spells out all the principles that need to be conformed to during research (Carlson, Boyd & Webb, 2004:4). The researcher ensured adherence to these standards in this study. This included the principles of autonomy through informed consent, beneficence and non-maleficence by ensuring privacy, anonymity and confidentiality. Further, this included justice in that the participants were selected and treated fairly. Veracity was also ensured as the true purpose and possible effects of the research before obtaining consent and afterwards when the research results were available were divulged.

1.10.1 Informed consent and veracity

Prior to conducting the study, ethical approval was granted by the Health Research Ethics Committee at the University of Stellenbosch, with the ethical approval number: S16/10/205 issued. As part of protecting the research participants' human rights (Grove *et al.*, 2013:177), the researcher obtained written informed consent for the study and allowed the participants to decide whether they were willing to participate or not. Therefore, participants were granted the opportunity to refuse to participate in the research and only those who were willing to share their knowledge and experiences were interviewed in the study. As autonomous beings, the participants were informed that they had the right to withdraw at any time without any explanation and such withdrawal would not have any consequences to the participant (Pera & Van Tonder 2011:333).

1.10.2 Right to anonymity and confidentiality

Protecting the research participants' right to privacy during this study was done via the assurance of anonymity and confidentiality (Grove *et al.*, 2015:107). The rights to privacy, anonymity and confidentiality were explained to the participants. The participants were allowed to choose which private information could be included during the study. The participants remained anonymous in the study, and were being referred to numerically, for example Participant 1 and Participant 2. Audio recordings of the participants were deleted, following transcript validation by the supervisor and independent reviewer (Polit & Beck, 2012:147). The anonymous transcriptions will be kept in a safe for five years, and then destroyed. Material on the computer was controlled by a password of which only the researcher has access in order to maintain confidentiality of all participants (Moodley, 2015: 324).

1.10.3 Justice

Participants were asked to generate as many names as possible of persons that could be contacted for an interview about the study topic. All such contacts were followed up, to ensure that they had a fair chance to take part in the study. Participants were given refreshments during the interview, and interviewed at a place of their choice.

1.11. Operational definitions

Concepts have different meanings and different interpretations according to the context in which they are used. Therefore, to eliminate differences in interpretation, concepts used in this study are defined below:

Migration is whereby people move from country of origin to a foreign country, (King *et al.*, 2010:13). However, in this study, migration referred to legal, voluntary, temporary and international mobility of South African nurses to a host country, seeking employment.

Return migration: In the context of this study return migration refers to South African educated, professional nurses who migrated to countries overseas for employment

purposes and decided to return to the country of origin, thus completing the migration cycle, also referred to as returnees.

A nurse in the context of this study refers to a professional nurse as defined by the Nursing Act 33 Of 2005 under section 30 (Republic of South Africa, 2005:25).

Brain(s) drain: In this phrase, 'brains' refers to workers who are highly qualified with high skills (qualification and skills often referred to as human capital or currency), whereas 'brain drain' is the process whereby such workers seek and find employment in foreign countries for various reasons (Biondo *et al.*, 2012:2). In relation to this study, brain drain refers to professional nurses educated in SA, migrating abroad for employment. Brain(s) gain are 'brains' as defined above, who return to country of origin with added human capital from the destination country (Biondo *et al.*, 2012:3; Zmejkoski, 2011:60). In relation to this study, brain gain refers to migrant nurses who worked abroad for more than a year and return to South Africa with intentions to join the healthcare workforce.

Human capital refers to knowledge, abilities (skills, competencies) and intangible assets of the individual that can be used to measure the individual's economic value (Pettinger, 2017).

Reintegration: The experiences of the nurse returnees in the labour market of the home country. In the context of this study, reintegration refers to the migrant nurse's experiences in the South African labour market upon return.

Country of origin in this study refers to South Africa.

1.12 Chapter outline

The study is presented in five chapters. In Chapter 1 the study is introduced. It briefly deals with the background to the problem, the purpose and objectives of the study, the research design and methodology, ethical considerations, trustworthiness of the study and definitions of the key concepts used in the study. Chapter 2 covers the literature review, with an overview on the reasons why nurses migrate and how reintegration takes

place in the workplace upon return to country of origin. A detailed description of the research methodology of the study is provided in Chapter 3. In Chapter 4 the data analysis is presented as appropriate for a descriptive phenomenological approach. Chapter 5 discusses the study findings, literature surveyed, conclusions and recommendations.

1.13 Summary

Chapter 1 gives the orientation to the study. The significance, rationale, aim and objectives are described. The chapter includes the theoretical framework as a guide for the progression of the study, which is a combination of Lee's theory of the push and pull factors influencing the migration process, with Levine's theory of conservation applied to the workplace reintegration process. Also, included in this chapter is a summarised outline of the research methodology, ethical considerations, operational definitions and chapter outline.

This study explored the factors influencing workplace reintegration of a return migrant nurse in country of origin. The end process of migration, namely return migration to country of origin is as important to understand, as the initial phase that refers to outward migration. Few studies were found regarding return of migrant nurses to countries of origin. Migrant nurses returning to home countries may have different reasons for returning, but successful reintegration is dependent upon an individual's unique preparedness, as well as circumstances within the workplace. A qualitative descriptive phenomenological approach was adopted to study this phenomenon in the South African context.

Chapter 2 gives a review of available literature regarding the push and pull factors of the migration processes and workplace reintegration upon return to country of origin.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The literature review consists of a summary and synthesis of the most relevant and current researched knowledge regarding a phenomenon of interest and thus helps create a picture of that which is known and unknown (Polit & Beck 2012:733).

In order to identify the relevant literature, a search was conducted with the following keywords: migrant nurse, brain drain, migrant health workers, return migrant nurses, brain gain and reintegration of return migrants, in the following listed sources:

- Relevant migration and research publications (print and online).
- Through Stellenbosch University's library: PubMed Central, SAGE Journal online, EBSCOhost (Health), including Google search and Google scholar, BioMed (The Open Access Publisher).
- Articles in accredited journals and books (print and online) published in English.

Given the scarcity of research on the return of nurse migrants, in particular South Africa, literature from different countries was reviewed to determine a worldview regarding skilled worker migration and reintegration upon return to country of origin.

With the literature review, the researcher intended to gain a better perspective regarding the process of returning among migrant nurses and the subsequent reintegration into the labour force. Return migration is an eventual component in most contemporary migration processes, but the research and thus knowledge available about this phenomenon is scanty, unlike that of outward migration which has been frequently studied (Kuschminder, 2014:1). Because the factors that influence migration are evolving, diverse and complex, the purpose of the research is to study and understand their influence on the final process of return migration to South Africa. Understanding these factors could contribute towards

the body of knowledge and help towards consideration of recommendations to address these issues.

2.2 Migration

According to Lee (1966:49), migration refers to a change in residence, be it permanent or temporary. The distance of the move depends on migrants' decision and no restraints are attached. Depending on whether the destinations' requirements are met, it may either be on a voluntary or involuntary basis (Lee, 1966:49). The move may be external or internal; from province to province or across borders.

In order to comprehend the factors that revolve around the return process, an understanding of some common reasons why people migrate is necessary, since temporary migration and return migration are frequently intertwined. Temporary international migration marks the beginning of the process, therefore return migration ends it. Despite the lack of accurate statistics for migrant health workers, an increased trend in migration has been observed, mainly from low and middle income countries to high income countries, posing a risk to delivery of essential services (Olajedi & Gureje, 2016:61; Kingma, 2007:10). Temporary migrants are often contract workers (Kingma, 2009:1) and are more likely to return to country of origin.

2.2.1 Ancient migration

Trends in migration are very dynamic and tailored to the needs of migrants. During the 16th and 19th centuries migration of African slaves to the western parts of the world was in demand (King *et al.*, 2010:24) from countries where employment was scarce, towards countries that could afford to pay for slave labour. Similarly, thousands of Irish struck by the potato famine during 1847 migrated to America in search for better living conditions. Instead they found themselves in worse conditions; living in unsanitary surroundings, 60% of children dying before they were six years old and adults dying within six years of arrival, while doing the lowest paying work.

With the abolishment of slavery, and the choices available for highly skilled workers to work elsewhere than their own country, such workers voluntarily and legally migrated to developed host countries to improve their economic status (King *et al.*, 2010:24). International mobility of skilled healthcare personnel has increased with globalisation, often exacerbating shortages of the most needed categories of manpower in countries of origin (Labonté *et al.*, 2015:2). Many workers migrate on temporary basis only, with plans to return to country of origin (King *et al.*, 2010:90).

2.2.2 Modern migration

Migration was termed a complex phenomenon by Lee (1966:49), but it appears even more complicated in its modern form. Labour migration takes place from a point of origin to a point of choice destination; thus, migration of workers may happen when the relationship between these two points is in harmony and the two complement each other; pushing as well as pulling, giving momentum to the idea or plan to migrate (Lee, 1966:48).

The discovery of oil, both on shore and offshore and the dawn of industrialisation in 1959 set an unprecedented record for the economy of the United Arab Emirates (Abed, Hayler & Shihab, 2001:254). Within a short period (1970 to 1990) economic development surged; with industrialisation, urbanisation and modernisation (Abed *et al.*, 2001:258) creating new employment opportunities for nationals, and more so for expatriates (De Bel-Air, 2015:4). Dubai as a famous tourist destination further increased the need for foreign unskilled labourers to aid in construction, infrastructure development and filled skilled professionals' posts in different categories (De Bel-Air, 2015:4). With the influx of male migrant workers, an appropriate health workforce becomes paramount, equally to meet and improve the health needs of nationals (U.S.-U.A.E. Business Council: 2016:7). Foreign female nurses have been recruited since 1970, as female nationals were not allowed to work, according to El-Jaraldi, Dumit & Mouro (2008:8,29). Currently the UAE healthcare system consists of 82% foreign healthcare professionals as opposed to 18% nationals, with approximately 90% of nurses being expatriates. This is an indication that the UAE is heavily reliant on foreign trained healthcare professionals to curb its health workforce shortage, with ineffective

retention initiatives and high turnover statistics (Bell, 2015). Shortage of nurses in the Arab countries is multifaceted; generally nursing has a poor social image, burdened with non-professional duties and unfavourable working conditions, limited training facilities and few new candidates applying.

It is difficult to govern migration due to a lack of international policy coordination (Boeri, Brücker, Docquier & Rapoport, 2012:11). In 2013 the world was short of 7.2 million healthcare workers, according to the WHO (2013). This is likely to escalate to 12.9 million in 2035. It is logical that health worker recruitment will increase (Bonner, Dywii & O'Brien, 2013:19), sparking many debates around the world (Akeson & Eriksson Baaz, 2013:9; George *et al.*, 2013:2; Aluttis, Bishaw & Frank 2014:1). An individual has the right to leave their country of origin as a migrant is they meet the criteria to enter the destination country (Miller, 2015:5). The WHO (2010) does not place any restrictions on health care workers' ability to migrate either This applies to migrant nurses as well, as acknowledgement of the human right of freedom of movement (Freeman, Baumann, Blythe, Fisher & Aktar-Danesh, 2011:1180).

However, this does exacerbate the shortage of healthcare professionals needed to deliver healthcare in their countries and impedes the intention of universal health coverage by relevant skilled personnel (Akeson & Eriksson Baaz, 2013:9). Thus, the WHO Global Code of Practice on International Recruitment of Health Personnel (Akeson & Eriksson Baaz, 2013:2-9) was adopted in 2010 to address the inequalities created by international health workforce migration, mainly from already deprived-source countries to wealthy host countries. This Code has no intention to halt migration but rather to control its flow in order to protect countries from its harmful effects (Akeson & Eriksson Baaz, 2013:10), such as depletion of a much-needed health workforce as this leads to lack of access of the necessary healthcare delivery for the population (Efendi *et al.*, 2016:2).

2.2.3 Push-pull dichotomy

Push factors according to Lee (1966:48), are unique to country of origin, and to individuals' desires for improved personal situations. They are often the result of a lack of

economic growth which leads to job-related obstacles and challenges. Pull factors, however, are what the destination country has to offer, and often it is imagined as utopia by the migrant, seen as the ultimate remedy, with better job opportunities (Troy, Wyness & McAuliffe, 2007:7).

2.2.3.1 International view

In Asia, with the Philippines trading with human capital on the global health market, the brain drain led to a drastic increase in nursing schools producing many more nurse graduates to match the international demand, in return for an external revenue through remittances (Diyama, McEwen, Curry & Bradley, 2012:4). Nursing, which has traditionally been seen as a calling towards serving communities, is now seen as a pathway to obtain a visa to work abroad and change the family's living status; therefore, families (and countries) serve as a push factor by encouraging their children to join nursing, and to seize an opportunity to migrate (Diyama *et al.*, 2012:4). According to Diyama *et al.* (2012:3), internal factors accounting for the push out of the country include low salaries, bad working conditions, lack of resources and very few employment opportunities versus the external attracting pull factors of better remuneration, good working conditions, new technology and employment availabilities (thus migrating for economic improvement) (Tjadens, Weilandt & Eckert, 2013:14). Some doctors in the Philippines even train as nurses after their medical degree, to take advantage of the many more nursing opportunities available abroad (Tjadens, *et al.*, 2013:14).

Similarly, the Indonesian government has a trade contract with Japan to recruit nurses as temporary migrant health workers (Efendi *et al.*, 2013:155). As a country with a large reserve of nurses; Indonesia has a population of 240 million, with 655 nursing study programmes creating a high production of nurses (Efendi *et al.*, 2013:154), with the knowledge that they will be able to obtain gainful and professional jobs abroad. Indian nurses, on the other hand, often migrate to elevate their individual and professional status as locally there is a perception that the nursing profession is for people of low socioeconomic background (Garner, Conroy & Barner 2015:2;11).

2.2.3.2 Africa

According to Aluttis *et al.* (2014:3), the African continent, with its limited health workforce in proportion to its population size, as well as fourfold burdens of disease, is particularly susceptible to this health liberation mobility. Such countries include Zimbabwe, Nigeria, Ghana, Zambia and South Africa. Their citizens mostly migrate to the US, Europe and Middle East to support the host country's health system in need of skilled manpower. Zimbabwean nurses owing due to the political unrest and economic instability, (Mandiyani, 2014:4), qualify as the highest brain drain of nurses in Africa (Breier *et al.*, 2009:44). Ghanaian nurses often migrate to the UK for employment purposes or to rejoin the family (Tjadens *et al.*, 2013:14). According to Tjadens *et al.* (2013:16), in some countries in Africa healthcare education and training do not comply with the international standards, such as medical education in Angola (intentionally set below international standard by policy makers to prevent migration) and nursing education in Egypt. This results in a low rate of cross-border migration, with the exception of acceptance of Egyptian nurses within some of the Gulf States.

2.2.3.3 South Africa (SA)

Labonté *et al.* (2015:12) identified a decline in outward migration of South African skilled health workers since 2000. The causes behind outward migration of the South African health workforce in general, and doctors in particular have been frequently researched using the push and pull model (Labonté *et al.*, 2015:7).

According to Kingma (2009:1), the push factors for nursing migration is often due to poor working conditions, hazards in the workplace and low salaries. Job dissatisfaction is reported by some South Africans health workers as push factors, mainly due to the working conditions, inclusive of little or no professional development (Labonté *et al.*, 2015:7; George *et al.*, 2013:2). The high rate of crime and violence served as a strong motivating factor to leave South Africa (George *et al.*, 2013:2), with migration for these reasons often resulting in permanent migration. According to Moosa, Wojczewski, Hoffman, Poppe, Nkomazana, *et al.*, (2014:323), health workers who migrated from South Africa, did so owing to a lack of personal security in the home and workplace. Reports of

high levels of corruption (Labonté, *et al.*, 2015:12), political instability, and nepotism have been cited by Tjadens *et al.* (2013:53) as push factors. The high rate of HIV/AIDS statistics in South Africa also serves as a health threat to the individual and at times family members. According to Labonté *et al.* (2015:12), more skilled health workers than before have reported dissatisfaction with the South African economic status and high cost of living. Therefore, migration serves as a solution to improve their living standards.

The pull factors seem to be the opposite of the push factors. A pull factors for South African health workers to destination countries is better remuneration (Labonté *et al.*, 2015:7) that cannot be matched locally. Labonté *et al.* (2015:13) mention that related to this, nurses are more likely than other skilled health workers to become temporary migrants to ensure their living standards improve.

Official and reliable statistics for South African nurse migration are lacking and are only estimated by using different sources to gauge this situation (George *et al.*, 2013: 4; Breier *et al.*, 2009:44, 47; Aluttis *et al.*, 2013:5). The nurse migration trend has drastically changed over the years. During 2001 the SANCS' verification statistics for nurses processing applications to work abroad increased fivefold (Breier *et al.*, 2009:47). This is an indication that SA-produced nurses have become more active players in the global market. According to the WHO (2013), approximately 5 – 7% of the nursing workforce in SA works abroad in the Organization for Economic Co-operation and Development (OECD) countries. This percentage is probably higher, considering that all other popular host countries where nurses are employed, such as KSA and UAE do not belong to the OECD (Breier *et al.*, 2009:44). The OECD includes Australia, Belgium, Canada, France Germany, New Zealand, UK, and the US, just to name but a few popular destinations, since it consists of 35 member countries.

2.2.4 Developed countries

Globalisation has increased the mobility of health workers mainly from resource poor to resource rich countries, proportionately to the demand of patient care (Breier *et al.*, 2009:43; Aluttis *et al.*, 2014:2; Li *et al.*, 2014:314). Benefits reaped from such a move

include the increased remuneration considered as rewarding for the migrant nurse with pecuniary difficulties. A host country's strong economy often affords it a quick solution (temporary relief of staff shortage) and cheaper labour than when training and recruiting a national (Tjadens *et al.*, 2013:23). Thus, dilemmas of shortages of healthcare workforce in destination countries (often more economically advantaged) are displaced to poorer developing countries in finding a temporary solution for themselves (Bonner *et al.*, 2013: 4).

2.2.5 Developing countries

Developing countries are unable to compete with developed countries regarding remuneration scales (Bonner *et al.*, 2013:16), thus losing highly skilled professionals. Migration of health care professionals is often immediately viewed as a loss of skilled labour for source countries in most low to middle income countries (El-Jaraldi *et al.*, 2008:12). The scope of global migration of health workers is intricate, often impacting negatively and positively (Aluttis *et al.*, 2014:1). The negative consequences are the reduction of manpower in the source country, affecting not only the health managers, but also nurses on ground level, as well as patients who need the nursing services that can only be delivered by skilled nurses. The nursing staff remaining in the source country is left with a heavier workload, leading to chronic job dissatisfaction, and adversely affecting morale (Kingma, 2007:10). Thus, the much-needed nursing services that largely fulfill the basic health right of many disadvantaged patients are not rendered.

The positive consequences are the temporary migrants' remittances if they have commitments in their homeland, which improves the sending country's economy (Kingma, 2007:10; Breier *et al.*, 2009:43; Castles, De Haas & Miller, 2014:13). On an individual level, migrants accomplish various goals as set by themselves (Akeson & Eriksson Baaz, 2013:6), as well as enriching their skills and advancing experiences (Breier *et al.*, 2009:43; Castles *et al.*, 2014:1). Furthermore, despite the loss of manpower, intellect and skill to the host country, some transnational bonds are often established for the source country which intend to impact it positively (Kuschminder, 2014:23).

2.2.6 Duration of migration

Migration patterns have been dynamic over the years; ranging from being permanent, to temporary, to, most recently, circular (Tjadens *et al.*, 2013:19). Filipino nurses who migrate permanently, often select the US as a destination country, because of its influence on the health education system of the Philippines (Tjadens *et al.*, 2013:15). The Middle East receiving countries have strict migration policies that allow workers only temporary migration permits. Subsequently, owing to the effects of periodic economic changes that often spread across the globe, migrant workers have adopted a newer form of mobility, known as circular migration (Tjadens *et al.*, 2013:19).

2.3 Return migration

Return migration refers to the phase in which migrants return to their country of origin after having spent a substantial time period in a country of destination (Efendi *et al.*, 2013:155).

In the past, return migration was considered a myth (Mandiyanike, 2014:4), but the changing face of global migration includes return to countries of origin (Haour-Knipe & Davies, 2008:5; Akeson & Eriksson Baaz, 2013:1).

During the early 1970s, Gmelch researched return migration and could only find 10 headings included under the subject of return migration as opposed to the 2041 listed in the migration bibliography (Brettell, 2003:47). Battistella (2014:25) agrees that many scholars are still under the impression that return migration has not been widely researched topic and requires better understanding. However, according to a study conducted by De Haas, Fokkema & Fihri (2015:2), return migration has gained attention among scholars and various policy-makers during the last two decades.

Given the presupposition that migrants are generally well-informed regarding the host country and integration probabilities prior to migration, neo-classical economist and push-pull theorists have difficulty explaining the factors involved in the process of return migration (De Haas *et al.*, 2015:3). There may be multifarious reasons why nurses

migrate from, and back to country of origin and it is often a combination of aspects that serve as deciding factors. Similar to the outward migration phase, return migration is not a simple decision and is dependent on different factors unique to the individual's needs (Biondo *et al.*, 2012:2).

Preparations for return migration requires planning by the migrant and are influenced by push and pull factors (Cassarino, 2014:7). The readiness to return to country of origin plays an important role when it comes to reintegration into the workplace – particularly the dynamics of the labour market is of paramount importance (Kuschminder, 2014:2). A study conducted about return migration of skilled workers by Biondo *et al.* (2012: 18) indicates that the probability of their return is dependent on two psychological agents of the migrant; namely risk aversion and initial expectation. If the former is higher than the latter, the migrants' decision to return becomes highly likely, whereas if the initial expectation is higher than the risk aversion, the migrant may postpone departure from the host country (more goals to reach). Return nurse migration is more common among healthcare professionals (Tjadens *et al.*, 2013:29). Amongst migrant healthcare professionals, nurses are most likely to return to country of origin.

2.3.1 Push factors

Return migration marks the end of the migration cycle. Cassarino (2014:7) categorises the returnees into three groups; namely as having a complete, an incomplete or an interrupted migration cycle, thus affecting the preparedness to return home and adapt there. Push factors that may influence individuals' decisions to return to country of origin may include the end of the contract, failing requirements, discrimination, job dissatisfaction, personal illness and retirement.

2.3.1.1 End of contract

With policy changes on global migration, the UK increased training of nurses and banned private agencies from recruiting South African nurses to ensure compliance with immigration regulation (Breier *et al.*, 2009:50). Furthermore, voluntary end of contract serves as a push factor within the workplace (Haour-Knipe & Davies, 2008:25).

Indonesian nurses return mainly owing to end of contracts and are usually faced with the same problem that pushed them to migrate to Japan; namely unemployment (Efendi *et al.*, 2013:156). The difficulty is embedded in the lack of vacancies in healthcare institutions and slim chances of career changes. Thus, for returning migrants the issue of unemployment is a reality they have to face all over again, resulting in an incomplete migration cycle according to Cassarino (2014:7). Forced end of contract that interrupts the migration cycle is also often caused by the inability to meet the requirements set by a host country (Efendi *et al.*, 2013:156).

2.3.1.2 Failing requirements

The migration cycle may be interrupted when a migrant fails to meet the stipulated requirements within a host country (Cassarino, 2014:7). Meeting migration requirements may include a renewal of a visa, work permit, residence permit and licensing through acceptance of qualifications according to the criteria (Tjadens *et al.*, 2013:36). Mandiyanike, (2014:4) mentions that the reasons that drive migrant workers back to country of origin such as Zimbabwe could be failure of integration in the destination country serving as an intervening obstacle and later a push factor. Where permanent residency is not allowed, migrants have to return to their home country or find an alternate destination (Tjadens *et al.*, 2013:16).

2.3.1.3 Discrimination

Sometimes discrimination in destination countries, as experienced by some South Africans, may spark and ignite the plan to return to country of origin (Tjadens *et al.*, 2013:42). Discrimination of migrants in the host country may lead to an incomplete migration cycle and individuals may return earlier than anticipated (Cassarino, 2014:7). Not all source countries treat all nationalities the same. This could be experienced as discrimination and trigger return migration. Indian nurses often experience substandard work conditions and accommodation (Battistella, 2014:26) while in the UK. Non-white South African nurses with basic nursing qualifications are more likely to have adverse experiences than South African white nurses with specialisation (Breier *et al.*, 2009:54). Other foreign nurses in the UK, recruited from different regions of Africa, also indicated

discriminatory actions and racism in the workplace. This relates to the theoretical and computational model of Biondo *et al.* (2012:19), where high-risk aversion (discrimination) must be endured to find greener pastures (reach initial expectation).

2.3.1.4 Job dissatisfaction

Job dissatisfaction was quoted by 93% of Jordanian nurses who were planning on returning back to Jordan from their respective locations within the GCC states (Nawafleh, 2015:3). Nepali nurses based in the UK, allocated in long-term care facilities doing less prestigious work, also had low morale and experienced low job satisfaction (Adhikari & Melia, 2013:365). Developing countries share some similarities with developed countries, such as burnout and job dissatisfaction. In some US and Canadian hospital these were mentioned as contributing factors to leave the job (Mitchell, 2009:60).

2.3.1.5 Personal illness

Personal illness is often a contributing factor for migrant workers from the Philippines, based in Japan to return to country of origin, as reported by the International Labour Organization (Efendi *et al.*, 2013:157); subsequently interrupting the migration cycle (Cassarino 2014:7).

2.3.1.6 Retirement

Once migrant nurses have secured work and successfully integrated in the respective host countries, some may continue working until retirement and then return to country of origin (Battistella, 2014:26). Ghanaian health workers, for instance, have no intention to work upon return to Ghana (Tjadens *et al.*, 2013:30) and will most likely remain permanently in their homeland owing to age restriction on labour migration.

2.3.2 Pull factors

Pull factors for the return process are factors that attract the migrant back to country of origin. This could also affect the migration cycle as described by Cassarino (2014:8) in section 2.3.1. Pull factors to the homeland are often stronger than push factors from the

destination country. Personal motivation and prospects in country of origin are often strong attractions.

2.3.2.1 Personal motivation

Some Indonesian nurses were motivated by their family members to return home (Efendi *et al.*, 2013:155), whereas doctors and nurses return to India owing to circumstances related to their children's education (considering the needs of children and spouses). Family ties are often another strong pull factor for return, especially reunion with parents as they age and need more care (Haour-Knipe & Davies, 2008). Some health workers return for entrepreneurial reasons; doctors in India often return to establish hospitals and create employment opportunities for the locals (Haour-Knipe & Davies, 2008:2:10). Depending on the individualised motivation, goal attainment is very important for the temporary migrant and return to the homeland is often postponed until completion of the migrant's projects (Battistella 2014:25).

2.3.2.2 Prospects in country of origin

According to Biondo *et al.* (2012:7), governmental policies could influence and facilitate return migration of its highly skilled professionals. Mandiyanike (2014:4) mentions that improvement in the economic and political status, together with strategies by the government for migrants to return, such as return incentives which was once used as a pull factor in Zimbabwe. African countries, such as Ghana, Cape Verde and Senegal, also managed to lure back skilled workers (Akeson & Eriksson Baaz, 2013:1), Ghanaian migrants were praised while abroad for economic contributions such as remittances and investments that serve as empowerment towards Ghana as a country (Kleist & Vammen, 2012:7), and Senegal once promoted the return of migrants with enriched skills, in an attempt to empower the country (Akeson & Eriksson Baaz, 2013:2).

2.4 Workplace reintegration process

Reintegration of migrants upon return has received minimal attention from researchers across the history of migration, rendering this phenomenon largely obscure (Kuschminder, 2014:1). The scarcity of research regarding return migrant nurse

workplace reintegration necessitated drawing of information from studies conducted for other highly skilled return migrant workers in Africa. IOM (2011:16) facilitated assisted voluntary return migration and reintegration (AVVR) of vulnerable migrants from previous war zones, children, and victims of trafficking. Reintegration needs time. Some may successfully reintegrate whereas others may fail at it, depending on the circumstances surrounding the processes and employment opportunities (Kuschminder, 2014:1).

2.4.1 Return migration reintegration in Africa

In a South-South migration study, Batista, McIndoe-Calder and Vicente (2016:28) discovered that return migrants to Mozambique were 13 % more likely to start a business enterprise than non-migrants in the same region. Research conducted by Dziva and Kusena (2013:8) on Zimbabwean youth migrants (although it was regarding unskilled workers deported or voluntarily returning to rural areas after working in South Africa), indicated that no reintegration strategies were planned by the government. Thus, they had to resort to criminal activities to fend for themselves.

Ghanaians, on the other hand, had nurses return through the IOM's Migration for Development in Africa (MIDA) programme for short periods to share their expertise and provide assistance where needed (Haour-Knipe & Davies, 2008:31). Highly skilled males returned to Ghana on different occasions, and managed to facilitate developmental contributions (Kleist & Vammen, 2012:82). Returnees in Ghana used their skills enrichment and vast knowledge acquired abroad in collaboration with their government, to activate change that could benefit both returnees and have developmental advantages for Ghanaians in various sectors (Akeson & Eriksson Baaz 2013:73-83). According to Kleist and Vammen (2012:74), despite deskilling in host countries, Ghanaian returnees enjoy professional growth upon return to homeland, in collaboration with the government that fosters development facilitated by returnees.

Returnees in the Democratic Republic of Congo have been laden with difficulties to successfully reintegrate (Akeson & Eriksson Baaz, 2013:41). Their establishment for development contribution in the form of starting a business is often dependent on social

capital within Congo and a strong determination to succeed. Social capital refers to who you know in high ranks. This network may be lost any time owing to the political fluctuations in Congo. In Somalia returnees often start or join existing NGOs, or take part in the country's development through business or entrepreneurial ventures during their reintegration (Akeson & Eriksson Baaz, 2013:52-54).

Burundi is a post-war region, recovering from lengthy political and social conflict, where the Hutus and Tutsis were fighting and killing each other (Akeson & Eriksson Baaz, 2013:109). About 50 000 Burundians migrated to the global North, the majority to neighboring countries within Africa (Akeson & Eriksson Baaz, 2013:110). According to Akeson and Eriksson Baaz (2013:127), accumulated finances and skills abroad alone does not make for a successful business venture, but for the incorporation of social capital built within the homeland.

To allow the network ties to function, returnees need to establish trust, reciprocity and generosity in order for a business venture to flourish. Social capital needs to be advertised and noticeable, by hosting social events and investing in symbolic assets, such as cars and cellphones in order to change social ties or networking from a horizontal to a vertical direction. (Akeson & Eriksson Baaz, 2013:126). This means that they move up in the hierarchy, while others remain skeptical about the locals, and fear for their lives and prefer to socialise with other returnees. Thus, human and financial capital invested for business development need the power of locals in the homeland (Cassarino, 2014:259).

Countries, such as China, India, Iran, Lebanon, Mali, Pakistan, Turkey, Sudan and Rwanda, used the Transfer of Knowledge through Expatriate Nationals (TOKTEN) that arranged short return periods of healthcare migrants to share their knowledge and skills (Haour-Knipe & Davies, 2008:31). Asian countries, such as China, Malaysia, Singapore, encouraged brain gain and facilitated the reintegration process for its highly skilled workers with some success, but much is still to be learned in this approach (Hawthorne, 2014:3). Nurses returning from Japan to Indonesia faced with high unemployment rates previously had to re-migrate elsewhere (Efendi *et al.*, 2013:155).

The economic improvement in homeland is vital, and often determines the outcome of reintegration (Mandiyanike, 2014:155). Return to country of origin should be motivated by reintegration strategies in place within the source countries. Government legislation and salaries have increased in South Africa across the public sector particularly for nurses with scarce specialties (such as Intensive Care Unit (ICU)) since 2007 to 2008, to reduce the disparity between the different health care sectors, including the destination countries (Breier *et al.*, 2009:58).

2.4.2 Local experiences

Nursing shortages in the South African healthcare structure is a known problem exacerbated by international migration. The Netcare Hospital group assisted South African nurses with return migration from UK (Breier *et al.*, 2009:58), ranging from offering them bonuses and advances to purchasing return tickets and offering employment (Haour-Knipe & Davies 2008). Netcare used the Homecoming Revolution of South Africa, an organisation dealing with return migrant issues, to recruit South African nurses from Dubai and the UK (Breier *et al.*, 2009:58). In order to narrow the remuneration gap between the public and private healthcare sectors and destination countries, the Occupational Specific Dispensation (OSD) Policy was implemented by the South African Department of Health (George *et al.*, 2013:3).

There are instances where migrant nurses' qualifications have not been recognised in destination countries, with subsequent rechanneling into a different skill (Haour-Knipe & Davies, 2008:15; Tjadens *et al.*, 2013:22; Mandiyanike, 2014:6). Tjadens *et al.* (2013:27) further state that some migrant nurses in host countries are forced into employment below their qualifications, allocated in working areas and regions with undesirable circumstances that are beyond their control. Nurses who worked in hospital settings in their source countries often have to settle for jobs in small health care settings, caring for mentally ill and or geriatric patients; being jobs that the locally trained often reject (Tjadens *et al.*, 2013:26). This leads to deskilling of migrant nurses. Losing skills could hamper the reintegration process upon return to country of origin (Haour-Knipe & Davies, 2008:14;

Breier *et al.*, 2009:50), which could serve as an intervening obstacle (Lee 1966:48), that may hinder adaptation process (George, 2014:234). Nurses returning from the UK were often deskilled, since they were placed in nursing homes and in hospitals where their scope was limited as compared with the SA scope (Breier *et al.*, 2009:58). Therefore, orientation programmes were designed to reintegrate the nurses into the SA scope of practice to foster retention.

Although return migration has received attention in most African countries recently, it is often regarding unskilled migrants assisted by International Organization of Migration; Assisted Voluntary Return and Reintegration (AVRR). Various governments encourage return migration and development, but there is a dearth of South African studies encouraging citizens to return and facilitate development. Workplace reintegration of return skilled migrants receives minimal attention. Consequently, inferences have been made from workplace integration and documented initiatives by the IOM in order to make the necessary adjustment needed to facilitate sustainable reintegration into the labour force. The South African government has participated in the Assisted Voluntary Return and Reintegration (AVRR) initiative of stranded migrants within South Africa, but no reintegration assistance has been given (IOM, 2011:60).

2.4.3 Reintegration copies from integration

In a study conducted by Soontiens and Van Tonder (2014:1038), work environment integration of South African skilled migrants arriving in Australia was associated with taking a few steps back in life, to adjust to the new, and at times, unfriendly destination territory. According to Breier *et al.* (2009:59), the same applied to some South African return migrant nurses who experienced reintegration problems created by non-migrant nursing staff. Subsequently this led to failure of reintegration and re-migration of returnees. Migrants are often willing to accept employment at less favourable levels that does not match their qualifications (Soontiens & Van Tonder 2014:1038; Mandiyanike, 2014:6).

In as far as healthcare is concerned, research conducted regarding the return of health workers to countries of origin, specifically in relation to workplace reintegration, is scant. Most of the literature is from within the African continent and pertains to studies of various migrants of mixed skill (often postwar zones) owing to limited studies within South Africa regarding the phenomenon.

2.4.4 Skills of the returnee

Skills of the returnee may vary depending on the type of integration in the host country. Skills enhancement, suitability, transferability, skill relevance, skill application and deskilling, all have an impact on the return migrant nurses' workplace reintegration process.

2.4.4.1 Skill enhancement

As far as skills enhancement is concerned; Efendi *et al.* (2013:158) and Pillinger, (2011:21) concur that return migrants may be considered a brain gain that may contribute to the improvement of the health systems in their countries of origin.

2.4.4.2 Suitability

According to Mandiyanike (2014:6), within Africa the returning of skilled migrants to Zimbabwe may have a positive impact in providing expertise that could rebuild the collapsed economy and the country as a whole. Haour-Knipe & Davies (2008:14) concede that most nurse migrants return to countries of origin with increased competencies and skill that may be of use. Relevance of skills and knowledge could contribute to solving local problems by return migrant nurses who have had international exposure (Haour-Knipe & Davies, 2008:14). Therefore, this type of brain gain could bring many positive effects for country of origin, if appropriate channels are followed to transfer the acquired knowledge and skills

2.4.4.3 Transferability

A programme in the Philippines encouraged skill-sharing by its skilled returnee migrants on a voluntary basis. Although it ended in 1998, it was an excellent initiative for skills

transfer in the midst of brain drain (Hawthorne, 2014:3). Tjadens *et al.* (2013:30) note that return migrants who intend to practise in their country of origin often encounter obstacles in transferring the human capital gained in host countries and have to start at the bottom of the ladder, despite their added qualifications and skills.

2.4.4.4 Skills application

Application of skills of return migrant nurses largely depends on their assignments in host countries. According to Haour-Knipe and Davies (2008:14), industrialised countries have the funds to uphold ongoing education and necessary training whereas developing countries' lack of funds restricts some mandatory activities. Therefore, returning nurses could likely contribute a wealth of knowledge, in assisting developing countries with the necessary ongoing education, in order to improve the nursing standards.

2.5 Implication of information and way forward for future research

Improved retention strategies are important to reduce turnover when taking into account the cost of losing highly qualified staff who contributes toward the health care provision of communities in need (Moosa *et al.*, 2014). Positive collaboration with colleagues in conjunction with managerial support may play a key role in retention of staff (El Jaraldi, Dumit, Jamal & Mouro, 2009:10).

2.6 Summary

In Chapter 2, a literature review is conducted to identify the motivating factors that are at play with regards to the migration process of nurses and subsequently workplace reintegration upon return to country of origin, with the focus on South Africa. Given the paucity of literature regarding the phenomenon under review, information was extrapolated from literature regarding Assisted Voluntary Return and Reintegration (AVRR) programs IOM (2011:1), mainly applied to countries in Africa.

Many scholars frequently research outward migration, as opposed to the study of the end product, which is return migration. Phenomenological studies related to factors

influencing outward migration can shed light regarding possible return migration pull factors; such as investment in healthcare systems, improving the working conditions, decreasing stress levels and addressing workloads, as well as improving communication with migrant nurses (Troy *et al.*, 2007:7). A literature review of the few studies available regarding workplace reintegration of return migrant nurses in South Africa was done. This assisted understanding and addressing the phenomenon to work towards improving the scarce nursing human capital of the country. The dream to return to their country of origin feature in the migration plans of temporary migrants.

In Chapter 3, the research methodology used to explore the lived experiences of return migrant nurses with regards to workplace reintegration is discussed in detail.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The literature review described in Chapter 2 examined the available information on the push and pull factors of nurse migration. However, little is to be found on the workplace reintegration experiences of return migrant nurse. It was because of this paucity of information that the researcher opted to do qualitative research.

Chapter 3 explains the methodology followed to explore the lived experiences of return migrant nurses during workplace reintegration upon return to country of origin.

3.2 Study setting

The study was mainly conducted in Gauteng, Western Cape and KwaZulu-Natal, three of the nine provinces in South Africa. The interviews in Gauteng were done face to face in the interviewees' places of choice, such as in their homes, during their off-duty time. Nurses from Cape Town and KwaZulu-Natal were interviewed via Skype, because of the distance. Skype interviews were also conducted with participants that had re-migrated and were currently working in the KSA and the UAE.

3.3 Research design

The research question to be answered in this study was based on describing human experiences – this required a systematic approach to describe the experiences from the perspective of the returnees (LoBiondo-Wood & Haber 2014:8; Grove *et al.*, 2015:67). Hence qualitative research was employed.

Phenomenology is a research methodology that is qualitative and underscores a philosophy that emphasises the study of human experiences (Dowling & Cooney, 2012:21; LoBiondo-Wood & Haber 2014:112). It studies phenomena or experiences as the person says it appears (Abalos, Locsin & Schoenhofer, 2016:19). This approach was

chosen in order to explore and understand migrant nurses lived experiences of reintegration in the SA workplace (Polit & Beck, 2012:471), as it emerged that there was a paucity of information regarding this phenomenon. In this study, the participants selected were South African nurses who worked abroad for more than a year, and were willing to share their experiences in the workplace upon their return. Phenomenologists believe that there is an essence within experiences that gives meaning to their perceptions.

Furthermore, the researcher had to distinguish between the Husserl's (descriptive) and Heidegger's types of phenomenological research in order to select the most appropriate approach to reach the study objective and increase validity (Grove *et al.*, 2013:202). This approach captures the lived experiences in the manner in which the truth is presented by the individual. The researcher finds meaning of such experiences in the former, whereas the latter interprets the experiences and finds hidden meaning by going beyond essences (Grove *et al.*, 2013:69; Lopez & Willis, 2004:728).

Descriptive phenomenology entails the study of individual's experiences, perceptions and feelings as they are lived and require the researcher to analyse data without biased ideas (Grove, Gray & Burns, 2015: 69). Descriptive phenomenology is also known as transcendental constitutive (Chan, Fung & Chien, 2013:1), being beyond common experiences. LoBiondo-Wood and Haber (2014:113) concur that transcendental phenomenologists are concerned with subjective experiences, using an interpretive descriptive mode.

The aim of this research was to obtain true insight in the phenomenon of reintegration. Honest perceptions were sought to understand all aspects of reintegration.

As a returned migrant nurse, the researcher bracketed her own previous knowledge and experiences, in order to capture the essential lived experiences of participants (Lopez & Willis, 2004:728) to increase rigour (Tufford & Newman, 2012:81). Bracketing refers to knowing one's preconceived ideas and setting that knowledge aside, and accepting and

pursuing the sense participants make out of their lived experiences (LoBiondo-Wood & Haber, 2014:113). In addition, refraining from adding non-given past knowledge to help augment what was presented (Giorgi, 2012:4), the researcher initiated a reflexive journal in order to implement bracketing effectively. The reflexive journal was helpful in identifying, clarifying and monitoring own views that may have interfered during the process of data collection and interpretation (Polit & Beck, 2012:471).

Returned migrant nurses most likely view their home country in a different light, considering their exposure to different paradigms, and their needs that may have changed since initial departure from the home country. The researcher uncovered and discovered meaning from the return migrant nurses' experiences in the context of their own world (Bultas, 2012:463).

3.4 Populations and sampling

According to Polit and Beck (2012:719), a population is the whole set of individuals having similar characteristics. Since a qualitative design was adopted, the researcher selected people who were illegible and had experienced the phenomena (Polit & Beck, 2012:491). The population studied was nurses who worked abroad for more than a year and had returned home to their homeland, South Africa. They were referred to as participants.

There were ten participants, of whom seven were from Gauteng, and one each from the Western Cape, Northern Cape and KwaZulu-Natal. Participants were South Africans that completed their nursing and midwifery training in South Africa prior to their international migration for employment reasons. Of the ten participants, nine were female and one was male. Ethnicities represented were two Coloureds (Afrikaans-speaking) from Western Cape, four Tswanas and one Northern Sotho from Gauteng, and two Ndebeles and one Southern Sotho from KwaZulu-Natal. The participants spoke fluent English and were allowed to answer the questions in their own way, according to their lived experiences.

A purposeful sampling method refers to the researcher's selection of participants for inclusion in the study. They met the requirement (Grove *et al.*, 2015:270), of having the

expertise to provide rich information (Palinkas, Horwitz, Green, Wisdom, Duan, 2015:2; Grove *et al*, 2013:365).

Participants were selected because of their experiences working abroad, inclusive of attempts towards workplace reintegration as return migrant nurses in South Africa. In this regard bracketing also assisted the researcher to reach deeper levels of reflection across other stages of the research, such as population and combing sampling. After finding participants who met the inclusion criteria through purposive sampling, six others were selected as a result of snowballing, since the four knew potential participants with similar characteristics (Grove *et al.*, 2013:366).

Snowballing sampling, also known as network sampling, was used to assist in selecting participants who would be difficult to locate through other forms of sampling (Grove *et al.*, 2013:366). At the end of interviews participants were asked for names of potential participants who met the selection criteria. All names given to the researcher as potential interviewees were followed up and contacted via social media. Those that responded were included as participants and provided with an elaborate explanation of what the study entailed. Consent was obtained via email. Snowballing sampling allowed recruitment of participants who would have been difficult to locate (LoBiondo Wood & Haber 2012:243) and data collection through interviewing until data saturation was reach (Polit & Beck, 2012: 60,497). Saturation of data is often defined as the stage where the data collection process becomes repetitive and no new and relevant information is discovered (LoBiondo Wood & Haber 2012:243, Dworkin, 2012:1320).

The researcher initially planned to interview six participants to gather an in-depth understanding of the phenomenon under study (Dworkin, 2012:1320). A total of ten participants were selected for the individual interviews, with the exception of one married couple (both migrant nurses who had previously worked in the UK) as they preferred to be interviewed together. According to Seaman (2015) there is no single correct number to determine the sample size, but to aim at reaching data saturation. A reasonable estimation used by Seaman (2015) starts by using five participants and subsequently

increase them by another five until incremental data collection contributes not much new information.

3.4.1 Inclusion criteria

The study included migrant nurses who had worked abroad and returned to South Africa to rejoin the healthcare workplace. These participants were included because they met the criteria to allow for a deeper understanding of the phenomenon, since the environment shapes the person and the person shapes the environment (Grove *et al.*, 2015:69).

3.5 Data collection tool

Collecting data in this study was through the medium of interviewing the selected participants. According to Knox and Burkard (2009:14), “to a large extent, the interview is a planned conversation to collect data and is intended to be carried out in a similar manner with all participants”. Following ethical approval by the Stellenbosch Research Committee (S16/10/205) (Appendix A), the participants were contacted telephonically and via social media to obtain permission and to explain the purpose and process of the research study. Once the participants had agreed to participate, appointments were arranged and they were provided with detailed information leaflets (Appendix B) to facilitate informed consent. All the participants who agreed to partake during the first telephonic request were included in the study. Once consent was during face-to-face data collection sessions or via email (Appendix B), semi-structured interviews (Appendix C) were conducted. Such interviews, according to Grove *et al.* (2015:90), refer to a set of fixed questions. These questions were open-ended in nature, based on the central focus of the study, and prepared prior to data collection.

Individual face-to-face interviews and skype interviews were conducted during the participants' off-duty time at a venue convenient, private and safe for participants and the researcher. This type of interviewing was selected, because it allowed the participants to respond freely according to their lived experiences. Probing questions during the first interview elicited rich data necessary for reporting according to a descriptive phenomenological design. Each interview lasted 45 to 60 minutes. During the interview

an audio-recorder was used, and detailed notes made soon after every interview. Missing data were identified during the transcription process and when reading and re-reading the transcripts. Second interviews were conducted with six participants available for this purpose, for further probing, clarifying and confirmation, lasting approximately 15 minutes.

3.6 Pretesting in qualitative studies

A pilot interview was organised and conducted to pretest the questions in preparation for data collection, support refinement of the questions as needed, and assess the researcher's competency with the interview technique (Grove *et al.*, 2015:45). The participant in the pretest met the inclusion criteria as a return migrant nurse with workplace reintegration experience in country of origin. Consent was obtained, and subsequently the same process of data collection was implemented, via a skype interview. The researcher used the developed semi-structured guide to interview the participant with permission to record during this engagement. The recorded interview was transcribed verbatim followed by data analysis according to the Colaizzi seven-stage method in preparation for the main study (Polit & Beck, 2012:540). The transcription and analysed data were submitted to the supervisor. Interviews for the main study commenced after feedback.

The data from this study were not included in the main findings, even though the data obtained and findings were congruent with that of the main study. The questionnaire guide was left unchanged but the pilot study was instrumental in assisting the researcher to learn and adopt better probing skills.

3.7 Trustworthiness

Trustworthiness of a qualitative study depends on four characteristics, namely credibility, transferability, dependability and confirmability according to Lincoln and Guba's criteria as described by Shenton (2004:63). Rigour has to be ensured via these concepts to allay critics' fears of a study not being trustworthy (Shenton, 2004:63).

The researcher adopted a descriptive phenomenological approach to ensure confidence in the truthfulness of the data and analysis (Polit & Beck, 2012:559). Participants' rights to take part, refuse or withdraw from the study was clarified prior to signing consent (see 1.10.1; Appendix B) (Shenton, 2004:67). In order to ensure the credibility of the study, the researcher ensured careful data collection with detailed documentation during the data analysis process (Grove *et al.*, 2015:392). Individual interviews were conducted to collect data; the first interview lasting for 45 to 60 minutes, followed by a second interview lasting 15 to 30 minutes. The researcher encouraged the participants to voluntarily present honest information to ensure accurate and authentic data collection related to the phenomenon studied (Shenton, 2004:66). Thick descriptions of the participants' experiences including the circumstances in which the experiences occurred were provided (Morrow, 2004: 252). The researcher returned to the participants and shared the analysis of findings, to ensure accuracy from the point of view of the person who lived the experiences (LoBiondo-Wood & Haber 2014:126). This was only possible with six of the ten participants since four were not available for a second interview. The study findings were compared with that of previous studies, to assess congruency of results (see chapter 5). Dependability is important to ensure credibility (Polit & Beck, 2012:558).

For dependability, detailed coverage of the research process is needed (Shenton, 2004:71) and the supervisor evaluated transcribed interviews and data analysis to ensure that every step was clear for another researcher to replicate the study if needed.

Transferability of a study relates to the necessary detail of the context of the fieldwork of the study to be declared, for another researcher to determine whether the findings could be applied to another similar population or study (Shenton, 2004:63). The researcher reported, in fine detail, the characteristics of the population, the sampling, and the circumstances around the data collection for evaluation for transferability of findings to another population or generalisation to the larger population.

Confirmability ensures that the findings emerged from the data and not the researcher's perceptions and predispositions, being a recently returned migrant nurse herself. In order

to ensure objectivity, the researcher ensured that results were the lived experiences of the participants only, as is expected of a descriptive phenomenologist who uses bracketing to do so.

3.8 Data collection process

A semi-structured interview study guide was used to capture the experiences of participants'; push-pull factors to migrate to destination countries, subsequent push-pull factors to return to South Africa as country of origin and reintegration in the workplace upon return. Collection of data was done using seven questions. The interviews started with an explanation of the aim of the study and rapport establishment. Data collection took place through interviewing the participants at their homes during their off-duty times in Gauteng, while other interviews took place via social media. The researcher skyped with one participant in the Western Cape because of the distance. Three other participants who had workplace reintegration experience as return migrant nurses in South Africa but then migrated to the Middle East for better jobs were also interviewed via Skype from their homes in KSA and the UAE after working hours. Interviews were recorded with the permission of the participants, and transcribed and reviewed by the supervisor. Interviews were conducted between December 2016 and July 2017.

3.9 Data analysis

Following each data collection session, the interviews were transcribed verbatim to ensure reflection of the real recorded lived experiences (example Addendum D). Data collected during interviews were analysed through application of Colaizzi's strategy (Polit & Beck 2012:540). Colaizzi's analytic method is appropriate for descriptive phenomenology (Abalos *et al.*, 2016:21). The seven steps of Colaizzi's strategy helped to induce a comprehensive description of the phenomenon and assisted in obtaining, organising and analysing the data to understand the essence of reintegration experiences of nurse migrants (Polit & Beck, 2012:540). Analysis continued throughout these seven steps.

3.9.1. Step 1: Transcribing process

Audio files were transcribed verbatim to ensure all that was said was captured. This brought the researcher closer to the collected data, and enabled preparation for subsequent interviews through reflexive diarising. Verbatim transcriptions capture the moral of the message according to the abilities of the participant; in their use of language and expressions (Grove *et al.*, 2015:88). On completion of the transcriptions, audio files were compared with the transcribed files to ensure accuracy. In order to obtain a true sense of the participants' experiences, the researcher read and reread the descriptions of each individual. Significant words and lines were highlighted and comments inserted simultaneously and reviewed against previous comments.

3.9.2 Step 2: Transcripts' review and extraction of essential statements

Transcription was followed by extraction of statements significant to the research questions and aims, bringing out descriptions of experiences of the return migrant nurse during reintegration in the workplace (Polit & Beck 2012:540). Direct quotations from the participants aided to reflect the research as accurately as possible.

3.9.3 Step 3: Coding

Following completion of each transcription and extraction of statements, coding of data took place, from the highlighted words and lines that were in line with the information needed to answer the objectives of the study. Data were then highlighted according to relevance to formulation of themes, to reduce the bulk of the data. Every significant statement's meaning was formulated from what was extracted. Coding took place until new information could be extracted.

3.9.4 Step 4: Organisation of formulated meaning

Quotes containing similar content were coded and these codes were further analysed to find true meaning and their relationships. Significant statements were analysed to understand the meaning of statements and themes from these meanings were formulated. The process of reading, extracting and formulating meaning was repeated to ensure accuracy. It was during this stage that new subthemes emerged through

identification of uncaptured data. The themes were refined and subthemes rearranged accordingly, with the researcher frequently analysing and interpreting the data (Vaismoradi, Jones, Turunen & Snelgrove, 2016:101).

3.9.5 Step 5: Description of results

A thick description of the unfolding findings in relation to the phenomenon under study was given (Polit & Beck, 2012:540), guided by the research questions and objectives.

3.9.6 Step 6: Identifying heart of study

This description was revised and rectified to reflect the true meaning of the findings. Findings were read and re-read to identify shortcomings. Irrelevant information was removed to avoid over-interpretation of data.

3.9.7 Step 7: Involving participants in validation

The formulated meaning was clustered into themes and refined. Themes were referred back to the original descriptions to ensure validation. Transcripts were read by participants to ensure validation (Shenton 2004:68). The researcher further discussed the themes and results with six of the ten participants based on their availability, as a final validating step. The participants agreed to the findings.

3.10 Summary

Chapter 3 outlines the research methodology employed. It further provides a description of participant selection, data collection and data analysis to facilitate study replication by ensuring trustworthiness.

Descriptive phenomenology enabled exploration and a better understanding of the lived experiences of migrant nurses during their reintegration in the workplace upon return to South Africa.

Chapter 4 gives displays a detailed discussion of the findings concluded from the data collection process through analysis of the data.

CHAPTER 4

RESULTS

4.1 Introduction

Chapter 4 describes the results of the data analysis and narrates findings according to the themes of push and pull factors and workplace reintegration. These themes are discussed in full with the help of subthemes that supply answers to the research question:

The chapter is divided into two sections. Section A introduces the demographic data followed by an elaboration of the identified themes in Section B.

4.2 AIMS AND OBJECTIVES

The main aim of the study was to explore, describe and gain an understanding of the experiences of reintegration of migrant nurses in the workplace on return to SA. Furthermore, the reasons why they migrate and return to country of origin and how this influences their reintegration process are examined.

The objectives of this research study were to explore the following:

- The push/pull factors that motivate South African nurses to migrate as well as return to the SA workforce.
- Experiences of returning SA migrant nurse regarding reintegration in the SA workforce and how they cope.
- The factors that motivate migrant nurses to reapply for employment abroad or to remain as part of the workforce in SA.

4.3 SECTION A: DEMOGRAPHIC DATA OF PARTICIPANTS: STUDY FINDINGS

Interviews were conducted with ten participants who met the inclusion criteria, which were that they had to be professional nurses and had completed a migration process for at least one year. The migration process involved outward migration to another country as temporary international employees, and return migration to SA, with further employment in SA.

Most of the participants were females who had migrated without their families. The demographic data are a compilation of personal as well as professional information of each participant's pre-and post-migration history. The demographic data are depicted in Table 4.1 below, and will be discussed in detail.

Table: 4.1 Demographic data of participants

Participant (P)	Ethnic group	Province	Marital status	Age in years during 1 st migration	Dependents' age in years during 1 st migration of parent	Qualifications prior to migration	Qualifications post return
1	Southern Sotho	KwaZulu-Natal	Married	35	Girl (10)	R425 Advanced midwifery	BCur Nursing Master, PHD in Nursing
2.	Tswana	Gauteng	Engaged	35	Boys (5 & 10) Girl (2) (re-migration)	R425	Unchanged
3.	Tswana	Gauteng	Single	37	Girl (6)	R425 ICU	Unchanged
4.	Northern Sotho	Gauteng	Married	38	Girls (10 & 3)	Diploma (GN), Psychiatry)	Unchanged
5.	Ndebele	Gauteng	Married	39	Girls (12 & 5)	Degree General nursing and Primary Health. Diploma in Pharmacology Midwifery, Community, Advance Community, Nursing Administration.	Dispensing course
6.	Ndebele	Gauteng	Married		Boys (8 & 13)	General nursing	Unchanged
7.	Tswana	Gauteng	Divorced	46	Girls (20 & 19) Boys (17, 9)	Diploma in Nursing (General Community and Administration) Midwifery & ICU)	Unchanged
8.	Afrikaans	Western Cape	Divorced	33	Boys (17, 12 & 6)	R425	Management (Nursing)
9.	Afrikaans	Northern Cape	Single	28	None	R425	Oncology Degree MBA (Online)
10.	Tswana	Gauteng	Married	35	Boys (17 & 11)	D (GN) Midwifery	Unchanged

4.3.1 Residence status and ethnicity

Of the ten participants interviewed, seven were residing and working in SA again, while two of the remaining three were still employed in the Kingdom of Saudi Arabia (KSA) and one in the United Arab Emirates (UAE).

Those that were back in SA indicated that they either strongly intended to re-migrate again (two), or that they would have to settle in SA, because of their advanced age (three), while the rest (two) had come to terms with the day to day struggles in their home country, but nevertheless decided to stay.

Three of the nurses initially migrated to the United Kingdom (UK) between 2002 to 2004 and stayed long enough to obtain citizenship. They qualified for UK passports and are maintaining dual citizenship in case they need to return to the UK. Seven of the participants migrated to the KSA between 2001 to 2004, a country strictly governed by Islamic (Sharia) law, and their length of stay ranged between nine months to 16 years. Two of the participants then migrated from the KSA to the UAE, because of more relaxed Sharia legislation in that country than in the KSA. Another participant migrated from the UK to the KSA owing to better benefits (tax-free salary, subsidised accommodation and free transportation to work), while one participant migrated from the UAE back to KSA.

Ethnicity indicates where participants originated from in SA, and this helped in reflecting on the experiences of different SA cultures in working in non-SA workplaces (Table 4.1). With the diversity in SA society, one needs to understand the value that the interviewees put upon the family as a unit. It is well-known that some cultures see the family as an extended, tightly-knit unit, not to be broken up, whereas other cultures in the same country (such as Western ones) see the family as a nuclear unit; consisting of a couple and their children. However, whether the family is nuclear or extended, the decision to migrate amounts to a mutually beneficial compromise within the entire family (Stark & Bloom, 2004:174).

The participants were from four of SA's nine provinces. Seven participants were from Gauteng, the smallest province. It is highly urbanised and has SA's biggest city, which attracts many migrants. KwaZulu-Natal, Western and Northern Cape were each represented by one participant only.

As the researcher lives in Gauteng, this distribution of interviewees was practical as a sample, as indicated in paragraph 3.4.

The majority of the interviewees in Gauteng were composed of the Tswana ethnic group that originates from the neighboring country, Botswana, and the previous homeland, Bophuthatswana. Both border on Northwest province. Owing to Northwest province's proximity to Gauteng, many rural persons became city-dwellers. Nurse training is then undergone in Gauteng. Furthermore, Gauteng boasts with many more diverse cultures, inclusive of the Ndebele and Northern Sotho people, who originated from Mpumalanga and Limpopo respectively.

4.3.2 Gender and marital status

The participants in this study consisted of nine females and one male, indicating a growing feminisation of migration (International Organization for Migration (IOM), 2014: 2; Mgubane, 2016). Thus, most of the participants were females who migrated individually, leaving their family behind, in search of economic improvement. Hagen-Zanker (2008:12) confirms that family structure plays a part in looking at migration from a gender aspect, as women would be more careful whom they ask to look after their children when they are away themselves.

In the past, traditionally the male was the main economic role-player and the family member who was most eligible to migrate for employment purposes, but according to IOM (2014:2) in the last three decades, international female migrants have steadily risen to 48% of the working population worldwide, making them equally important economic contributors to men. This has created a modern role change between males and females,

as upon female migration, the male (unlike tradition) has to stand in for both parenting roles as agreed upon.

While most of participants were married when they migrated, two were single and one divorced. Married women left dependents in the care of the remaining spouses, mainly men, while single parents requested relatives to take care of them. Not all families managed to deal successfully with such role changes, and two of the participants agreed that the distance of the host from the home country contributed to communication breakdown, and subsequent divorce proceedings.

4.3.3 Age

While 80% of the participants were in their thirties when they first migrated, there was one who was in her late twenties and another in her mid-forties. The tendency to want to improve financial status by going abroad seems to correspond with the age where most have children and additional finances are required for their upbringing, including schooling.

All participants did have the necessary training, experience and expertise as SA professional nurses, as a requirement for employment abroad. This put them in the age group of late twenties to early thirties.

4.3.4 Dependents left behind

Since seven of the participants were females with own children as dependents staying behind in SA, the number and age of the children left in care of others were of significance as catalysts for the nurses to return soon. Nearly 40% of the children were below ten years of age, while 60% were above ten years. Most of the parents had one or more dependents in these age categories. The dependents left behind ranged from one to four with the average being two dependents per household and 61% boys and 39% girls. As the children grew, so did the financial responsibilities, often influencing the decision to earn money abroad for their needs.

4.3.5 Qualifications prior to migration

Being trained and registered as nurses at SANC made them eligible for registration in the Middle East and the UK, without extra qualifying examinations needed, as insisted upon by countries such as the US.

Basic qualifying training included the Diploma in Nursing (General, Psychiatry and Community) and Midwifery (R425) obtained by half of the participants, while four had completed a Diploma in General Nursing and one a Degree in General Nursing. Four of the participants had completed post basic courses in different specialties prior to migrating. Two of the participants had completed diplomas in Intensive Care Unit, two in Nursing Administration, one in Advanced Midwifery, and another in Pharmacology and Advanced Community Nursing.

Recruitment and allocation to areas of work within a host country are arranged according to that country's specific needs. This resulted in only one participant being allocated to a similar unit to the one she had worked in prior to migration. Instances of different areas of placements included that of a participant with an Advanced Midwifery Diploma who was placed in a remote area to serve as a midwife in the emergency room, but ended up attending mostly to medical patients. Another participant with ICU training and experience in SA who was allocated to a step-down unit from ICU, equivalent to a high-care unit in SA. This indicates that the qualifications pre-migration at times dictated the level, type of job and area to be employed in the foreign country.

4.3.6 Qualifications obtained in host country

Exposure to other cultures and ways of nursing in a host country seem to stimulate further studies with these nurses with international experience. However, not all made use of such opportunities, and study directions actually followed were not necessarily nursing-oriented, thus not contributing towards their career as a nurse. There are ample opportunities at various SA distance learning higher education institutions to study further in nursing when abroad. Furthermore, the host countries also have opportunities to study via international institutions. Unfortunately, countries are very specific regarding

qualifications they recognise as contributing to the nursing field, as this relates to their own needs and to their accreditation bodies, which are similar to the SANC.

One exceptional participant worked in KSA for 18 years completed a General Nursing Degree, followed by a master's degree and subsequently a Doctoral Degree in Nursing. Another completed a diploma in management in nursing, and was studying towards a Master's Degree in Nursing via a SA university, while still in KSA. One participant completed a Degree in Oncology and a Diploma in Dispensing whilst in the UK.

Short courses are available at workplaces abroad, and nurses are expected to do several such programmes as continuous professional development every year. These include Basic Life Support, Advanced Life Support courses for adults and obstetrics, Neonatal Resuscitation Programmes and a flight nursing course.

Non-nursing short and long courses were also available and followed by some through various institutions, such as a jewelry design course and an MBA in healthcare.

While it is compulsory for nurses to take courses in terms of continuous developments, migrants mostly choose whether to engage in further studies or not. Half of the participants had other pressing needs that influenced their decisions not to get involved in extra-mural studies abroad, apart from just what was expected on host hospital level for Continuous Professional Development (CPD) purposes.

4.4 SECTION B: THEMES EMERGING FROM DATA COLLECTION

A temporary migration process has three phases: the outward migration, the return to country of origin, and then re-migration or settlement in country of origin. The reasons indicated by SA nurses for migrating from SA stems from a variety of causes, which are categorized into push and pull factors. Every participant's decision to migrate outwards, or back to country of origin, were influenced by some of this push and pull factors.

The themes and subthemes obtained from the data collection are presented in Table 4.2 and discussed in detail below

Table 4.2 Themes that emerged under the migration process

<i>Themes</i>	<i>Subthemes</i>
1. SA outward migration – push factors	1.1. Economic factors 1.2. Personal situations 1.3. Status of health services in SA
2. SA outward migration – pull factors to host country	2.1. Taxation relief 2.2. Opportunities to save 2.3. Opportunities to bring families over 2.4. Opportunities to travel 2.5. Opportunities to study at internationally recognised universities 2.6. International nursing experience
3. Return migration to SA – push factors from host country	3.1. Short type of contracts available 3.2. Goal attainment 3.3. Preferred SA education 3.4. Economic downturn in host country 3.5. Lack of recognition of skills and discrimination 3.6. Lack of democracy and fairness
4. Return migration to SA – pull factors	4.1. Family needs 4.2. Family ties and events
5. Reintegration experiences: positives and negatives	5.1. Advantages of short courses 5.2. Intellectual and practical experience 5.3. Attitudes and work ethics 5.4. Staffing and workload 5.5. Budgetary issues: salaries and equipment 5.6. Policies and procedures
6. Decision influencers towards re-migration	6.1. Permanent return to SA 6.2. Temporary return to SA

4.4.1 Theme 1: SA outward migration – push factors

The reasons for leaving SA for employment overseas are multifactorial, but also individualised according to specific needs that cannot be met in SA, inclusive of poor nursing salaries to managing an affordable lifestyle. However, participants also mentioned general and personal factors, such as the status of the health services in SA and relationship issues. Li *et al.*, (2014:315) agreed that factors influencing nurse migration are not necessarily due to the global market, but are rather complicated. These factors emerged as the subthemes of migratory push from the home country.

Subtheme 1.1: Economic factors

The majority of nurses stated that they migrated to improve their standard of living, thus they had an economic motivation. A study conducted by Douglas-Harrison (2014:1,19) in Jamaica cited economic difficulties as the main reason to migrate. Remuneration in SA for professional nurses were perceived as being very low, owing to the high tax deductions from salaries and further taxation by government on all items bought and sold, thus surviving on a low income was difficult.

P1: “the main one (reason) was the finance, as you know that in SA our salaries, really it’s difficult to cope, to live on ... that money. So, it was about my economic status.”

As children were growing up, so did the accompanying demands and responsibilities increase, with some not being able to afford school fees for what they perceived as good education for the children. These individuals prioritised better education for their children, Better schools often meant that higher tuition fees had to be paid, which were not affordable as professional nurses in SA. Single parents, or either one parent of the family, often migrate to high-income countries in the Middle East, such as KSA, which employ temporary migrants contractually on a bachelor status.

P3: “...I had a daughter; she was turning 6 when I left, she was just about to start school. It was one of the toughest decisions to make, but for her to get a better school, I had to. Financially there was no way. I could have done it at home.”

In SA, annual tuition fees largely depend on what and where you study. SA government schools are subsidised with minimal amounts or no fees and the curricula are nationalised, but the employability rate after matriculation is very low. Since education is considered a vital edifice upon which children’s futures depends, parents often select private institutions at primary and secondary levels for their children and encourage tertiary education in order to enhance their employability.

P7: *“... it was clearly financial ... I am a single parent ... three of my children were at tertiary, so with the fees at home, with what we are getting at home I couldn't have afforded it. So, that's basically one reason that I had to go and work abroad ... it was difficult ... it was a decision that I didn't make out of my (own) will. If I had any other way, I would have decided to stay, but as I told you, I had to go, because they needed to be somebodies in life as well, so I figured the only way was to go abroad so that I can achieve and they can achieve their (goals) ... academically.”*

P5: *“... That's what drove nurses out of SA, to go and find a better salary, to pay off debts, because living from borrowing from Peter to pay Paul, is not a life.”*

Thus, the only way they were able to ensure that children reached their educational goals was to migrate to a country where they themselves would earn an improved salary. In that way, they would ensure that their children would not suffer from the restraints of poverty.

Subtheme 1.2: Personal situations

A participant used migration as an escape from her emotional turmoil owing to marital problems she was facing at the time, as the distance and detachment from the current situation would assist her in making less emotional decisions.

P1: *“... I wanted just to be away from home so that whatever (decision) that I was making ... was about to make, regarding my ... marriage and what not ... were not influenced by my presence. I wanted to be away, to detach myself from my environment.”*

The effects that migration of a family member has on the rest of the family can sway the decision to join the migrant in a country that allows family status. One husband migrated to England while his family remained at home, with his wife assuming a dual parenting role for two years. The wife and children migrated two years later to the UK to maintain the traditional family unit.

P5: "It was not easy hah! Because I was used to the fact that, every morning their dad will drop them off at school and he would pick them up. ... I had to take over that role, preparing kids in the morning, rush to drop them off in different places, and then after work pick them up and then come home, and prepare a meal for them. Actually, I was playing a two-parent role for them, even trying to over-compensate for the father who suddenly was not there for them."

Hardship is not only experienced by the adults left behind, but more so by the minor dependents who may not fully understand why a parent suddenly leaves home for prolonged periods. Not only does the day to day routine change for those left behind, but it highlights some complexity migration imposes on family life. In kind, migration of a family member may have adverse effects on significant others left behind, leading to social vulnerabilities (Global Migration Group (GMG) n.d.; Chae, Hayford & Agadjanian 2016:1047).

P5: I won't say she got used to it, because you only realised and saw the results when we moved (to the) UK, when we were with him (the father), that the child started changing. (When the father migrated to the UK) suddenly she started bedwetting. We did seek medical help actually. So, after having going through all those procedures which were unnecessary, then I realised that it's psychological. When we got to UK, suddenly the whole thing just came to an end. So, I wouldn't say she got used to it, because when we got to the UK you saw changes as opposed to when we were here at home. The child started gaining weight, she started being a friendly child..."

This participant not only realised that the father and husband's absence influenced the daughter negatively, but also how hard it was on the relationship and the psyche to deal with it. A person who is a major part of the family, was leaving continuously, and they had to cope on their own. Every single meeting and good-bye brought adaptation, with the person not feeling part of the family anymore. Such effects caused this family to unite abroad sooner than later.

P5: "He started feeling like a stranger in the house (migrant husband from the UK, visiting his family in SA). You didn't even want to be attached to him, because I mean what's the point, he is here for 2 weeks. When you think, you are bonding after 2 weeks, whoop, he is gone, you have to re-start readjusting again. So, it was just not nice for all of us, even for me. You could even feel the rift, so that you were drifting apart..."

From these comments, one realises that some hardships to be endured had to be measured up against each other in the process of compromise regarding which parent should go and which one should stay with the children. Was it going to be more difficult to cope on one's own in the host country without family, or was it more difficult to stay with the family and cope without the important father/mother figure?

Subtheme 1. 3: Status of health service in SA

The working conditions in both the public and the private healthcare sector leave much to be desired for, according to these interviewees. Posts are frozen to manage budgets, as an effect of near-recession situations, with the remaining nurses having to cope with the ever-increasing patient population, and a larger span of control. vacancy rate of healthcare professionals reached up to 60% in the public-sector compared to 2.3% in the private sector in 2011 (Pillinger, 2011:8).

One participant in particular was so frustrated with the private healthcare sector, that she opted to return to Saudi Arabia where she felt there was more support in terms of staffing, especially with more doctors available on the premises. She reiterates that in private healthcare in SA the necessary resources (equipment) are readily available, but medical care is often delayed owing to a shortage of doctors and especially specialists.

P6: "... if you are in ICU, the doctor is on call, he will be coming from home, the doctor is not in the hospital ... should anything happened whether you are in ER or ICU, you will be the first one to write the medical report ... when by the time that doctor come(s) to that emergency... it's too late ... the nurses are the first witnesses ... So, I just felt it's not right, that's why I decided that I may not come back to SA to work, as a nurse."

In the SA health institutions, the professional nurse in the Intensive Care Unit has far more responsibilities than in a similar setting in the destination countries.

P3: "In SA once you are qualified as a critical care nurse, in the private sector you are actually the doctor's eyes and ears, because he is not there, you have to make sure everything is going right all the time and if it's an emergency you have to deal with it. (Therefore) ... you have to decide and do something about the situation. Meanwhile in Saudi there's always a doctor on board. (When) you need (the doctor), you see a patient changing condition, you just have to shout: Doc(tor) the patient is changing condition, because it's his responsibility, he takes over whatever is happening."

However, this shortage of doctors is not only in the private sector, as a participant who works in the public healthcare sector commented:

P2: "... doctors are just not enough."

This situation places tremendous strain on the remaining doctors and nurses in the SA healthcare sectors. In 2013, SA had 92 private doctors and only 25 state doctors per 100 000 people whereas the world's average is 152 doctors per 100 000 (Brits, 2016). This number decreased in 2016 to an average of 60 doctors per 100 000 across both healthcare sectors. With only 20% of the SA population able to afford to utilise the private sector, the accessibility to a doctor of 80% of inhabitants whom are reliant on the public service are severely compromised. Tsewu (2017) mentions in this context that intern doctors are often expected to be on call 30 hours non-stop and qualified doctors' hours are often endless.

Compounding the problem further, is the chronic shortage of nurses, which according to Becker (2017), is about to become critical; due to inadequate nursing training facilities and the aging population of nurses, some migrating, while others simply decide not to practise anymore.

P2: "... SA is too behind to recognise that nurses are not enough, and they don't develop their nurses."

This huge shortage of nurses and doctors in SA healthcare facilities raises concern regarding the challenge of delivering quality health service to the patient as a human right.

4.4.2 Theme 2: SA outward migration – pull factors to host country

The pull factor for migration towards the host country complements the push factors discussed above, often in the forms of benefits that are not available in country of origin. The subthemes that emerged as pull factors are the tax-free income in the host country, opportunities to save, to travel, to bring the family over, to study at internationally recognised universities and to gain international nursing experience.

Subtheme 2.1: Taxation relief

The majority of participants migrated owing to improved benefits, for example tax-free salaries offered in the Middle East. The UAE and KSA do not levy direct personal taxes, except for the use of municipal services, restaurants and hotels (Kapur, 2015; Indirect Tax Alert, 2017:2). As such, working in the Middle East can be most advantageous for expatriates, since there are no tax deductions from salaries. Furthermore, as employment is usually in urban areas in countries with a well-known history of open trade, it offers a vast arrange of shopping opportunities and products that have been mostly tax-free, with value-added tax (VAT) only expected to be implemented from January 2018 in the Gulf Corporation Countries (GCC) (Indirect Tax Alert, 2017:2).

P7: "I think Saudi Arabia was the best choice for me, because the salary is ... non-taxable."

Some participants initially moved abroad to a developed country such as the UK, but found taxation and the cost of living too high, and then opted for the Middle East. Skilled

migrants in the UK pay far more taxes than the state benefits they stand to gain in Britain (Travis, 2014). Another participant was able to afford housing in London while he was living on his own, but had to move to an affordable area to accommodate his family.

P9: "... even though food and clothes was cheap, but your rent was extremely expensive in the UK, so that was killing you ... so towards the end it was really difficult to survive there."

P4: "... which means I had to move, I went to Northampton, which is in the Midlands ... London was too expensive, I wasn't earning that much, in order for my wife and kids to join me) I had to move to the Midlands which was cheaper (to stay in) than London."

South Africans working abroad were previously exempted from foreign employment earned income tax in SA, but recently there have been proposals of a Taxation Law Amendment Bill to implement such taxes (Omarjee, 2017). One participant who migrated twice to KSA had strong intentions to re-migrate, but had to reconsider when this provisional new SA taxation on foreign earnings was mentioned in the SA budget speech of 2017 for 2018.

P2: "Maybe we will start thinking twice before (we migrate) ... If they tax, then we will have to reconsider that, maybe we will not (migrate)."

Subtheme 2.2: Opportunities to save

Professional nurses employed in SA live from the hand to mouth, unable to meet their demands and needs, such as to save money, as per the following participant's opinion:

P5: "There are nurse (s) which I knew when I was training ... even today ... they can't even afford cars. It's sad, it's so sad we not saying we are materialistic, but we have to have a living wage..."

Accepting nursing employment in KSA often meant that the package consisted of fully (or partially) subsidised housing, services (water and electricity), transportation to and from work, and medical aids offered by the employing hospital. However, this is dependent on the host country, and personal situations, as one migrant to the UK found that he had many opportunities to save with the many work opportunities available, whilst another felt she had to move from the UK to KSA because of the poor pound to rand exchange rate, and the subsidies received as part of payment enabled her to save most of her income, as also mentioned under section 4.3.2.1.

P 4: "I was looking forward (to) ... a lavishing life, I thought ... working overseas, I will earn more than the nurses ... here in SA, which was of course the fact ... there is a lot of work for nurses in the UK...The salary (not spent, and still in the bank account) finds another (week's) salary before it's being used. So, for you to be broke, it wasn't that easy in the UK ... that's the reason why I had to move abroad and make money there."

P7: "... (I was able) to save a lot, to bring the money home, where it was needed."

P9: "... at the time (when left the UK) the rand to the pound, it was ridiculous, I think it was 9:1. At the time when I arrived it was 17:1. So, there you can see there was a big difference. So, when I went to Saudi (from England), the company I'd worked for, was giving us almost free accommodation. Your water and electricity was free and you could basically ... save 90% of your salary there."

To make the choice to leave your family and safe career option, and then to arrive in another country, with the realisation that you are unable to save and reach goals, caused some frustration and gave the decision to migrate further impetus.

Subtheme 2.3: Opportunities to bring families over

Some families plan from the beginning for the whole family to join the family member in the foreign country. Often one parent is left with the children in SA, while the other parent investigates the circumstances in the potential new country. One such couple had the

wife and daughters follow the husband after a period, for her to subsequently also work as a professional nurse in the UK. The husband spent the first two years alone working in the UK, to assess how conducive it would be to live and bring up the children there.

P4: "... for the first 2 years I went there alone (Whipcross in London) ... I was preparing for my family within that 2 years ... they joined me in my 3rd year whilst I was staying there ..."

Migration can also open up new possibilities for the family, as one participant that worked in the KSA found out. She had resigned to work in UAE, because she realised that her family could obtain visas and join her, unlike other countries in the Middle East.

P6: "... I came to the United Emirates, because I actually wanted to stay with my family and that concept; now you could actually stay with your family in the Middle East. So, that thing of staying with my family did have an impact on me for taking the offer. (In) Saudi, my family could visit me, but I wanted one of them to live with me or ... for them to come as they wish, unlike Saudi where ... there were some barriers. They were still allowed to visit, but they wouldn't visit as much as they can in UAE."

Migrating with the family has a positive impact on the length of service in the host country, whereas migrants with bachelor status tend to keep their contracts as short as possible to rejoin their families.

P10: "... my contract was 2 years so I didn't want to renew it, because that time the money rate was so bad; it was the same as when I'm home. I'm home (now). I'm doing overtime (rather than work abroad). I'm overworking myself with overtime when I'm off, but the advantage of that (is) ... I would be with my family. Unlike when I'm there (abroad) working for that money with my normal shift, without the family ..."

The pros and cons were carefully weighed, and the person seemed to have made peace with the choices she made for her family, even though she had to work harder in SA in the process to reach her goals.

Subtheme 2.4: Opportunities to travel

One of the advantages of working and living abroad is the travel opportunities you can suddenly afford. A range of holiday destinations is geographically closer to the Middle East and Europe for expatriates from Africa. Living in the GCC, oil prices are to their benefit, and airfare is more affordable when travelling, with many connecting flights to most parts of the world. For migrants to the UK, Europe is on their doorstep, and easily reachable when earning pounds.

P6: "... it was very easy for me to travel from Middle East to other parts of the world. It was cheaper in terms of the airfares and the hotels and the way they charge you, because if I was to book a holiday from SA, I would pay the double amount for the flight and for the hotel ..."

One couple expresses how privileged they were to explore the wonders of Europe and its surroundings together with the children, while working and living in the UK, and how it expanded their children's vision of the world and ideas of what is attainable for themselves in the future as world travelers.

P5: "... they've been to Disneyland, which is every child's dream, they've flown in and out ... now they say: I need to travel the world, I need to go to so many countries, ... before I can have a child (myself) and settle down ..."

For South Africans in the southern hemisphere these countries are generally quite far away and expensive to travel to, and with taxation of fuel, airplane travel can be quite unaffordable, apart from the fact that they also have to spend in overseas currency against which the Rand cannot compete.

Subtheme 2.5: Opportunities to study at internationally recognised universities

The opportunity to study at internationally recognised universities remains a far-fetched dream for many parents and children alike, yet by working abroad and being able to take your children along, becomes a realistic possibility.

P6: "... My first son is 25 years, he just finished his second qualification in UAE of BCom accounting (Bachelor of Commerce), (the second one) - he completed an internationally accredited accounting course ..."

Some have taken the opportunity themselves to study through institutions that they could easily access while working abroad, owing to their financial stability and available free time as a single person without family responsibilities. One such participant resigned from the UK to migrate to KSA, and so fulfilled her wish to, among other qualifications, also complete an international MBA.

P9: "... if I was in Saudi ... the plan was to save the money and do the MBA in SA, but while I was in Saudi I had enough time to do it through an American University. So, I was able to do it while I was there ... In the UK, I did my BSC Honors in cancer care."

Most of these countries popular among South Africans to migrate to, have very well-rated universities. A qualification obtained at one of them is seen as very valuable, and would help towards obtaining a management position in SA in certain career fields.

Subtheme 2.6: International nursing experience

A sense of adventure and a taste for experiencing other countries and at the same time gaining international exposure were more reasons given to migrate. Having international nursing experience teaches one about diverse cultures; by working with people with different worldviews cultural awareness and sensitivity improve. Generally, participants gained the experience of a lifetime; both professionally and personally.

P5: "... I think the other thing which was in me, I wanted to have a feel of the other part of the world, because everybody was just going overseas, I said, ok let me go and feel, how is it to work overseas..."

P4: "I wanted to be able to see what the world looks like that side, I wanted to be a world class nurse. To see what other nurses are doing in other countries as compared to us here."

Furthermore, gaining international nursing experience has made one participant a better nurse practitioner and more marketable at the same time. By ensuring that she developed herself, the participant excelled within her scope of practice, and became a resource nurse in the ICU.

P3: "Compared to the way I practice before I left, and the way I practice now that I'm back home, it actually put me on a higher level than the general population of nurses in SA, because I applied for the job when I came back, I worked in that unit for about a year and a half and they asked me to be a clinical facilitator for the unit because my knowledge is up to date from when I was abroad ..."

Another participant with international oncology expertise could select the area where she needed to work, which was closer to her aging parents. This meant that she became sought after, and in a sense 'head-hunted'.

P9: "I also applied for a job in Cape Town ... (it was) also outpatient; oncology and ..., I got the job, but then (at the) last minute, it was still ... (going to) be away, because I'm from the Northern Cape, it was still ... (going) be away from my parents. So, at the end I decided not to take that job."

Thus, their experience abroad facilitated contact with new and fresh ideas of looking at old problems, and this created initiative, confidence and choice on return to SA.

4.4.3 Theme 3: Return migration to SA - push factors from host country

Return migration is a consideration in the individual's initial migration plan, but the actual time frame is dependent on integration in the host country and the type of contract, as well as the ease to obtain another contract abroad. Other subthemes that emerged were those of goal attainment, preferred SA education, economic changes in the host country and professional growth.

Subtheme 3.1: Short type of contracts available

The type of contract offered to migrant nurses in the host country is determined by the company. Short-term contracts in KSA can be renewed by mutual agreement between employer and employee, and it is not unusual for migrants to work in the KSA for more than ten years, but foreigners may not obtain citizenship (Lexology, 2016). The UAE employment contract is governed by labour law under Federal Law no. 8 of 1980, with specific time limits attached to each contract (United Arab Emirates, 1980). Therefore, a residence employment permit is offered only in the presence of a valid work offer and expires at the end of such contract or stipulated timeframe. Another way of obtaining citizenship in the UAE is through the purchase of real estate or starting a business (Company Formation Dubai, 2017).

Although these types of tax-free short-term contracts can be renewed in KSA and the UAE, nurses who left their dependents in SA migrate for the shortest period possible and hurry back home to rejoin the family. The short-term contracts are thus to their advantage, to relieve the most pressing financial needs.

P2: "... I left my family, and my kids were still young, so I was not free to leave them for long without leaving there. The main reason was just to be back to meet my family ... I went to get money for them, now after getting money I had to rejoin them. They really need me as a parent. If they were allowing me to take my family with me maybe I wouldn't have come back. The real reason is my family."

Retirement age in KSA for men is 60 and women 55, but the employment contract may continue if both parties are in agreement. In the UAE, expatriates can apply for work permits until the age of 65 (Gulf News Community, 2017).

The participants that migrated to the UK obtained citizenship, and maintained dual citizenship to be able to return to the UK if necessary as a lifelong option.

P5: "... but if things get worse we might, we've got British citizenship, we've got an indefinite leave to remain in the UK. So, every 2 years we do go to the UK, visit. Our pension funds are still in the UK, so when we retire, we'll be getting a pension from the UK."

It thus seems that different goals and different family situations in SA determine the individual's decision to finish a short-term contract, or to renew it for longer in the host country.

Subtheme 3.2: Goal attainment

The majority of participants migrated to the Middle East; mainly to KSA, as temporary migrants who set goals to accomplish what was needed and to return as soon as possible to SA. Consequently, the duration of migration ranged from two to 15 years in this sample group, with six of the participants migrating several times in order to achieve their desired outcome.

P7: "... I had managed to do whatever I said I wanted to do (accomplish the goals I set for myself); like the car I bought cash, the house was extended, the furniture I bought..."

P10: "... I accomplished more than I bargained for; because when I went there for the first time, (in SA) we were staying in the suburb (suburban area) in a beginner ('s) house (5 roomed) then I had to move to a bigger house, which when I came back, it's paid off, paid off the car, the boys are all back, finished their schools ..."

Apart from material gains, the intellectual gains obtained by the courses done as mentioned earlier, helped them towards improving their situation on the career ladder, as the persons who obtained better posts demonstrated in section 4.4.2.

Subtheme 3.3: Preferred SA education

The couple that migrated to UK with their two young daughters, decided to return home so that the eldest daughter could matriculate and commence tertiary education in SA. Observing the demotivated children in the UK and subsequently their dependence on social grants, they felt that they had to teach their daughters the SA culture of independence, in order to groom them into responsible adults.

P5: "... the kids were growing ... and our agreement was that when she (the eldest) turned 16 ... in the last year of schooling, she will come and complete her matric in SA and get into the university here. So ... (we were concerned that... she was now becoming too comfortable in the UK, (the government subsidises everything) ... whether you go to school or not, (it) doesn't make any difference ... So, we didn't want to let her see that there is no need to get (an) education and be independent. She was already turning into a British child ... (in) that everything will be handed over (to her) on a silver platter."

The education obtained for themselves through the distance-learning programmes done via SA institutions, also helped towards improving their intellectual capital. These qualifications (often more so than those obtained internationally) equipped them to deal with SA conditions and burdens of disease. However, conditions like such as HIV & AIDS, have a stigma attached in KSA, making it very difficult to study in this direction within the Kingdom (Raheel, 2016:1) especially by migrant health workers.

P1: "... after doing my BCur, I decided to do HIV & AIDS, which was my master's degree. With HIV and AIDS it was an interesting subject, but I had problems, ... I had to involve myself in some kind of research. But knowing the subject of HIV and AIDS especially in the Arab country, it's a no-go subject, so I wasn't allowed to do anything. I wasn't even allowed to mention that I was doing HIV and AIDS. ... I did speak to the officials, you

know they discouraged me from the beginning; (said) don't even try to do it otherwise you will end up in jail ... clearly ... I shouldn't even attempt to do it or to even ask any permission, so ... whatever I was doing, it was all in SA. I didn't stop there, I continued. I applied to another university, I did my PHD which was not easy at all. I had to go down (to SA) so many times for conferences, I had to go down for so many things, even for data collection I had to go down to SA as well, because here they wouldn't allow me (to do it). ”

Subsequently, on completion of qualifications through hardship, the participants returned to SA to use the knowledge and experience gained between the two countries as a lecturer at a university.

Subtheme 3.4: Economic downturn in host country

The economic crisis that started in America in 2007 soon spread to become a global financial crisis and many countries experienced recessions (Republic of South Africa, 2011). This situation affected the rand/dollar/pound exchange rate, with the money earned abroad not worth as much in rands as before. Some of the UK migrants returned to SA in 2008, fearing the possible effects it could have on them should the crisis worsen. Thus, the wife returned with her two daughters, leaving her husband in the UK while he was arranging and finalising his move back to SA.

P5: “... when there was a credit crunch ... (with poor exchange rate) ... and there was not...much difference of what the Pound was doing to the Rand ... we decided that before things became worse, and we can't even go back and reestablish our lifestyle (we had to go back to SA).”

While many economies around the globe, especially developed countries, continued to experience severe negative impact induced by the crisis, the Saudi Arabian economy managed to continue with their recruitment of many employees abroad, due to the global need for their oil reserves.

Four of the eight participants started and continued their employment contracts successfully in KSA between 2007 and 2011, which indicated that they saw better opportunities for themselves abroad than in recession-struck SA.

At this time, SA had been struggling for a few years because of shortages of staff, and tried to tempt those working overseas to return home with the 'homecoming revolution' advertised and facilitated by some private healthcare companies, such as Netcare (Breier *et al.*, 2009:58). This, together with the dooming recession and politics of the host country, eased the decision to return to SA.

A participant came to know about the 'homecoming revolution' initiated by Netcare, as she was working for Netcare in the UK. Placement into the same job position with the SA market salary was offered. The same "homecoming drive" accounted for Dubai nurses' drive to return to SA ((Breier *et al.*, 2009:58).

P5: "... I was working with Netcare ... (which was) involved also as an employing entity in the home ... coming revolution. Because ... it was the time ... when there was a credit crunch, and Labour was voted out of power, Toni Blair was voted out and most of the work which Netcare was doing...was influenced by Toni Blair, because he wanted health entities from outside UK who would come and help with operations in the UK. So, Netcare was one of the chosen companies to come and help there. So, how I got to know about the home coming revolution ... most of the people who came with that agreement to the UK, were moving back home and Netcare was like integrating them into Netcare in SA. So, they were like finding a position for you at the same level as what you were at in the UK. So, that's how I knew ... about the homecoming revolution."

Another private SA healthcare company with branches abroad - Mediclinic in Dubai recruited staff to these countries and promised them a post when they return home once their contracts expired. Having a company operating nationally and internationally somehow serves as reassurance that you will get employment on return; helps towards confidence to spread your wings.

Attempts by several role-players to lure SA nurses abroad back home included Operation “*Buyela e khaya*” (meaning return home) with promises that salaries of returnees were to be matched with those of countries abroad, according to the Department of Public Service and Administration (Republic of South Africa, 2011). The Occupational Specific Dispensation (OSD) was policy instituted to improve conditions of service through salary improvements in order to attract and retain employees by providing remuneration according to scarce skills.

P4: “ Occupational Specific Dispensation, where the nurses ... were remunerated to be at the level of worldwide class, the nurses were promised that now, they will be paid like the United Kingdom nurses. The government was aware that the overseas nurses were poaching nurses from SA, so now they came up with a solution; that what can be done about the nurses going out and then they decided that oh, if we were to remunerate them better then or just like the other nurses worldwide, then they will come back home. That’s why they called it Operation Buyela e khaya (return home).”

Subtheme 3.5: Lack of recognition of skills and discrimination

Placement abroad was not necessarily in areas of expertise. Section 4.3.5 refers to the participant who started working in KSA with a specialist Diploma in Advanced Midwifery but was placed elsewhere, with resultant loss of her midwifery specialisation skills. Although she managed during the fifteen 15 years of working there to upgrade herself significantly with other qualifications, she remained in the same rank, feeling less challenged, overqualified and not using her specialised skills. She subsequently resigned to work in SA, where her current knowledge and skill are mostly used as a lecturer to empower student nurses. Using her human capital in her home country might give a sense of self-actualization not reached in host country due to intervening obstacle.

P1: “ ... I learned a lot . But now in this juncture with all what I had accumulated or accomplished (PhD in nursing), I feel now I’m no longer challenged by anything being around here, I feel stagnant. Whatever I have learned or acquired in terms of

*qualifications, I am not putting it into practice, I'm not given ... any opportunities, because here things are different... I need to give it to the people because. Sitting here with all this is useless, investing so much and at the end of the day you don't apply all is like a waste of time, waste of energy, waste of everything, because for me I feel that I need to grow more and more and also in terms of research. And also being the person who loves teaching - I love teaching. The only place, the only thing to do is to resign. Yes money is good, but money is not everything, because I need to reach **self-actualization**.*

This same participant also mentions the discrimination experienced overseas. This is a challenge to deal with, as SA had legally rid itself of such discriminatory practices in 1994 with the acceptance of the world's most liberal constitution, which forbids racial and gender discrimination according to the Constitution of the Republic of South Africa (1996). This indicates that although their home country has discontinued discrimination, abroad many South Africans still stand a chance of being marginalised owing to their foreign status.

P1: "It counts as to where you come from, racially there is discrimination and culturally everything is about discrimination, you are not given a chance, regardless of what you have."

This situation was also experienced in the UK, where local nurses were promoted to managerial positions over SA nurses, even if the latter had higher qualifications and experience. A manager verbalised to another participant that UK citizens took priority when it came to promotions.

P4: "I worked there for two years because my contract initially was for two years, as time went by, they asked me to renew, that but they couldn't give me a managerial post so I decided to look for another job, still in UK."

P5: "...If there's a senior position, you (are) interviewed (together) with a UK nurse, (and) they'll give it to a UK nurse, they will give it to that one as opposed to you, and even tell

you; (it is) because she's from here, and she has 1,2,3,4,5 problems, we are go(ing) to give her the position as opposed to you..."

This triggers resentment and instant decisions to repatriate from the UK and return to SA.

P5: "I had a return ticket, we were coming on holiday for December (2008) and then I said to him (her husband who was also working in the UK) we (are) not going back. I'm going home (SA), even where I was working (in the UK) on my last day, I told them I'm not coming back, I'm resigning. (They asked:) why? I said; no, I'm not coming back. Because you always felt like you are a second-class citizen there."

However, despite negative experiences expressed by others, there is always some exception to the rule, such as the nurse who worked in the UK and was promoted twice, but later migrated to Saudi Arabia for better remuneration.

P 9: "As soon as I started, I was working in a chest medicine ward ... the sister motivated me to do the mentorship course ... we had to teach the students, so once you've got that, you immediately get promoted. So, I did the ... then I was promoted ... from staff nurse D (a low grade) ... to the E-grade. Then when I moved over to the oncology unit, I was promoted to the F-grade, which was the highest grade before you get your matron. So, we were all F-grades in the unit, senior staff nurses, (with) your sister who is in charge of the whole unit. And (following) in Saudi, I was ... just a chemo nurse, but for about more than a year I was doing the charge nurse position..."

This poses the question whether the first two participants above were aware of the way to progress on the career ladder in the UK, or whether it was just a case of plain discrimination. In most countries, even SA, it seems like one has to work one-self up from the bottom of the career ladder each time, with little recognition for skills and experience obtained elsewhere.

Subtheme 3.6: Lack of democracy and fairness

A participant who returned from the UK always felt like a foreigner during her stay in the UK and expressed how there were constant reminders that UK was not 'home'.

P5: "From the laws, from being reminded every time that you are a foreigner. ... There were friendly people, OK, but ja, you didn't belong, you felt you didn't fit in, I would say you did stand out really. Even in the banks when you say ok, I need a mortgage: (They say) no, we don't give to foreigners. So, they always reminded you that you are a foreigner."

The same participant decided to return to a democratic SA, to shake of the feeling of being in exile and regain the sense of belonging, as well as freedom.

P5: "... and then thinking, you know they didn't chase me from where I come from. I always said to my husband; they didn't chase me from SA. How do I bring myself to exile, at least you were brought here (being recruited) ... (but) I brought myself here, I can take myself back ...? (For you), maybe that agency which brought you here, you owe it (to them), I owe nobody anything, I need to go back home."

The difference between SA and KSA Sharia law is vast. Sharia law is prescribed from the Qur'an and Muslim traditions, with a very strict dress code especially for females in public, which is not well understood or tolerated by all. Furthermore, females in KSA are very restricted, and were not able to even drive a car until 2017, which severely restricted movement in the country.

This hampers movement, dress, communications and other such activities of migrant workers, which they are not used to.

P3: "... when you're living in another country; it's another country's rules and laws and dress code."

Lastly, KSA and the UAE tend to remunerate different nationalities different salary packages, and although South Africans are not the lowest paid such as with Indians and Filipinos', UK and US citizens usually are the best paid, for the same work. Since 1994, all SA citizens have equal rights according to the SA Constitution, and one's inability to voice issues regarding parity of salary packages, dress code and human rights in the host countries owing to legislation and tradition frustrates. This aspect also instills some animosity towards migrants being paid differently and treated unequally, although on equal footing in terms of job category and education.

4.4.4 Theme 4: Return migration to SA – pull factors from host country

Return migration is a consideration in the individual's initial migration plan, but the actual time frame is dependent on integration in the host country and the type of contract, as well as the ease to obtain another contract abroad. Other subthemes that emerged were those of goal attainment, preferred SA education, economic changes in the host country and professional growth

Subtheme 4.1: Family needs

One participant told with some amusement that her children could be considered a child-headed family in SA terms, as she was divorced at the time when she worked abroad, with the eldest daughter minding the younger children. She did add, however, that they had the immediate help of relatives. Since most of the participants were females with dependents left behind in SA when they migrated, the need for family reunion was critical, and return migration was usually expedited. Therefore, a pull factor to return to country of origin for most migrant nurses was to attend to family needs.

P7: "... it was a child headed family; the oldest I think by then was 20, so she was in charge, she had to grow up overnight to be me, with of course some help of families..."

P2: "I left my family, and my kids were still young, so I was not free to leave them for long without leaving there (without returning from KSA). The main reason was just to be back

to meet my family. I went to get money for them, now after getting money I had to rejoin them, they really need me as a parent.”

Long distance relationships as a reality became a problem for many married couples, leading to communication problems. One participant breached her contract to return and attend to family matters.

P2: “The distance, ja, caused the conflict between me and my husband.”

P7: “... the family couldn’t cope; my husband couldn’t cope with the three boys and also there was a communication breakdown between (us) and it put a strain on our marriage.”

Different age groups of children (and adults) demanded different types of attention and input from parents (and spouses) and migrants realised how their input was missed, hence some decisions to terminate contracts and to return to address problems at home.

Subtheme 4.2: Family ties and events

The male participant who was based in the UK, ended up feeling nostalgic, missing his extended family as well as friends. Attending funerals of close family members, which is an important part of one’s culture, was not always possible due to the distance. His non-attendance was perceived by relatives as being selective and thus unfair, as they did not understand the restrictions of the situation.

P4: “... And as a result, you end up not attending some of the funerals of the people that you were closer to, and it really haunts you.”

Another participant reported missing weddings, as well as other significant family gatherings, with the need to be closer to her aging parents, in need of her care. This need of the elderly parents was a common reason for returning home and spending time with them.

P 9: "... my mom and dad are still alive; my mom is 77, dad is 80, he will be 81, so for me that was also a good time to come back because, they (are) getting older. Not that I say they will die before me, I can also die, but you know, you want to spend time with them."

The pull of our traditions and culture remains in our memory and our DNA, and the ultimate longing when abroad can only be satisfied by our return. Basically, a common denominator in all spheres of the pull factors is our heritage, culture, traditions and customs.

4.4.5 Theme 5: Reintegration experiences: positives and negatives

During the data collection process the participants described their transition back into the different roles and routine upon return to the SA healthcare labour market. Given that the environment and practice of institutions abroad and in SA are different, return migrant nurses generally acclimatised with relative ease to new situations.

Workplace reintegration was expressed mainly by different lived experiences in the public and private health sectors.

The positive experiences are dealt with first, which are the advantages of short courses done, and the transfer of intellectual and practical experience.

Negative experiences described by the participants ranged from poor attitudes and work ethics, to the impact of lack of staffing and heavy workloads. Furthermore, budgetary issues such as salaries and equipment were also mentioned. They reiterated how important the need and application of well-written, updated policies and procedures are within the both healthcare sectors.

Subtheme 5.1: Advantages of short courses

Prerequisite requirements regarding CPD vary between host and sending country's nursing licensing bodies. In KSA an updated 2-yearly BLS certificate is compulsory to enable one to renew a nursing license. BLS is also a compulsory short-course in the UK,

in contrast to the SANC that had no requirements necessitating nurses to obtain or update BLS certification prior to relicensing at the time.

Such short courses done in the Middle East and UK come in handy in the day-to-day practice of these nurses in SA. One participant who returned to SA in 2011, last renewed the BLS courses in 2010 in KSA as part of the accreditation requirements; Even though her certificate was outdated, she was aware of the latest BLS standards.

P2: "... but when I came back in 2011 I've never done it (BLS) in SA, meaning that the last one I did in Saudi Arabia was in 2010 ... They (her SA counterparts) don't want to learn, they follow the routine of working, they just don't want to learn new things because they're not used to, for example Basic Life Support. They only know that method of ... 15: 2 breath, when you teach them the new thing (the latest standards); you don't start with ABC (Airway, Breathing and Circulation), you start with CAB (Circulation, Airway Breathing) ... they will argue with you, they will argue until they get maybe somebody higher to come and tell them it's right".

Participants state that there is no staff development in the public healthcare sector and responsibility rests with the individual. The new CPD draft as proposed by SANC (2017) is not known to all parties, and has not been enforced yet. This proposed CPD will be mandatory for renewal of an annual license certificate (Manganye, 2013:15). CPD is self-directed and must be relevant learning activities based on the individual's needs that improve knowledge and skill to ensure quality patient care.

P2: "...in government they don't develop us – when it comes to that you have to do your own developmental goals."

P7: "They would just say you are dreaming, that will never happen, here we don't even have Ringers Lactate, where is the money, where do you think we can be able to send you for BLS or ACLS, that's a dream."

Return migrant nurses employed in the public healthcare sector have not updated their BLS courses since they returned from abroad, and they recognise the need for this, as well as the need to work together as a team when doing resuscitation. Thus, only upgrading the one person will not be enough, the whole hospital staff needs this update to coordinate a BLS attempt successfully.

P7: "... I'm still struggling with ... our resuscitation strategies in the public sector ... how to go about if a patient collapses, if you are just haphazard when the patient collapses, what are you doing? It is important that in every ICU, high-care, casualty, each and every professional nurse should be ACLS-trained, in the entire hospital everybody who works at the hospital must have the BLS, because you know BLS can save (a patient's life), if ... (you are) trained in Basic Life Support, you can save a life..."

Contrary to the status of the public healthcare sector's reported lack of development, a nurse who previously worked in the private healthcare sector in SA confirmed that she did BLS as a requirement to improve and maintain patients' safety in this institution:

P2: "In SA ... I did it (BLS) when I was still working in 2004 at Milpark."

Short courses, such as BLS are compulsory, they are required for accreditation according to international nursing standards. However, in the public healthcare sector in SA this is not the case as experienced by the interviewees.

P5: "... there was health and safety courses which they would train you as to how to lift patients, how to deal with patients. You know, you look at your safety first before you look at the patient, I mean you have to assess the safety of yourself and the patient, which is not what we are taught here in South Africa. And another thing was the Basic Life Support as well. For everybody working in the hospital and the nurses' home, it was mandatory that you have the fire course ... health and safety, and then you have Basic Life Support course."

As knowledge and skills were acquired in host countries, return migrant nurses' nursing practices differ from the non-migrant nursing staff, and frustration is felt that new knowledge is not welcomed, accepted and applied to the benefit of the SA patient.

Subtheme 5.2: Intellectual and practical experience

Return migrant nurses use their knowledge and experiences acquired from abroad in their day to day routine in the workplace in SA, benefiting the patients as well as staff members in both the public and private health sectors. Knowledge and experience acquired abroad are transferred vertically – up to down or down to up, and horizontally.

A returned migrant nurse, who is currently working in the private sector in SA, stated that she became a better practitioner, because of her experience in KSA, keeping abreast through reading up, attending congresses, in-service training and symposiums. Learning new ideas and methods about one's professional environment assists in being more effective and efficient at work.

P3: "(acquiring international nursing experience) ... Made me a better practitioner when I came back home. I can say that SA has no requirement for you once you've studied, you can just work, you don't need to keep yourself updated. So, the system that they had there actually, made it a point that I saw the need to update myself. So, even when I came home, I still kept myself updated; I attend congresses, I attend in-service training, I attend many symposiums. I read up anything I don't know; I have to find out about it. That's the system that I pick up when I was abroad, here at home if you don't know something if they don't know it's fine: the doctor wrote it, they'll see to it. With the system, they had there (in KSA) the accountability is on you, the responsibility is yours. So, it just made me a better practitioner in that sense."

Vertical transfer of knowledge and skill usually takes place across different hierarchies; from superiors to subordinates, or from subordinates to superiors. However, in SA such transfer remains a challenge, as fellow-nurses are not interested in learning new skills. A

participant stated that a managerial position was needed within the workplace to facilitate transfer of international standards that could benefit quality nursing care.

P8: "It is not that easy to make changes in the workplace. People are set in their workplace and if you are not in management it's not easy to bring forward international standards to implement it."

However, having a management position is no guarantee for people accepting change. Another participant as a newly appointed nursing manager at the correctional service, had difficulties with his subordinates regarding changes he needed to implement in the department.

P4: "I had to become their manager, they offered ... resistance, they were against me. Every change that I tried to bring, they were saying: 'who does he think he is, he shouldn't come and bother us here, he must go to wherever he comes from and all those things'."

The same participant was grateful for having some supportive superiors and colleagues, because their support gave him the authority to continue with his efforts to implement change.

P4: "... I used the executives, the other managers who were supporting me and then you know (how) to fight these negative attitudes, from these other guys and I remain myself. And I stood by my principles saying; I'm here for one and only reason; to work and to stick to the policies and procedures as they are laid down at the department."

As a clinical facilitator in a private sector, a return migrant nurse served as a resource for patients, nurses and even some doctors at times, because of the knowledge she acquired while she was in KSA and continued to accumulate by reading up on new information regarding her profession and specialty.

P3: “The nurses, the patients even some of the doctors when they are unclear on some of the things. it’s just really so much easier, because for me it was ingrained; if I see something, I had to go find out what it was, what it does, how it works.”

However, it was not always easy to facilitate staff members who had been working in the unit for many years and were used to old ways of executing activities. The clinical facilitator diverted her teaching to where it was most needed.

P3: “We have a lot of young inexperienced staff who come into the ICUs. I ended up concentrating on them because I felt we were equipping the future ICU nurses. So, if they get the correct information and the correct way of doing things, we rule out the danger of the old timers that are used to shortcutting and doing their own things.”

In the private health sector management is reported to be more receptive to new ideas, as they consider staff’s input. The exchange of knowledge is not taboo to them.

P10: “... In the private sector, any input that you give is (perceived as) positive, (they will consider you input), but they have their policies (are guided by policies), which is good. ... they will keep on asking me: (on) that side, how were you doing this (on) that side? It’s something, asking (to improve) knowledge, not like mocking you or something.”

Horizontal transfer of knowledge does happen between nurses occupying the same rank, mainly within their different departments. According to a participant, this usually happens during troubleshooting or emergent patient care when she will guide her co-workers how to apply international standards, such as the resuscitation of a patient. On-the-spot teaching of co-workers has promoted staff co-operation, because they often realise the benefits of this different nursing practice.

P3: “... (knowledge and expertise learned abroad) was ... very efficient, which helped me a lot, when I came back, I was able to teach my colleagues ... I educated a lot of my staff

members at least, so that we can be efficient for our own people (meaning for the patients).”

The return migrant nurse often finds it easier to transfer knowledge to the patient or client. One return migrant nurse who was discouraged on rejoining the public health sector, subsequently become an entrepreneur; dealing with health products, stated that using nursing knowledge and skill is what makes her business endeavours worthwhile.

P5: “The health products are very good. Having the background of primary healthcare, I still do my nursing, but in my own capacity...So, I’m a nurse entrepreneur, that’s what I am doing at the moment.”

With new skills gained abroad, better nursing care can be rendered. Seeing how your patients recover because of your improved expertise, is very fulfilling, despite all the other negative aspects, such as the poor financial compensation.

Subtheme 5.3: Attitudes and work ethics

There are major differences between the public and private health sectors in SA regarding work ethics. Seven participants preferred the public health sector as a workplace on return, since the private sector is sometimes perceived as being very demanding and overstressing staff to maintain high standards.

P2: “I just wanted to work in a relaxed environment, I didn’t want to work under the pressure we experience in the private sector. So, I went to the public area.”

However, applications for employment in the public health sector were not a smooth process for all participants. One participant was discouraged by those in management positions, who were insinuating that even if there were vacancies, the participant would not be welcome. Subsequently, this participant decided to rather do research in SA for an American not-for-profit organisation for a period, and is currently an entrepreneur, selling health products.

P5: "So, coming back, we were a threat to the (local) nurses ... (it was perceived that) now ... we're coming to take their positions. I, for one was told...when I went to apply at the municipality, the regional office (at)...primary healthcare management level ... they won't even tell me when there are positions, because I'm threatening (their positions). It was not easy ... it was that thing of you have to start there (from the beginning as in the country abroad) ... you can't just come ... in and ... go up (in senior position). So, I was supposed to come in as a primary healthcare nurse and be a subordinate of somebody (to whom) I was a manager ... when I left the country. So, ... (al)though there was a shortage, there were some obstacles because of people's (attitudes)."

Although people with managerial experience in both the host country and SA are willing to accept a junior rank to work themselves up at a later stage in the public health sector, some obstacles are just unmanageable and unfair. One participant explains how because he left SA, he was denied promotion several times, as the non-migrant nurses were considered patriotic and loyal to the institution and thus were in line for promotion. After having no success in five interviews, he resigned and started working at correctional services, and was promoted after only one interview to a managerial position, where his expertise obtained as manager was appreciated.

P4: "It was the same experience (as abroad), I had to start from scratch, become a junior nurse from being a manager. My aim was just to get into the job and then I would work myself up. I knew that there would be posts advertised and then I would apply for those posts. But I applied five times, I went for interviews five times for the managerial post and I was denied that in the Department of Health, and I asked the reasons why? And (they were:) 'no (you) left people here, (we) have to promote these people first before (you) get (your) turn'."

When this person managed to obtain the managerial post, he was challenged by the other interviewees, as they felt threatened and acted with resistance towards his new appointment – similar to the interview situations mentioned above.

P4: "... when I got this managerial post at the department of correctional services, people were against that, especially those that (were) at the interview(s). They felt (that) I've taken their post, they felt because I came from overseas, ... maybe I've bribed the interviewers to get the post. And ... because I had to become their manager, they offered ... resistance, they were against me, every change that I tried to bring, they were saying: 'who does he think he is, he shouldn't come and bother us here, he must go to wherever he comes from ... They thought because I was earning pounds, ... I bought my way to seniority'."

One participant compared the public sector negatively with the private sector as basic supplies such as clean linen and curtains are often not available for basic patient care at the former. The response from a senior was disturbing to the participant. The participant had worked at the same hospital 20 years ago, and the service had significantly deteriorated instead of improved.

P10: "... I worked (there) 20 years back; it was worse than when I was there for the first time, nothing improved. Basic supplies such as clean linen and curtains are often not available (to) us here, there are so many different doctors, we don't even have a screen, a lousy screen... to separate - to make a screen for the patient. We hold the blanket like this (in between two patients) ... 'No, no, you know we tried to organise,'. I said. But there's no privacy here ... the patients they're just like (exposed), with so many students, one patient is done ... (an) internal examination, with so many students around, it's not comfortable. I mean you want to treat people like you want to be treated, but she said 'this is not Saudi Arabia'."

Opposed to this, another participant identified how she perceived the situation in ICU in the private healthcare sector.

P3: “(In the private health sector) ... work ethics, work system, salary, employees, amount of staff, quality of staff are a completely different setup. For me, it wasn’t as bad coming back to this because it’s where I left from. I was there before I went to Saudi Arabia.”

Work ethics in SA has been depicted as generally poor in the public healthcare sector where nurses display a non-caring attitude. Nursing ethics learned during student years was all put into practice in the UK, whereas in SA nurses needs takes priority when it comes to patients’ needs and there is lack of caring, respect and teamwork.

P5: “... the total care of your patient and your patients’ needs and everything were your priority. So, going to UK, that was brought back, (something) which we don’t ... see in SA. It’s nurses first, patients after.”

Involving patients in caring decisions ensures better cooperation according to participants that practised in KSA and the UK. One such nurse who worked in a private hospital in KSA, adopted efficient methods to care for her patients there, and continued to implement such care in the private sector in SA.

P3: “... let the patient know and you get cooperation from the patient. So, my interaction with the patients as well, informing the patients, getting their cooperation ... relieving anxiety, explaining whatever they will be going through, letting them talk about whatever they will be going through – so it helps.”

On the other hand, a participant who previously worked in a private hospital in KSA and is currently working in the public health sector, stated that quality of care is determined by the individual. If the individual prioritised quality care, it would increase the prevalence of such improved practice.

P2: “The quality is up to the individual (the nurse), the care should be the same, because we are guided by the ethics of nursing, so nursing should be the same. We don’t work under pressure in government.”

Contrary to the practice in SA, UK nurses display courtesy around their patient by honoring them, and this served as a reminder to the participant of the fundamentals of ethics taught during nursing training.

P5: "There (referring to the UK), respect (is) no 1, going an extra mile to do whatever you (are) doing. All those ethics and what we were taught in nursing, when we were in training, were brought back, that this is how the real world of nursing is operating. So, you would respect, you would give your all and you would even go an extra mile and in return, you would get cooperation and you would get respect from those patients. So, there was not what we (are) seeing happening here in SA, the don't care attitude that we have in our country."

A participant working in the public sector noted that teamwork is lacking, especially during the management of an emergency situation; where she often was the leader and executing assigned tasks while there were other nurses around the patient. This highlights the need for teamwork and that needs to be encouraged. Members of the team are perceived as not being willing or understanding how to assist, despite the fact that they were taught how to implement certain tasks.

Thus, counterproductive behaviour increases stress for co-workers, because it often means an individual has to assume extra responsibility that could have been shared among the team.

P2: It is very strenuous ... because instead of working as a team you end up being alone doing multi-tasking, being a leader at the same time, taking other people's responsibilities and doing it yourself. ... they don't know what teamwork is. It's something they need to learn.

In the public healthcare sector the lack of teamwork has been reported as reaching unacceptable levels. Student nurses are not mentored as expected, and the fear of ill-

prepared future qualified nurses is a sad reality in the already short-staffed SA. Student procedures are signed off blindly, without the necessary guidance and nursing practice being in place.

P10: "People (permanent nursing staff) will sit there, because we (are) having student nurses ... They have 2 groups of student nurses (from different institutions) so, there are so many students who need to be taught by the sisters, but most of the time they (sisters) will be sitting. Students will be running around the ward and not knowing what to do (be) because nobody is telling them what to do, nobody is educating them, as long as they are making the beds and they have dusted, that's it! ... They are in a midwifery institution, but when we deliver the baby they are somewhere in the ward loitering, they are not even there. So, I call them (the students). I tell them you know what, you are sisters, nobody is going to keep on calling you ... I think since you are RNs, you have to be hands on. Wherever I'm going, all of them would be coming to me, because most are RN midwives ... So, it was like that for two weeks - I'm sure I signed the files of all those nurses. And because I don't sign to sign, I want them to do a thing before I sign. So, when I left, they were frustrated, they said for the past two weeks that you were here, we were seeing what we were (supposed to be) doing; otherwise we will normally ... come and sit, we go to the kitchen, we eat, (for) the other one it's lunch time. (Come) month end, (the student's placement is finished, and the student asks): Sister I was working with you, sign (my workbook for procedures done), sister sign. (I say) -sign for what? (Not having witnessed the student doing the procedure) Dah! And those are our future nurses."

Thus, on return to SA, after a taste of international nursing practice and becoming aware of new standards to abide by, employment opportunities in SA might be less attractive to return migrants when compared with those abroad, owing to challenging working relations with co-workers.

Subtheme 5.4: Staffing and workload

The South African public healthcare sector faces staff shortages which hinder effective and efficient nursing care delivery, with particular emphasis on the different skills mix

needed regarding specialist nurses. It seems like the exodus for better opportunities abroad was not stopped as was the intention during the 2007/2008 era, with promises made then, which could not be kept. Nursing abroad seems to become more and more attractive with the good exchange rate in Rand for overseas currency, with some markets recovering, but unfortunately not for those staying behind in nursing jobs in SA.

P2: "At the moment, we are having a very serious problem of shortage of staff; they don't have enough nurses, the skilled nurses are not there, they are also going overseas most of them and ... it's difficult to get the right knowledgeable, skilled professional nurses."

It is management's function to ensure a good nurse–patient ratio to promote quality patient care. SA's quest for profit is questioned when the current poor ratios are considered. Agency nurses are used to alleviate staff shortage instead of ensuring that there is enough permanent staff on duty. This saves on matters such as pension, and permanent nurses being on duty when patient numbers are small. However, disproportionate nurse–patient ratios are a global challenge (DENOSA, 2011:1) and vary between countries.

P2: "There is a difference, because in SA (in private healthcare sector) they are concerned about profit. They want to make (a) profit so, they will use as little nurses as they can to save money, but in Saudi they don't look at budget, they just want the safety of their community. They make sure that there is enough staff for their patient. Even though KSA hospitals also experience staff shortages, this is curbed through planning well in advance."

P10: "... (In KSA) it was not like as much short staffed like here at home (private healthcare sector), where we want a person like now – (then) I call somebody now! And sometimes you even call a person who does not even know the department. So, there (in KSA) it's a planned thing...; we are five to seven 7 staff (members are needed during every shift ... the person will know two weeks beforehand she's having overtime."

An inadequate staffing level leads to overload among available staff, compromising patients' safety. The increased workload in both SA healthcare sectors is multifactorial; nurses experience high work pressure due to the lack of staff, and have to do more work inclusive of those of the subcategories. In the private healthcare sector in a critical care unit the work is all the professional nurses' responsibility, whereas in destination countries other interventions are outsourced to special technologists.

The amount of work and the number of staff who needs to implement the tasks are even more disproportionate in the public healthcare sector.

P3: "it is a lot of responsibility which puts you under a lot of pressure, because you're dealing with lives, and then the work itself has a higher turnover and less staff because, they (SA private healthcare sector) don't pay so well, a lot of people don't end up working there. So, you end up doing the physical work, it's so much more. ... There, in Saudi you only have to do certain aspects of the job, meanwhile here at home you do all the work.

P2: "I am not coping, to be honest in the SA workplace (public healthcare sector), because the work is too much ... to be honest we take it one day at a time, ... The job is not fulfilling for nurses in our country."

Subtheme 5.5: Budgetary issues: salaries and equipment

On return, salaries are considered miserly in comparison to the amount of work and responsibility expected from the South African professional nurse. Equipment maintenance is also a problem presenting because of low budgets in the public sector. The private sector does not seem to have such issues.

P3: "... (on) receiving the miserly salary: the first month I worked, the pay was like 20% of what I used to earn when I was in Saudi ... 20%! Now that was the worst-worst thing, hm. The work itself it's quite different from what I used to do when I was abroad ... (in the) private sector in the critical care unit, the work is on the nurse, so I was working that much more for so much less."

This participant wants to warn future returnees of the need for adequate savings prior to returning, to augment the low salary at home and ease the negative impact of readjustment.

P3: "It would help - if you are going to stay home for several months-(to) put away some of the money to augment the money at the end of the month when you earn the salary in SA. Because while you're staying at home (for the months before re-employment) you are spending the money you have, by the time you're going (back) to work, funds are a bit depleted, sometimes there's nothing left and then when you get that salary, it's such a shock."

In the public sector, one may find that the necessary equipment is available, but owing to a lack of maintenance, or qualified capacitated personnel to operate it, it cannot be used. This is another reason for resignation to work elsewhere in better circumstances:

P10: "... I resigned in the government hospital ... I resigned from the government hospital without even a job, I stayed home like a year not working just doing part-time. Because the working conditions there were really bad; there were shortages of medication ... we didn't even have linen. You find that patients don't have linen in the government, it was really stressful, so I couldn't stand that and I left."

Fortunately, within the private healthcare sector the necessary resources are readily available; therefore, nurses are able to execute their tasks with more ease.

P10: "In the private sector, they have resources ... we didn't have problems with the resources; you stock the thing, you want the thing, you go to the meeting (mention it on the meeting), then we get it. Anything that you need for the quality care of the patient, (it will be provided) because patients in the private are paying a lot and then they need quality care..."

Subtheme 5.6: Policies and procedures

In KSA, hospital management protects its nursing staff by compiling and updating protocols to guide practice. Policies and procedures are formalised in order to promote workplace safety, with the delivery of high quality nursing care. These international hospitals also strive towards regular accreditation and thus such procedures need to be adhered to. In SA, this has not been a priority, but it might become one soon. The National Health Act 61 of 2003 (Republic of South Africa, 2003) reiterates the need to ensure good quality health services by developing health structures to monitor compliance of health establishments with health standards, through provision of the creation of an Office of Standard Compliance. International hospitals and the SA private healthcare sector have similar standards in place, but compliance is sometimes breached by nursing staff in SA.

P10: "Mostly (abroad) they have protocols... you know there's a protocol for this condition. You normally go and page and see the condition is like this, you give this (follow the steps on the relevant protocol). And it's signed and served by the doctors, the whole team there, (in acknowledgement of how things should be done)."

UK hospitals tend to adhere staunchly to their legislation in place to ensure patient safety.

P5: "And they practice on law, I mean UK follows laws. You are just on a straight line. You don't, you won't even deviate, you know the deviation –(of) the acts and omission we talk about, they stick to that. You would know that if you've have given Panado when it was not prescribed, it's an offence. So, I mean we came back knowing that this is how things have to be done, this is what we can impart with our colleagues in the country, that you know if we do this, it's not supposed to be done, this is how it's done in other countries, but there were roadblocks as to ... no we can't let you in. And another thing, because now they are used to doing things the wrong way, if you come in and come with new things and positive things, you are an enemy."

Well-written policies and procedures are available in the private healthcare sector in SA, guiding the nursing practice to avoid standard variability. The following participant needed to familiarise herself with the protocol since she was in an early phase of workplace reintegration and recently made a transition from the public service to a private hospital.

P10: "In the private sector, any input that you give is positive, they're taking it, but it's a Netcare (hospital), they have their Netcare policies, which is good. They are guiding us, we have protocol, according to Netcare; we do things this way ... Which is better than in the government sector. (Netcare), which is almost the same as where I'm coming from (in KSA), because that side is using the protocol guideline, so they also have their protocol guidelines, the only thing ... for me, I had to readjust back to the protocol."

According to a participant, a clinical facilitator in private healthcare in SA, updated policies and procedures are available, but are occasionally disregarded by some professional nurses, posing a risk to patient safety.

P3: "...they might think that cleaning the wound with Hibiscrub is ok, but that wound could get septic and it won't get septic the first day, it won't get septic the 2nd day. At that time, it doesn't look like it's a major thing, but I do go and call it out: but policy says: Why are you doing this? Stop using it like that. So, in the end the people will end up doing that when I'm not around..."

Policies and procedures can serve as a resource for nurses, but are not commonly used in the public healthcare sector in SA, because they are either non-existent or out-of-date, if available. Nurses use doctors as resources, although there is a shortage of doctors, with the few available already overworked.

P10: "At home (in the public health sector), we don't have protocols, we all rely on doctors. Even if the protocols are there, they not even updated."

A participant who previously worked in the UK's National Health Service and KSA private healthcare sector mentioned that policies in these countries were of paramount importance to guide the nursing practice, as opposed to the SA public healthcare sector. As a newly appointed manager, the participant was able to initiate some changes in the SA practice.

P9: "But I found that people didn't like the questions I was asking; how do you do this, do you have this, do you have this policy in place, do you have this in place? People didn't like that, so I started putting things in place that were not there, that I know that wherever you go in the world you should have this in place. I started putting policies in place for safe practice. Those things were not in place, I started with the small things at least, but I am still working on a few policies at the moment."

Reintegration into the workplace is a slow process that requires careful planning by the returnee to ensure success.

4.4.6 Themes 6: Decision influencers towards re-migration

Approximately half of the participants returned permanently to SA with the other half as temporary returnees. Different factors and individual situations influence this decision. Situations of both groups are discussed in the following subthemes.

Subtheme 6.1: Permanent return to SA

Reasons to remain in SA stem from a number of different influences and vary from person to person. Some migrants set realistic and achievable objectives for themselves; subsequently participating in only one cycle of migration, therefore giving the impression of successful workplace reintegration upon return. Four of the participants migrated once only and then returned to SA with no intention to re-migrate. A sustainable return to SA is often determined by factors such as age, needs of dependents, goals reached and the love of ones' country of origin.

Three participants in their 50s felt comfortable being back in SA, after living in the UK for more than four to seven years.

P5: "Age is not allowing, but if things get worse we might, we've got British citizenship, we've got an indefinite leave to remain in the UK. So, every 2 years we do go to the UK, to visit. Our pension funds are still in the UK, so when we retire, we'll be getting a pension from UK."

P7: "I wouldn't see myself ever going away again. Why? Because I had a reason, I had some objectives, I had some goals. I achieved them, so ... there is really no need for me (to re-migrate)."

SA is home. Participants stated that they had come to realise how special SA was, once they were abroad. Being away from home, has made them appreciate it more.

P3: "There's no place like home. I had enough, but my financial status is much more stable, as I said I left the child at home with relatives ... and I missed home ... You come home ... and those are the laws you grew up with so, it was just time to come home."

Migrants realise when they are abroad, that the culture in SA is much warmer, as this participant mentioned after experiencing the English culture:

P9: "... when I decided to come back I said to myself, I'm going to give myself two years, if I don't get married I'll go back, because I am happy now and UK is still away from family. It's the culture - It's a cold culture; the British people are cold people..., they take long to warm up to you. I didn't have many friends...you have to check if people are available, comparing to the SA culture, you can go to somebody's house you know. But in the UK, you cannot do that, people have to check their diaries you know those kind of things, so I don't think I will go back there, change what I have here and go to the UK, because I know now what it's like to be there, you know."

Permanent return of the migrant nurse thus is dependent on the cultural and family ties they have with their country of origin.

Subtheme 6.2: Temporary return to SA

Of the ten nurses interviewed; three re-migrated owing to financial reasons. After the experience of the initial return, their workplace reintegration stage was interrupted by the quick decision to re-migrate sooner, and a new migration cycle was commenced. Two more were strongly considering re-migration, because the better working condition overseas are more conducive workplace to quality nursing practice.

P2: "The positive things that can make me to go abroad again is the government outside, they recognise their workforce, their nurses, they will give you what you need, conducive areas to function. If you are working they will make ... the patient: nurse ratio ok. ... your workplace will be conducive; you will have all the equipment you need for practising. ... in SA, you are not recognised as a nurse."

South African nurses who worked abroad felt that they were recognised as nurses outside their country of origin and preferred to migrate for work satisfaction accompanied by remuneration. One participant that was currently working in SA in the public sector had strong intentions to re-migrate to the Middle East owing to the small remuneration for nurses in SA. Yearly salary increments in SA are quite insignificant, because of the tax implications and inflation rate in this country.

P2: "...they (SA employers) give you uh money, ... they give you 7.5% but at the same time they will tax that money, meaning that ...they give and (then) take it back, it's never enough, you stay (on) the same salary level even if they said they gave you (an) increase. So, that's what is happening in SA. they give you money (that) they take back in a form of tax.

P10: "... if it was not (for my) age, I'll be happy to go, if they say there is a job here (overseas) I will go back again because financially here at home things are expensive,

even the little money you are making in (the) private (sector) is still (not enough) ... I don't know maybe we started setting our standard(s) (too) high, now we're home, we have to reduce our standards, which is difficult, the money the agencies are paying is too little."

Ineffective reintegration into the labour market and lack of proper remuneration may lead returnees to seek work opportunities abroad and therefore, if successful, re-migrate.

4.5 SUMMARY

The researcher explored the lived experiences of ten return migrant nurses with regards to their reintegration process in the workplace through semi-structured interviewing processes. The information obtained contributed to the findings presented as six themes with subthemes.

The findings of the study indicated that the participants' decisions to migrate were mainly influenced by their economic status. The low income earned as professional nurses employed in the SA healthcare sector was a major push factor to migrate internationally complemented by the high salary offered by the host country. Other contributory push factors were the poor condition in the public health sector and patient safety in the private sector owing due to medical staff shortages.

The return migration process is largely influenced by personal motivators, with the pull factors towards SA often having a stronger impact on the initiation of the mobility than the push factors from the host country. If the migration cycle is interrupted during integration in the host country, the migrant is likely to re-migrate.

The workplace reintegration is not often a smooth process merely because they are return migrant nurses; having to start at the lowest possible rank, with unnecessary delays in promotion even when they meet the criteria.

Despite the negative experiences, they mentioned the positive encounters, such as serving their community, practising evidence-based nursing, and acting as resource

nurses for co-workers. All the participants were temporary migrants and their return sustainability partly dependent on optimal workplace reintegration. Those who reintegrated successfully, made it clear that the process was not without difficulties. The majority of the participants became circular migrants, for various reasons, ranging from workplace reintegration intervening obstacles and personal reasons.

In Chapter 5 the results are discussed and recommendations made with regards to the findings.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study findings are discussed in Chapter 5 and debated in relation to the research questions and objectives, as well as the existing literature in the field of return migration and workplace reintegration, with recommendations provided to improve these processes and the experiences of returnee migrant nurses in SA.

5.2 Aim and theoretical framework

The aim of the study was to explore the lived experience of return migrant nurses during workplace reintegration in SA.

To assist in this aim, a conceptual framework was structured. It borrowed from Lee's push and pull theory (Lee, 1966:48) regarding the outward and return migration processes (see 1.8.1). This was combined with Levine's theory of conservation (George, 2014:232) to explain how reintegration of returnees in the workplace takes place (see 1.8.2).

In this study, **SA migration push and pull factors** outline what influenced the participants to take part in the process of migration, either as a single experience, or as a continued circular experience.

Labonté *et al.* (2015:12) report that a possible push factor to migrate from SA could be due to dissatisfaction with the economic and political situation; corruption, poor government policies and poor conditions of the public sectors. Similarly, the main push factors identified in this study was; economic, reasons particularly the low salary for nurses in SA which does not match the inflation rate, followed by the poor working conditions. In the same way, every participant had their own set of push factors. Biondo *et al.* (2012:2) concur that there is no unique solution to brain drain. For an individual with the right set of human capital, strong push factors in the country of origin with attractive pull factors in a possible host country become an intervening opportunity and migration

takes place (Lee, 1966:48). The pull factors are a perfect fit to their opposing push factors; in this study the increased remuneration in the destination country was the solution needed by most of the participants to overcome their economic struggles – a decision made to meet their basic needs (see section 4.4.1).

According to Battistella (2014:25), migrant skilled workers are highly valued by their country of origin, equally so by the destination country, for the scarcity and significance of their skill, leaving them with various options to choose from, and they are often able to plan suitable times to migrate between these countries.

In the case of this study, the participants did not share this experience of being valued by their country of origin, or the destination country, rather they experienced themselves as a commodity that should be grateful for being given the opportunity for applying for posts on both sides. Thus, most suffer from a lack of recognition (see 4.4.3), with an added specific burden of the lack of professional growth afforded to them in SA. Lee's theory refers to this as intervening obstacles that may be in present in both countries (Lee, 1966:48) and that need to be negotiated by the migrant (see section 2.2.3).

Preparedness to return is determined by the individual, and considered pertinent at a personal level (Cassarino, 2014:7). Kuschminder (2014:2) elaborates that the readiness to return to country of origin plays an important role when it comes to reintegration into the workplace. The dynamics of a volatile labour market as a second factor are also important. Thus, saving prior to return, and adjusting your budget in order to survive on a meagre SA salary at the end of each month were mentioned as coping mechanisms to survive financially as returnees (see 4.4.5). Similarly, Withanage (2015:3) mentions that the Sri Lankan government encourages purposeful savings by their return migrants and Cassarino (2014:10) acknowledges that readiness to return and reintegrate is associated with not only accumulation of financial, but also human capital by the individual (see section 1.11).

With the application of Levine's theory in attempting to understand why and how returnees reintegrate in the SA work environment, one has to consider that individuals are

constantly in an adaptation process during their encounters with their environment, which may result in conservation (George, 2014:234). Some adaptation attempts are more successful than others; thus, during the reintegration process the returnee seeks the best fit with the work environment. This explains the participant with managerial experience from the UK who made multiple applications for promotion to a managerial position in the public healthcare sector, and then had a best fit in the correctional services sector (see 4.4.5). Similarly, the participant who became an entrepreneur adapted and used her nursing experience obtained in primary healthcare and abroad in her new role. Several participants did courses abroad that eventually helped them obtain better posts in SA. Part of successful adaptation then includes careful planning of careers to return to while abroad, and preparation towards such anticipated or preferred career moves.

According to Levine's theory, responses could vary depending on characteristics such as gender (George, 2014:233). The female participant with a previous managerial position in SA prior to migrating to the UK was not willing to restart her career, as she already had to endure a lower position in the destination country while the male participant from the UK was willing to restart at the bottom and reestablish himself (see 4.4.5). However, gender as a determining factor could not be the exclusive reason, as age and place on the career path and ladder and self-esteem could also influence decisions (George, 2014:236). Holmes (2012:17) mentions the personal individualised journey that each returnee has, as well as the conscious decision of each to take responsibility for his own journey, instead of having circumstances thrust upon him.

Every participant has a unique range of adaptive responses and internal coping mechanisms. These are affected by the individual's past experiences and determine the ability to adapt, as stated in Levine's theory (George 2014:233), and in the reintegration process in SA as a nurse returnee. Levine furthermore considers conservation as part of adaptation and indicates that conservation protects the system's (individual's) integrity by regulating the ability to approach and deal with environmental deviation swiftly to maintain its (the individual's) uniqueness (George, 2014:234). Participants often have to go an extra mile to prove themselves despite non-migrant critics. Standing firm aids in

adaptation and conservation (see 4.4.5). Also, new methods learned abroad improving resilience in dealing with diverse cultural populations give the returnee an advantage above SA citizens who still struggle to get along with each other against the backdrop of the earlier racial divide. Such resilience helps towards more courteous treatment towards patients, and recognition of ethical and caring nursing, which is an important evolving need all the time in all situations, public and private.

Levine believes that conservation is a product of adaptation. The conservation of personal integrity helps the person to self-actualise, which is the highest human need on Maslow's hierarchy (George, 2014:235). According to George (2014:235), Levine's theory likens the awareness of self to independence. If the person cannot conserve his personal integrity and an acceptable sense of self-awareness in the new work environment at home, he will not be independent and not be able to reach self-actualisation, and thus he will not have social integrity. Conservation of social integrity goes beyond the participant and is necessary for the human being to be a whole unit.

The satisfaction displayed by the returnees who mentioned their improved social, financial and personal situations, is an indication of successful adaptation and social conservation as a result. This conservation is especially valuable when it can be carried through to the next generation, as displayed by parents' satisfaction about the improvement in their children's' outlook in life after the period abroad (see 4.3.1). In this way, social capital and human capital have been important additions to the whole family as a result of the experience abroad, and their ability to elevate their social status and reintegrate on a higher level socially in SA.

In the next paragraphs, the following two research questions will be dealt with in a discussion of the objectives of the study: "What are the experiences of returnee migrant nurses regarding reintegration in the workplace in SA?", and "What could possibly re-influence returnee migrant nurses to seek employment abroad?".

5.2.1 Objective 1: The push/pull factors that motivate SA migrant nurses to migrate, as well as return to the SA workforce

The push/pull dichotomy influences outward migration, and determines the length that the migrant stays in the host country, and how soon (if at all) the migrant will return. It also influences repeat migration (commencing the whole process again if the person sees the need for this). However, the focus of this study is on those aspects that play a role in the migrant's return, reintegration and decisions to stay/migrate again, to determine how they can be addressed for ultimate retention of the SA workforce. Biondo *et al.* (2012:2), in line with the findings of this study, agree that many aspects are considered prior to making the final decision to return to country of origin.

Tjadens *et al.* (2013:29) state that nurses are more likely than other healthcare professionals to be temporary migrants, and to subsequently return to country of origin.

This study found the same trend of temporary rather than permanent migration, as most of the nurses were either back from working abroad, or still planned to come back to SA from their host countries in the future. This is also as a result of the most popular countries for migration (apart from the UK) not allowing permanent citizenship (KSA), or doing so only on the accumulation of property in that country (UAE). Owing to the success of the goals obtained during the first round, many migrants consider a second round of employment in the host country. However, some destination countries have their own restrictions to limit such migration (Efendi *et al.*, 2013:156; Inter-Parliamentary Union, 2015:38). Thus, initial return migration to the home country is often delayed until all goals are met Battistella (2014:27), with a longer period abroad than initially anticipated, unless urgent family responsibilities require their presence sooner (see 4.4.4).

However, most nurses in this study kept their goals at a minimal reachable level to expedite return migration when dependents were left in the care of spouses or relatives. When migrants were able to have, their relatives join them, such as in the UK or the UAE, they were able to stay much longer.

Although the KSA is one of the most popular places to migrate to, owing to the tax-free salaries and good benefits, this country plans to complete the Saudiasation programme of the health care industry. This means that positions have to ultimately be occupied by the Saudi nationalities (see 4.4.3). However, the KSA government has invested more than \$4billion for needed health care transformation in the kingdom (Waqas, 2013), but will still need many foreign nurses in the immediate future to complete these projects. It has been observed though, that increasingly countries are changing their laws due to economic situations, making it more difficult for migration for temporary work. Akeson and Eriksson Baaz (2013:1) mention the negative effect of the economic crisis in most parts of Europe on migrants, resulting in change of policies, such as marginalisation of labour markets, with the effect that migrants had to return to countries of origin. Nicholson (2014) states that with the changes and effects of the economic twists in most countries such as KSA, Dubai, Hong Kong and Japan highly skilled migrants are returning to SA in their thousands. Companies overseas are finding alternative ways to avoid lucrative migrant packages and less migrant workers are leaving SA. Despite this influx of expats and brain gain as many return home, Nicholson (2014) reiterates that there is a great need for medical professionals among other rare skills.

Simultaneously, African economies are booming and in need of skilled labour to reverse their brain drain. According to Akeson and Eriksson Baaz (2013:1), international returnees are expected by the global north, international agencies and non-governmental organisations (NGOs) to play a pivotal role in the development of their home countries during their return and reintegration phase. Countries of origin are increasingly encouraging skilled migrant workers to return with the aim of maximising their skills and expertise, and to bring home savings accumulated while abroad (Akeson & Eriksson Baaz, 2013:1). In SA, the private healthcare sector joined the 'homecoming revolution' in response to the global economic downturn during 2009, in order to assist migrants with the return process and concurrently curb the severe shortage of nurses (Breier *et al.*, 2009:58).

SA, as one's home country, remains an attraction to return to in such circumstances, owing to its post-1994 open and democratic society. Government is based on the will of the people with the right to freedom and security of the person (Constitution of the Republic of South Africa, 1996:2). This hard-fought freedom affords individuals choice regarding place of residence, education and career paths, which are not available in host countries where constant reminders about them being foreigners or having to abide to strict Sharia law prevail (see 4.4.3).

Economic reasons are the main ones given by participants of this study for initial migration from SA, despite the freedom experienced in South Africa (see 4.4.6). These findings are congruent with a study conducted by Li, *et al.* (2014:315) as well as Labonté *et al.* (2015:15), who cited low remuneration and lack of resources as primary push factors in some developing countries to migrate temporarily to developed countries. Aluttis *et al.* (2014:2) and Li *et al.* (2014:315) mention that higher earnings in developed countries in exchange for nursing care for those from developing countries make the migratory process worthwhile. Especially when nurses migrate as single persons, they manage to save owing to these higher incomes and tax-free benefits, and this enables them to have shorter terms abroad (Breier *et al.*, 2009:43).

Participants who migrated for the sake of accumulating means to afford better education for their dependents at home (see section 4.4.1), migrated back to SA soon after that their financial goals had been reached (see 4.4.3). Some had their children migrate with them to benefit from superior education and job opportunities. Battistella (2014:9), however, mentions that complications may be experienced regarding children's education in the destination country; such as integration into the new schooling system. Apart from this problem, tertiary education abroad may be expensive, such as in the UK. Only 24% of UK-born workforce are university graduates (Travis, 2014) compared to more than 60% of the new western and southern European migrants to the UK. As a result of this situation, two migrants in the UK returned to enroll their daughters in SA tertiary institutions (see 4.4.3).

Although most migrants in the UK are better educated than the British workforce (Dunford & Kirk, 2017), first preference for promotion is granted to UK citizens in some health sectors in the country. Nationals are promoted over foreigners, despite the latter's superior qualifications. This phenomenon is explained by Hagen-Zanker (2008:11) as the labour market being a social system, where migrants hope to achieve a desired state in the destination country, but a migrant coming from a country with low ranking is unlikely to achieve a high rank in the destination country. In this scenario, migrants take on the lowest position in society to their frustration, with lower stratum natives experiencing upward mobility in terms of income and power (see 4.4.3).

Many African migrants who reside abroad dream about their return to their homeland, either permanently or temporarily (Akeson & Eriksson Baaz 2013: 1). Migrants' incentives to return to home countries are motivated by emotional and familial ties to the home country (Battistella 2014:9; Efendi *et al.*, 2013:155). Such ties refer to relationships with marriage partners, children, ageing parents and the extended family.

Kariuki (2014:9) describes a long-distance marriage as one where spouses live in separate geographical locations for short or long durations with the term 'distance' applicable to the emotional state of a relationship. Participants to this study also testified to such relationship issues, as divorces owing to separation was mentioned, as well as the difficulty endured to cope alone with the children, the emotional problems children had, and attachment problems when the partner had to leave again after a holiday back. Long distance relationships are vulnerable and delicate, and members are predisposed to family challenges without each other's physical support and presence. Kariuki (2014:20), Battistella (2014:10) and the IOM (2014:1) all concur that imperfections in such family arrangements can lead to irreparable damage to individual members.

Many women within the family have become breadwinners over the past few decades and this has had a positive impact in the workplace (IOM 2014:1). However, this positive impact is not necessarily experienced at home, and can be at the cost of their dependents. The majority of the participants in this study were females with dependents, denying their

children the presence (IOM, 2014:2) of the emotionally more caring and understanding parent. Fathers staying behind with dependents are often not well-equipped to fill the female role (see 4.4.4), especially in a society that is still very patriarchal, with traditional male and female roles in place. Thus, mothers' incentives to return home are accelerated when they recognise the need of the dependents in the home country.

Findings of this study objective affirm that the majority of participants migrated owing to financial reasons, leaving their families behind partly because of destination countries' migration policies as confirmed by the IOM (2014:5). Therefore, participants' major return pull factors were family ties, followed by unacceptability of different cultures, lifestyles and high inflation rates abroad as enforced by legislation in countries that do not encourage permanent migration. This is congruent with the study findings of Labonté *et al.* (2015:6) that health workers returned as soon as possible to SA because of nostalgia and appreciation of country of origin.

5.2.2. Objectives 2: Experiences of returning SA migrant nurses regarding reintegration in SA workforce and how they cope.

Hemingway and Hart (2014:39) mention that effective reintegration could mean collaboration and breaking new ground with innovative ideas. The public and private sectors of the countries of origin could work together towards addressing and curbing migration, and improving effective and efficient return to the workplace.

The Occupational Specific Dispensation (OSD) is an initiative by the SA government to attract and retain international migrant nurses through adding benefits and by narrowing the salary gap (Ditlopo, Blaauw, Rispel, Thomas & Bidwell, 2013:142). This could explain why 70% of the returnees preferred applying for employment in the public sector.

However, situations at home are not always improved and welcoming, with Efendi *et al.* (2013:155) reporting that Indonesian nurses who return home, face high unemployment rates. Fortunately, this is not an issue in SA, as this country with its many vacant posts

and a national health insurance system that needs to be rolled out, is in need of its nurse-driven community health services (PHASA, 2015). South African returnees nevertheless find reintegration into the public healthcare system to be difficult and fraught with discriminatory practices. They also find that they are envied experience by non-migrant nurses (see 4.4.3) for their international migration. This then results in a loss of a well-credentialed nurse to the private sector, which only provides healthcare for 20% of SA's population, who could have been very productive in contributing towards public healthcare. Becker (2017) mentions that owing to poor working conditions (and probably poor attitudes because of these), an estimated 18% of SA professional nurses are currently not practising in SA. Ultimately the loss of even one specialist nurse in the nursing career field contributes towards the total 'dire' shortage in the healthcare sector with only 5.14 nurses per 1 000 people reported in 2016 (Becker, 2017). The average salary for a professional nurse in Netcare is R262 092 per year (Indeed, 2017). Thus, replacing a professional nurse accompanies direct and indirect cost for the health sectors.

Holmes (2012:25), however, states that one has to own one's integration journey. This was also illustrated in this study. With some innovativeness following discouragement during job-hunting processes, a professional nurse obtained employment at a not-for-profit organisation that was conducting research. Later this returnee became an entrepreneur. Continuing to apply for several posts in different sectors, be it governmental, such as the correctional services, or private, or any of the many private hospital groups, also helped ensure successful integration of other returnees in this study.

According to Holmes (2012:21), many migrant workers face the challenge of not being employed at the same level as in country of origin when they reach a destination country. Soontiens and Van Tonder (2014:1037) reiterate that SA migrants in Australia had to re-establish their careers as part of a new workplace adjustment. This was also the experience of the participants of this study, as narrated by those who migrated to more than one country, as mentioned in this study. However, on return to the home country one would expect that experience and knowledge gained locally as well as abroad would be considered. This unfortunately was not the case at all, and nurses were offered lower

ranking nursing positions on return to SA. Such migrants that were in managerial positions before migration, were expected to work as junior professional nurses on return, even when there were vacant posts. One participant was deliberately sidelined, irrespective of the fact that he was a good candidate with previous managerial experience because of his return migrant status (see 4.4.5).

Workplace integration as a highly personalised journey (Holmes, 2012:17) includes having to be integrated again in the workplace in SA, as with any new employment associated with job change (see 4.4.5). For a migrant health worker, reintegration upon return means being able to use some, or most of the accumulated skills and experience gained abroad to help country of origin develop (Public Service International, 2017:9). Biondo *et al.* (2012:3), affirm that when brains return to country of origin the accumulated human capital may have a positive impact on the average population's development.

However, this study found that return migrant nurses encountered different lived experiences during workplace reintegration in SA. Very few workplaces had strategies in place to facilitate professional reintegration. Thus, the human capital much needed for the development of the respective communities in SA is wasted.

Developed countries have the means to uphold CPD and on-the-job training whereas developing countries' lack of funds restrict vital mandatory activities (Haour-Knipe & Davies, 2008:15; Efendi *et al.*, 2013:158). Hawthorne (2014:3) report how the Philippines as a developing country exercised an extraordinary initiative by running a programme to encourage skilled migrants to share knowledge and skills on a voluntary basis, in the midst of brain drain. A blueprint for compulsory self-directed CPD to be linked with yearly nurse licensing has also been developed in SA and is being refined for implementation by the SANC. Returnees in general are quite willing to share their intellectual and practical experiences (some in the form of short courses attended) obtained abroad. This could help towards initiating CPD programmes in the public sector, if supported. Unfortunately, they experience resistance from co-workers and management in this matter (see 4.4.5).

Experiences reported by returnees as public servants are that the government sector puts limited effort into developing their nursing staff (see 4.4.5), with participants left to their own means. Their returnee colleagues in the private sector do attend mandatory courses to maintain a high standard of care and take own initiative to keep abreast with evidence-based practice (see 4.4.5).

In a study conducted amongst nurses in a public healthcare facility in Cape Town, Brophy (2015:80) confirmed a degree of uncertainty of how to communicate and share knowledge effectively in the public sector, with some nurses being reluctant to share this with their colleagues. However, as illustrated by Holmes' (2012:25), encouragement of employees to take ownership of workplace integration, such as returnee migrant nurses in the private sector, often serve as a resource for patients, nurses and even some doctors. The same applies to keeping abreast with evolving nursing information (see 4.4.5), as a strategy encouraged and learned abroad.

A study conducted by Brophy (2015:81) validates that short staffing compromises service delivery to the patients, and that better management of resources would assist the professional nurse to deliver effective, safe and efficient patient care.

The Constitution of the Republic of South Africa (Act 108 of 1996) and the Department of Health proclaims the National Patient's Rights Charter in order to ensure healthcare service delivery. Participants raised concerns related to inadequate staffing and high workloads that impact negatively on quality patient care in SA, compared with the developed countries where nursing responsibilities are limited with the presence of special category workers, such as technologists to help (see 4.4.5).

Matlala and Van der Westhuizen (2012:22) uphold that the root causes for voluntary turnover of nurses in the SA public health sector appears to be poor working conditions, inclusive of executing duties that other category workers should do, overall low morale, ineffective communication between nursing staff and their leaders, a lack of support for career development, unsatisfactory performance appraisals and handling of grievances.

In VantagePoint (n.d.) it is stated that detrimental aspects such as understaffing, large staff turnover, depleted morale and increased stress levels ultimately lead to other physical and mental health issues. The right mix of training, experience and critical skills developed over a period of time to facilitate patient safety and well-being is needed, rather than concentrating on staffing numbers in a staffing plan.

Participants in this study as representing employees in both the public and private healthcare sectors reiterated that the quality of staff is often a concern and that staff development may be needed to combat some effects of staff shortages through critical thinking skills (see 4.4.5). Further concern was raised regarding the clinical lack of accompaniment of students in public hospitals by professional nurses as a potential problem for future qualified nurses, as they were not observed to be adequately mentored.

Soontiens and Van Tonder (2014:1038) find that workplace integration is based on new terms, with a string of new protocols that often translate into doubt, with countless hindrances. A similar lack of comprehensive written policies to guide the safe nursing practice in the SA public healthcare sector was experienced and reported on in this study. Knowing the importance of policies and procedures, a newly appointed manager utilised her expertise to create new policies that would promote occupational safety and safe, high quality patient care (see 4.4.5). On the other hand, in the private healthcare sector policies are well written and up-to-date but these guidelines are sometimes neglected and not enforced by some nurses. Nurses are the health workers that are at the frontline and are the backbone of the healthcare system playing a pivotal role in translating appropriate policies into action (Gray & Vawda, 2015). Nurses as healthcare providers are responsible to ensure that the government health policies are implemented into specific service delivery actions (Health & Democracy, n.d:318).

5.2.3. Objective 3: Factors that motivate migrant nurses to reapply for employment abroad or to remain as workforce in SA

Reintegration is generally a slow process that takes time and Kushminder (2014:1) mentions that some may successfully reintegrate, whereas others may fail at it, depending on the circumstances surrounding the process and the performance in the labour markets. As an example, Tjadens *et al.* (2013:30) mention that Ghanaian health workers have no intention to work upon return to Ghana, with no plans to re-migrate owing to age restrictions on labour migration. Three of the SA permanent returnees concurred with this situation, as they mentioned that it was important and more comfortable for them to retire in SA.

The outcome of reintegration into the workplace determines whether the return migrant nurse remains in SA or decides to re-migrate. Only four of the SA participant migrants reintegrated successfully without any programme in place to assist them along the process. The IOM (2016:9) reasons that reintegration of voluntary migrants could be more sustainable should appropriate assistance be available. If the conditions cater for sustainable reintegration, more migrants may consider voluntary return to SA.

Hemingway and Hart (2014:9) state that it is important to identify the factors that contribute to effective and successful reintegration, and to apply them as valuable stepping stones for future returnees and their reintegration process. SA nurse returnees as temporary migrant workers simply prefer being in SA, irrespective of the low salaries and high inflation rate and poor working conditions. It might be that the family presence as social support in difficult working environments plays a larger part than anticipated, or that they have developed more resilience in dealing with situations abroad and able to also apply this resilience at home.

Cassarino (2014:5) states that those who do not return voluntarily or complete their migration cycle (this could include those participants who return to SA owing to family problems) and have reached their objectives, will not reintegrate optimally and are likely

to seek employment abroad and re-migrate if they are physically able and eligible. This is evident in participants who re-migrated and were interviewed while abroad on work assignments. Subsequently, two other participants are strongly contemplating to re-migrate towards attainment of their unmet goals, which are impossible to reach in SA with the meagre incomes earned. Battistella (2014:9) advises that in such cases, continued circular migration could be a solution. Furthermore, it could also help to mitigate the negative impact that migration has on the already weakened healthcare sectors of SA as a developing country for the individual, and in the form of remittances to the country towards economic improvement.

This concludes the discussion of the objectives, with some answers given to the research question initially generated.

5.3 Limitations of study

The first limitation of this study was the large selection of participants from Gauteng, instead of from other provinces. Other populations from the other provinces might have migrated elsewhere than the Middle East, with other experiences. Obtaining this sample was the result of a purposive sampling method, followed by snowballing, with seven participants from Gauteng province and only three from other provinces. Some potential participants were contacted, but unfortunately did not have the necessary media (Skype) to conduct the lengthy interviews. Since the researcher resided in Gauteng, personal face-to-face interviews were not possible with potential participants in other provinces.

Interviewing only the return migrant nurses regarding workplace reintegration provides this study with a one-sided opinion, where the view of non-migrant nurses may further provide valuable insight with regards to the process of reintegration.

By using snowball sampling, three of the first four participants contacted were migrant nurses who worked in Saudi Arabia. They then suggested more participants with work experience from Saudi Arabia, which resulted in the majority recruited from this

geographical area. Thus, the findings of this study cannot be generalized to the entire South African migrant nurse population.

5.4 Recommendations

Based on the results of the study, recommendations are suggested to assist return migrant nurses with workplace reintegration and to benefit from their international exposure.

Cruz, Tan and Yonaha (2015:6) mention the volatile world we live in, and how economic and political turmoil and vulnerabilities force countries to prepare for a possible influx of returnees. Similar issues are at play in SA, such as the proposed amendment of the 'Law of No Taxation' for migrants who work outside the country for more than 183 days of the financial year (BizNews, 2017). Currently this legislation states that SA residents are liable to pay tax on worldwide income, with those who are citizens but not residing in SA only responsible to pay tax on income generated within SA (SARS non-residents, n.d.). However, if the proposed amendment is adopted, this could change soon, with foreign earned money being heavily taxed. SA policy-makers and SA employers of nurses need to plan to benefit the country in case of an influx of return migrant nurses in the near future, especially with the near implementation of national health insurance.

Based on the results from the study, the following recommendations are suggested to assist return migrant nurses with workplace reintegration and for the workplace to benefit from their international exposure.

Recommendations for sustainable migrant nurse return and reintegration are made in the form of a plan and explained below (Figure 5.1).

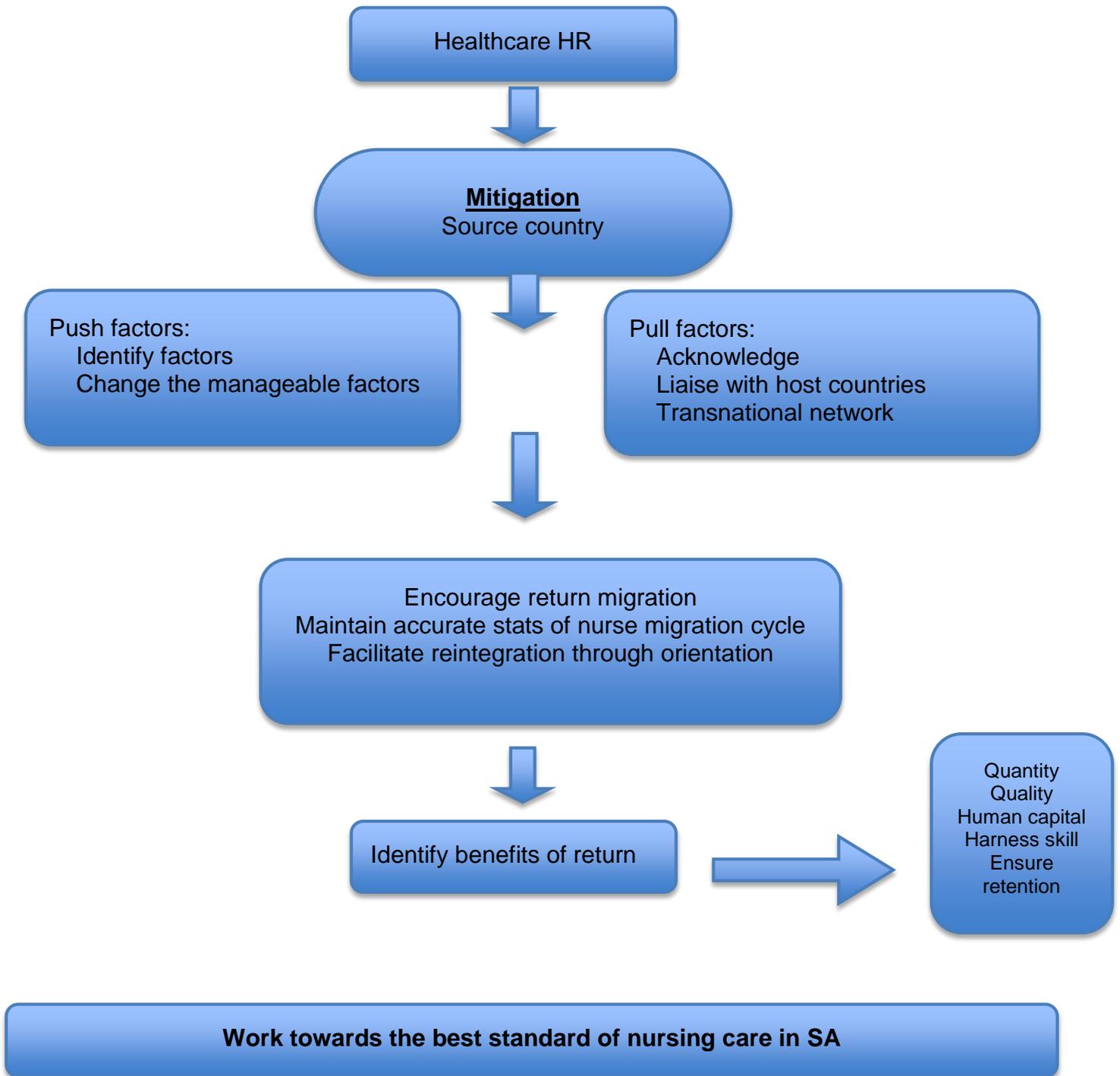


Figure 5.1 Migrant nurse return sustainable workplace reintegration plan

Sustainable migrant nurse return and workplace reintegration plan

Reintegration strategies for returnee migrant nurses need to be in place to ensure a sustainable return.

Healthcare human resource

The health sector needs allocated human resource managers to focus on facilitation of sustainable return of migrant nurses to work towards abovementioned goal.

Mitigation by source country

Mitigation of the negative experiences of reintegration through intervention initiated by healthcare human resource managers, with the assistance of migrant nurses and programmes to create awareness amongst existing staff of problems with reintegration.

Push factors from country of origin

There is a relationship between the push and pull dichotomy, because for labour migration to materialize, a strong push factor within the source country is required. By identifying the main push factors, plans can be formulated to work towards a strategic plan to eliminate shortcomings. The push factors identified in this study were the low salary for nurses in SA – which does not match the inflation rate, and the poor working conditions. Some factors may have already been addressed in a way; such as the low remuneration of nurses via the implementation of the OSD, narrowing the remuneration gap and assisting some nurses to reintegrate successfully in the public sector.

Improving the status of healthcare facilities may alleviate some of the detrimental effects poor working conditions have on healthcare workers. This could be achieved by actively adhering to and applying government policies such as the National Core Standards and ideal Clinic Initiative to improve healthcare infrastructure (Fryatt & Hunter, 2015:2) and working conditions. The initial motivation to migrate plays a significant role in understanding the corresponding pull factors and influencing factors to return and how this could influence reintegration into the labour market.

Pull factors in host country

By identifying pull factors in host countries, healthcare human resources may learn what makes the opportunities so attractive for SA nurses and thus help in countering the opposing push factor prevailing in SA.

Liaise with destination country

The source and host countries need to liaise and meet each other half way regarding advantages and disadvantages created by the migration of nurses. The host country may intern train nurses in a way that they may be able to transfer knowledge and skills in return. Healthcare human resource management could promote the establishment of a transnational network of nurse between the source and host countries. When nurses work abroad they may serve as SA's nursing ambassadors. This could be seen as nurses migrating for their personally-motivated reason, but learning new skills that they could share with the country of origin upon return. Hospitals in developed countries adhere to continuous development programmes to ensure patient safety and can help with such training programmes as well as research shared regarding improvement of services. Many nurses are studying through distant learning institutions improving their qualifications while abroad, which increase their human capital (see 1.11). New knowledge should be harnessed to address SA health management problems, such as adhering to international and national accreditation.

Return migration of nurses could be encouraged

SA needs to attract international migrant nurses during current difficult global health market conditions, since the country is facing severe shortages of professional nurses and nurse specialists. This can be done by attracting nurses with expertise and who are near retirement, to act as consultants or advisors to transform and upgrade the standard of care in the public healthcare system. Introducing and coordinating programmes to facilitate evidence-based practice in the public sector, where it is most needed, should be a priority

By maintaining accurate statistics of nurses' migrant cycles the South African health sector would have an idea of which nurses could potentially contribute towards improving the nursing standard of care.

A well-structured **orientation** and on-boarding programme for every single new employee in all healthcare institutions are needed in healthcare sectors. This could facilitate the reintegration process and set clear measurable goals at the beginning of employment. This includes the agency nurse. Reorientation to the workplace often starts with working at the new workplace as an agency nurse, before permanent employment is offered in SA. Countries importing large numbers of workers have good orientation policies in place (such as KSA and the UAE), and these could be consulted in drawing up policies to deal with migrant workers. This could ultimately be very helpful in the SA context, as major migration also takes place between provinces and other countries from Africa.

Identify benefits of return

With the shortage of nurses in SA spiraling, even one returnee may make a difference in **quantity**. Further, the returnees could add richness, quality and diversity to the skill mix. Returnees, having been exposed to SA and overseas healthcare sectors have a fair idea of what is needed most for positive change, therefore, policy-makers should collect data from returnees. This could then be analysed and used to design returnee workplace reintegration policies directed at sustainable reintegration of returned nurse migrants. Active healthcare labour market policies should be included, with consideration of national health insurance labour needs. Many experienced SA nurses have helped formulate such policies in countries with rapidly emerging healthcare structures, such as the UAE, and there is no reason why it cannot be done locally.

Harness skills that may serve as great contributions to healthcare organisations, the nursing workforce and education department to develop new goals to achieve quality of care.

Owing to budgetary concerns, staff members are unable to attend many mandatory courses and training in the public healthcare sector. Return migrant nurses could

contribute towards in-house training without the institution spending exorbitant sums of money. It is necessary, however, for such training be done as soon as possible after arrival, so as to not become outdated. Healthcare education evolves and dates rapidly.

Fostering participative management styles and encouraging staff development, accompanied by fair compensation, may improve **nursing retention** and in the long run patient care. The public sector needs to strengthen co-operation between employer and employee; and work together as a team, with the common goal of improving quality of care through facilitation of career development and joint decision-making.

Together the healthcare Human resource, the returnees may and host country may work towards the best standard of nursing care in SA.

5.5 Implications of findings

Findings imply that nurses are mostly temporary migrant nurses, who had a return migration plan from the beginning of the migration cycle. Understanding the root causes of temporary international migration of SA nurses has helped in exploring their reintegration process in the healthcare labour market in SA upon return. The majority migrated for economic improvement and returned as soon as their goals were obtained to fulfil their parental roles and attend to other family obligations.

Participants indicated positive and negative experiences during their different reintegration processes. Far too often the participants' experiences implied that their human capital obtained and offered via suggestions were rejected, because of ignorance and non-exposure to new ideas and experiences. This led to frustration in the workplace as evidence-based nursing practice could not be applied to nursing care and improvement in quality nursing care in SA. Non-migrant nursing staff have adopted a sense of complacency regarding the day-to-day struggles, which was often found to be unfortunate, unpleasant and unmanageable by the return migrant nurse with nursing experience abroad, if compared by some developed countries' standards.

5.6 Conclusion

The study aimed to explore the lived experiences of migrant nurses during their workplace reintegration process upon return to SA.

According to the participants, the new knowledge and skills accumulated while abroad could have a positive impact on the improvement of SA nursing healthcare and assist to raising the standard of care bar.

Nevertheless, it is important to keep in mind that there is no single solution to ensure effective workplace reintegration.

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Appendix A

Ethical approval from Stellenbosch University



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10-Nov-2016 Pretorius, Cleopatra C

Approval Notice New Application

Ethics Reference #: S16/10/205 Title: An exploration of the workplace reintegration of returning migrant nurses

Dear Miss Cleopatra Pretorius,

The **New Application** received on **20-Oct-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **10-Nov-2016** and was approved. Please note the following information about your approved research protocol:

Protocol Approval Period: **10-Nov-2016 -09-Nov-2017**

Please remember to use your **protocol number (S16/10/205)** on any documents or correspondence with the HREC concerning your research protocol. Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or

monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372 Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms. Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics

approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research. For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at.

Included Documents:

Investigator Declaration C Young.pdf HREC: Health Research New Application

Sincerely,

Francis Masiye HREC Coordinator Health Research Ethics Committee 2

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2. Participant Enrolment. You may not recruit or enroll participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to

recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.

4. Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur**. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC

8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that

report to the HREC. You may submit the report at the time of continuing HREC review.

9.Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognized as research nor will the data obtained by any such activities should it be used in support of research.

10.Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11.On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Appendix B

Participant information leaflet and consent form

TITLE OF THE RESEARCH PROJECT:

An exploration of the workplace reintegration of returning migrant nurses

REFERENCE NUMBER: S/16/10/205

PRINCIPAL INVESTIGATOR: Cleopatra Malebo Pretorius

ADDRESS: Stellenbosch University

CONTACT NUMBER: 0610864158

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The study will be conducted in the Gauteng region at participants' homes with a total of six participants who will be interviewed twice.

This study aims to explore workplace reintegration of return migrant nurses in South Africa. The researcher aim to gain knowledge into reintegration experiences in the workplace and how the process could be maintained and improved. Understanding of the reintegration process might give a returning migrant nurse perspective about what difficulties to expect and how to cope with them, for retention in the workforce. The individual face-to-face interviews will assist towards collection of valuable information for implementation of an improved reintegration process for migrant nurses returning to South Africa. An analysis of the workplace reintegration of the returned migrant nurse may assist in relevant policy making, practice and further studies about the phenomenon.

Two separate interviews will be held for 45-60min, the second interview will be a follow up of the information collected during the first interview. Why have you been invited to participate?

In order to share knowledge and experiences regarding workplace reintegration as a return migrant nurse. What will your responsibilities be?

Participants needs to share knowledge and experiences regarding workplace reintegration as a return migrant nurse during two separate face-to-face interviews.

Will you benefit from taking part in this research?

There are no personal benefits, but return migrant nurses may benefit from changes in the workplace reintegration process.

Are there any risks involved in your taking part in this research?

There are no anticipated risks and discomfort involve.

If you do not agree to take part, what alternatives do you have?

Participants will be granted the chance to refuse to participate if they choose not to part take in the research and allowed to withdraw at any time without any explanation.

Who will have access to your medical records?

The information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participant will remain anonymous. The audio tapes will be researcher and supervisor will have access to the information.

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

There will be no compensation available.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but your transport and meal costs will be covered for each study visit. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your researcher. You will receive a copy of this information and consent form for your own record.

Appendix C

Semi-structured questionnaire

The following questions may be asked during the interview:

1. What influenced your decision to apply for nursing employment abroad?
2. What courses or ongoing education did you do whilst abroad (this may include any courses offered by distance education South African institutions)?
3. What experiences did you gain that may have a positive impact on the South African Healthcare system if applied here?
4. What were the factors influencing you to return to your country of origin?
5. What is or was your experiences (positive or negative) during your reintegration in the workplace upon return?
6. How did you cope with these experiences in the South African work environment?
7. What were the deciding factors(s) that influenced your decision to remain in South Africa or migrate again?

Appendix D

Transcripts

P4: *No, it wasn't, it wasn't easy to get into the position, because no 1; people feel threatened by us, we left the country went overseas. Much as I said earlier I didn't learn much in terms of who I was, there were a few things which I picked up, which I would have brought into the country; I said to your patient care, management from observing which was better than what we were doing here. So, coming back we were a threat to the nurses who were here in the country, that we left, we went overseas now we coming back, now we coming to take their positions. I for one was told by somebody when I went to look, I mean when I went to apply at the municipality, the regional office for being at the primary healthcare management level. They said no they won't even tell me when there are positions because I'm threatening them. It was not easy and again it was that thing of you have to start there to come up again, you can't just come up again, you can't just come in and flat and go up. So, I was supposed to come in as a primary healthcare nurse and be a subordinate of somebody of who I was a manager for, when I left the country. So, as I said it was not easy coming back to where were, though there was a shortage, but there were some obstacles because of people's yes*

Interviewer: peoples' perception especially as because you've mentioned the people who have remained in South Africa.

Participant 5: *I mean, instead of us being assets to them that we are going, we are coming to part with what we learnt overseas, we tend to be enemies to them that we are coming to threaten their positions and take over.*

Interviewer: Ohk so, this brings us to that positive impact that you could have, *could have brought in in to the country had and in-cooperated, Yes. to the country. Yes. Because countries like UK practice on a level of evidence based practice uhm more so than...South Africa.*

Participant 5: *And they practice on law, I mean UK follows laws, you are just on a straight line. You don't, you won't even deviate, you know the deviation the acts and omission we talk about, they stick to that. You would know that if you gave, you've have given Panado when it was not prescribed it's an offence. So, I mean we came back knowing that this is how things has to be done, this is what we can impart with our colleagues in the country, that you know if we do this, it's not supposed to be done, this is how it's done in other countries, but there were road blocks as to no we can't let you in. And another thing because now they are used to doing things the wrong way, you come in and come with new things and positive things, you are an enemy.*

Interviewer: I do understand that uhm like you've mentioned when you went to the UK you had to start at a lower level from where you've been previously when you left the country, now coming back to the country the same exact thing happens. And this is whereas you've worked yourself up in the UK and now you return back and with all that

knowledge and skill, you have to be right at the bottom, which is also in a way going to make it very difficult to have that positive impact. **Yes.** On-on the practice. **Because now you are there on the floor. You can't advice management.** And-and for you to advice management it's still going to be perceived as a threat, that you know too much and more so that you have applied for that position so the struggle just become worse.

Interviewer: What about you sir, when you came back did you experience?

Participant 4: It was the same experience, I had to start from scratch, become a junior nurse from being a manager. My aim was just to get into the job and then I will work myself up.

I knew that there will be post advertised and then I will apply for those posts. But I applied 5 times, I went for interview 5 time for the managerial post and I was denied that in the department of health and I asked the reasons why? And there were those things; "no I left people here", they have to promote those people first before I get my turn. And yah. It was an unfair, yah I was treated unfair yah. So, that's what made me to leave the department and apply for a managerial post at the department of correctional services, which I went only once for an interview and I was the only one person outside, with the people who were internal and then I got that post.

Interviewer: So, this position that you applied for at the correctional service, is it pertaining to health or is it something totally different?

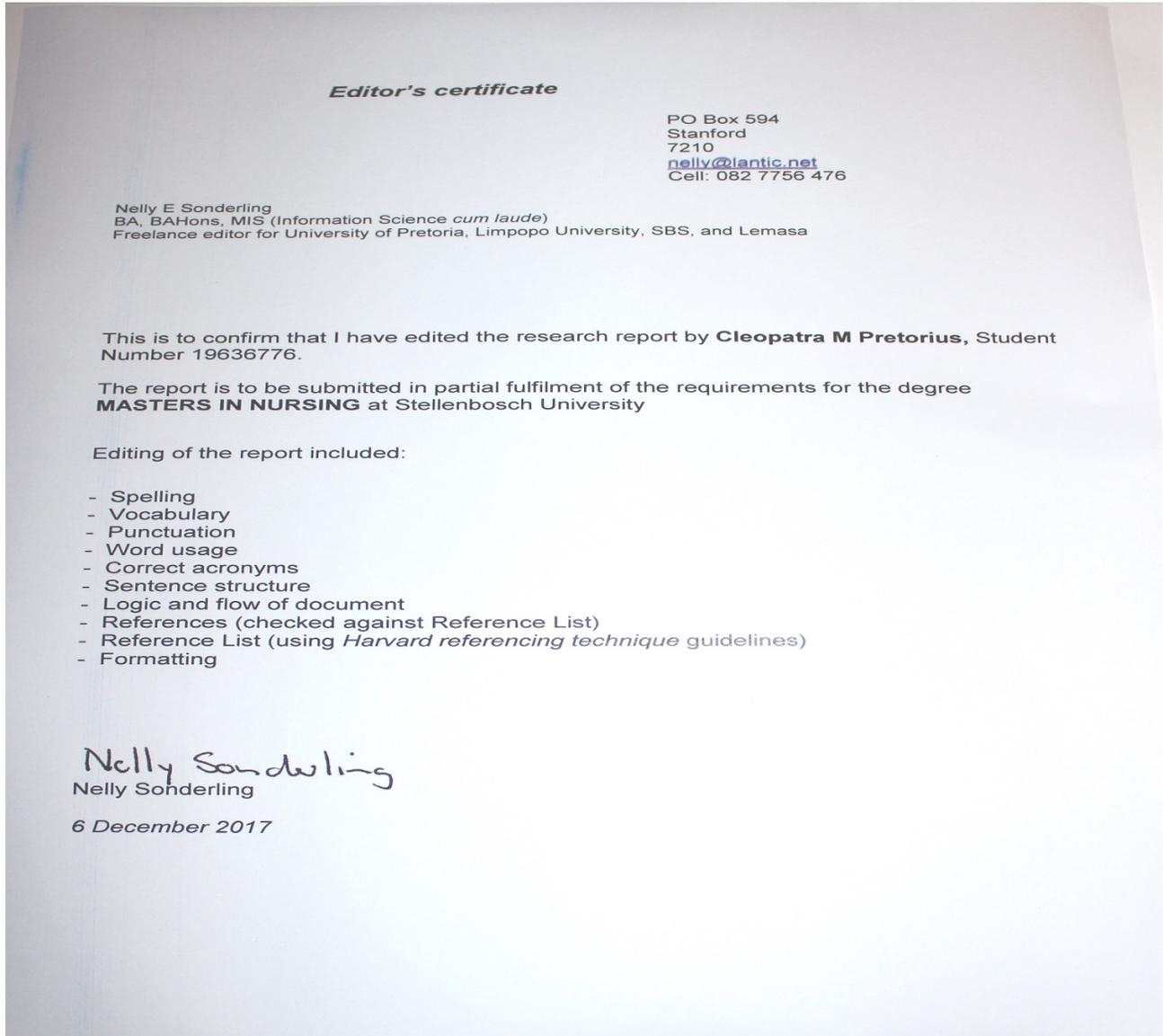
Participant 4: Yes, it is pertaining to health because I worked at the healthcare services of the department of correctional services.

Interviewer: Ohk so you will still be able to in-cooperate those positive uhm skills and practices that you've gained along the line. Which brings us to which brings us to, notice that there's sort of a vendetta against nurses who leave the country, because I wouldn't know if they feel like there is a struggle in South Africa this is what I get from what you've mentioned, I, but looking at perhaps the experiences that you have the qualifications that you actually can be appointed into these positions, but these obstacles are just because you left the country.

Participant 4: And not only that, even when you get the post. Like when I got this managerial post at the department of correctional services, people were against that, especially those that I went with at the interview. They felt I've taken their post, they felt because I came from overseas, I've taken out some money to buy maybe the post, they thought maybe I've bribe the interviewers to get the post. And you know now because I had to become their manager the offered you know resistance, they were against me, every change that I tried to bring, they were saying: "who does he think he is, he shouldn't come and bother us here, he must go to wherever he comes from and all those things. They thought because I was earning pounds, I came with pounds, I bought my way to seniority.

Appendix E

Declaration by language, grammar and technical editor



Appendix F

Turnitin Report

SUNLearn Cleopatra Pretorius

Dashboard ▶ My courses ▶ 2017 ▶ Geneeskunde En Gesondheidswetenskappe ▶ Verpleegkunde ▶ Navorsingstesis - Research thesis - 876 ▶ Thesis submission ▶

Thesis submission link

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 - ▶ Verpleegkunde - Nursing science - 888
 - ▼ Navorsingstesis - Research thesis - 876
 - ▶ Participants

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