The Life History Experiences of Zimbabwean Students Studying Pre-Registration Nursing in a UK University

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by

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Abstract

A considerable number of students undertaking pre-registration nurse education in the UK are international students from Zimbabwe. The aim of this study is to listen to their narratives in order both to understand their experiences and to make suggestions for improving their educational management.

The context from which the Zimbabwean students have migrated is discussed, outlining the current Zimbabwean educational and health care systems; prevailing social mores, religion and kinship ties; and the more recent sharp economic downturn in the Zimbabwean economy and the effects of the prevalence of HIV/AIDS in Southern Africa.

Nine pre-registration nursing students from Zimbabwe attending one UK university, and one further respondent who had qualified as a nurse and was practising in the same locality were recruited to take part in life-history interviews. The interviews covered experiences in Zimbabwe leading to migration to the UK; accounts of arriving in the UK and challenges experienced in starting the course, working in health care settings as placements, and becoming reconciled to life in the UK.

Factors prompting migration to the UK are reported to include the emphasis on education as a means of social mobility; the economic crisis, and the disruption of family ties by the HIV epidemic. Educational courses for nursing are the means to prevent their aspirations for professional occupation floundering on current economic and political instability in Zimbabwe, rather than a positive career choice. The reliance of the NHS on internationally-recruited students to cover shortfalls in labour in the UK contributes to this process. Experiences upon arrival in the UK include problems with visas, immigration officials and banking facilities. Zimbabwean students find it challenging to adapt to self-directed learning styles, to combine studying in a context without their familiar domestic help, and under financial pressure to remit monies home. They also report experiences of racism both in the college and in placement settings. Despite these challenges the next step seems more likely to be to work in nursing in the UK and to bring family to join them when financially possible.

These life-histories have implications for the educational management of Zimbabwean nursing students at the level of the University, the University International Office, the School of Nursing and Midwifery, the individual nurse tutor, and the local NHS placement settings. They also have implications for the future prospects of Zimbabwe after the Mugabe regime.
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Chapter One: Introduction

Life History and Zimbabwean Nursing Students

My interest in the lived experience of student nurses from Zimbabwe who are currently studying at a UK University began with a routine visit to a clinical area of care. One such student had been placed on a busy ward in an acute local hospital in order to gain experience of nursing adult patients whilst undertaking a Diploma in Higher Education in Nursing at the investigator’s own university. Routine visits of this nature are normal practice and are undertaken by Senior Lecturers involved in delivering the pre registration curriculum, which is a three year programme leading to the award of a degree in Nursing (BSc Hons) or a Diploma in Higher Education in Nursing (Dip HE).

Students on both the undergraduate degree programme and the Diploma programme share the first year in terms of taught sessions and practice experience. However, the following two years or branch programme in which students study a specialist area of nursing, (care of the adult, the child, the client with learning disabilities, the client with mental health problems) finds undergraduate students studying at a higher level in order to gain an honours degree. In relation to the practice element of the programme, degree and diploma students are required to achieve the same level of competency in line with 'Fitness for Practice’ (UKCC, 1999), and needed to register as a qualified practitioner with the Nursing and Midwifery Council (NMC).
The routine visit to the student in practice provided an opportunity to check on achievement of learning outcomes, attendance and general progress. However, it later transpired that the visit provided what Giddens (1991) has called a 'fateful moment'.

**Fateful Moments**

Giddens (1991) has spoken of fateful moments, occasions of opportunity when we are given a challenge out of which one may construct new ways of thinking about things. The student, a married woman in her early thirties, had arrived in the United Kingdom from her native Zimbabwe eighteen months ago to pursue a nursing course, accompanied by her two young sons. The student's husband, a school teacher, remained in Zimbabwe in order to support his ageing family. The student's parents and younger siblings also reside in Zimbabwe and rely on her for financial support.

In the student's words the chance to study nursing in the UK presented itself as a 'once-in-a-lifetime' opportunity. Consequently she arrived in the UK full of optimism and hope, with a view to successfully completing a Nursing Diploma in a country whose National Health Service was, in her view, second to none.

On arrival in the UK the student encountered problems concerning accommodation and financial assistance. These were compounded by communication difficulties relating to unfamiliarity with UK support mechanisms for overseas students and a general lack of information. Although the student was in some way prepared to encounter technical difficulties, by virtue of having had conversations with friends who had preceded her footsteps, she was not prepared for the attitudes of the people she met from the moment of her arrival. The student recounted incidents with co-
workers, students, teachers and administration staff in the academic and practice setting in which they made her question her right to be in the UK.

Examples given by the student include being asked frequently of her plans for returning home on completion of the course. She felt there was a constant suggestion that she was training to be a nurse at the British tax payer’s expense, and that she was “scrounging off the State”, whilst getting free education and healthcare for herself and her family, in other words, having something for nothing. The implication for the student was that she was sending other people’s money out of the country. The student also indicated that comments were made regarding the health of her family in Zimbabwe. For example:

“People seem to think we are all suffering from HIV or that we all have AIDS and that’s why we are coming here now...just to get money to take back to Zimbabwe.”

The incident recounted was initiated by a routine clinical visit to the student’s placement area. The constraints of time and the environment precluded further exploration of issues of obvious concern to the student. Plummer (2001) talks about the ’chance encounter’, indicating that many life histories are not planned, and that an interesting volunteer is a common way of finding subjects for the research. Subsequent visits to placements allowed the investigator to make tentative enquiries of other Zimbabwean students regarding their willingness to participate in a research study, which would focus primarily on their life histories. The response was overwhelmingly positive and pointed to a need for some background exploration of the context in which overseas student nurses are drawn to live and work in the UK.
The Context

Since its inception in 1948 the British NHS has relied extensively on international nurses and other workers to maintain the required complement of staff. From the very outset nurses were recruited into training from East Europe, Eire, the Caribbean and Africa. Although the 1962 Commonwealth Immigrants Act prevented further direct migration as Commonwealth citizens, overseas nurses have continued to be recruited into training. The fate of such nurses has remained relatively hidden, with few studies examining experiences in detail, and fewer still monitoring any patterns in prospects and achievements of such nurses (Culley et al, 2001). One recent study has sought to examine in detail the experiences of internationally recruited nurses to the UK (Allan and Larsan, 2003). However, whilst this study reports extensively on the experiences of qualified nurses, it does not address the experiences of international student nurses undertaking pre-registration courses in the UK.

In recent years, research by Iganski et al (1998) and Iganski (1998) suggests that minority ethnic applicants to nurse courses in England are over represented at the applications stage of recruitment compared with their numbers in the population. In fact, they are more likely to be rejected without interview for pre-registration nursing courses. These findings were based on a three-year research project carried out across a sample of universities providing pre-registration nursing education in England and show both over and under representation. The authors imply all is well if over representation of minority ethnic groups occurs and cast doubt on claims of under-representation of ethnic minorities on pre-registration nursing courses (Chevannes, 2001). However, they are not able to account for the difference in the number that apply, the number that are short listed, and the number that are offered a place.
Chevannes (2001) concludes from this that we still do not know the factors that prevent black and other minority applicants surmounting the hurdle of first-stage selection and moving to the short listed group of applicants. Similarly, little research systematically examines reasons why black and other minority ethnic nursing students may 'drop-out' of the course or choose not to practise as qualified nurses on achieving registration. In light of work by authors such as Smaje (1995), Gerrish et al, (1996) and Culley and Mayor (2001) who consistently point to the need to pay attention to inequities and inequalities in health and health care provision, and the need to develop health care services which are responsive to the needs of an ethnically diverse society, it is necessary to address this shortfall in the data as a matter of urgency.

One way of collecting data in relation to ethnic groups is through ethnic record keeping and ethnic monitoring. However, ethnic record keeping without monitoring is a pointless exercise, and wasteful of resources (Johnson, 2001). If information is collected and nothing is done to consider the implications of what it shows, it becomes a redundant exercise. Therefore to record numbers of students from African countries applying for pre-registration nursing courses without monitoring what happens to them during the next three years provides little insight into the relevant aspects of people's ethnic origins and the relationship to patterns of attrition.

There are many ways of defining an ethnic minority (Pringle et al, 1997). Crucially, the categorisation used should be relevant to the service being delivered, in this case nurse education. At De Montfort University one such ethnic minority is the contingent of African-born nursing students who make up nearly 20% of the population of nursing students currently on the diploma course.
However, a significant number of the African students (140 or 14.6%) originate from Zimbabwe, a country well known for its current political and economic difficulties. This relatively high number was a factor prompting the decision to focus the study on those particular students using life history as a way of sensitising the researcher to key issues or time periods (Plummer, 2001).

Having established a population of students (from Zimbabwe) that can be categorised as a majority within an ethnic minority (from Africa) the next question is 'what is the problem?' Plummer (2001) suggests only some problems and questions will lead to suitable life history research, for example certain themes such as health, family life, and careers. In the case of Zimbabwean students, who, in beginning a course of study in a new country usually discover that changes occur in family circumstances, in career aspirations, and possibly in health status, suitable life history material is readily available.
Various authors have suggested that problems exist for ethnic minority groups who choose to live and work in the UK (Smaje 1995, Gerrish et al 1996, Iganski et al 1998, Chevannes 2001, Culley et al 2001). This is supported by tentative soundings taken by the investigator whilst visiting Zimbabwean students in practice and discussions with them in the School of Nursing. It is argued therefore that research is required in order to address these problems and it is important that the UK University in which this research study is undertaken takes account of the findings and addresses those issues within its power. In this context the aims of the research are:

1) To describe the experiences of Zimbabwean nursing students, studying in one UK university School of Nursing and Midwifery using a life history approach to collecting data.

2) To develop an understanding of the factors affecting Zimbabwean nursing students, studying in one UK university School of Nursing and Midwifery that may impact on their future plans for nursing in the UK, following registration with the Nursing and Midwifery Council (NMC).

3) To provide a useful source of information to the international office within the university in relation to the ways in which overseas students may be supported based on their lived experiences.

Outline of the Thesis

Chapter Two: Review of the Literature follows this introductory chapter and reviews the literature on the country of Zimbabwe and its people. Education provision, religion and social customs, health, health care and nursing are discussed, with particular attention being paid to the crisis presented by HIV and AIDS, which has reached epidemic proportions in Zimbabwe. The socio-economic situation is discussed with reference to the effect this has on the ability of Zimbabweans to support themselves and their families. The chapter identifies that while a number of
recent studies report on the experiences of registered nurses working in the NHS, there is a distinct lack of literature relating to the experiences of overseas nursing students. The chapter concludes with a proposal to examine the lived experience of Zimbabwean student nurses studying in a UK University using students’ personal life histories to gain understanding of the issues affecting people who leave their country of birth to live, study and work in a foreign land.

**Chapter Three: Methodology** presents a detailed examination and justification of life history research. Within this chapter the question of validity, consistency and transferability within the life history approach are considered. Next, the methods used in data collection are examined including choosing the sample, interviewing students and transcribing the data. Methods of analysing the data are then considered. The chapter concludes with a review of the ethical issues that arose during the research.

**Chapter Four** presents and analyses the data relating to the students’ experience of *life in Zimbabwe* including their educational experiences, family life, language, nursing, politics, and HIV/AIDS. These subheadings reflect the themes contained in the life history narratives.

**Chapter five** presents and analyses data relating to the students’ experience of *life in the UK*. Themes within this chapter include arriving in the UK, financial implications of living and studying in the UK, social life, and racism in the health care setting and in the classroom.
Chapter Six presents data relating to the students' plans for the future, and includes the themes of career aspirations, and returning to Zimbabwe. Within this chapter data are presented from the life history interview conducted with the subject of the chance encounter, which provided the impetus for the study. This student has since registered with the NMC and is working in the NHS.

Chapter Seven: Implications and recommendations returns to the initial research aims with regard to the findings. Implications for the policy and practice of supporting overseas students, grounded in knowledge derived from the students' lived experience, are considered and recommendations are made for educational leaders and managers.

Chapter Eight: Conclusion summarises the research process and reflects on the methodology. The limitations of the research are considered in light of the findings. The chapter concludes with a summary of the recommendations and reflections on the strengths and limitations of the study as a whole.
Chapter Two: Literature Review

Introduction

This chapter reviews relevant literature relating to Zimbabwe in order to set the context for the study. The chapter provides an overview of the geographical location of Zimbabwe and its people, before moving on to discuss the education system; religion and social custom; health, in particular the current HIV/AIDS epidemic, and the implications of this for health care and nursing. The chapter also includes a commentary on the prevailing political and socio-economic situation in Zimbabwe.

The chapter culminates with an insight into the reasons why the UK Government is successful in recruiting students from Zimbabwe to train as nurses in the NHS, to the apparent detriment of that country. The introduction begins by locating Zimbabwe within the African continent and presenting literature, which reflects the ways in which Zimbabwean people are able to live and work, including life expectancy, language and communication.

Zimbabwe – a geographical overview

Zimbabwe, formerly Southern Rhodesia, is situated in South Central Africa between the Limpopo and Zambezi rivers. A land locked country, Zimbabwe is bounded by Zambia to the north and north-west, by South Africa to the south, by Mozambique to the east and north-east, and by Botswana to the south-west. It lies entirely to the north of the Tropic of Capricorn (www.cia.gov/cia/publications/factbook/geos/zi.html). Zimbabwe covers an area of 390,245 square kilometres, being about three times the
size of England, or nearly as big as California. Almost the whole country lies more than 300 metres above sea level.

About two-thirds of the land in Zimbabwe is suitable for cultivation, which makes the country self sufficient in foodstuffs. Nearly half the population depend on subsistence agriculture, and up to 75 percent rely directly or indirectly on agriculture for a living. Most Zimbabweans are farmers, with only a quarter living in cities. However, most city dwellers maintain social and economic links with their rural homelands (Owomoyela, 2002).

The last census, held in 1992, indicated a population of 10.4 million, with an annual growth rate of 3.14 percent. It is anticipated that the population will increase to 15.5 million in 2005. More recent figures suggest the population to be 12,576,742, with 7.2 million infected with HIV (http://www.revolutionmag.com/newrev12/out.html). Estimates for Zimbabwe explicitly take into account the effects of expected mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in distribution of population by age and sex than would otherwise be expected.

The age structure of the Zimbabwean people is as follows:

0-14 years: 39% (male 2,517,608; female 2,471,342)
15-64 years: 56.8% (male 3,600,832; female 3,542,497)
65 years and over: 3.5% (male 224,631; female 219,832)

The birth rate in Zimbabwe is 30.34 births/1,000 population, with a death rate of 22.02 deaths/1,000 population. Overall infant mortality rate is 66.47 deaths/1,000 live births. Life expectancy at birth is 39.01 years for the total population, with males at
40.09 years living slightly longer than females at 37.89 years

Ethnic groups in Zimbabwe are comprised of 98% African, with mixed and Asian groups accounting for 1%. Of the African group Shona (82%) and Ndebele (14%) are the two major indigenous languages spoken, while English is the commercial language and indeed an entry requirement for studying at the University of Zimbabwe. 90.7% of Zimbabweans over the age of 15 can read and write English. The religious affiliation of Zimbabwe people is syncretic (part Christian and part indigenous beliefs). Fifty percent of Zimbabweans are Christian, while twenty-five percent adhere to indigenous beliefs. Two percent of Zimbabweans are Muslim and one percent of Zimbabweans follow other religions.

Zimbabwe is divided into eight provinces; Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Masvingo, Matebeleland North, Matebeleland South, and Midlands. The country gained independence from the UK on the 18th April, 1980 and this is celebrated as a National Holiday. The constitution of Zimbabwe was formed on the 21st December when Robert Gabriel Mugabe was elected president and chief of state. The last election was held between 9th and 11th March, 2002 and Mugabe and his ZANU PF party (Zimbabwe African National Union-Patriotic Front) were re-elected with 56.2% of the vote. Morgan Tsvangirai and the MDC (Movement for Democratic Change) received 41.9% of the vote. The next election is not due to be held until March 2008, and most international observers regarded the 2002 poll as seriously flawed. Blair (2002: 246) noted prior to the election that Mugabe was busily tilting the electoral playing field in his favour to the
point where it threatened to become vertical. Chan (2003) has since commented that the commonwealth observer group reported major electoral deficits as well as violence and intimidation, including a failure on the part of the police to protect the opposition, a biased application of the law, and a basically flawed legislative framework. To summarise Mugabe’s view of electoral democracy Meredith (2002) uses the following quotation taken from a radio broadcast in Mozambique in 1976.

“Our votes must go together with our guns. After all, any vote we shall have, shall have been the product of the gun. The gun which produces the vote should remain its security officer – its guarantor. The people’s votes and the people’s guns are always inseparable twins.” (Mugabe, 1976)

**Education in Zimbabwe**

From the first, education in Zimbabwe was the handmaid of religion, deriving from the legacy of the missionaries who had embarked on a programme to formally educate the local people (Golby, 1995). Reading and writing was a prerequisite to the teaching of Christian religion, and the building of small huts in order to facilitate this enterprise was the forerunner of the first schools in Zimbabwe (Rusere, 1993). To promote the education of the local people, Roman Catholic colleges were formed to train teachers who later taught the local people.

The first primary school in Zimbabwe, St Joseph’s in the Midlands province, was established in 1951 and offered classes from standard I to IV. The advent of more primary schools in the district encouraged local Zimbabwean people to move their children away from the village schools to the mission schools. In this way the idea of sending children to ‘board’ at school developed and became custom and practice.
The early primary schools offered basic education up to standard IV and selection for higher education was made on the basis of moral worthiness as much as educational attainment (Golby, 1995). In this way the church produced generations of people imbued with Catholic doctrine and perpetuated schooling as a means of spreading the word.

The first secondary school was built by catholic missionaries in response to a greater demand for secondary education by the Zimbabwean people. This school placed emphasis on technical and practical subjects such as woodwork, metalwork, agriculture and animal husbandry - a brand of education that conformed to the colonial government’s native education policy, which advocated a division in the secondary education offered to Africans. The Kegwin Report on Native Education, (1952) suggested that some black children could not cope with the rigours of academic work and therefore needed a less mentally strenuous education; one biased towards practical skills. The report gave rise to a division within secondary education in Zimbabwe, (so called F.2 schools) which paralleled the advent of secondary schools in the British post war period (Golby, 1995).

F.1 and F.2 schools, much like the secondary modern/grammar school experience in Britain, bore no resemblance to each other, the first being concerned with academia, the second concerned with practical subjects. However, it was the F.2 system that revolutionised the community and served to improve the ordinary Zimbabwean’s way of life. These schools improved standards of life as a result of the availability of money as former pupils became gainfully employed (Rusere, 1993). The effect of this
practical education was enjoyed as much by girls as boys, who had previously looked towards early marriage and motherhood as a way out of poverty and dependence on the male. In spite of this, a point worth noting is that the Zimbabwean government did not look to students educated in F.2 schools for jobs in teaching, health, and the civil service but looked instead to the F.1 schools. With independence in 1980, the F.2 system was abandoned in line with government policy. However, the legacy of the boarding school system was by that time firmly entrenched.

The formal curriculum in Zimbabwe, inherited at independence, was modelled on the British education system, in which girls were educated for domesticity (Wolpe, 1994). Boys, on the other hand were prepared for employment in the public sphere, fitting them for the role of bread winner and family head (Davison and Kanyuka, 1992).

Education policy in Zimbabwe during the first decade of independence was firmly based on the ZANU (Zimbabwe African National Union) government’s commitment to education as a basic human right and a means by which racial inequalities could be redressed (Swainson, 1999). Throughout the 1980s enrolment in Zimbabwean primary schools increased ten fold and by the late 1980s there was virtually universal primary education.

Religion and Social Custom in Zimbabwe

Christianity is the main religion in Zimbabwe, commanding an allegiance estimated to include 40-50% of the population. Historically, a Portuguese attempt to establish Christianity in 1561 proved abortive, and it was not until 1859 that the Reverend Robert Moffat of the London Missionary Society laid the foundations of the religion (Golby, 1995). Protestant sects including Methodist, Anglican, Salvation Army,
Seventh Day Adventist, Dutch Reformed, Presbyterian, Congregational, Episcopalian, North American Apostolic, and African churches account for a million followers. However, the Catholic Church now has the largest number of adherents (Owomoyela, 2002). The Asian minority adhere to mainly Islam or Hinduism, and there are Jewish and Greek Orthodox communities in the main urban cities (Chan, 2003).

Alongside Christian doctrines, the traditional religions of the Shona and Ndebele co-exist. Shona religion is monotheistic, the people believe in a supreme being who like the Christian God created and sustains the universe (Moyo, 1988). The Ndebele maintain a belief in their own Supreme Being, or God. However, the Ndebele, being descended from the Zulu tribes of South Africa have their own name: Unkulunkulu, meaning “the Supremely Great One” (Owomoyela, 2002). Both indigenous peoples, Shona and Ndebele, believe in the spirit world and the presence of primary contacts for humans in the spirit world. The underlying belief common to Shona and Ndebele people, although expressed differently within the context of the language, is for the existence of “spirit elders”, the spirits of the departed members of the family unit, who are present within the living community, caring for their descendants and sharing experiences, although remaining invisible. The presence of the spirits has been variously described as beneficial and vengeful. The qualities favoured by these spirits are good behaviour, respect for elders, and conformity to the life led by one’s ancestors, seeking little or no wealth or position. The belief is that material progress, especially the material progress of an individual, is likely to lead to an erosion of traditional features of Zimbabwean society (Gelfand, 1962).
The indigenous people of Zimbabwe believe in the presence of spirits that communicate with humans through mediums, chosen at random, or through dream revelation. Mediums are expected not to partake of substances processed through Europe, for example, tobacco (a main crop of Zimbabwe), tea and coffee. They must not receive medical attention from a European doctor or an African doctor who practises Western medicine, nor may they enter a hospital. On the contrary they may only be treated by a traditional healer (Reynolds, 1996). The traditional healers derive their powers from vengeful spirits and are said to be evidence of the ancestors’ active involvement in ministrations to the sick. In consulting the spirits, the traditional healers use divining dice, which for the Shona people consist of wooden or animal bones, whilst consisting of seeds for the Ndebele (Nzenza-Shand, 1997).

Although theoretically distinct and separate, Christianity and the traditional religions enjoy a significant degree of integration. Zimbabwean people profess Christianity without necessarily abandoning the traditional spirits or turning their backs on observances designed to honour their ancestors, ensure their pleasure, and ascertain their wishes. Both the Shona and the Ndebele adopted Christianity as a calculated and expedient decision, historically as a means of gaining access to the services and amenities provided by the missions, for example health care and education. Moreover, because Christianity was associated with the dominant white settlers, the Western way became regarded as the way of the future and invested with connotations of privilege and progressiveness. To be a Christian was to be better, socially and often materially (Owomoyela, 2002).
The Economy

In pre colonial times Zimbabwean people practised shifting cultivation, moving seasonally to new farmlands as the old ones became exhausted, as did much of the rest of Africa (Owomoyela, 2002). The efficiency of this system satisfied the needs of the native Zimbabweans, sustained the white settlers, and provided Africans with the means to pay the taxes levied on them.

Agriculture predominated in Zimbabwe until the imposition of economic sanctions on the Smith regime after its Unilateral Declaration of Independence (UDI) in 1965, which forced the country to diversify (Meredith, 2002). Following UDI, local food processing and metal manufacturing developed and expanded, making up for the lack of commodities, which were no longer readily available. At the same time, agricultural output and service sector provision developed. Zimbabwe produces gold, nickel, and asbestos, and exports cotton, tobacco, and maize, along with manufactured goods (Blair, 2002). Its gross domestic product (GDP) is well distributed over several economic sectors, but the gross national product (GNP) lags behind that of the population. Per capita GNP remains relatively low by world standards, although it is well above the average for southern Africa (Owomoyela, 2002).

After independence in 1980, the Mugabe government attempted to adopt a one party state based on a Marxist economic system. The collapse of the Eastern European economies similarly based on Marxist models undermined this effort. In addition, the failure of the mixed economy prevailing during the first decade of independence forced the government to adopt an Economic Structural Adjustment Programme (ESAP) (Chan, 2003). This programme, prescribed by the International Monetary
Fund (IMF) required Mugabe to pledge himself to the free market. Increased borrowing by Mugabe resulted in a lack of confidence in Zimbabwe government bonds, which in turn required the government to seek support from the IMF to cover the budget deficit, in return for which Mugabe agreed an ambitious package of economic reforms (Blair, 2002). Mugabe subsequently ignored most of the free market reform package and it was never implemented in full. Corrupt loss-making state industries have remained in the public sector and the economy in Zimbabwe has continued on a downward slide (Meredith, 2002).

**Socio-economic decline in Zimbabwe**

The World Fact Book dated the 9th of October, 2003 records the Government of Zimbabwe as facing a wide variety of difficult economic problems as it struggles with an unsustainable fiscal deficit, an overvalued exchange rate, soaring inflation, and bare shelves. Its 1998-2002 involvement in the war in the Democratic Republic of Congo drained hundreds of millions of dollars from the economy. Badly needed support from the International Monetary Fund has been suspended because of the country’s failure to meet budgetary goals. Inflation has grown from an annual rate of 32% in 1998 to 59% in 1999, 60% in 2000, over 100% by year end 2001, to 228% in early 2003. The Government’s land reform programme, characterised by chaos and violence, has nearly destroyed the commercial farming sector, the traditional source of exports and foreign exchange and the provider of 400,000 jobs. One example of how Zimbabwe has deteriorated under the control of Robert Mugabe’s government is the state of the country’s telecommunications system. This system was once the best in Africa, but now suffers from poor maintenance. There are more than 100,000
outstanding requests for connections despite an equally large number of installed but
unused main lines (www.cia.gov/cia/publications/factbook/geos/zi.html).

Communication difficulties in Zimbabwe directly affect the nation’s struggle with
HIV and AIDS, as does the general socio-economic status. Barnett and Whiteside
(2002) discuss the global situation in relation to HIV/AIDS suggesting in Africa,
HIV-related illnesses now kill ten times more people a year than does war. They
further suggest that Sub-Saharan Africa (including Zimbabwe) is the region most
affected by HIV/AIDS – now the area’s leading cause of morbidity and mortality.
According to the authors, most if not all, of the 25 million people in Sub-Saharan
Africa who are living with HIV/AIDS will have died by the year 2020, in addition to
the 13.7 million Africans already claimed by the epidemic. These frightening
statistics demand a closer examination of the effects of HIV/AIDS on Zimbabwe.

**HIV/AIDS in Zimbabwe**

HIV/AIDS is predominantly a sexually transmitted disease. It causes illness and
death among mature adults. The groups at greatest risk are those between 15 and 50
years of age, often described as the sexually active. These are also the most
economically productive in any society. HIV/AIDS has been reported from every
inhabited continent and from every country. Barnett and Whiteside (2002) write
extensively about the globalisation of HIV and AIDS. They argue that globally in
2001, approximately 36 million individuals were living with HIV/AIDS. Assuming
that each HIV/AIDS case directly influences the lives of four other individuals, a total
of more than 150 million people are being affected by the disease.
Zimbabwe is facing a serious AIDS epidemic. In the year 2000, the national adult HIV prevalence was estimated to be 25% (Barnett and Whiteside, 2002). However, HIV/AIDS experts announced recently that figures released from government showing a drop in the number of HIV positive people in the country did not represent a real drop in the prevalence of the disease but a correction of flawed figures from previous surveys (www.thebody.com August, 28th, 2003). This makes it extremely difficult to be sure of the extent to which HIV/AIDS is affecting Zimbabwe. Current figures, compiled using surveys conducted by local experts with technical assistance from organisations such as the World Health Organisation (WHO) and Imperial College London, show that 24% of Zimbabwean adults are HIV-positive, down from 33%. As with other African countries, young people are at a particularly high risk of HIV infection due to the frequency with which they change sexual partners and their physical immaturity (Chifunyise, Benoy, and Mukiibi, 2002).

Legislation has impacted in a number of ways on Zimbabwean people in relation to minimising the risk of HIV and AIDS, both positively and negatively. For example, the Sexual Offences Act (SOA) made marital rape an offence thus making it clear that women have the right to say yes or no to sex whether in marriage or not. Traditionally non-consensual sex in a marriage was not classified as rape, nor was it in the UK until relatively recently (The British Council, 2000); therefore the SOA should protect women who are at risk of sexual abuse and the risk of HIV infection. However, SAFAIDS (2002) reports that few test cases have been brought before the courts as a result of this legislation. Similarly, the Children’s Act, which provides for the protection, welfare and supervision of children and juveniles, has had little effect.
in that the legislation has failed to cope with the demand made by millions of orphaned children as a result of the AIDS pandemic.

The Deceased Estates Act (DEA), in providing maintenance out of the estate of a deceased person for certain remaining family members has seen the increased provision of benefits for wives and children. However, the DEA does not go far enough in that defacto guardians and grandparents, who may be the only surviving guardians of children are not included (Ingham-Thorpe, 2002).

Finally, the Land Acquisition Act (LAA), which has been high on the political agenda in Zimbabwe, has resulted in the large movement and displacement of people. The resettlement of large numbers of people has been accompanied by regrouping of family units and new and often unsafe sexual relations, which has exposed children and women to the risk of HIV and AIDS (Barnett and Whiteside, 2002).

An initiative has been set up in Zimbabwe to counteract the threat posed by HIV and AIDS. In 1994 Zimbabwe introduced a nation-wide programme to teach AIDS education. A project to evaluate whether or not this programme had an impact on student teachers’ level of knowledge about transmission, symptoms and prevention of sexually transmitted diseases and HIV/AIDS; their attitude towards persons living with AIDS; and their sensitivity to the impact of the epidemic and to discussing teaching about these issues found an increase in knowledge of HIV prevention and in teachers’ ability to discuss reproductive health and sexual issues (Chifunyise, Benoy and Mukiibi, 2002). However, the authors report that this change may be due to students’ exposure to HIV material outside the programme. They conclude that
course attendance needs to be enforced and the curriculum needs to be updated with student participation. Peer educators and participatory techniques are needed if students are to internalise positive attitudes and behaviour. In addition, Chifunyise et al (2002) argue that education materials need to address the lack of female empowerment in making decisions and negotiating for safer sex.

The lifetime risk of acquiring HIV infection in many rural as well as urban areas of southern Africa is currently as high as two-in-three. Gregson et al (2003) argue that for women, much of this risk still accrues rapidly at young ages despite high levels of knowledge about HIV/AIDS. They advocate programmes that are more participatory and address structural and community level factors. Using cross sectional data from a large scale population based survey in rural eastern Zimbabwe; the authors describe the relationships between membership of different forms of community groups and young women’s chances of avoiding HIV. Gregson et al (2003) claim that participation in local community groups is often associated with successful avoidance of HIV, which in turn is positively associated with psychosocial determinants of safer behaviour. However, whether these relationships hold depends on a range of factors that include how well the group functions, the purpose of the group and the educational level of the participant.

A project entitled the Chirumhanzu Home Care Based project in the Midlands province of Zimbabwe grew out of an initiative by hospital health workers and expatriate doctors. The project was launched because of over crowded hospital wards, the high cost of hospital care, and the desire of AIDS patients to receive care at home from their families. Home care services are provided for people living with
HIV and AIDS by the local people, which in a nation where hospital care is an extremely scarce resource, makes good sense (Singhal 2001).

In summary, whether a person contracts HIV depends on his or her social class and economic position (Barnett and Whiteside, 2002). In Zimbabwe more than 2,500 people die every week of AIDS-related causes in spite of government programmes and legislation designed to stem the process (IRIN, 2003). Since poverty and poor nutrition accelerate the progress of the disease (Singhal, 2003) the HIV/AIDS epidemic in Zimbabwe is set both to continue and to become more severe.

**Health, Health Care, and Nursing in Zimbabwe**

In 2003, the United Nations Office for the Co-ordination of Humanitarian Affairs reported Zimbabwe to be in its fifth successive year of economic decline (IRIN, 2003). The country faces critical shortages of foreign exchange; inflation has reached 364% and is forecast to exceed 500% by the end of 2003. Five million Zimbabweans, more than half the population, are in need of food aid (IRIN, 2003). The effect this has had on the nation's health and subsequent provision of health care has been catastrophic. It is reported that Zimbabwe’s main public hospital in the capital city, Harare, is in an exceedingly poor state of repair, with broken windows, and leaking pipes. Patients at the hospital have to rely on families to prepare food for them and to transport it, sometimes many kilometres from rural villages, into the hospital each day. In addition, patients and their families have to pay for the drugs they require to treat their conditions, which are for the most part HIV and AIDS related (Manz, 2002). In many cases, the poorest of people who cannot afford health insurance, are not able to access the drugs and treatment they desperately need.
The poorest and consequently the sickest people rely on home-based nursing in Zimbabwe. However, very few of the people providing this care are nurses because they lack the necessary education. Manz (2002) reports that two-week and three-week home-based nursing programmes help women graduate prior to providing care for people with AIDS. These women are all HIV positive themselves. Upon graduation they receive a 12-inch long bar of soap, a pair of rubber gloves and a uniform to wear.

Zimbabwe now has the dubious honour of being the world’s most HIV infected country with life expectancy in Zimbabwe at birth, on one estimate, poised to fall to 38 years. The reason for the high rate of HIV infection relates to Zimbabwe having an economy advanced enough for the virus to spread, in particular on relatively good roads, with epidemiologists tracking HIV prevalence along the main freight routes (Davis, 1999). The impact of HIV on the health of Zimbabweans is particularly deep because unlike most health disasters to befall Africa, HIV/AIDS kills the strong, the parents, the productive; the very people on whom functioning societies inevitably rely (Barnett and Whiteside, 2002).

Nursing in Zimbabwe is said to be conceptualized within the context of primary health care (Mapanga, 1990), which was adopted when the country became independent in 1980 (World Health Organisation, 1978). Mapanga and Mapanga (2000) write that nursing in Zimbabwe is considered as a practice discipline which regards the person, health and environment as central to its philosophical underpinnings. The person is believed to be a bio-psycho-social, cultural and spiritual
being whose health and illness continuum are interactive with family and environmental conditions. Mapanga (1996) suggests that nursing education in Zimbabwe takes place within the context of developments in Zimbabwean society, the increasing educational level of society, and the increasing complexity of health care needs. In light of this a number of nursing programmes are offered including a basic Diploma in Nursing, the minimum entry requirement for which is the Zimbabwean General Certificate of Education with passes of grades A to C in at least five subjects including English Language and a science (Zimbabwean Health Professions Council, 1999). This programme runs over three years with the opportunity for those enrolled to progress to the award of a degree. Graduates usually find employment in Ministry of Health and Child Welfare institutions in rural and urban locations, for example primary health care centres, district, provincial and central hospitals (Zimbabwe Ministry of Health and Child Welfare, 1997).

Direct entry to the Bachelor of Science in Nursing programme requires students to possess a minimum of a UK Cambridge General certificate of Education at A level with two passes in science subjects. This programme lasts for a duration of four years and is accredited by the Zimbabwe Health Professions Council. Graduates of this programme are usually employed in public and private health sectors (Mapanga and Mapanga, 2000).

Other nursing programmes offered include a Post Basic Diploma in Nursing, which requires a minimum of the Registered General Nurse Qualification. This programme allows the qualified nurse to specialize in Midwifery, Community Health Nursing and Nursing Administration. Other post basic programmes offered include a six month
specialisation in Intensive Care Nursing, Nurse Anaesthetist and Theatre Nursing. In addition, qualified nurses can opt to study paediatric and ophthalmic nursing or study a programme in Nursing Education (University of Zimbabwe, 1998).

A Post Basic Bachelor of Nursing Science degree requires students to be registered as a General Nurse and possess two UK Certificate of Education advanced level passes in two subjects of which one must be a science. This programme is offered by the University of Zimbabwe and comprises three years of full time study (University of Zimbabwe, 1998). There is also the opportunity for qualified nurses who meet the necessary entry requirement to study part time at the Open University of Zimbabwe. This programme is offered as distance learning modules. Both degree programmes find graduates employed in the public health sector as the sponsoring body is the Ministry of Health and Child Welfare (Mapanga and Mapanga, 2000).

There are also opportunities to study to Masters and PhD level in nursing in Zimbabwe. These programmes are offered by the University of Zimbabwe and allow specialisation in statistics, informatics and epidemiology, advanced health assessment, nursing research and a dissertation, and health economics and budgeting. In addition students study major clinical courses including applied neuroscience for mental health/psychiatric nursing, pathophysiology for medical/surgical nursing as well as community health nursing and child health/paediatric nursing, embryology and neonatology for maternal child health/midwifery (Mapanga and Mapanga, 2000). Masters level programmes are accredited by the Zimbabwe Health Professions Council, with the majority of graduates employed within the public health sector.
Mapanga and Mapanga (2000) report the major weakness in Zimbabwe’s nursing education to be the provision of programmes promoting horizontal progression. Provision of programmes promoting vertical progression, for example to masters and PhD level, have been lacking. In addition, the authors claim that access to university education for degree level preparation has been limited and the provision of clinical specialisation at masters’ level was previously non-existent. However, they add that the strength of nursing education in Zimbabwe lies in the availability of candidates for recruitment into the programmes. Whilst, it is clear that most school leavers will meet the entry requirements to access these courses, it is questionable whether recruitment to nursing programmes in Zimbabwe will flourish in the way the authors claim. The numbers of recruits to UK nursing courses from Zimbabwe suggests that students are instead choosing to study nursing in the UK, rather than in their native Zimbabwe. Tentative reasons for this are likely to relate to a lack of health care provision in Zimbabwe, which makes it difficult for students to acquire clinical experience, and the current socio-economic situation, which encourages students to seek opportunities overseas, at a time when the UK is actively recruiting registered nurses and potential nursing students to staff the NHS (Buchan. 2002).

All practising nurses, currently standing at 17,000, are required to register with the Zimbabwe Health Professions Council and to renew their practising certificates annually. The Council serves as Zimbabwean nurses’ regulatory body, equivalent to the NMC in the UK. Nursing practice takes place at various levels in the primary health care delivery system, including urban and rural health centres, which constitute the primary level and the first point of contact for the client in the health care delivery system. A referral system operates based on the need and complexity of the client’s
problems in which they may be directed towards district hospital or provincial hospital based care (Zimbabwe Ministry of Health and Child Welfare, 1999). However, as shown previously in this chapter, the level of care the client receives upon referral to the hospital is completely inadequate due to decline in the state of the buildings, which is a feature of a more general decline in the nation’s economy.

Conclusion
In conclusion, this chapter has considered the literature in relation to the geographical location of Zimbabwe and its people, the education system, religion, social custom and beliefs, health, health care and nursing. These areas are seen as having a major impact on the lives of Zimbabwean nursing students and are influential in their decision to leave Zimbabwe to live and study in the UK. The literature suggests that Zimbabwean people value the role of education in their lives in as much as it provides them with access to a better standard of living, through access to white collar and therefore better paid jobs. However, the current state of the economy impinges on the capacity of Zimbabweans to enjoy a minimum standard of living, let alone a standard that would provide any quality of life. Similarly, the literature relating to state of the nation’s health and the provision of health care indicates a crisis to exist due to the impact of HIV and AIDS. The disease, now epidemic in Zimbabwe, affects those people whom the country relies upon to support the economy, in other words, the work force. The consequences of HIV and AIDS on the socio-economic status of the country are such that those infected have little access to treatment, cannot afford what treatment is available, and therefore have little chance of recovery.
Whilst nursing programmes exist in Zimbabwe upwards of a basic Diploma in Nursing to Masters and PhD programmes, uptake is limited and only 17,000 nurses are currently registered to practise. The literature suggests that nursing programmes offering specialised clinical experience are limited. This is most likely due to a lack of health care provision and technical expertise as Zimbabwean doctors and nurses leave the country. It is within this context that Zimbabwean students are seeking to study nursing outside Zimbabwe at a time when Britain’s NHS is seeking to address its own recruitment and retention problems. Buchan (2002), in a major study funded by the Royal College of Nursing (RCN) into overseas recruitment, reported a significant growth in the level of inflow of nurses from other countries to the UK, so much so that the Department of Health in England issued guidance on ethical international recruitment to counteract the charge that developing countries health care provision was suffering. Whilst Buchan’s study highlights the experiences of qualified nurses coming to live and work in the UK, it does not illuminate the experiences of student nurses, who are exposed to similar push and pull factors responsible for driving qualified nurses overseas. It is in this context that the following study proposes to give a voice to Zimbabwean student nurses in the UK who previously have not had their experiences acknowledged.
Chapter Three: Methodology

Introduction

This chapter is concerned with documenting the process of collecting and analysing data. It begins with an overview of the rationale for using life history methodology for collecting sociological data. In so doing the chapter draws on extracts from life history interviews with Zimbabwean nursing students.

Next, the chapter discusses the issue of validity within life history research drawing on the work of Hammersley (1992), who introduces the notion of falsifiability as opposed to verifiability as a means of judging the truthfulness of an account. Lincoln and Guba's (1985) concepts of consistency and transferability are used in place of the more positivistic scientific concepts of reliability and generalisability in determining whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) respondents in the same (or similar) context.

The third section considers the method for obtaining a sample for the study, for conducting the life history interviews, and for analysing the data. The chapter concludes by discussing the ethical implications arising from the research and the responsibilities incumbent upon the researcher when undertaking a life history study.

Life History Method

Data was collected in this study using a 'life history' approach, although this particular methodological style has gone by various names, for example personal documents, the documentary tradition, oral history and narrative (Plummer, 2001:3). Life history and narrative are often used interchangeably. However, the key
difference is that life history is representative of a more general class of narratives. As such whilst all life histories are narratives not all narratives are considered to be life histories (Hatch and Wisniewski, 1995). Life history is often presented as a special case of the more general class of narratives, often termed autobiographical narrative (Foster, 1995).

The place of 'stories', within life history and narrative helps in clarifying the difference between the concepts. Life histories often take stories at face value and work off them in terms of content to generate interpretations. In narrative work the focus is on how the stories are formed and structured by the wider culture in terms of their telling, and during the face to face interaction that generates their telling (Sparkes, 1994). The stories told by Zimbabwean students provided content about life in Zimbabwe, life in the UK, nursing in the UK, and plans for the future. In other words, they comprised autobiographical content. In addition the students not only told their stories, but offered interpretations of their stories. For these reasons, the approach used is deemed to be a life history rather than a narrative analysis. The focus of this study is the story of a life (the student), told from a particular vantage point (studying nursing in the UK), with emphasis placed on what is being told, more than how it is told.

Life history is a way of connecting the lives and stories of individuals to the understanding of larger human and social phenomena (Hatch and Wisniewski, 1995). By examining the life histories of Zimbabwean nursing students studying in the UK, understanding is gained of the realities of current political and socio-economic life in Zimbabwe. Using other methods of data collection, for example a questionnaire, were
felt to be limited and incongruous irrespective of their potential to incorporate more open-ended questions. Life history allows the depth, complexity and diversity of views of the respondents to be recorded in a way that other methods would not (Plummer, 2001). This point is well illustrated when students discussed the extent of the HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) problem in Zimbabwe. They alluded to a variety of reasons why the virus is escalating and considered to be epidemic (Barnett and Whiteside, 2002). Among these is the tendency of male Zimbabweans infected with the virus to visit a traditional healer or 'Witch Doctor', a practice embedded in Zimbabwean culture and returned to in times of political and personal crisis. Students commented

"In our culture we believe in witch doctors, when you are sick, you can tell if you have HIV or AIDS disease but they will still go to a witch doctor and try and find a cure and the witch doctor is ignorant as well, and he would advise them to go and sleep with a small child of their own as a cure."

(Student 4)

"They go to a 'traditional' doctor and the doctor tells them that if you have sex with a virgin you will become clean. So they rape them, so the girl dies as well."

(Student 9)

It is questionable whether, in these circumstances, a questionnaire would have been successful in eliciting responses around the re-emergence of such practices resulting in a lost opportunity to shed light on a central component of the students' life histories.

The life history interviews highlighted the fact that Zimbabwean students do not leave the structures imposed by a culture behind when living and studying in another country. The students acknowledged the importance of historical factors and structural constraints (although they would not use such technocratic language). This
became apparent when students talked about the current political situation in Zimbabwe. Using a life history approach ensured that the findings became alive in terms of historical processes and structural constraints, for as Faraday and Plummer (1979: 780) suggest “people do not wander round the world in a timeless, structure-less limbo”.

In addition to the ‘fateful moment’ or ‘chance encounter’ a number of other reasons make a life-history approach pertinent to data collection in this study. One such reason is the extent that the African students comprise an unacknowledged part of the British public sector labour market. Gerrish et al (1996), in research commissioned by the English National Board for Nursing and Midwifery (ENB) which looked at the preparation of nurses and midwives to work in a multi-ethnic context, discuss a lack of a national overview of the ethnic mix of the nursing workforce. Beishon et al (1995) attempted to address this deficit on behalf of the Department of Health by conducting an extensive survey of over 14,000 nurses in order to provide a breakdown of ethnic origin in the nursing workforce. Whilst Beishon et al’s work does nothing to provide data relating to the ethnic origin of nursing students it does highlight a problem in interpreting data relating to ethnic identity in that Black was defined as including Black, Black African and Black Caribbean. Clearly, this type of research, if used to identify the ethnic origin of nursing students, would do little to establish the complexities facing particular ethnic groups, for example Zimbabwean students. Life history on the other hand, enables the researcher to see pathways into a culture and moreover a culture at a particular historical juncture, and to gain an understanding of the struggles embedded in that particular culture that may impact on higher education institutions and so may help to initiate change.
A further reason for choosing life history as a method for analysing and interpreting the experience of Zimbabwean nursing students is that narratives encourage the teller to place themselves in a position of strength. This is because narratives have a structure in which the beginning, middle and end are defined by the teller, and the interviewer is relatively more obliged to listen and respect such structures, especially the ceding of 'the floor' to the teller. Since the power of a life history lies in its telling it becomes necessary to accept the story as it is told, even if it can be shown to contain 'lies' or 'false memories' since, as Plummer (2001) argues, all life story work is selective work. Furthermore, using life histories with Zimbabwean nursing students would take account of the fact that African traditions rely heavily on oral histories passed from one generation to the next (Gallman, 1994). Moreover, it is argued that of all Western methodologies, the one that does least violence to the African experience is one that values such story-telling.

It is likely, given what is known about the persistence of racism in British society (Gerrish et al, 1996), that such students will be faced with particular types of challenges. Accounts of such experiences to an audience who will validate them, at least gives a voice to their concerns, even if it does not of itself challenge the power relations upon which such racisms rest. As Culley et al (2001) have shown, constructing one's experiences within a narrative framework can be a powerful way of resisting negative experiences and provide a source of personal healing to the narrator. Moreover, it can be a narrative that others experiencing racism can value. There are a number of important issues still to be resolved, not least those related to preparing for a life history study and how many students to include in the study.
However, by far the most important consideration for this researcher is how to avoid exploiting students who may anticipate that the research may have an immediate positive outcome on their experience of studying nursing in the UK. The measures taken, included a discussion with each student at the start of the life history interview which clearly explained the aims of the study. Despite this having been clearly stated in the information sheet given to the students prior to gaining their consent to participate in the study, it was felt necessary to reinforce the fact that the research was not intended to offer immediate solutions to the problems encountered by the students. It was on this basis that the students agreed to participate.

However, this did lead to a number of ethical issues arising from the research, which are discussed later in this study. The important issue for this researcher was that in developing a trusting relationship with the students, helped by the fact that the researcher is herself a nurse by background and currently the students’ lecturer, a professional understanding was created which may have made the students more trusting and thereby provide more detailed narratives. Price (1996) discusses trustworthiness suggesting that this needs to be considered in relation to validity and reliability. The more trusting the students were the more explicit and open their narratives became, which is well illustrated when the students talked about their experiences of racism in the UK. For example, one student commented

"Recently, about two weeks ago, we tried to get into a club and all the black people and Indian people were not allowed into the club. We tried to get in and they said that it was full inside. So we waited while people were being let in, so I argued my case with the guy on the door and they said that it was their club and they could do what they wanted. So I took it as a racial issue." (Student 6)
Whilst arguing in favour of life history as a way of analysing and interpreting the experience of Zimbabwean nursing students the researcher needs to be mindful of some of the pitfalls associated with the method. Plummer (2001) draws attention to issues of truth, value and memory offering extensive advice on ways a 'true story' might be told. The view taken is that all voices need to be heard but some voices are heard less often than others as in the case of Zimbabwean students. Life history guides the researcher, stage by stage, through the story teller's entire life course, and affirms, validates and supports the story teller's experience in relation to those around them. Life history is a major research tool that whilst having its roots in sociological research is both relevant and appropriate for use in an educational setting.

**Validity within Life History Research**

Critics of life history research often claim the method to be invalid for reasons that authors of personal accounts can: easily give free play to their imagination; choose what they want to say; hold back what they do not want to say; slant what they wish; and say only what they happen to recall at the moment (Blumer, 1979). In short, they allegedly engage in both deliberate and unwilling deception thus making the method invalid. However true this may be, the subjective story is exactly what the researcher is after when choosing to use a life history approach to collecting sociological data. If this were not the case, then the method has been chosen in error and other methods, for example, attitude scales or questionnaires should be considered. Three domains exist within the context of validity: those arising from the subject being interviewed, from the researcher, and from the interaction between the two.
Subjects of life history research may lie, cheat, present a false front or try to impress the interviewer in some way (Plummer, 2001). However, of particular importance is the claim that an interviewee may attempt to create a consistent and coherent story for the interviewer's benefit. This begs the question of the value of life history research, if it is possible that nothing recounted by the subject can be relied upon to be true. Radley and Billig (1996) shed light on this when explaining how subjects might recount a version of events that whilst not necessarily 'untrue' is dependent on their beliefs about whatever is being asked of them. They argue that people's views of health and illness are best understood as accounts that they give to others and suggest that such beliefs are neither the expression of fixed inner attitudes, nor evidence of shared social representations. The argument is that a distinction can be made between a so-called 'private' and 'public' account and furthermore a variety of rhetorical devices are used dependent on which type of account is being offered.

To explain further, a subject will determine what type of account is most appropriate once they have internalised whom the account is for, for what purpose, and how it may be of benefit. For example, a Zimbabwean student may potentially recount two versions of their 'story' of studying nursing in the UK. First may be a 'public' account in which the student feels the exchange is one of being questioned by an expert (Cornwell, 1984). One of the key features of the public account is that it reflects the speaker's (students') concern with the authority of the researcher against whose criteria their statements will be judged. A Zimbabwean nursing student may well perceive the researcher (a Senior Lecturer in the University) to hold a position of authority and to have some notion of acceptable/unacceptable answers to the question of what it is like to study nursing within that University. The student may even
imagine there to be some repercussions for unfavourable comments about the experience, thus calling into question the validity of the account given.

In contrast, Cornwell (1984) describes a 'private' account that may be offered once the subject is invited to 'tell stories'. Here a shift in control from researcher to respondent allows the individual to recognise the researcher as someone like himself or herself, enabling the use of a language recognisable as shared between similar groups. A Zimbabwean student may give a 'private' account if the researcher is presented as a past student having studied nursing in the UK, albeit in a different time and place, who is interested in learning about convergent or divergent experiences. The argument is that once trust has built up speakers relax into a private account divulging more of themselves to hearers (Cornwell, 1984). However, when accounts are complex and intertextual and when the account typically involves justification then matters may not be so simple: stories may be told when giving formal accounts and justifications and legitimations are still in order during private accounts (Fairclough, 1993).

An example of the dichotomy between public and private accounts is highlighted in accounts from students undertaking training in the field of Mental Health. A pre requisite for entry onto a nursing programme is that the potential candidate should demonstrate, through a written statement, an understanding of that particular area, in other words a 'public' account. When questioned about the reason for choosing this branch of nursing during the life history interview it was clear from the 'private' account that the student's understanding was limited. The student commented
"I had an uncle who was ill, but there isn't much known about mental illness, there are no facilities for people like that, there are just a few. So when I came here and I saw that they have places for people with mental illness, so I said I wanted to know more about it. Then that's when I realised that my uncle had dementia, we didn't know what it was. There were times when we could go to the hospital and they has a small unit called an annexe for mental illness so they could send him there but it wasn't much, but we recognised it here. If you had someone with a mental illness they would just keep them at home. We look after them ourselves."  

(Student 7)

This extract highlights the ways in which contradictory narratives may be manifest in a public and private account. The student was justifying and legitimising the ways in which patients with mental health problems are cared for in Zimbabwe, in a private account given to the researcher during the life history interview. In the public or formal account (the written statement) the student had described a desire to become a mental health nurse and an understanding of what this entailed. This student’s lack of knowledge can be explained by the lack of provision for people with mental health problems in Zimbabwe. However, if this student had indicated this level of ignorance about mental health nursing in the written statement it is doubtful whether a place on the course would have been secured.

Zimbabwean students’ stories are both complex and intertextual regarding the experience of studying nursing in the UK. Their stories involve issues relating to admission into a UK university and the difficulties this posed for them. It is well documented that minority ethnic groups including ‘Black African’ students may be less likely to secure a place in nurse training than their ‘White’ counterparts (Culley and Mayor, 2001). Furthermore these differences cannot be accounted for by qualification level, specialism chosen, or visa requirements, but may be more to do
with the selection procedure, which discriminates against them on the basis of their ethnic group (Iganski et al., 1998). The Zimbabwean student, who on the one hand is successful in securing a place at a UK university against the odds, is on the other hand, faced with a situation whereby their minority status is compounded and where they may be subject to racism in the college and the practice setting (Gerrish et al., 1996). The evidence suggests that securing a place is by no means easy since the large numbers of Black and Asian nurses who apply to train as nurses in England diminishes at the short listing stage, and reduces further when they are offered a place on a course (Chevannes, 2001).

Bearing in mind the profound nature of Zimbabwean students’ experiences the researcher engaged in life history research must pay attention to the authenticity of the account given by the respondent in a life history interview. An extract from one life history interview with a female Zimbabwean student serves to illustrate how validity can be attributed to an account even where it is not necessarily representative of the majority of other life histories. The student, a widow in her early thirties moved to the UK to study nursing following the death of her husband. Unlike other Zimbabwean students this women’s story departed from the positive framing of family experience that characterised all other accounts. Her particular life events had led her to conceptualise the domain of family life as one that evoked pain rather than a positive sense of nurturing.

"Myself, I don't think I will go back home. I have got this feeling about the death of my husband and what happened at home and everything. I think of my sisters at home, my mum and dad, but if I just think of myself in Zimbabwe I feel something that I can't explain. It's not the politics, it's just
myself, it's the things that happened to me. I think I'm alright here if I can finish this nursing course and get employment."  
(Student 1)

The experience recounted by the student includes a narrative regarding how other family members treated her and claimed her property following her husband’s death, leaving her virtually penniless. These events led to her decision never to return to the country of her birth.

Hammersley (1992: 50-51) addresses the issue of validity using a subtle form of realism in that validity is identified with confidence in our knowledge, but not certainty; reality is assumed to be independent of the claims that researchers make about it; and reality is always viewed through particular perspectives, hence our accounts represent reality, they do not reproduce it. This approach is useful in that it represents a shift in perspective away from a notion of verifiability to that of falsifiability. In short the onus is on the researcher to judge knowledge claims in the light of “their likely truth” (Hammersley, 1992: 63). Zimbabwean nursing students’ accounts are plausible, given existing knowledge about conditions in Zimbabwe at the current time (see chapter two). Similarly, the account of what it is like to study nursing in the UK is judged a credible account by virtue of the researcher’s own contextual knowledge, being a senior lecturer in the University at which the students are studying.

Hammersley’s criteria provides a framework for accepting as valid those accounts which can be seen as plausible and credible. However, it is worth noting that some students may give an account that is unrepresentative of the majority. To exclude accounts that would seem implausible or incredible renders research as unable to
surprise and by implication only able to replicate existing ways of thinking about the problem (Silverman, 1993). To ensure the research findings are useful in supporting overseas students each participant’s experience is acknowledged, not merely those experiences which share common elements. Life histories facilitate this process having as they do the power to identify the unique value and worth of each life (Atkinson, 1998).

Consistency

Reliability is primarily concerned with technique and consistency, and is generally the concern of ‘hard’ methodologies (Plummer, 2001: 154). Within conventional studies reliability is typically demonstrated by replication – if two or more repetitions of essentially similar inquiry processes under essentially similar conditions yield essentially similar findings, the reliability of the inquiry is indisputably established (Lincoln and Guba, 1985: 297-299). However, applying the concept of reliability to naturalistic forms of inquiry is problematic, resting as it does on the assumption that there is a tangible and unchanging truth out there, which can serve as a benchmark if the idea of replication is to make sense. The essentially naturalistic nature of life history data renders conventional measures of reliability inappropriate as a valuative standard (Atkinson, 1998).

Instead, the notion of consistency (Lincoln and Guba, 1985) allows for a primary quality check that can be used by both the interviewer and the storyteller to square or clarify early comments with recent insights if they appear to be different. This measure of internal consistency recognises that an individual inherently sees life events as related or connected in some way, because this is how that person’s life is
made meaningful. External consistency on the other hand, where what is said conforms to what the researcher may already know or think about the person telling the story or the topic being discussed, is not considered overly important because a narrative approach to the study maintains an emphasis on internal coherence as experienced by the person, rather than external criteria of truth or validity (Atkinson, 1998).

Throughout the life history interviews measures were taken to ensure that standardised methods were used in writing notes and preparing transcripts. Each interview was taped and transcribed in full by an experienced transcriber, used to working with lengthy interview material. The tapes were listened to by the researcher and the transcripts were read in full. In this way internal and external measures of consistency were used as the researcher was able to not only listen repeatedly to the narratives and to read the written accounts, but also to internalise the narratives and compare what was said with the researcher's own contextual knowledge.

Transferability

Generalisability, or the concept of representativeness, is deemed problematic in life history work. Plummer’s (2001) work is useful here in arguing that the claim that life history fails to provide representative cases completely misunderstands the nature of the research, where insights, understandings, appreciation, and intimate familiarity are the goals, not facts, explanations, or generalisations. Lincoln and Guba (1985) suggest a more appropriate approach for a naturalistic inquirer is to move from a question of generalisability to one of transferability. The authors suggest that in order to extrapolate the findings from one context to another the investigator is required to
accumulate empirical evidence about contextual similarity (Lincoln and Guba, 1985: 298).

In the study, transferability was sought by comparing one student's narrative with another. In this way, an insight was gained into the representativeness of each student's narrative, without compromising the aim of the study, which set out to describe the unique experiences of Zimbabwean nursing students within one UK University. In relation to the context from which theses narratives are drawn, full descriptions of the sample and how they were recruited, the contextual situation of the particular students interviewed and the relationship of the researcher to the researched, are all described in detail. This contextual depth permits others to judge the transferability of the findings to other contexts.

The Sample

At the time of conducting the study, the total population of one university of students from Zimbabwe was 129, with students grouped in the following cohorts and studying the following areas of nursing practice:

Table 1: The Nursing Pathways Studied by Different Cohorts of Zimbabwean-born Students at one UK University 2003.

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Adult</th>
<th>Mental Health</th>
<th>Learning Disability</th>
<th>Children's</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 1999 Entry</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>January 2000 Entry</td>
<td>21</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>September 2000 Entry</td>
<td>20</td>
<td>10</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>January 2001 Entry</td>
<td>15</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>September 2001 Entry</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>January 2002 Entry</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>September 2002 Entry</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Branch Total</td>
<td>72</td>
<td>49</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Total Students</td>
<td></td>
<td></td>
<td></td>
<td>129</td>
</tr>
</tbody>
</table>
Recruitment to adult nursing occurs twice per year in January and September with numbers equalling 160 per intake. Recruitment to Mental Health and Children’s nursing occurs twice per year. However, the numbers per intake are smaller, being approximately 40 and 20 respectively. Recruitment to Learning Disabilities nursing occurs once per year in September and averages approximately 20 students. The table above shows a general decline across all branches of nursing in numbers of Zimbabwean students since 2001. This reflects the change in Government regulations whereby from 2001 overseas students need to have been resident in the UK for three years prior to applying for entry onto a pre registration diploma level nursing programme in order to be eligible for NHS bursary support (DoH, 2001). The total population of Zimbabwean students during the period of the study amounted to 129.

Thought was given to the most appropriate method for selecting a sample from the overall population. The different ways a sample can be drawn for life history work include happenstance, selective, and snowball sampling (Miller, 2002). Plummer (2001) discusses the chance encounter, looking for the right person, strangers, outsiders or marginal people, or the search for ordinary people as ways of drawing a sample for life history research. A chance encounter and snowball sampling were used in this research.

The chance encounter occurs when a subject of interest emerges from a wider study or an interesting volunteer (Plummer, 2001). The chance encounter that initiated the life history study has been detailed in the introductory chapter. It occurred during a routine visit to a student’s practice placement area for the purpose of checking and monitoring student progress. From this chance encounter an attempt was made to
look for 'the right person' (Plummer, 2001: 134) by asking the student for names of others who might be interested in participating in research focusing on Zimbabwean students. This approach proved to be entirely successful and 'snowballed' (Denzin, 1978) until the required number of respondents was achieved.

In addition to the 'chance encounter' nine Zimbabwean students were contacted by telephone and asked to participate in the life history study. In each case the student had prior knowledge of the study by virtue of the previous respondent asking if they were willing to be contacted by the researcher. Every student contacted agreed to take part and recommended a further potential participant. The purpose of the study was fully explained, confidentiality assured, and anonymity guaranteed (Atkinson, 1998). Permission was requested to tape record the interviews and students were informed that the material would only be used for the purposes of the research. The students were made aware that they would have full and final approval of the written transcripts. The students were asked to complete a consent form on receipt of which an appointment was made to conduct the life history interview at a mutually convenient time.

All the interviews took place at the University campus during the students’ study day. This proved to be the most convenient arrangement as it meant that students did not have to make extra journeys to the campus; an important consideration for students on a bursary. Each life history interview lasted between 90 and 120 minutes. Mention was made in the information sheet given to students of the length of time a life history interview may take.
Data Analysis

Data analysis was undertaken using an eclectic approach, combining elements of realist and narrative approaches. Although fundamentally different, in that the view of the nature of the data differs, both approaches are suitable for interpreting data from the life history interviews. Researchers are not required to adhere rigidly to one particular mode of analysis and may mix and match techniques pragmatically (Miller, 2000). Realism takes as its starting point an inductive grounded theory-building logic. The nature of reality is viewed as definitive and may never be comprehended in its totality (Atkinson, 1998). The goal of a realist approach is to draw near to reality using theory-testing and theory building procedures (Miller, 2000). The key point is to constantly evaluate developing concepts in the light of concrete data, hence grounding the theory in data.

A realist approach necessitated conducting the interview in as non directive and unfocused a fashion as possible. Zimbabwean students were informed at the beginning of the interview that no structure would be imposed save the collection of biographical data, in the hope of obtaining as close to a monologue as possible. The monologues produced were then grouped into pragmatic categories based on the nature of the account. Broad categories, at this stage were classed as 'Life in Zimbabwe', 'Life in the UK', and 'Plans for the Future'. The results of this first ‘pass’ through the data, form the building blocks for the beginning of the analysis (Miller, 2000: 115).

The next stage in realist analysis involved re-sorting the material in each transcript into more well defined categories. 'Life in Zimbabwe' was subcategorised into
education, family, language, nursing and HIV/AIDS. 'Life in the UK', was subcategorised into 'arriving in the UK, 'the financial implications of living in the UK', social life in the UK', and racism in the college and practice setting'. Finally, 'Plans for the Future' was subcategorised into 'going home', and 'nursing'. Completion of this stage led to the next analytic phase, which utilised a narrative approach.

The inherently invasive nature of interviewing means that the narrative approach must place special emphasis on the interaction between interviewee and interviewer (Miller, 2000). The view is that reality is malleable and multiple. Focusing upon the social aspects of the interaction between the interviewee and interviewer does not mean that reality is completely fluid, but accepts that a respondent's situation imposes limits on the ability of each participant to manoeuvre. For instance, whilst all the Zimbabwean students recounted the experience of 'boarding school' some had a positive experience of separation from family, and some had a profoundly negative experience. However, all the students achieved the end result of acquiring 'A' level standard education. A narrative approach emphasizes the subjective negotiation between the individual and their situation without being counter factual (Atkinson, 1998).

A narrative analysis can be thought of as having a triangular structure whereby one apex is formed by the respondent with their pre-existing subjective view of reality. The second apex is the researcher with an agenda of research interests and goals, and the third apex is the responses to the interviewer's questions (Rosenthal, 1993).
The manner in which the respondent frames a response to a question is determined by how they see the researcher and the effect they calculate their response to have. The researcher, a senior lecturer in the School of Nursing was well known to the students; therefore their responses were cast with regard to their perception of this role in relation to themselves. For example, all the students discussed encounters with racism in the School of Nursing and the NHS and appeared to have developed coping strategies for dealing with this. However, their discussions would have been tempered by knowledge of the role of the researcher within the organisation. Miller (2000: 131) terms this a 'double hermeneutic' and suggests the same phenomenon applies to the researcher who frames questions with regard to a perception of what the respondent is capable of providing. It was anticipated that students would talk about education, family life in Zimbabwe, and life in the UK, but not about racism in the School of Nursing or in the NHS. The fact they did necessitated investigation within the context of the life history interviews and became the subject of further analysis.
Just as the respondent has a subjective awareness of their social situation in relation to the researcher's position, the researcher evaluates the respondents' answers in the knowledge that this phenomenon has taken place. The researcher then filters the data through a mesh of perceptions, engaging in 'objective hermeneutics' (Miller, 2000: 131). This stage is claimed to be 'objective' since the analysis proceeds on a step by step basis and 'hermeneutic' since the researcher is aware that any material produced by the respondent is generated with regard to the perceived situation, a perception of the researcher and the relationship between the two (Miller, 2000: 131).

The practicalities of narrative analysis require first the construction of a biographical life history. Details were collected about the Zimbabwean students in relation to age, gender, and place of birth in Zimbabwe. Next, information was gathered regarding the sequence of events in Zimbabwe and the UK. This included schools attended, educational attainment, employment, thinking about nursing, coming to the UK, life in the present moment at University, and plans for the future on completion of nurse education. Collection of factual data is used to clarify and order temporal sequence and arrange it in chronological order (Rosenthal and Bar-On, 1992).

The second stage is concerned with thematic field analysis. The respondent chooses areas for discussion and the manner in which these are to be related to the researcher during the course of the interview. The issue here is one of memory, which is notoriously selective. Much salient material may not be recalled due to the course the questioning takes, or by being simply forgotten. In addition, the facts recalled may be wrong, warped by social prohibitions or reinterpreted due to intervening events (Miller, 2000). The purpose of the analysis of the narrated life story is the
reconstruction of the present meaning of the experience. The present perspective determines what the subject considers biographically relevant, how themes are developed and links made between various experiences, and how past, present, or anticipated future realities influence personal interpretation of the meaning of life (Rosenthal, 1993). Zimbabwean students described factual events, narrated actual or fictitious occurrences that linked factual events in a sequence; then augmented their interpretations with a particular viewpoint. For example, when discussing the rising cost of education and the implications of this for parents, students referred to the onset of socio-economic decline in Zimbabwe. This was followed by their opinions on the current political situation in relation to Robert Mugabe’s Government.

The combination of realist analysis, which allows identification of broad themes followed by sub categorisation, and narrative analysis which takes into account the subjective nature of life history work and the relationship between interviewee and interviewer provided for detailed data analysis. Findings from the study are presented in the next three chapters beginning with Life in Zimbabwe.

**Ethical Issues**

Everything that takes place during a life history interview, from what the interviewee is told about the purpose and process of the study, to what happens to the data and who has access to it, has ethical implications (Jackson, 1987). This section considers the researcher’s role as a life story interviewer, and the respondent’s position during the interview.
The researcher's role in life history research

The role of the researcher in a life history project is to protect the rights of the storyteller (Atkinson, 1998), therefore the proposed study was presented to the School of Nursing and Midwifery Research Ethics Sub Committee. The committee were concerned to know the proposed outcomes of the study, the research design, the rationale for the study sample and details of intentions in respect of the findings. Of most importance however, given the research methodology, were the details regarding arrangements for the participation of human subjects, including recruitment, consent and confidentiality procedures. The committee were informed that recruitment to the study would involve contacting potential subjects by telephone, followed by a letter containing full details of the study and a consent form (Atkinson, 1998). Each participant would be assured complete confidentiality and anonymity (Cormack, 1996) (Appendix One). In addition, participating students would be given a detailed information sheet explaining methods for recording the interview, transcribing and analysing the data, and for storing the data on completion of the study (Appendix Two).

The respondent's role in life history research

The respondent cannot be an uninterested participant in life history research having a more exposed position than the researcher (Miller, 2000). Life history interviewing can be invasive, with the possibility of old hurts and traumas being reopened, especially since this study required students to talk about life in Zimbabwe, in the UK, and future plans on completion of the course. The potential to encounter psychological pitfalls was a major consideration given the current difficulties faced by Zimbabwean people. In order to minimise any possible trauma, each interview began
with an explanation of the interview process and the line of inquiry. Students were told that an essential quality within life history work is respect for the interviewee, which includes flexibility in response to their conversations. It was important to assure students that understanding and sympathy would be expressed for their viewpoint regarding Zimbabwe, however that was expressed, and that the researcher would sit quietly and listen (Thompson, 1988). Care was taken to close the interview relationship by giving students the means to contact the researcher at a later date if there were concerns about the data or the progress of the research project.

This chapter has reviewed the methodology and methods of data collection used in the study. Life history has been justified as a suitable approach for examining the lived experience of Zimbabwean nursing students. Issues of generalisability, internal validity, and reliability within the method have been addressed. Sampling and data analysis were considered and the chapter concluded by addressing the ethical issues arising from a study of this kind.

The following chapters present the findings from nine life history interviews undertaken with students currently studying the Diploma in Higher Education nursing programme. A tenth interview was conducted with the student who was the subject of the 'chance encounter' who has since qualified as a registered practitioner and is now working in the NHS.
Chapter Four: Life in Zimbabwe

Introduction

The following three chapters present the findings from ten life history interviews conducted between February and June 2003. Nine life history interviews were conducted with students currently studying in the School of Nursing and Midwifery. The tenth interview being conducted with the student who provided the impetus for the study.

The data from each life history was read many times in order for the values that appeared to have the greatest influence on the students’ lives to be identified and themes to be developed (Atkinson, 1998). Data is presented under the themes of Life in Zimbabwe, Life in the UK, and Plans for the future. Within these themes the findings are sub divided to reflect the researcher’s initial interpretation. A commentary, which is a combination of the theoretical and interpretive, is provided as explanation and annotation to the students’ life histories, drawing attention to the text of the stories themselves (Atkinson, 1998). The first in this series of chapters discusses life in Zimbabwe. The life history subjects talk about education, family, language, nursing, politics, and HIV/AIDS.

Life in Zimbabwe

All the life history subjects talked about life in Zimbabwe. However, their conversations centred on a number of different areas, which reflected the relative importance of certain life events. The first of these relates to their educational experience. Analysis of data concerned with education is grouped under the following
themes: experience of separation from family in relation to the boarding school system, the importance of education in relation to family expectations and achievement of desired social position, and the spiralling cost of education, and subsequent employment prospects, which has served to drive the students overseas.

**Education – "I just never really stayed at home"**

The life history subjects talked in detail about their school life. Without exception this was achieved through attendance at predominantly catholic 'boarding schools'. This system, which is a legacy of colonialism, continues to flourish in Zimbabwe (Golby, 1995), and is based on a Western model. This model is seen very much as a necessary condition for modernisation and has been assumed to be a solution to the problems of allegedly 'backward' traditional ideologies and stereotypes (Odora, 1996). The experience of 'boarding school' was seen by the students as both positive and negative. Seven students attached importance to being away from distractions, such as family and siblings, and outside influences. The view taken was that boarding schools provided a more concentrated atmosphere, conducive to study and educational achievement. In addition, the students held that a better standard of education, albeit at the expense of being separated from family and friends, was obtained through attendance at boarding school.

"My mum preferred us to go to boarding school because it was the only way to read and study. I think it was the best and I think it helped because all of my sisters passed their O levels."

(Student 9)

"The school system is that most people go to boarding school. I was in boarding school since I was in year 3. I was about eight. I was there from a really young age right up to until I was 17 and in my second year doing my A levels. In primary school I went to a boarding school that was very near to home, it was about 40 kilometres, so it was really near and my
While accepting an educational system in which boarding school was seen as the norm, students struggled with separation from parents who in general were only allowed to collect their children each weekend if the school was relatively close to home and the children were of a young age. For other students, their families were not able to collect or visit them as often as they would have liked, due to geographical location.

"I came home and saw my parents just in the holidays, not at weekends. Some weekends in High School it had to be, exit weekends, just like the half term we have here, that’s when we would go home and in the holidays and some weekends, but we were not allowed to go home that often because the school system was if you keep going home and coming back then you have to choose whether you want to be in day school or boarding school, so you really don’t have an option, but I wanted to go home all the time." (Student 2)

Exit weekends are used by the Zimbabwean students to denote weekends during term time when they are allowed to go home. The phrase could well be a corruption of ‘exeat’, a word in common usage in the English public school system to denote given weekends during term time when boarders are allowed to go home. In Zimbabwe, exeat is used in a similar way in the general education system. Indeed, a recent report on political violence in Zimbabwe suggested that school authorities were using exeat weekends when children were away from the premises to engage in party politics (Zimbabwe Human Rights NGO Forum, 2003).

In addition to limited visits from family, there was also the possibility that the students would not ‘fit in’ or ‘be liked’ by other pupils at the school. The pupils’
activities were closely monitored and telephone calls to family and friends were limited. It would seem that the boarding school system is based on an autocratic model (Meighan, 1992) whereby decisions are made without consulting the students, in an atmosphere dominated by rules and regulations.

"It was a catholic school, very strict. We were not even allowed to make phone calls to boyfriends or whoever, you had to say you were phoning your parents and the receptionist would actually make the phone call for you and make sure you were actually phoning home, that was just an example of how strict it was. So, you couldn't be naughty or anything."
(Student 2)

The implications of this type of education for students who later choose to study overseas are far reaching. On the one hand separation from family at an early age may well have fostered independence in the pupils; but the autocratic atmosphere in which the education was delivered would do little to encourage autonomy and to foster decision-making skills. International nursing students face many difficulties when studying in the UK, not least financial problems, accommodation difficulties, communication barriers and racism (Gerrish et al, 1996). It could be argued that the system of sending children away to board at school does little to equip them with the necessary life skills needed to face future challenges overseas. Furthermore, the traditional extended family system, a feature of pre-colonialism, has been eroded by urbanisation, industrialisation, and economic hardship (Musengeyi, 1996).

Historically, this system removed children from their families and delivered them into the hands of a bureaucratic, domineering institution, albeit in the name of education. Although all the students recognised the importance of education as a means of achieving social status and independence, being removed from home and sent away to school proved to be a traumatic experience.
"I missed my home, my mum, my sisters and my young brother -- and I didn't like it, it was terrible. I didn't get bullied or anything like that but I just didn't like it, being away from home and it's three months at school. It was difficult in the beginning. At six years old I was used to staying at home with my parents and having everybody around and I had to go to school with all the rules and possibly people who maybe didn't like you." 

(Student 8)

A further feature of the students' educational experience was the connection between a so-called 'good' education and the capacity for students to obtain white collar work, namely employment in health, teaching and the civil service. These white collar jobs were seen as both desirable and essential for any kind of comfortable life, or to put it bluntly, the difference between being a maid and having a maid.

"I think generally Zimbabweans, they like feeling good about their job and most people like white collar jobs rather than any other jobs, so most aim for white collar jobs. A long time ago, like our fathers, they used to view teaching, nursing, teaching medicine and maybe doctors as being the only jobs and you would hear them saying they wanted their child to be a teacher, they didn't know about any other job. So, most people are teachers, doctors, nurses or secretaries, in Zimbabwe. Most people go to University." 

(Student 1)

In general, all the life history subjects accepted the boarding school system as being the best way to gain an education. Those students who expanded on the topic appeared to suggest that being sent away from home and family was normal if somewhat unpalatable. The fact that they were not particularly happy whilst away at school was seen as a fact of life and one which had to be accepted in order to fulfil family expectations and to secure employment in white collar jobs. The students felt they didn't really have a choice in a country where children are presented with Western patriarchal ideologies and stereotypes, which they are taught are superior to indigenous ones and will lead to development (Odora, 1996).
The general consensus is summed up by one student who said "Boarding school is the best education, you get the discipline, you also get an environmental learning and a sense of community, you don't pick children up like you do here and that is very distracting". The student refers here to the idea that as a day student in Zimbabwe, daily returns home present a distraction, whereas the all-encompassing experience of boarding school represents pure education without diversion. This suggests that the 'norm' of nursing education in the UK, of a daily return home to lodgings, friends and other Zimbabwean students might be experienced as an unfamiliar distraction and one which they may require some support to adapt to.

Whilst it is clear historically why the boarding school system dominates in Zimbabwe, students' attitude towards it requires further analysis. The system is based on an authoritarian ideology of education, in which the government is dominant and the people are dependent. The system is autocratic in the sense that order is imposed through fear, which is both physical and psychological (Meighan, 1992). Students are indoctrinated to view education as the key to social success and financial security, in other words life chances (Reading, 1977). Government policy which had, before independence, differentiated between education which allowed school leavers to eke out an existence or lead to the prospect of white collar work perpetuated the belief that the only way out of a life of poverty was through education. This pervasive attitude ("you aim high and you live happily") led students to accept separation from family at an early age as the norm and indeed to regard such separation necessary in order to achieve a minimum 'A' level standard. All the life history subjects harboured the expectation of continuing on to a university education. However, it is clear that this is becoming more difficult as the economic situation in Zimbabwe worsens. The
ramifications of this for students who have been indoctrinated with the belief that to
do well necessitates continuing education, is that the majority of young people in
Zimbabwe are looking to overseas universities in order to fulfil their ambitions.

"Over half go to University. These days it's just a general
feeling that most people don't get what they wanted at O
Level, so nearly everyone is trying to go to University. If they
have better grades then they try to go to University."
(Student 4)

The introduction of school fees, and large increases in exam fees; a by product of
devaluation of the Zimbabwean dollar, was an issue for all the students, especially
since the cost of schooling in Zimbabwe has risen at a time when incomes are being
eroded. Despite this, evidence suggests that education, albeit based on Western
models, continues to be seen in Zimbabwe as a necessary condition for modernisation
(Gordon, 1996). Six students commented on the expense of education in Zimbabwe
and the sacrifices their parents had made in order to ensure that they were able to
attend school.

"All the way through you have to pay for your education and
every school has a uniform so you have got to buy the uniform
and pay the fees as well from grade 1 up to grade 7, then you
can go to secondary education". Boarding schools are very
expensive, you have to be at a sort of level or you can
negotiate with the missionaries to pay your fees or pay them
later."
(Student 8)

The economic situation in Zimbabwe and subsequent rising cost of education has
resulted in difficulties for some students in fulfilling their ambitions and the
expectations of their families, thus creating push and pull factors. On the one hand
students referred to traumatic separation from family and friends, whilst on the other
hand recognising that study overseas is the way forward in securing their education.

This begs the question of whether it is the desire for education per se rather than nursing as a career, which is driving the students overseas.

"I did my education in Zimbabwe from grade 1 up to my A levels. Unfortunately I couldn't proceed in Zimbabwe because of financial problems. I believe that a lot of people now just stay at home and are doing nothing with their 5 or more O Levels because they can't afford to go into teaching, or nursing or anywhere. So, most people are trying to go to other countries to use their education. I think that there are teachers and nurses coming to England." (Student 7)

It is not always the case that students viewed education as the means to an end.

Where students' families were financially secure, education was seen as a commodity and one which enabled the family to 'buy' loyalty from the student. The payment of fees was used as a bartering tool in order to entice the student into the family business.

"My parents asked me before the O Levels, what do you really want to do? If you pass, do you want to go on to do your A Levels or what are you going to do, because you have never talked about it. I said that I would just do the A Levels and then decide because I didn't have any focus at all. I just went to school because they paid the fees. School was where we went to grow up, because I knew that one day I would join dad's company. So did everybody who went into that school. The parents knew each other through business so whenever they came to visit it would be more networking. So you would get to know all of that. So I started form 1 at 13. I went on quite fine. We had GCSE's which is the junior certificate in form 2 when you are 14. You have to pass them so you don't get into trouble but it's not like if you fail them you are not going to proceed. You proceed still but the chances are that when you pass them, there are already companies and so on who are already to see students like, if you are good at rugby, you are already spotted at a young age, they start to recruit from them." (Student 5)
This attitude, contrary to the experience of other life history subjects, meant that payment for education ensured attendance at school; a return on the investment. This student’s socio-economic status ensured that education received equated to a private education in the UK. The student referred to the way education had been used as a means of ensuring he remained in the family business. However, the student rebelled against what arguably was a privileged education, choosing instead to go against the wishes of the family and pursue a career as a teacher in a rural part of Zimbabwe.

The implications of using education in this way, in other words to socialise the student into the family business, is redolent of a structural functionalist view of society, in which the activity of school is in training the child to fit into some necessary slot in a relatively harmonious society (Meighan, 1992). However, in societies where forces mitigate against harmony, as in Zimbabwe, people adopt different cultural values which emphasise individualism, resulting in the erosion of values such as sharing and consultation amongst families (Musengeyi, 1996).

In concluding the discussion regarding the educational experience of the life history subjects, attention needs to be paid to the socio-economic situation in Zimbabwe, which has had a direct impact on the state of the nation’s health. Life expectancy in Zimbabwe has dramatically decreased due to the HIV/AIDS pandemic (Barnett and Whiteside, 2002). The average length of working life has decreased along with the capacity for the people of Zimbabwe to sustain their families. Among the many consequences of this is the inability of families to pay for their children’s education. One student commented “My mother and father passed away along time ago. So I was living with my aunt. The fees were too much, she had other children to send to
University, and so it was very difficult”. The ramifications of illness and death within this student’s life were clearly being felt by the wider family. The long term implications of HIV/AIDS are discussed later in this thesis.

Educational life chances are related to a variety of factors, not least socio-economic status, which in the case of Zimbabwe now determines whether people can access education. The rising cost of education means that those students whose families were once able to afford school fees are now struggling to do so. In the course of writing this thesis, one of the life history interviewees, has left the course for non-payment of fees. This student, whose family owned a business and had previously had the means to pay for tuition fees and accommodation in the UK, now find themselves in a position of needing the student to return home in order to work and supplement the family income. The life chances of this student are now seriously curtailed. Where once the view was that the educational life chances of middle-class children are better that those of working-class children (Meighan, 1992), in Zimbabwe at least, the trend is for the life chances of all people to be adversely affected, irrespective of social class and related socio-economic status. The economic down turn in Zimbabwe appears to be a social leveller. The life history subjects experienced separation from home and family throughout their childhood in the hope of securing future prosperity. The changing face of Zimbabwe during their lifetime questions whether their childhood has been bought at too high a price.

"It was interesting – I hated it the first day but when I had finished my O levels I had a choice to go back to boarding school or day school. I actually opted to go to a boarding school because I had got used to it. I had been away from home since the age of 13. I just never really stayed at home."

(Student 3)
Alongside education the students talked about family life, including the way in which relationships within families affected their life course, the 'duty of care' within Zimbabwean families, and roles and responsibilities within the family. The next section draws together the students' thoughts in relation to these issues.

Family Life – “Everything I have I owe to her”

Eight life history subjects referred to the role of family in their every day lives. In doing so emphasis was placed on the psychological, emotional and financial aspects, making family a central component of their life histories. Although there is increasing evidence that the traditional extended family system is being eroded in Zimbabwe (Musengeyi, 1996), the students discussed the close family ties that exist and the burden this sometimes placed upon them in relation to providing ongoing support for ageing parents whilst exercising autonomy over their own lives.

“All I know is this existence and my friends and my mum and dad. Every month a load of us would go to the farm with our kids just to see how our mum and dad are and we would spend the night if we want. We would take money, groceries; each child pays so much towards the upkeep of our parents. In our culture we have domestic workers and there are some that do for the animals and then for the planting so every child has something. When I send the money for fees I have to send the money for that as well, it’s just the way we brought up, they tell us that we have to keep the family together, we have to look after our brothers and sisters and their kids. When I hear my brother’s child has been bad I can’t sleep, I have to do something and they love you so much you just feel like loving them back, there isn’t a lot of fighting. I think it’s because the father, we just cannot do something wrong and when you do something wrong, try and break away from the family, the whole family closes in so you can’t. My family think I’ve done the most outrageous things like my job and coming to England, but they still support me. My mum writes letters to me, which make me cry sometimes.”

(Student 4)
The students experienced a tension between fulfilling a duty towards their families and the desire to achieve a better life for themselves. Urbanisation, industrialisation, economic hardships, adoption of Western values and widening of socio-economic gaps are disrupting family life and encouraging the youth of Zimbabwe to migrate to urban areas in search of employment (Mupedziswa, 1996). These factors, along with the education for all policy, which has ensured that most people have educational qualifications has brought conflict to a once traditional close knit society. As the economic crisis deepens, the youth of Zimbabwe are not only looking to migrate to urban areas, but are leaving the country in search of opportunity overseas. However, on coming to the UK the students experience a culture shock in that they are entirely used to having domestic help in the home:

"I don't know where it came from, but in Zimbabwe everybody, working class, we've got maids. That's the most difficult thing, everyone who is working has a maid. I know it's maybe abusing them but the maid is responsible for the housework and all the other things, so you basically do nothing and when you come home from work you find a cup of tea there and with everything done. So I think we're used to that, so when we came here we found it a bit difficult to do everything by ourselves." (Student 4)

There is the possibility that Zimbabwean students, in conversation with UK students, teachers and practitioners may discuss what for them is normal custom and practice in their own country. However, having access to domestic help, especially for a student in receipt of a bursary, would be considered a luxury not a necessity in the UK. This may be one reason why students from Zimbabwe feel ostracised and alienated within a UK workforce, where women in particular are used to working long hours before going home to look after their families.
Another interesting feature of the students’ conversations was the perception that the care of elderly people is not as good in the UK as in Zimbabwe, which is contrary to the view taken towards the general provision of health care, which is seen to be much better in the UK than in Zimbabwe. The students believed care of older people, to be the duty of families and not of Government.

“I would never put my mum in a home, I can’t agree with that, because in our culture if your mum cannot work or cannot take care of herself, one of the family members would have to give up work and go and care for them. Everything I have I owe to her. If I’m the one elected to take care of the parent and I still want to work, I would do, I would get a domestic in but I would be there every day. I would know if they washed, or what they were eating, no body would do the washing for them, I would.” (Student 4)

The implication here is that Zimbabwean culture demands that families support each other. This student indicated very clearly an unwillingness to hand over care to outside agencies. The expectation is that family members provide support; physically, emotionally and financially, during periods of illness. In other words ‘a duty of care’ is owed within families. In addition to strong family ties, students find difficulty accepting a system that does not appear to value its older people in the same way:

“One thing I don’t understand here is the way young people treat old people. It doesn’t make sense to me, but I put it down to the culture. I don’t know if it’s the money or the way they are brought up.” (Student 6)

The fact that students find difficulty accepting a culture, whereby government and not family is expected to take responsibility for the old and sick is an interesting one, given that the health of the Zimbabwean people is deteriorating rapidly. At the same time Zimbabwe is experiencing a dearth of young people to provide care. This study has shown that the youth of Zimbabwe are leaving the country to seek opportunities.
elsewhere due to the need to secure an education, and the opportunity to live and work in a more stable environment. The implications for students of living and working in a country whose government remains committed to a National Health Service that provides care on the basis of need to the whole population (Fatchett, 1998) are that many will choose not to return home on completion of the course. The Zimbabwean diaspora, which already includes 600,000 people living in the UK (Summers, 2003) looks set to continue.

The decline in the fortunes of the Zimbabwean people may go some way to explaining the actions of family members in relation to financial security. One life history subject recounted a harrowing tale whereby her husband had been killed and after receiving the news the deceased’s family did not support her through her grief, but rather took her possessions and left her destitute.

“I've got two children, I had three children but my first one died, she was actually disabled, she died in 1993. Then I was with my husband, who was an aircraft engineer, he used to work in the air force and then worked in the United States of America. So when he came back home for holidays, he was crushed by a bus on his way back home. Somebody told me that my husband was dead. I couldn't cope with it. The police came to my house, and I was sleeping, and they asked me to wake up. I got up and I asked them what was wrong and they said that there had been an accident, would you come with us to the hospital. I said for what, and they said that the nurse wanted to see me, and I said, no I'm not going to the hospital, if he's dead then tell me, and they told me. It was so hard after that, they took everything that belonged to my husband and left nothing.” (Student 1)

This traumatic experience serves to further highlight the changing nature of Zimbabwean society. Musengeyi (1996) talks at length about the ways in which socio-economic gaps are serving to erode society and impact on changing beliefs and
values. He argues that economic hardships are causing families to disintegrate, to avoid the extended family, and of families not wanting their addresses to be known to their relatives. The impact of this change in cultural attitude may be that future students coming to the UK will not return home to Zimbabwe.

Language – “Everything is in English”

The life history subjects referred to the powerful role of the English language in their lives in spite of the fact that the indigenous languages of the Shona and Ndebele people are still considered to be first languages.

“Shona is my first language, but you learn English as well at school. You are not allowed to speak Shona in school in Zimbabwe. I went to a group A school, which started off when the white people came, so especially in primary school there were loads of white children and then if you could afford it you could go to them. We were not allowed to speak Shona in those schools but the other schools speak Shona all the time. When I went to a mission school, it was English all round and by now everyone is supposed to speak English in school anyway and you write the subjects in English.” (Student 2)

Africa, particularly Sub-Saharan Africa, is probably the most linguistically complex area of the world, if population is measured against languages (Spencer, 1985). However, it is the colonial languages that have enjoyed pride of place in formal education in Africa (Bunyi, 1999). African societies have always been multilingual. However, since independence in Zimbabwe, English is recorded as the official language, followed by Shona and Sindebele (the language of the Ndebele). English is a pre requisite for studying at the University of Zimbabwe and is spoken in all schools in spite of the view with regard to education in indigenous languages, that the best medium for teaching a child is his mother tongue (UNESCO, 1953:11). However, in spite of the fact that all Zimbabwean students spoke English as a matter of course,
they identified communication barriers when in lectures and in clinical practice and appeared surprised that in spite of the global dominance of English (Bradby, 2001) difficulties were experienced.

"So, when we work everything is in English, although I find it really difficult, the way we pronounce words, it's difficult. When we are talking here, people keep saying 'what did you say'. But everyone in Zimbabwe, nearly everyone who has been to school, can speak a bit of English." (Student 1)

When the student, lecturer or practitioners are English-speaking it is assumed that there are no barriers to communication. However, the meaning of words also depends on social, cultural and historical traditions (Schulte, 1996). The interpretation of the same words can vary and this may coincide with religious, ethnic or other cultural divisions within a single language group (Bradby, 2001). This phenomenon became apparent through conversations with the Zimbabwean students who identified the tensions between the Shona and Ndebele people. The majority of interviewees were of Shona descent, with two students being Ndebele. This reflects the general ratio in Zimbabwean society of 82% – 14%.

"Basically, the South west going on to Botswana, that's Ndebele. We shun people who speak Shona. We shun people who speak Shona because we are the minority population, we will always be stepped on, we never get anything, if the government decides to put any money out it goes to Shona people." (Student 5)

The conversations revealed that whilst English is the official language, this serves to mask the real tensions that exist between the ethnic groups of the Shona and Ndebele. Two Ndebele students clearly felt that Shona people have a better standard of living, more ready access to support systems, more financial aid, and are awarded prestigious
contracts based on belonging to the 'right' political party, a justifiable comment since
Zimbabwe is under the control of a predominantly Shona Government.

"The contracts were given to certain people. That's the way
the Zimbabwe line has always been. Money only goes to
where money is." (Student 5)

Just as religion is said to be an important marker for local, regional or national
identity (Moore et al, 1997), so too is language. In the case of Zimbabwean students
who without exception speak English, the danger lies in assuming they are all the
same, when in fact they may belong to different ethnic groups with very different
attitudes, values and beliefs. Communication between students, lecturers and
practitioners can be compromised much as it can between nurses and patients. This is
compounded when varieties of the same language, and different vocabularies or
accents are not recognised when it is assumed that the group in question are the same.

The implications for UK universities include the need to offer support to overseas
students that reflects their specific needs and not that based on an assumption of what
their needs might be, based on a predetermined idea of the group in question.

Nursing — "When you go to the UK, the nursing is more advanced"

The life history subjects discussed thinking about the option of studying nursing as a
career, whilst they were living in Zimbabwe. However, their reasons varied and can
be broadly associated with dissatisfaction with their current job or prospects, or
related to nursing being 'in the family'. The end result for all the students was to
study nursing in the UK, and not in Zimbabwe. One student in particular, saw nursing
as a way out of what was perceived to be an unsatisfactory job with few career
prospects. The student had been an aircraft instrument technician and had risen to the
rank of supervisor within the organisation. However, after being in the post for five years she felt the chances of progression were limited because she was a woman;

"As you may realise, it is a very responsible job because you have people's lives at stake. I had been in that post for five years and I could see that I wasn't going anywhere considering I am a women. I have done a job which is primarily a man's job and the guy who was above me was only three years older than me, there was no way I was going anywhere."  (Student 4)

The status and role of women are among the least understood aspects of African traditional social organisation, in part because there are no contemporary written studies before the arrival of Europeans (Owomoyela, 2002). In Zimbabwe, women's inferior status is attributed to several factors. First, men present the parents of the bride with a gift (lobola) as part of the marriage ceremony. Second, women leave the home and become part of their husband's family after marriage. Third, men own and control land and therefore the means of production. Finally, women have limited legal rights and minimal participation in political and religious institutions (Muchena, 1984). Although in traditional Zimbabwean society men and women have well defined roles, this is not to say that women are not interested in trying to resist the limitations this type of thinking imposes on them (Nair, 1995). Most subjects were disgusted with the status of women in the family.

The student's response to her experience of sex discrimination was to think of another career option but one which would enable her to continue to support her children financially. The student reported reading an advert in a Zimbabwean newspaper for nursing in the UK;
"They were in the Zimbabwe Herald. The adverts just said that if you wanted to train in the UK and I was fascinated with that. I got interested and then I discovered that all they do is send you to go through NMAS (Nursing and Midwifery Admissions Service)." 

(Student 4)

It seems clear that nursing as a career was not the student’s first choice but came about as a response to discrimination in the workplace based on gender, a fact which is consistent with the traditional view regarding women’s place in Zimbabwean society. The fact that the UK was at the time actively recruiting to nurse training from Zimbabwe, so much so that potential candidates were given information regarding the UK admissions system, serves to highlight the current problems in recruiting and retaining nurses within the NHS (Mills, 1998). It is reported that thirteen thousand overseas nurses were granted permission to work in Britain to the year ending in March 2003; nearly half the total number who joined the UK nursing register (Revill, 2003). This is at a time when Zimbabwe has been forced to recruit three hundred nurses from Tanzania. The consequences of a successful overseas recruitment campaign on behalf of the NHS are such that Zimbabwe is now faced with having to run its own overseas recruitment programme, in order to meet an acute shortage of medical personnel, including nurses (Kithama, 1998).

In addition to dissatisfaction with life in Zimbabwe, the life history subjects discussed the role that family played in the decision to study nursing in the UK. Six students referred to discussions with siblings about how to apply and what to expect on arrival in the UK.

"My sister is a nurse. So she was telling me about the opportunities in the United Kingdom and I wanted to do nursing, so that’s when I stated to think about coming here."

(Student 6)
"I thought about nursing because I've got a brother that's here, and he's the one person in my family that I really like and I look up to him lot." (Student 2)

"My brother was doing mental health nursing. My sister said that you could do children's nursing, or adult of mental health. I though I couldn't do children's or adults because it's all medical stuff, all these sick people in bed because I had a very sick childhood. So I couldn't cope with the psychological part. As a child I spent a long time in hospital." (Student 8)

Further exploration with the students revealed that none of them considered studying nursing in Zimbabwe to be a viable option, for reasons of limited access to nursing courses in Zimbabwe and the fact that, upon qualification as a nurse, opportunities to progress are limited. In addition, students indicated that the available health care technology in Zimbabwe does not compare well with that in the UK.

"It's difficult. If you don't know anyone who is big in the nursing world, you don't get in or some people just get in because they are lucky. Some people get in because they have good grades, but some people get it through the back door. I applied to several towns and didn't get anywhere. This one was the first one where I got a positive response, so I took it up." (Student 9)

"Of course if I did it in Zimbabwe I would be five or ten years upgrading myself and it would take a long time to become a senior nurse and to do something else." (Student 3)

"I thought it was more advanced, people used to say back home, when you go to the UK the nursing is more advanced, it's not like here, they have more machines than we have. So I wanted to experience this and see how it was." (Student 7)

Whilst it is clear that the life history subjects could justify their decision to study nursing in the UK as opposed to Zimbabwe, their explanations require further analysis. The ten year National Health Strategy for Zimbabwe (Zimbabwe Ministry of Health and Child Welfare, 1999) and the Zimbabwe Patients Charter (Zimbabwe Ministry of Health and Child Welfare and Consumer Council of Zimbabwe, 1996)
provide the overall framework for the health care delivery system within which
nursing is considered to be an integral part (Mapanga and Mapanga, 2003). Courses
leading to a BSc in Nursing, a post basic diploma in Nursing, a post basic BSc in
Nursing, and MSc in Nursing and a PhD in Nursing are all offered in Zimbabwe. The
minimum entry requirement onto a basic diploma in nursing programme is the
General Certificate of Education at Ordinary level plus passes of A to C grades in at
least five subjects, including English and a science. These entry requirements are
comparable to those required for entry onto a UK nursing diploma, and are certainly
not beyond the reach of potential Zimbabwean nursing students, given the fact that
most Zimbabweans achieve ‘A’ level standard education. This begs the question of
why students are choosing to study nursing in the UK when they could access a
comparable nurse education in Zimbabwe. The life history students provided some
possible answers when discussing the experiences of family members who had
suffered ill health and whose experience of health care in Zimbabwe had been, in their
view inadequate:

“I'm not sure what he died from, he had some kind of chest
infection, but he died within a week of diagnosis. I don't think
the health system is as good as here anyway, so they probably
didn't look into it properly. He was about 33 or 34.”
(Student 2)

“When I left in December he had been complaining of chest
pain and then they diagnosed him as having TB but there were
no drugs so he died.”
(Student 4)

The issue of poor quality health care is further compounded in that what is available
has, for the most part, to be paid for.

“It's private, you have to pay for it. There are people within a
certain level like domestic workers, general hands, they don’t
pay for their medical fees, the government pays for that but if
you are working, if you earn that much, you have to pay.
Well, my kids get some of the bursary. My son gets something and my daughter. So I send the money for their school fees and medical fees. You don’t get any cover if you are not on medical aid because it’s so expensive.” (Student 4)

Zimbabwe is currently in its fifth successive year of economic decline. The country faces critical shortages of foreign exchange, inflation has reached 364% and is forecast to reach over 500% by the end of the year 2003 (UN Office for the Co-ordination of Humanitarian Affairs, 10th October, 2003). The consequences of economic decline on the country’s health service have been catastrophic. Many hospitals are shabby, with broken windows and leaking pipes, badly in need of medicines, equipment and medical supplies. Hospital pharmacies are poorly stocked, and when drugs are available patients are unable to afford them (IRIN, 2003). The implications of a failing health service are that Zimbabwe is losing potential students to the UK, in spite of the fact that Zimbabwean universities still offer nursing degrees and diplomas comparable to those offered in other countries.

Politics – “People in the UK haven’t got the full story”

Eight Zimbabwean students implied that the current political situation in Zimbabwe influenced their decision to leave the country. Their comments ranged from open hostility towards the current Government, to an apparent acceptance of the prevailing political situation.

“My parents think, what we have always grown up to think, is to live for the day, don’t worry about what’s going to happen tomorrow or what has happened in the past.” (Student 2)

In contrast, one student, whose father owned a successful business, talked in detail about the corrupt nature of Mugabe’s Government. The student discussed the price his father had paid in order to support the family, suggesting that the method for
securing business contracts was not always legitimate and depended in part on being a member of the right political party. Interestingly, in spite of an obvious distaste for the Government, the student was no more predisposed towards the opposing Movement for Democratic Change (MDC) party led by Morgan Tsvangirai

"Tsvangirai is just a man on the street, who probably doesn't have very good motives. He's just trying to put money in his own pocket - all he was, was a trade union leader. That was it and at that time we just needed someone who could talk and who wasn't afraid. I would have voted for him just to get Mugabe out. Tsvangirai doesn't have any business sense - he can be manipulated. When I talk to people here (in the UK), we have very different perspectives. What they see on TV is not really what happens on the ground. I can sit down and actually hear how people are planning and what is really happening behind the whole scene. You would probably find out that my dad is with them and the only reason he is going to do that is so that he can make money. He still has to pay fees for my little sister-and the only way to make money is to be where the money's at. It's a bit political-even though you might not follow it, that's what it boils down to. So I was running away from all that. I had been brought up in it and have seen a lot of things that I didn't really agree with, so I wasn't happy with it. So I started applying for Universities in England."

(Student 5)

Political patronage and corruption is spawning the growth of a rich and crooked business elite, described by Professor Hawkins, Head of the University of Zimbabwe's graduate School of Management, as the "crony capitalists" of President Robert Mugabe's regime (Dempster, 2003). The effect this appears to be having on the life history subjects is to fuel their desire to leave Zimbabwe, in spite of the fact that some of them have escaped poverty and have led relatively comfortable lives.

"I can't say that I am struggling because I know of some people who are really struggling and I think I'm really lucky. I don't know how they are coping."

(Student 2)

Those students who appeared to have suffered most under the present regime had lived in rural areas of Zimbabwe, where economic hardship has been most widely
experienced, for example one student commented "Things were getting a bit tight though because some of the farmers couldn't get things." This is due in part to the land resettlement programme itself, which by placing people on land over which they have no right of individual ownership and expecting them to grow food for the collective, with inadequate water, seed and fertilizer, has always been the worst form of farming imaginable (Meredith, 2003). The beneficiaries of Mugabe’s land reform programme have usually ended up poorer than they had been at the start. In spite of this, one student commented that it is the rural workers in Zimbabwe that continue to provide the most support for the Government.

"It's unfortunate that I have not participated in the politics but when I came from Zimbabwe most teachers were denouncing this present Government and there was a feeling that how things were out there, the teachers were the victims of this political unrest. The Government has a lot of support in the rural areas where the people are and they don't know anything and they are all staunch supporters of the government." (Student 1)

A note of cynicism can be detected in the voice of one student, who, whilst talking about the political situation in Zimbabwe, suggested that the outside world does not fully understand the complexities of the situation.

"Well, to start off with the people in the UK haven't got the full story. To know the full story you would have to be in Zimbabwe to understand the situation. The thing is that our government have sought to redress the colonial injustices in equity with a land reform and resettlement programme that would affect economic and social justice because Zimbabwe is a colony, so the land is the economy. So our government has sought to do that but the response from the colonial powers has been drastic, that's when all these problems started." (Student 6)

In spite of the wealth of literature denouncing Robert Mugabe's approach to the land reform issue (Blair 2002, Meredith 2002, Chan 2003), for this student the approach
taken can be justified in relation to the apparent unequal distribution of land as an historic consequence of colonialism. It is worth pointing out, however, that the student’s father worked in the Zimbabwean parliament as an accountant and it is fair to say that this will have influenced his view of the current situation.

"Britain and the United States are not in support. They are saying that it’s being done unconstitutionally, but in my own perspective it was done in a constitutional manner in terms of the law. I think it was more trying to protect their kith and kin because 30% of the land in Zimbabwe was owned by the White people and 1% by Zimbabweans. So obviously there was disparity in relation to land ownership. So that’s what the government were trying to do and that’s when all the problems started." (Student 6)

This student went as far as to say that in spite of the obvious corruption in the government the current sanctions should be lifted in view of the fact that Zimbabwe is a third world country and dependent on first world countries for support and economic development.

"I believe in the government, but the problem in Zimbabwe right now is that Zimbabwe is a heavily sanctioned country and for each to progress economically... because the first world and the third world countries are inter-dependent, one cannot do without the other – that’s how I see it. For us to exist without first world countries at the moment is next to impossible. The government is quite good, yes, there is corruption now and then but there is corruption everywhere. People make mistakes, what is important is that we learn from those mistakes.” (Student 6)

It is interesting to note that this student, in spite of a sense of injustice at a land distribution policy that saw a black Zimbabwean population of one million in 1931 allocated 29 million acres of land, whilst a white population of 48,000 were allocated 48 million acres (Meredith, 2003) is prepared to concede that his country still needs the help of the colonial power that confiscated the land from his people.

More important than the issue of land reform, students appeared most affected by the political situation as it impacted on their career plans and subsequent travel
arrangements. Students commented about problems with immigration policies in Zimbabwe, having to face officials and attend immigration interviews.

"I had been anticipating starting the course in January, but somewhere between immigration and this call, I don't really know what happened. No one is giving an explanation but someone somewhere knows what really happened. I think they may have mixed me up at immigration with my brother or something. I ended up going for the interview with immigration in January to see who I was." (Student 8)

The implication behind this student's commentary is that a mix-up occurred with the immigration department in Zimbabwe. Although the student does not criticise the department for immigration, his narrative can be compared to other life history texts, which appear to suggest that the Zimbabwean government are beginning to make it difficult for people to exit the country.

"I didn't know whether I was coming here and if they would change my visitor's visa to a student's visa because I didn't dare go to the British High Commission to change my visa to say that I wanted to be a student nurse because a couple of other people who had everything, sponsorship, they were denied. They were told you are not going to England to be trained as a nurse. You should know that the British High Commission back home, I don't know if that is what they are supposed to do but they scare people. You really have to have courage to face them and go through the interview with the immigration officers. I didn't dare do that, in a way I'm a coward in that respect, I didn't want anything to go wrong with my immigration papers so I decided since I was working for Air Zimbabwe, I just went as a visitor." (Student 4)

This commentary is echoed by another student who experienced similar difficulties and was afraid to face the British Embassy in spite of having secured a place to study at the university in the UK. The implication here, however, is that the fault lies with
the British government who on the one hand were, at the time, actively recruiting students into nurse training from Zimbabwe, but on the other hand making it difficult to enter the UK.

"Yes, they had sent me my acceptance papers and they sent me my visa forms and then told me that they had agreed to give me accommodation, but still I wouldn't dare to go and face the British Embassy because they were horrible. They just don't understand, they think that we would be taking all their resources, that's the way they view it. They don't look at you as somebody who wants to change life." (Student 6)

The apparent dichotomy between a government that has been recruiting nursing students overseas and one that was reported to be reluctant to allow those same students into the country warrants further analysis. The high number of foreign nurses working in the NHS comes at a price in that however much their arrival benefits the UK health care system, it is clearly having a damaging impact on the level of care in hospitals in their homelands. In light of this the Department of Health has produced a list of countries where NHS managers should not venture to recruit nurses. It includes virtually every developing country (Revill, 2003). It seems clear from students' discussions that whilst it is simple to access information regarding nurse training in the UK, and to subsequently apply and gain a place in a UK university, the British government have to be seen to have a policy of non-recruitment where it is detrimental to the well being of that country. It could be argued that the UK is paying lip service to this policy in an effort to shore up its own seriously under resourced health service. Furthermore, in so doing it is taking advantage of a country experiencing extreme difficulties brought about by the historical legacy of colonialism. The relationship that exists once the ties of colonialism are broken, is reminiscent of the bond between a mother and child, the consequence of which, for
the Zimbabwean students, is their affiliation to a country, which in the past has exerted control and dominance over them, and which will continue to do so in the future, by offering them a land of opportunity.

"To start off with, I thought about Britain. There is a natural affiliation to it, then secondly, it had to do with the opportunities and thirdly, I think the education system for nursing is quite splendid." (Student 4)

HIV/AIDS - “There is no point giving me a pen if I can’t write.”

Without exception the students discussed the situation concerning HIV and AIDS, which is now considered epidemic in Zimbabwe (Barnett and Whiteside, 2002). The depth of discussion generated by HIV/AIDS has led to this section being presented under the three subheadings of (1) feelings about HIV/AIDS, (2) responsibility for HIV/AIDS, and (3) the impact of HIV/AIDS.

**Feelings about HIV/AIDS**

Three students indicated feeling afraid of the scale of HIV/AIDS in Zimbabwe. They discussed the problem as being the most important issue facing the country at this time, more so than the socio-economic situation, although this was felt to compound the problem. The students expressed their concerns in different ways depending on the extent to which they perceived themselves to be at risk from the virus.

“I think it’s really scary to be honest. I mean touch wood I’ve been lucky in my family so far but it’s not very good. Now I think it’s worse because of all the problems, people starving. Somehow I believe that if your immune system can be boosted by just what you eat and exercise, but if you don’t eat a healthy meal everyday then you deteriorate quicker.”

(Student 2)

This student makes the link between overall health status and the progress of the illness once acquired. However, her comment implies that avoiding contracting HIV is more a matter of luck than judgement. Work undertaken by Gregson et al (2003),
which looked at amongst other factors, the psychosocial and behavioural mechanisms associated with HIV avoidance, suggests that women believe their chances of acquiring the condition are related to the type of sexual partner they have. If a partner can be persuaded to be faithful, then women perceive themselves as more likely to avoid infection. The implications of this is for Zimbabwean students to feel empowered to take control of their own health, which may be relatively easier for them to achieve outside a culture, which tends to view women as subservient to men (Owomoyela, 2002). In Zimbabwe, in times of economic crisis polygamy has traditionally been accepted as a more attractive option than monogamy, in that it allowed men to acquire land, money and gifts from each prospective bride's family. Although most modern African women are critical of the system of polygamy, traditional women are quite comfortable with it in the cultural context that sustained it (Owomoyela, 2002). The cultural context of economic hardship that sustains the practice of polygamy, brings with it as a consequence, the mechanism for the acquisition and spread of HIV.

In addition to having more than one partner at a given time, one student expressed concern at the frequency with which partners are changed.

"I'm scared of it. I think it's everywhere. People just change partners, but back home the bad thing is that there is no medication so people are dying. I have an auntie who died in 2000. She was staying at our house when I came here for my interview, and I looked after her for a few weeks. It was shocking. At first I didn't know what was wrong with her. I only knew she wasn't well. Then my father told us. She was 34, but she was in denial until the day she died. She didn't believe she had HIV." (Student 9)
In the year 2000, the national adult HIV prevalence in Zimbabwe was estimated to be 25%, with young people particularly at risk due to the frequency with which they change partners (Chifunyise, Benoy, Mukiibi, 2002). Whilst this student’s commentary indicates awareness regarding the relationship between HIV infection rates and number of partners, it points to a lack of understanding on the part of the general population, in spite of the fact that Zimbabwe introduced a nation-wide programme to teach AIDS education in 1994.

In contrast to the aforementioned student, another respondent discussed HIV as being the scariest thing ever, but in relation to the nature of the disease itself more than first hand experience of the condition.

"It's extremely bad at the moment. Our people are just dying. Everybody is scared. It's the most scariest thing we have here. If it was just that somebody got infected and they died tomorrow then that would be fine – but people fall sick and have to go through the whole process. I think if I were to get it I would just kill myself, I wouldn't want to wait until I fall apart."  (Student 8)

This student's concern was with the nature and progress of the disease rather than the risk of acquiring the infection. The student believed that the body degenerates over a period of time before inevitable death. This belief alongside knowledge of the inadequate treatment and care for people who are HIV positive or suffering from AIDS terrified this student and may well be a factor in the decision to leave Zimbabwe.

Responsibility for HIV/AIDS

Six students alluded to the fact that the government was to blame for economic decline in Zimbabwe and that this had a bearing on the HIV/AIDS crisis. Their
thoughts centred on the inability of the government to provide adequate care and treatment for people suffering from the illness.

"I think it's very bad, even if there was proper treatment, the current economic situation means that they wouldn't be able to afford it. Drugs are very expensive and very hard to get hold of. Most people go without treatment and they deteriorate into a very bad state and that's what's scary." (Student 8)

"I think it's because they are not getting proper food. They cannot afford to buy even an apple, it's so expensive. They can probably eat food like that once a month. Or if you are really sick you cannot afford the fruit." (Student 7)

"I know the treatment is very expensive. It's only the people who can afford it that are getting the treatment or maybe going to other countries to get treatment. Some people just live with it, living with the stigma and labelled as having HIV and AIDS. The quality of treatment might be there but it's only the people who can afford it." (Student 3)

These students identified the relationship between infection from HIV and progression to the condition of AIDS and the sufferers' general health and nutritional status. Evidence suggests that not only is the epidemic devastating the populations of poor countries in Africa, it especially affects the poorest people in those countries (Singhal and Rogers, 2003). One explanation is that the epidemic cuts down the economically weak who do not have access to basic health care services and who cannot afford the expensive anti-retroviral drugs that prolong life for an HIV-positive individual. A rich country with a relatively small percentage of its population infected will be able to provide these drugs to everyone, but HIV positive individuals in Zimbabwe are doomed to an early death by economic factors. The implications of

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treatment and the outcome of infection with HIV is for them to leave the country in search of a safer environment in which to live and work.

In addition to economic decline in Zimbabwe and its impact on the HIV/AIDS epidemic, the students discussed the government's response in relation to health education and general information regarding HIV avoidance.

"To me it's pretty worrying because three years ago, Zimbabwe was the highest distributor of condoms, but they had the highest number of cases of AIDS. It is being re-advertised and the government are trying to do something about it. It's reached alarm levels really. You really wonder why there was still that rise." (Student 6)

This student felt that in spite of the government's response to the crisis of issuing free condoms, the rising number of AIDS cases was worryingly inexplicable. However, another student felt the problem lay in a reluctance to use contraception, which may have been associated with a lack of understanding of how to use it. This student added that the rural population of Zimbabwe suffered most from this lack of knowledge.

"People living in the cities are obviously at more of an advantage than those living in rural areas. In some areas it has to do with ignorance, they think why should they start using contraceptives now. The message is not reaching all the people." (Student 4)

In relation to the lack of information concerning advice on contraception one student discussed in detail where the fault lay and his efforts to address the problem.

"The biggest mistake that I think they did was that they went out into the country and just distributed condoms and they thought they had solved it, but there is no point in giving me a pen if I can't write. Where I come from some of the people who are quite close to me as friends were catching the disease and I was thinking, you guys aren't using condoms, there are
condoms everywhere. It really wasn’t that they were not using condoms; they didn’t know how to put them on properly, or take them off or get rid of them. So what I did with a friend of mine, we started a little club in college and we used to talk about HIV and within about a couple of months we had a club of about thirty or forty people coming over every Thursday for the meeting.” (Student 5)

The student’s response to the lack of knowledge on the part of his friends and the wider population was to take matters into his own hands and set up an information and support group. Gregson et al (2003) have shown that participation in local community groups is often positively associated with avoidance of HIV, which in turn is positively associated with the psychosocial determinants of safer behaviour. However, the authors point out that whether these relationships hold depends on a range of factors that include how well the group functions, the purpose of the group, and the educational levels of the participants. Community groups are only effective in direct proportion to the ability of the group to understand the information imparted (Campbell and Luben, 2003). In light of comments from students suggesting that the rural community in Zimbabwe lack knowledge of HIV and AIDS, and the fact that it is this very group who are most vulnerable to infection (Barnett and Whiteside, 2002), suggests that the widespread and indiscriminate distribution of condoms, without information as to how to use them and dispose of them, is a completely ineffective approach to combating the epidemic. It is indeed like giving someone a pen without teaching them to write.

The impact of HIV and AIDS

The life history subjects talked about the impact of HIV/AIDS on their lives. One student discussed changing his behaviour in order to minimise the risk of infection, and implied that concerns about the epidemic were a factor in his decision to leave Zimbabwe.
"I will always protect myself and I will make sure I don't get HIV and as long as I'm faithful to my wife I will be alright. It still scares me. It's really, really bad if you are still in Zimbabwe. That was another reason for leaving."

(Student 5)

Although the combined effects of stigma, denial, and confusion with other manifestations of poverty make HIV a difficult subject to analyse in Zimbabwe (Singhal and Rogers, 2003), it is clear from their commentaries that for these students at least, leaving Zimbabwe is one way of minimising the risk of becoming infected with the virus. The impact of an exodus of young people on a country devastated by disease is intensified in that unlike most health disasters, HIV kills the strong, the parents, the productive, the very people on whom functioning societies inevitably rely (Davis, 1999).

Zimbabwe now has the dubious honour of being the world’s most infected country with about a quarter of the adult population HIV positive with life expectancy poised to fall to 38 years (Barnett and Whiteside, 2002). HIV has now reached a grim turning point in that the number of deaths is outstripping the number of new infections, taking the overall level of HIV prevalence down (Davis, 1999). One student summed up the enormity of the problem in discussing the link between culture and the attitudes of Zimbabwean people that serves to perpetuate the problem.

"Our culture is a nice culture, but also our culture has spread HIV. In my country there is nothing to a man having two or three girlfriends or having two or three wives, it's accepted, and I think that is why the AIDS disease has spread more. Ignorance is another reason. In our culture we believe in Witch Doctors, when you are sick. You can tell if you have the HIV or AIDS disease, but people will still go to a Witch Doctor and try and find a cure and the Witch Doctor is ignorant as well. The Witch Doctor tells the man to go and sleep with his daughter. There has been so many child rapes because of that. Some people just sleep with other people. I know that we are now aware of AIDS, but either they are
denying it or they just don't care. Also there is no medicine. It's a vicious circle, we can't win. Our lives are getting worse. Also the government is mismanaging the social services. You see all these people dying in hospitals and they could have lived. You see kids getting infected – our culture is bad in that respect.”

(Student 4)

This lengthy quotation serves to highlight the student's feelings about HIV, where responsibility for the epidemic lies, and the impact it has had on her life. The overwhelming feeling from all the students was that Zimbabwean culture is at least partly to blame for the rapid spread of HIV. Furthermore this culture, that has been variously described as both 'good' and 'bad', is responsible for atrocities such as child rape with the reversion to the practice of consulting traditional or witch doctors as the country's health care system begins to fail.

Conclusion

This chapter has presented the findings from nine life history interviews in relation to life in Zimbabwe. Within this theme the students discussed education, family life, language, thinking about nursing, the current political situation, and HIV and AIDS. When talking about education, students commented on the boarding school system that has its roots in catholic mission schools that were set up to bring the catholic doctrine to the masses. Children were transported from their villages to primary schools set up in various centres of each district as the missionaries embarked on a programme to formally educate the local people (Golby, 1995). The legacy of this system has left some students with memories of being separated from their families at a young age and of having to abide by rules and regulations imposed on them from above. On the other hand, students indicated this very separation had made them self sufficient and able to cope with the demands of life in another country. The implications of this are that whilst some students may be able to operate
independently, others may need considerable support. The onus is on universities to meet the needs of each student and to have appropriate support mechanisms in place.

The students discussed family life in Zimbabwe. The overriding feeling is that whilst family is extremely important, the urge to leave Zimbabwe is stronger than the ties that bind families together. Musengeyi (1996) has discussed the rapid break up of the extended family in Zimbabwe. He blames urbanisation, economic hardships, adoption of Western values and widening social-economic gaps for a disruption in family life. It seems clear that the lure of life in the UK is stronger for these students than the need to stay close to family and friends. However, the students still identified family life as central to their beliefs, and indeed some students appeared horrified at a British culture that apparently does not recognise the importance and value of the older members of society.

A number of students discussed the importance of their mother tongue to their lives in Zimbabwe. Although English is considered the official or first language, the students felt the indigenous languages of Shona, or Ndebele to be their mother tongue, and often used this language to communicate with other Zimbabwean people. The discussion surrounding language highlighted the very real needs of the students in relation to communication barriers. On the one hand communication difficulties would seem not to be a problem for these students as their spoken English was excellent, having been learnt from an early age. However, as Bradby (2001) has pointed out, communication can be compromised in a number of ways, not least when varieties of the same language are spoken, or when different vocabularies or accents are employed. The danger lies in assuming that because English is considered the
first language, all Zimbabwean students are comfortable with it, or indeed derive the same meaning from conversations when English is used predominantly.

When discussing the reasons for choosing to study nursing, the life history subjects indicated that whilst nursing courses are available in Zimbabwe to a comparable level of those in the UK, the state of the country's health service and the available health care technology mitigated against students opting for study in Zimbabwe. Mapanga and Mapanga (2000) give a perspective on nursing in Zimbabwe and conclude that Zimbabwean society is becoming more and more educated and highly enlightened about the degree of quality of nursing care they deserve. They argue that if the quality of nursing care is to be socially relevant, nurses need to be prepared at levels which are congruent to the general educational pattern of the society which they serve. However, it would appear that Zimbabwean students feel the opportunity to experience technologically advanced health care is ultimately of more benefit to them and their families and therefore constitutes a reason for choosing to study nursing in the UK as opposed to Zimbabwe.

When discussing the current political situation in Zimbabwe, students pointed to the current government as being responsible for economic decline, corruption, lack of health care, and a general decline in living standards. The effects of this are far reaching and some students had experienced first hand the poverty that has resulted from a government hell bent on a land reform policy at the expense of the nation's well being (Meredith, 2002). The experience of poverty has led to a rising number of health care professionals being recruited from Zimbabwe as the UK attempts to relieve the shortage in the NHS. The exodus from Zimbabwe highlights the plight of
its people as they attempt to find a better life for themselves and their families (Carvel, 2002). However, the UK’s recruitment policy has clearly been at the expense of the Africa’s poorest nations and has led to Zimbabwe’s desperate attempt to engage in a recruitment policy of its own (Kithama, 1998).

Finally, the students talked about HIV and AIDS in Zimbabwe. They discussed their fears in relation to the epidemic, the view that government was partly to blame, and the belief that the cultural practice of polygamy has increased the risk of spreading HIV. Students appeared to understand the relationship between the progression of HIV to full blown AIDS and the overall state of an individual’s health. However, their narratives contained a sense of powerlessness in that the economic situation meant that most people were unable to sustain an adequate diet in spite of knowing that this is essential and that most people cannot afford the necessary treatment if infected.

The overall view, drawn from narratives related to life in Zimbabwe, is that a combination of socio-economic factors and the emergence of HIV and AIDS, combined with a decline in health care provision has led students to leave Zimbabwe. Choosing to study nursing at a UK university was one way that students could legitimately leave their own country. The UK’s own health care crisis provided students with the opportunity to leave Zimbabwe. The colonial ties between Britain and Zimbabwe make studying in the UK a palatable option, in spite of the fact that the Zimbabwean government is locked in battle with the very country that is now providing a haven for its young people. The following chapter presents data from the life history interviews focused around life in the UK.
Chapter Five: Life in the UK

Introduction

The previous chapter presented data associated with students' lives in Zimbabwe including educational experience, family life, nursing, politics, and HIV and AIDS. Initial analysis of data suggests the students to have experienced an overwhelming desire to leave Zimbabwe, with the UK being the preferred destination. Reasons given by students for leaving, include the desire to study nursing in the UK, and to work within a health care system considered to be the best in the world. However, detailed analysis of students' narratives points to a more complex picture, involving the existence of 'push and pull' factors other than a desire to study nursing.

While students recognise the UK health care system to be technically more advanced than in Zimbabwe, it appears that they are leaving in order to escape the current socio-economic situation and to minimise the risk posed by HIV and AIDS, which has now reached epidemic proportions in Zimbabwe (Barnett and Whiteside 2002, Singhal and Rogers, 2003). The mass exodus of young people from Zimbabwe has been encouraged and facilitated by a UK government attempting to address a chronic problem of recruitment and retention in the NHS (Buchan, 2002).

This chapter continues to present data collected from nine life history interviews, concentrating on the students' lived experiences after their arrival in the UK.
Life in the UK

The life history subjects discussed the experience of arriving in the UK, the financial implications of living in the UK, social life in the UK, and the experience of racism in both the college and in health care practice settings.

Arriving in the UK — “When I got here; questions, questions, questions.”

Students experienced difficulties with the immigration department in the UK, similar to those experienced with immigration officials in Zimbabwe (see chapter four). Problems ranged from lack of effective communication to difficulties in obtaining a student visa.

"I had to go on my own. They took me in their offices and I had to wait one hour. It was a long time to be on your own and you don't know what they want and then a lady came in and that's when she interviewed me for about two hours." (Student 9)

The student described feeling traumatised by the experience of being detained at the airport by immigration officers. She indicated that a “file full of papers” existed in relation to her entry into the UK, yet more questions were asked in spite of having the necessary paperwork confirming an offer of a university place. In order to make sense of the actions of the UK immigration department it is helpful to examine current policy on international recruitment of nurses. The Department of Health in England has reacted to concerns about the 'brain drain' from developing countries by issuing guidelines in November 1999 to all NHS employers on overseas recruitment (Buchan, 2002). Included in these guidelines is the edict that NHS employers should avoid direct recruitment from South Africa and the Caribbean, and should instead look to the countries of the European Union (EU) as appropriate places for recruitment (DoH, 1999a). However, figures produced by the Nursing and Midwifery Council for the
period of April 2000 to March 2001 on the number of new registrations from selected countries highlights that recruitment of qualified nurses from Zimbabwe has increased from 52 in 1998/99 to 473 in 2001/2. It seems clear that in restricting recruitment practices in South Africa, recruitment activity has been displaced in other developing countries, one of which is Zimbabwe (Buchan, 2002). The students’ accounts suggest that it is not only qualified nurses who are entering the UK, but student nurses as well, and that whilst the immigration department is anxious to appear to be enforcing DoH guidelines, eventually the necessary visas are issued.

“They [the immigration department] told me on the Sunday that I would have to go back. I didn’t have any problem with that. I went back on the Sunday and they gave me my passport. You feel like a criminal, like they are deporting you, they’ve got your passport and they are holding you and I wasn’t doing anything wrong, and then they sent me home. Then they told me that I had a place and I had to come back again. When I came back it was only about fifteen minutes and they gave me a visa.” (Student 9)

Students were prepared to undergo the lengthy process of obtaining permission to enter the UK. However, for some this process proved traumatic.

“When I got here; questions, questions, questions. They look through your bag; you feel like you have done something wrong. They took my passport and gave me this paper. I came at the end of June 2000 for my interview and I got three weeks stay. But the whole process made me feel like I had done something wrong. They treated me badly.” (Student 2)

The pull factor of meeting the NHS Plan staffing targets and the new targets set for 2008 are likely to mean that the UK, particularly England will continue to be active in recruiting from international labour markets (Buchan, 2002). At the same time the new UK government policy initiative to increase the number of nursing students will ensure that the push factor driven by the decline in the fortunes of Africa’s developing countries will ensure students continue to be recruited from Zimbabwe despite the presence of ethical guidelines for recruitment of nurses to the UK. A recent analysis
of the national pattern of applications from members of minority ethnic groups to pre-registration nursing and midwifery training points to a complex pattern across minority ethnic groups, with differences not readily explained by qualifications, visa requirements, age, or a combination of these (Iganski et al, 1998). The authors conclude that selection procedures for nurse training in the UK discriminate against some applicants on the basis of their ethnic group. In light of the Zimbabwean students’ narratives, no such discrimination appears to have existed in their efforts to secure a place on a pre-registration nursing course. In fact, the opposite appears to be the case in that the Universities and Colleges Admissions Service (UCAS) is actively advertising in Zimbabwe for entry onto UK university courses.

Financial Implications of Living in the UK – “I couldn’t pay my rent.”

During the discussions relating to the experience of living in the UK a number of factors became apparent including the reasons for choosing one particular university over another, and the financial difficulties arising from being away from home, in spite of initial funding from family and sponsors in Zimbabwe. The overriding factor which led students to choose to study at De Montfort University was the close proximity to family and friends already living and working in Leicester who could offer emotional and financial support.

“I had a couple of friends in Leicester who I visited. They were the ones who told me that there was an opening at De Montfort University. One of my friends suggested I call and find out what it was all about. So I sat in and found it interesting, so I applied.”  
(Student 5)

This student had originally wanted to study pharmacology and had secured a place at the University of East London. However, within six months of commencing the
course, the economic situation in Zimbabwe impacted on the student's family finances and financial support was withdrawn.

"My dad was feeling the strain and called me to say that he thought I had better come back because he couldn't promise that he would be able to make the next payment." (Student 5)

Summers (2003) makes the point that some people get into difficulties on coming to the UK and may even end up destitute and on the streets. Of these people a number will choose to return to Zimbabwe, whatever they might face when they get there. This student explained that returning to Zimbabwe was not an option. The chance to study nursing presented itself as a lifeline and one that this student was determined to take.

"I didn't want to go back, I don't think I would have gone back anyway. I was going to proceed and go into debt and just do it and then finish it and work to pay off the debt." (Student 5)

The life history subjects openly discussed the importance of financial support from family in Zimbabwe in relation to their continued presence in the UK. However, one student appeared disgruntled by the fact that in addition to financial support his parents placed the responsibility for his overall welfare on his sister, who was resident in the UK. The student appeared ready to accept financial help, but did not want to accept or appear to need emotional support from his family.

"I lived with my sister since I came here. She is my older sister and she knows it all and she wants to rule over everyone. She knows what's best for me and how to run my life. She wants to be in control of everything. I've got my mum and dad to tell me what to do, she can advise me but that's all she can do. We used to have arguments. At times she would call my parents." (Student 8)
This student's family in Zimbabwe remained committed to supporting him throughout the period of his studies in the UK. However, the student felt resentment at what he perceived as a lack of autonomy to control events in his own life. The reasons for the student's resentment may derive from the new social arrangements in Zimbabwe, which have seen dispersal and fragmentation of so called traditional family life (Owomoyela, 2002). In addition, as shown in the previous chapter, modern schooling in Zimbabwe has changed the ways in which the young people of Zimbabwe think about their position within the hierarchy of the family.

For some students, support from family in Zimbabwe, both financially and emotional was crucial to their well being in the UK. One such student commented that on being unable to secure a place at university to study psychology, she decided to study psychiatric nursing on the advice of her brother. This student intended to return to the original career choice on completion of the nursing course.

"I wanted to do Psychology, but I couldn't get a place at University, so I decided to do psychiatric nursing. My brother said that this way might be the longer way but I could still get there." (Student 3)

Another student commented on his intention to continue with his preferred career in pharmacology, adding that he had completed the first year of the pharmacology course and expected to be credited for it. Once again, the student chose to study nursing as a way of remaining in the UK, the intention being to return to the first choice of pharmacology on completion of the nursing programme. A recent study funded by the World Health Organisation, the International Council of Nurses and the Royal College of Nursing indicates that in countries such as Zimbabwe where there is
home country push due to relatively low pay or career prospects, nurses will wish to
prolong their stay in the UK beyond the completion of their first one or two-year work
permit, if they are allowed (Buchan, 2002). Similar conclusions can be drawn as to
the intentions of nursing students who, in their narratives, indicate unwillingness to
return to Zimbabwe and the intent to remain in the UK on completion of nurse
training.

The life history students discussed problems in opening a bank account in the UK and
cited a number of banks, which appeared to actively discriminate against them.

"They wanted utility bills but I didn’t have any, it was the first
month of the course. I tried the Abbey National, then I
managed to get one from HSBC. But they didn’t give me a
student one, I told them I was a student and I gave them the
details, but they didn’t give me one, just a basic account. You
can’t use the card to buy anything. When the money gets in
today, it doesn’t reflect it, you have to wait to take it
tomorrow. I got that one, then a few months later I tried
Lloyd’s and they gave me a current account, so I stopped
using the HSBC account."

(Student 9)

In establishing the existence of a direct policy affecting Zimbabwean students’ ability
to the open a bank account in the UK, three banks were approached. The first of
these, HSBC, indicated that no specific policy existed in relation to Zimbabwean
students. Requirements for opening an account with HSBC included production of a
passport or National Identification card, a letter from the local education authority
confirming the status of the student, and a letter from the university confirming the
conditional offer to the student with confirmation of the student’s address.

The second bank, the National Westminster, also indicated no special arrangements to
exist in relation to Zimbabwean students. The requirement for all foreign students
wishing to open an account includes production of a passport, a utility bill confirming the student's name and address, and a letter from the university confirming the status of the student. National Westminster does not offer overseas students full bank account facilities. Students are issued a bank account number and a 'paying in' book and have direct debit facilities. However, they are not issued with a cheque book, cheque guarantee card, overdraft or loan facilities.

In contrast, the third bank, the Halifax, did have a policy that covered so-called 'sanctioned' countries, which included, at that time, Zimbabwe, the Federal Republic of Yugoslavia, and Iraq. Students applying for bank accounts from these countries cannot make telephone applications, but have to apply in person to a specific branch. In addition to the usual requirements for overseas students, those students from sanctioned countries need two forms of identification consisting of a passport and a letter from the Home Office.

"It was difficult opening an account. They were talking about sanctions, which we don't know about. They said they couldn't give this or that, only basic accounts, it was the same as keeping your money at home. You can only deposit or withdraw, you don't get any interest. You don't get a credit card; they won't because of things in Zimbabwe. They were talking about it and I said I wasn't here to hear about Zimbabwe. I gave them my driving license and he saw Zimbabwe on it and he said he would need to talk to his colleagues. They don't talk in front of you." (Student 7)

The difficulties faced by the life history subjects in attempting to open a UK bank account add to the more general financial problems faced by overseas nursing students.

"I had debts that I had with me and I was worried about them. I didn't know if I was going to get a bursary. That proved to be difficult and I had to get a job, but I didn't have enough experience. So I had this debt and I owed money, so it was all
mounting up. I wanted to go home in December and I couldn't go because I had sent in my passport to the immigration and I didn't have it. Even if I had had my passport I didn't have the money because I was anticipating having a job, but I didn't have one. This was all boiling up. I was getting stressed and I wanted to go home. I got up one morning and I thought I didn't want to wake up. I had no motivation whatsoever."

(Student 8)

The UK government pays tuition fees for nursing students. However, it has recently changed the eligibility rules for overseas applicants to diploma level nursing and midwifery courses. Under the terms of the NHS Bursary Scheme, diploma level nursing and midwifery students are currently eligible for the non-means tested bursary and tuition fee support irrespective of place of residence. In order to bring these students into line with all other students in higher education, government Ministers have decided to extend the residence conditions that currently apply to other students, to those applying to study nursing and midwifery at DIP HE level. This effectively means that in order to qualify for NHS bursary support, those applying for diploma level courses will have to:

1. have been ordinarily resident in the UK, Channel Islands or the Isle of Man throughout the three years preceding the first day of the first academic year of the course, other than for the purpose of receiving full-time education; and

2. have settled status in the UK within the meaning of the immigration Act 1971 on the first day of the academic year of the course; and

3. be ordinarily resident in the UK on the first day of the academic year of the course (DoH, 2001).

There are a number of exemptions, mainly affecting migrant workers within the European Economic Area (EEA) (DoH, 2001). Students coming directly from Zimbabwe, who have not been resident in the UK for the three years preceding the
start of the course, will not be eligible for bursary support. The implications of this change in policy are that future Zimbabwean students, who experience pressure to remit monies home to Zimbabwe, are likely to suffer a serious decline in health status as a consequence.

In relation to the complex issue of HIV/AIDS, whilst figures regarding HIV positive students in the UK are unknown due to the current policy of non compulsory-testing of immigrants, given what is known about HIV infection rate in Zimbabwe (Barnett and Whiteside 2002, Singhal and Rogers 2003), it is likely that a proportion of Zimbabwean students will be HIV positive. Recent evidence suggests that an increase of 33% in the prevalence of heterosexually-acquired diagnosed HIV infection in England, Wales and Northern Ireland, has been attributed to the increase in immigration from Sub-Saharan Africa (Bernard, 2003). In addition, recent figures released by the UK Health Protection Agency on ethnicity and new HIV diagnoses indicates that the overwhelming majority of heterosexually acquired cases of HIV were acquired in Africa (74%) (Carter, 2003). In light of the fact that how the disease progresses, in other words its outcome, is also an expression of social and economic inequality (Chaisson et al, 1995), coupled with the fact that nursing students in the course of experiencing clinical practice are often exposed to opportunistic infections it is reasonable to surmise that some Zimbabwean nursing students will succumb to AIDS whilst studying in the UK. It is incumbent upon the UK government to recognise the potential for a serious decline in the health status of overseas nursing students who are set to be part of the future NHS workforce.
Social Life in the UK – “We go out and they take care of me”

The life history subjects discussed social life in the UK and the importance of having a network of friends. For some students, this network comprised predominantly of Zimbabweans, for others it included people from other ethnic groups.

“I have a couple of friends from Zimbabwe in Leicester, then there are a few British guys, ones I worked with when I started nursing part time, then there are people that I started the Diploma with here.” (Student 6)

“With my group we have no problems, we are mixed. There are quite a number of Zimbabweans in my group, Mauritian and people from Ghana, Sierra Leone and British, from Ireland, so it’s a mixture. We have accepted and support each other.” (Student 9)

All the life history subjects relied, to a greater or lesser extent, on the support of other students in order to help them cope with life in the UK. However, some students discussed the support derived from belonging to an identified mentor group within a larger cohort of students, often referring to socialising with this smaller group in their private time.

“I have discovered with my friends, my mentor group is perfect because we go out every so often and they take me with them and then they come to my hall of residence and I don’t mind.” (Student 4)

One student focussed on the difficulty of reconciling traditional Zimbabwean culture, with regard to the social more of regard and respect for elders (Owomoyela, 2002), with British student culture, whereby mature students are integrated alongside younger students within any student group. For this student, the age difference represented a barrier to the development of a relationship with older group members.
"I was only 18, turning 19, with 30 and 40 something's. I felt so small. There were other Zimbabweans in the group who were much older than me and you know at home, when people are older, they are a parent figure or something, and you respect older people at home, whether they are your parents or you don't know them, but you always leave a space, you don't just treat them like a classmate. So that was a barrier for me." (Student 2)

This student went on to explain that whilst she was too quiet too ask questions within her group, she recognised that support would have been there, if she'd needed it.

When looking at official support systems within the university, in particular the International Office, whilst a number of services are offered, for example the management of international enquiries, collaborative ventures, and sponsorship applications, the only direct reference to overseas students is the organisation of a meet and greet service for new international students http://intranet.dmu.ac.uk/internationaloffice. While this service is undoubtedly useful for overseas students, a more focused approach, and one that takes into account the specific needs of Zimbabwean students is needed. Among the services offered, support should be available for students experiencing financial problems including opening bank accounts, and obtaining specific health advice. In addition, information could be available that would allow students to access other students who may be experiencing similar difficulties, who would be willing to offer their support.

Racism in the College and Practice Setting – “Maybe they just don’t like my face”

The life history subjects discussed encounters with racism in both the college and the practice setting. One student discussed a covert type of racism, which whilst not openly expressed nonetheless existed and gave rise to distress. The incident was made worse by occurring in the practice setting and involving nurses, whom the student felt should not behave in a such a way.
"These people are supposed to be nurses, people who are supposed to have no racial relations or nothing but you just get to a placement where you don't exist. They look at you, they sweep past you, and they will send you to do all the bad jobs."  
(Student 4)

The student went on to describe a form of discrimination in the clinical placement in which a white student had been offered the opportunity to gain clinical experience, which she had not been exposed to.

"They will take another student, who is not from Zimbabwe, who is not my colour; they will take you and teach you how to insert a catheter. If you go in the first day, and there are two of you, they will call the white student, you don't exist, you can just sit there."  
(Student 4)

It is possible that other explanations exist to explain the student's experience. However, she perceived a situation where learning opportunities were denied her on the basis of her colour. A similar experience was recounted by another student.

"I got a placement once where I went in early, but there was a girl who did everything. I got to the point where I was asked to go to a clinic room and put these papers in order, and she had to take people for treatment, and to the main hospital, and make all the phone calls. I was putting papers in order and I thought what do I gain from this? I should be taking people to the various places as well to see what goes on and see how it works. No one really took any notice; they didn't care so I just left it."  
(Student 9)

The concept of 'backstage' racism (Porter, 1993) is useful in shedding light on the experiences of these students. Porter (1993) introduces the notion of racisms occurring when the mask of professional relations is let slip, for example when nurses are on their breaks or in other informal circumstances. The teaching of student nurses occurs in informal as well as formal situations, therefore, instances of 'backstage'
racisms, in other words those which are not observable in any immediate interactions, goes someway to explaining the covert nature of the discrimination that the students describe.

When recounting experiences of racism, the students drew attention to what can be described as coping strategies albeit in a variety of different forms.

"You kind of get used to it. You just have to get on with it, you either conform or you just have got to walk away and go back where you came from. I've only been in this placement for eight days, and it's only one person. When she's not there, as far as I'm concerned she doesn't exist and vice versa, but she can harass me. I don't know but for the main part I just ignore her, she's not there." (Student 8)

This student appeared to accept that racist comments were 'the norm', and indeed a part of everyday life in health care practice in the UK. However, by refusing to acknowledge the racist comments, the student was able to distance herself from this kind of behaviour and cope with clinical practice. The alternative, in her words, was to leave the course and go back to Zimbabwe, which was not an option she wished to consider. Culley et al (2001) discuss how Caribbean nurses regarded what could have been interpreted as racist remarks as being a consequence of the occupational hierarchy which applied irrespective of ethnic status. Similarly, Zimbabwean students attributed negative remarks they experienced to their student status. In other words, it was seen as part of the occupational socialisation of nurses in which student nurses are fair game to be treated badly until the transition from new student to established student has been made (Culley et al, 2001).
"Sometimes you ask how to do something and they will tell me they are busy or I'm a student so go on and do this and this, then you see a colleague getting different treatment. Then you think it's because of the colour or maybe they just don't like my face. I know it's wrong, but I ignore it. I can tell this person really does not want to know, I just leave them. Because I'm a student I'm only there for a few weeks, so if they don't want anything to do with me that's fine."

(Student 9)

In contrast to coping with racism by ignoring it, another student developed a strategy of smiling and looking happy throughout the day, in the hope that a cheerful, pleasant personality would in some way ward off racist behaviour. However, as with the previous quotation, an undercurrent of accepting racial comments as normal within health care practice in the UK was detectable in this student's narrative.

"I just go in with a beaming smile and they can't really be rude to me or say anything, that's how I think I've managed to deal with the abuse."

(Student 2)

An alternative coping strategy is evident in the following quotation, in which a student discusses learning to forgive the perpetrator of the racist behaviour. This student appears able to draw on some moral or religious strength, which may find its roots in a Catholic upbringing in Zimbabwe (Owomoyela, 2002).

"I have learned to forgive. You just learn to forgive because they are ignorant."

(Student 7)

Each of the above extracts points to the existence of coping strategies in relation to episodes of racism in nursing practice, including ignoring the perpetrator of the racist behaviour, forgiving the perpetrator, and making it difficult for the perpetrator to operate. An understanding of why overseas students are able to develop coping mechanisms is provided by Culley et al's (2001) study, which looked at the responses of Caribbean nurses to racisms in the NHS. The authors make the point that in responding to racism, the Caribbean nurses developed three strategies. First, they
refused to assume that all negative experiences were attributable to racism. A parallel can be drawn here with the Zimbabwean student, who suggested it might be her colour, that provoked the racist behaviour, but could just as soon have been ‘her face’, in the sense that any newcomer might be treated as an outsider in a social setting, at least for a while. Second, the Caribbean nurses had to deal with backstage racisms, in other words covert racism. Similarities are found with Zimbabwean students who discuss learning opportunities being denied them in practice, in favour of white students. Third, Caribbean nurses constructed a sense of moral resistance in response to perceived racisms. Similarly, Zimbabwean students constructed a sense of moral resistance to racism in being able to forgive those responsible for perpetrating it.

In relation to racism in the college setting, this was less evident in the students’ narratives. However, one student recounted an incident in which the possibility of racist behaviour existed. The student recognised the possibility that communication difficulties lay behind the episode. Nevertheless, the outcome was that the student felt her voice was not heard. In acknowledging barriers to communication educators should not lose sight of the fact that there is the potential for racist behaviour in the classroom setting.

“Part of the problem is, it may not be you, but if you say something they would say pardon, or they wouldn’t listen to you. It has happened to me a couple of times and my friends wouldn’t let it continue and at times they say ‘she wants to say something’ because they know what I say is valid but because I don’t know whether it’s me or it’s my accent or what, they don’t listen.”  
(Student 4)

Racism is ultimately bound up with other explanations for the student’s experience in the college settings. One such explanation is that a communication barrier existed, which resulted in the lecturer focusing attention on students whose first language is
English. If this is the case, it by no means excuses this type of selective behaviour, but points to the need for awareness of how it may perceived as racist in origin.

**Conclusion**

In conclusion, this chapter has considered Zimbabwean students’ accounts of life in the UK, including arriving in the UK for the first time, the financial implications of living and studying in the UK, the impact on their social lives, and the experience of racist behaviour in the college and practice setting. Students recounted problems with obtaining visas and the traumatic events surrounding encounters with immigration officials. It seems that, on the one hand the UK government has endorsed a policy of active recruitment of international students to nursing courses, while at the same time being seen to adhere to an ostensibly ethical recruitment policy (DoH, 1999). The resultant bureaucracy serves to cause Zimbabwean students distress as they enter a country that has already offered them the opportunity to study. After successfully negotiating immigration departments, students then encounter extreme difficulty in obtaining a UK bank account. The university’s official website advises international students to access banks close to the campus as these are more likely to be used to dealing with overseas students ([www.dmu.ac.uk/study/international](http://www.dmu.ac.uk/study/international)). However, it does not advise students which banks provide which type of account. Indeed, it misleads students into thinking that they will be able to access full current account facilities. This is not the case, as most UK banks provide only a limited facility to overseas students, and in cases of so-called sanctioned countries (including Zimbabwe), strict limitations are imposed.
The financial difficulties encountered by students living in the UK are compounded by the socio-economic situation in Zimbabwe, which has meant that students often have to remit money home. The implications of this are that students may suffer from a poorer diet than would otherwise be the case through lack of available money to sustain a healthy diet. In light of the statistics in relation to HIV/AIDS infection in the UK (Carter, 2003), which suggests that the increase is due to an increase in immigrants from Africa, it is likely that at least some of the Zimbabwean students will be HIV positive. Given that a poor diet linked with exposure to opportunistic infections accelerates the progression of HIV to AIDS (Chaisson et al, 1995), the possibility exists for some Zimbabwean students to see a rapid decline in health.

Students discussed the experience of racism, for the most part in areas of clinical practice, but also in the college setting. In spite of the fact that students had developed a variety of coping strategies, the experience of backstage racism (Porter, 1993) was disturbing, in that it occurred in situations least expected by students, namely by nurses who were expected to know better. In some cases communication barriers might have played a part in a student’s experience of racism in the classroom. Nevertheless, this particular student felt discriminated against, in the sense that her voice was not heard.

The following chapter considers Zimbabwean students’ accounts of their plans for the future, including data relating to career aspirations and returning to Zimbabwe. This chapter includes data collected from the ‘chance encounter’ (Plummer, 2000), which was the initial impetus for the study.
Chapter Six: Plans for the Future

Introduction

The previous chapter presented data from nine life history interviews with Zimbabwean students in which they discussed the experience of living and studying in the UK. The students discussed arriving in the UK, the financial implications of living in the UK, the impact on their social lives, and their experience of racism in the college and health care practice settings. Analysis of the data reveals that whilst the UK government has been actively recruiting student nurses from Zimbabwe (recent policy changes (DoH, 2001) now prevent this) in order to address the longer term staffing problem in the NHS, at the same time an ethical policy for the recruitment of overseas qualified staff is in operation. The implications of this policy are that NHS employers are advised to desist from actively recruiting nurses from a developing country where it is shown to be detrimental to that country’s own health care service (DoH, 1999). The Universities and Colleges Admissions Service (UCAS) informs Zimbabwean students how to apply to UK universities. However, the immigration department in the UK does not make it easy for students to gain entry to the country, in spite of a university place being secured.

Once admitted to the UK, students were confronted by financial problems, due in part to the socio-economic situation in Zimbabwe, which necessitated the remitting of monies home, but also to difficulties in opening a UK bank account and accessing full bank account facilities. In some cases, where a bank has designated Zimbabwe as a sanctioned country the facilities offered to Zimbabwean students are extremely limited. The university’s international website does not adequately inform students,
or advise them of difficulties, real or potential, that they may face. The implications of financial hardship are such that in light of current figures relating to HIV infection in Zimbabwe and indeed in the UK, where a rise has been attributed to African immigrants (Carter, 2003), it seems likely given the link between nutritional status and the progression of HIV to AIDS, that at least some of the Zimbabwean students will see a decline in their health.

Analysis of the data revealed that students had suffered experiences of racist comments, in the health care practice setting and in the college. Whilst this was extremely distasteful to students who found difficulty in accepting such behaviour from nurses who were expected to know better, the students had developed a variety of coping strategies to deal with the racist behaviour. These included ignoring the perpetrator, resisting the idea that racist remarks had been made, and forgiving the perpetrator. Racism in the classroom, although not as prolific as in the practice setting was also reported to have occurred. However, students tended to attribute this behaviour to more general communication difficulties.

This chapter presents and analyses data from nine life history interviews in relation to the students’ plans for the future, during which they discussed the options open to them on completion of pre-registration nurse training. Some students indicated a desire to consolidate their initial training, whilst others planned to move into specialist areas of practice. Irrespective of career aspirations, students talked about plans to return to Zimbabwe. However, the time frame varied between individuals. In order to reflect the students’ conversations the chapter is structured under the headings of career aspirations and returning to Zimbabwe. Commentary from the ‘chance
encounter' (Plummer, 2001), with the student who provided the initial impetus for the study is included under each subheading.

**Career Aspirations — “I have been trained the British way”**

The life history subjects discussed future career plans upon achieving registered nurse status. Some students indicated their futures lay in developing their nursing careers in the UK. However, whilst some students expressed a desire to consolidate their initial nurse training, at least in the short term, others appeared intent on moving into specialist areas of nursing practice, for example primary health care or psychiatry.

“I think I’ll work for a while and see how I get on. I want to get to where my brother is because he’s working for the NHS now and he’s actually thinking when he goes back home he is going to start up his own practice. We have nurse led clinics, so patients come in for whatever, a child with bruises, high temperature, any kind of thing, anyone can come in.”

*(Student 2)*

This particular student planned to consolidate the skills gained during initial nurse training with a view to specialising in primary health care in the future. However, it is interesting to note that whilst Zimbabwean diploma-prepared nurses mainly find employment in rural and urban settings including primary health care centres (Mapanga and Mapanga, 2000), in the UK a diploma-prepared nurse would need to undertake further training for this role, for example a degree in Specialist Nursing Practice (Primary Care) or a Community Health Care degree in Health Visiting, District Nursing, or General Practice Nursing (DMU, 2003). The student described how it would be difficult to advance to the required level for employment in the primary health care setting in the UK as quickly as she would like, due in part to the
size of the NHS (the largest employer in Western Europe) and to her perceived current low status within the organisation.

"I would like to run my own clinic in the UK, but I don't think I could do that because the place is too big for me. If I go back to Zimbabwe I will be someone big. I don't think I could do that there unless of course I keep on working here I could do it, but if I want to actually become my own person, become a big somebody. There are already big people here, like the NHS for starters, we haven't got that in Zimbabwe." (Student 2)

Although the student does not expressly suggest that her career aspirations will be thwarted in the UK, nevertheless it is clear that a more rapid progression will be available in Zimbabwe. A recent study looking at institutional and individual racism in the UK shows several ways in which nursing staff from minority ethnic groups are disadvantaged in the UK including differences in employment characteristics and career paths of white and minority ethnic nurses (Beishon et al, 1995). According to the authors one quarter of staff believed that they had been denied opportunities for training because of their ethnicity and the same proportion thought that they had been discriminated against in recruitment or promotion. Whilst this may be the case, Zimbabwean students who indicated a desire to specialise after qualifying as registered nurses, did not express concerns that opportunities would be denied them in the UK.

"I want to work here because I want to advance after I qualify. I would like to be a psychiatric nurse." (Student 7)

Whilst this student indicated a desire to remain in the UK on completion of nurse training in order to specialise in the field of psychiatric nursing another life history subject expressed a desire to return to Zimbabwe to specialise in the same area. The student indicated that provision for patients with mental health problems is limited in
Zimbabwe to the extent that little knowledge exists regarding appropriate treatment and care.

"I am thinking of going back to Zimbabwe because now that I have all this knowledge I want to go and see what they do in my country, because I have no idea. It was nothing that was talked about or that we knew about, you would just label people and run away from them. I want to go back and see what's going on." (Student 3)

A perspective on nursing is provided by Mapanga and Mapanga (2000) who write extensively on the types of nursing programmes available and how these fit with the overall concept of health care in Zimbabwe. Individual programmes are detailed including specialist areas of nursing practice. However, no mention is made of programmes specifically designed to address the needs of clients with mental health problems. Neither is mention made of the extent of mental health problems in Zimbabwean society. Whilst the authors' work does not relate specifically to the health needs of Zimbabwean society, nevertheless in discussing nursing programmes that are designed to reflect the health care needs of Zimbabweans, the absence of a programme leading to a qualification in mental health nursing points to a lack of provision in the care of people with mental health problems.

In discussing chances of career advancement, one student felt more options were open by virtue of being trained in the UK. In addition, this student expressed a sense of loyalty to the UK government for providing the initial opportunity for nurse training. Given the conversation with the subject of the 'chance encounter', in which she referred to comments accusing Zimbabweans of "scrounging off the state", it appears that in reality Zimbabwean students are keen to remain in the UK beyond initial
training, to 'pay back' the country that has provided them with an opportunity to undertake nurse training.

"I plan to work here. It would be unfair to go back because I trained here and I don't want to just go back home. I have been trained the British way, so I think I stand a good chance of advancing into whatever I want to do." (Student 9)

This student maintains a positive view of nursing in the NHS. However, the commentary provided by the subject of the 'chance encounter' presents a different picture. Since qualifying, this student has experienced problems relating to the level of support received from trained staff to help her adapt to the role of newly qualified staff nurse. She discusses the role of preceptor and how it is impeded by the demands placed on staff nurses who have a case load to manage. The student recognises the reality of working in the NHS means coping with a rapid turnover of patients. However, the consequences of a lack of support are that she is unable to consolidate skills acquired in training or take the opportunity to develop ward management skills.

"You are put on a rota with your preceptor, but your preceptor has got a caseload. She will be put with her own caseload and you will be put with your own caseload. The turnover in the NHS is so fast, so the time set aside for you to work with your preceptor is out of the question because as you are walking down the corridor to go and sort out issue a), you meet up with issue b), and c), and d), and therefore you end up either she allocates to me what she thinks I can manage to deal with, as she goes to deal with whatever she thinks I can't manage to deal with, and thus we are already apart."

(Student 10)

Nursing literature emphasises the importance of support for all those working as registered nurses, and suggests that a lack of support can contribute to attrition from the profession (Morle 1990, UKCC 1990, Ashton and Richardson 1992, Merchant 1992, Bain 1996). This view is supported by the life history subject's portrayal of a
situation in which preceptorship was inadequate enough to make her consider leaving the profession.

"It's not about recruiting, it's about retaining, and so there is a problem there and how they are going to solve it I still do not have the answer. I don't have any option except out."

(Student 10)

The preceptorship of newly qualified nurses is an important factor for a Government facing serious problems of recruitment and retention in the NHS (Buchan, 2002). In an effort to address this, and in addition to an overseas recruitment policy, the government have funded a longitudinal questionnaire survey investigating the careers of people who qualified from the pre-registration nurse diploma, in particular exploring the experience of preceptorship (Hardyman and Hickey, 2001). Interim findings from this project suggest an overwhelming demand for preceptorship, with the majority of respondents anticipating that all aspects of preceptorship would be important in their first jobs. Whilst the project has yet to report on the extent to which these expectations are met, it suggests that newly qualified nurses are demanding preceptorship for a duration of between four and six months. The life history subject sheds further light on the problems of preceptorship, in that she indicates a misunderstanding in clinical practice regarding the meaning of the word.

"The issue is all about support. In nursing, I think that word is repeated and repeated but whether people understand the meaning is something else. Even as a student nurse, when you go into the nursing field, into the ward scenario and nurses are busy, you take yourself out as a student and say let me see whether they are supporting themselves. That's where you notice the difference and you know that there is something lacking in nursing and I do not know if there is a solution to that, but this is the biggest issue in nursing and if it's not rectified it's still a long long way to get nursing numbers sorted out. When you go into an interview you are told about preceptorship for as long as you need it, but in reality is that so?"

(Student 10)
The student discusses a lack of clarity regarding the term 'preceptorship' and a lack of understanding in relation to the demands of the role. In addition, the life history subject felt she was misled at interview into believing preceptorship would be available for as long as she needed it.

The United Kingdom Central Council advocates preceptorship as an essential part of ensuring a smooth transition from student to professional practitioner. According to the UKCC (1990), a preceptor should be prepared to take on their role ensuring that they:

1. Have sufficient knowledge of the practitioner’s programme leading to registration to identify current learning needs

2. Help the practitioner to apply knowledge to practice

3. Understand how practitioners integrate into a new practice setting and assist with this process

4. Understand and assist with the problems in the transition from pre-registration student to registered and accountable practitioner and set, with the practitioner, objectives for learning to assist with this transition

However, in spite of these extensive recommendations regarding the criteria for preceptorship the UKCC offers no prescribed framework and suggests that the form preceptorship takes 'will be dependent upon the nature and context of the care to be given, the location and the experience and confidence of the practitioners concerned' (UKCC, 1993:3). Arguably, the reason why the concept of preceptorship is clearly failing in practice is due to the fact that the rapid turnover of staff, partly as a result of a lack of preceptorship, prevents practitioners from becoming experienced and confident enough to act as preceptors, thus creating a vicious circle.
In light of the Zimbabwean student’s experience, which is consistent with the majority of newly qualified staff nurses, it is essential that preceptorship programmes are put in place as a matter of urgency if the drain of staff from the NHS is to be stemmed. The implications of a failure to pay attention to supporting newly qualified staff will mean that NHS Trusts will continue to face difficulties in retaining staff. This will result in NHS employers having to continually recruit overseas nurses to the detriment of developing countries.

In addition to a lack of preceptorship, the newly qualified life history subject talked of difficulties in meeting the requirements of her work permit on becoming a qualified practitioner. The discussion centres on the belief that British nurses who consider full time work (37 ½ hours per week) too demanding can reduce their hours and work part time. However, the student found this facility denied her on the basis that the work permit issued related to a full time position thus requiring 37 ½ hours work per week. The student felt this to represent discriminatory practice.

"My opinion is, if a British nurse feels 37 ½ hours is too long and does not give her time for her family, I do not see why that rule does not apply to any international student, if they are interested in international nurses or student nurses to help them in the current shortage. Do international students not have a life? Don't they have the same problems the British nurse is expressing? To be family friendly, all the hours the working patterns that have been introduced for the British people, why is it that my work permit stipulates 37 ½ hours? Already the policies that are put that they are saying are equal opportunities do not apply. I hate to say, but already there is some unfairness and the worst word that has been used is if you find you are being discriminated against, but I already am being.” (Student 10)
Employers can apply for a work permit to enable them to offer jobs to someone who would not otherwise be allowed to work in the UK. Certain jobs have been categorised by government as 'shortage occupations', and nursing and midwifery fall into this group (UKCOSA, 2004). Students who have permission to be in the UK as a student and obtain a degree qualification do not need to leave the UK whilst the employer applies for a work permit. However, the employer will only be able to apply for the work permit once it has been established that it has not been possible, in spite of reasonable efforts being made, to fill the vacancy with a UK person with suitable qualifications and/or experience. (Permits2Work Ltd, 2004). The fact that an employer can only make a work permit application for a named person to do a specific job for them, normally on a full-time basis, meant that the life history subject was committed to working 37 ½ hours per week. In addition, since a person cannot transfer a work permit to a different job or to work for a different employer, the student was unable to reduce the number of hours worked, as this would have represented a different job to that which she applied for.

"I was so tired and dissatisfied and I lost so much confidence I didn't know where to run to. All I could think of was to come home and put in my resignation." (Student 10)

The student's predicament means that she is working long hours and is continually tired. The implications of this are that she is more likely to need extensive support in order to make the transition from student to staff nurse. All international nurses are bound by UK law governing the issue of work permits. However, this student had not fully understood the implications of committing herself to working in the UK health service.
In summary, this section has looked at the students’ plans for the future in respect of nursing careers. In the short term the students indicated a desire to continue their careers in the UK. However, some students envisaged a period of consolidation of skills acquired during initial nurse training, whilst others intended to move into specialist areas of nursing practice as soon as possible. On the whole, the students portrayed a positive view of the NHS and the career options available. Some students felt more rapid career advancement would be possible in Zimbabwe. Some students regarded the NHS as a large organisation, in which they have a relatively low status. The students’ positive view of the NHS was in contrast to that put forward by the subject of the ‘chance encounter’ who, upon qualifying, experienced a lack of support for the transition from student to staff nurse, coupled with inflexible working hours. The following section considers the students’ narratives on returning to Zimbabwe.

Returning to Zimbabwe – “I think things are very bad back there”

When talking about plans for the future, the life history subjects referred constantly to returning home to Zimbabwe. However, all the students expressed the view that this would not be in the near future. While they talked about their love for the Zimbabwean lifestyle and culture, the socio-economic situation appeared to prevent a return home. Indeed, for a number of students, future plans involved encouraging family members to join them in the UK. For others, the desire to remain in the UK related to the fact that in spite of the financial hardship associated with being a student, life was more settled and easier.

“At the moment I think things are very bad out there. I don’t think I’ll be going back in the next two or three years. I think it will take time for things to get back to normal, but at the moment I will probably go and visit now and then. If things are not fine then it’s difficult as I have been used to this other life. I will be giving up a lot.” (Student 8)
This student did not perceive any imminent change in the political situation in Zimbabwe. Furthermore, until the political climate stabilises a return to Zimbabwe would not be contemplated, apart from a temporary visit to see family.

A different response to the dilemma posed by not wanting to return immediately to Zimbabwe whilst at the same time needing to be with family was given by one student who anticipated having her family join her in the UK.

“I don’t think my baby would cope with life back home because he was born here. I think it best that I stay here with my husband and child. All my family will be here soon. My Aunt came over a year ago to do nursing. So, all that’s left would be for my mother to come here when she is retired.”

(Student 7)

The student discussed the need to remain in the UK as her husband and child are here. In traditional Zimbabwean families the women moves into her husband’s home on marriage. A wife, at the time of her marriage, exchanges the authority of her father for that of her husband, and is gradually absorbed into her husband’s patrilineal descent group (Owomoyela, 2002). This goes some way to explain the reluctance on the part of the student to return to Zimbabwe after having met and married her husband in the UK, thus becoming part of his family. The student looked to her family moving to the UK, as a way of maintaining traditional family ties, rather than returning to Zimbabwe herself.

In relation to returning to Zimbabwe, another student discussed conversations he had with other Zimbabweans who expressed a desire to return home. However, in his view, they were misguided and would soon return to the UK once they discovered how difficult life really was in Zimbabwe.
"I know people who have said that they are going back. I have a cousin who said he was going back. Give him a couple of months, when he realises that he has to queue for fuel and their electricity is cut off at a certain time, and he realises all the little things that he is missing out on. He'll be back. My parents were telling me that the other day they had to go into town on the bus because there wasn't any fuel. I've got two cars parked outside back home and I haven't got fuel for them. So I will wait a couple of years." (Student 8)

Some Zimbabweans obviously feel that change is on the horizon, but this particular student remains pessimistic, indicating life in the UK to be preferable to life in Zimbabwe, at least for the moment. The student’s view of the current situation is understandable in light of events following the recent Zimbabwean elections. Blair (2002) commented that political change in Zimbabwe would come in 2002, and not before time as only new leadership would allow Zimbabwe to recover from its vicious spiral of decline. Change did not come. The 2002 elections saw Mugabe re-elected with 1,685,212 votes to Morgan Tsvangirai’s 1,258,401. In spite of claims of ballot rigging, political intimidation, and police brutality, the scarcity of international observers and a reluctance on the part of African observer teams and presidents to declare the election anything other than legitimate led to Mugabe being returned to power for another five years (Chan, 2003). As Blair (2002) has argued, the tantalising vision of change is all that Zimbabweans have left to cling on to.

However, not all students referred to Zimbabwe disparagingly. One life history subject painted a portrait of a country that has much to offer in respect of lifestyle and culture. Climate, atmosphere, and freedom to move around are cited as key differences between the two countries. The view taken is that whilst the political situation in Zimbabwe is responsible for people leaving the country, ultimately this is a pity because life is better in Zimbabwe than it is in the UK.
"Besides the political situation, Zimbabwe is a very good country to be in. It's the weather. It's the atmosphere, because we grew up in it and because that's what we are, we like it. It's a pity that this political situation is making people run away from home because there is freedom for everything. The life is completely different from this life we are leading here."

(Student 1)

Owomoyela (2002) writes that custom and lifestyle in Zimbabwe owe much to the European presence, which has caused profound changes in the way people live. In addition to changes to the manner and content of education, Zimbabweans were exposed to notions of tidiness and cleanliness, and to ideas about dress habits. Prior to colonialism Zimbabweans would have been typically free of obsession about the body, or embarrassment about it, paying more attention to the prevailing climate and environment than to concealing as much of the body as possible from view (Burke, 1996). In other words, Zimbabweans would have enjoyed freedom of expression, in a variety of forms. Traditional Zimbabwean culture may have been eroded by Western influences, but the student's narrative suggests the notion of freedom is still firmly embedded in Zimbabwean life. As a consequence, a perceived lack of freedom is one of the least attractive features of life in the UK.

A further insight into Zimbabwean life is provided by one student's account of land ownership and the importance of space. The student makes the point that all Zimbabweans, irrespective of economic status, are accustomed to spacious living accommodation, even if they are not land owners. However, the comment below suggests that in addition to space in which to live, Zimbabweans value the sense of freedom that having access to open space provides. Furthermore, it is freedom of movement that the student feels is lacking in UK society. Living in the UK may
provide economic and political stability, which are seen as aspects of life that cannot currently be relied upon in Zimbabwe. However, in order to benefit from this stable environment, the Zimbabwean students have to forgo freedom of movement, which is seen as a highly prized aspect of life in Zimbabwe.

"It's like when we are at home, we have big houses and big land. Nearly everyone, even those who don't have their own land, they have big space. And the children, I know I brought my children here, but it's very hard because the children are not free to move around, my children in Zimbabwe would go to school and come home on their own. Everybody has a maid, so you basically do nothing. So I think we were used to that. I think the atmosphere is much freer than here."

(Student 1)

An aspect of Zimbabwean life that further highlights the disparity between the UK and Zimbabwe is the concept of help within the home. Household help is becoming less affordable for Zimbabwean women in the current economic climate. Nevertheless, the concept of having 'help' in the home remains an important one. Whereas some Zimbabweans will be able to afford paid help, others will not. However, all Zimbabwean women are accustomed to help in the sense that it is synonymous with being cared for and is seen as the domain of women. In this respect Zimbabwean culture is explained by the traditional gender division of labour whereby men and women have well-defined roles and obligations specific and exclusive to their respective genders (Owomoyela, 2002). The division of labour is such that the domestic sphere, or private domain, belongs to the woman, who has sole responsibility for managing household affairs, whilst the man is responsible for aspects of family life, which constitutes the public domain. This aspect of Zimbabwean society has given way to Western influence, which advocates a more balanced division of labour, the role of caring for family and helping around the house remains with the woman. Consequently, if female family members cannot fulfil this
role, then Zimbabwean women will look to employ paid household help.

Zimbabwean students who find they cannot employ household help whilst they are students in the UK, or rely on informal help from family, who for the most part remain in Zimbabwe, face a challenge in reconciling aspects of their culture with contemporary British culture, which views household help as a luxury and not a right.

The issue of household help has been discussed previously in this study in relation to challenges Zimbabwean students face in adapting to life in the UK. However, in relation to students’ thoughts regarding returning home, the custom of considering household help to be a right, not a luxury, represented a considerable push factor in relation to returning home. Furthermore, while it would be unusual for the life history subjects to be in a position to afford household help during their time as students in the UK, having a maid continues to be valued by Zimbabwean women in that it represents freedom from domesticity.

“You know that when you are back home you can have a maid that lives with you throughout and will do everything for you and look after the baby, but here it's different.” (Student 7)

Burke (1996) discusses how the new social arrangements in Zimbabwe have weakened the family and in effect reduced women’s quality of life. He argues that the modern school system has affected the traditional women’s position negatively. Older children have been enticed away from the traditional role of caring for their younger siblings and helping around the house, with the result that those women, who in the past could count on older children to help them, must now employ paid household help. However, in Zimbabwe, being cared for carries with it a mutual obligation to care. Therefore, if care in the home is provided by a maid, a reciprocal
arrangement will exist whereby the well being of the maid, including the provision of housing and education for her children, becomes the responsibility of the family. It would appear that lifestyle in post colonial Zimbabwe, in particular as it affects Westernised Zimbabwean women, has created some expectations that have not been met by life in the UK. However, when discussing the issue of household help, it appears not to have entered the consciousness of the Zimbabwean students to realise the controversy that a superficial reading of their discourse produces. Taken at face value, the students appear to be privileged without knowing it, when in fact, on a deeper level, they are explaining an aspect of Zimbabwean life that is deeply embedded in traditional cultural practice.

Conclusion

In conclusion, this chapter has presented data from the students’ narratives relating to plans for the future on completion of nurse training. Students discussed career aspirations, indicating that having trained in the UK, chances of promotion in Zimbabwe would be enhanced. However, should they choose to remain in the UK, the life history subjects perceived chances of career advancement as limited due to the size of the NHS as an organisation, and to their status within it. However, the students did not perceive this lack of opportunity in the UK to be related to racism, in spite of evidence to the contrary (Beishon et al, 1995).

Subtle differences are seen to exist in relation to diploma prepared nurses in the UK and diploma prepared nurses in Zimbabwe, irrespective of nurse training in Zimbabwe following a Western model (Mapanga and Mapanga, 2000). In Zimbabwe it is not unusual for diploma prepared nurses to practice in primary health care clinics
due to the fact that health care is predominantly centred on this type of provision. However, in the UK employment in primary health care requires further specialist education. This was seen by the students to limit their opportunities in the UK and cited as a potential reason for returning to Zimbabwe.

The most damaging criticism of the NHS was recounted by the Zimbabwean student who has since qualified as a registered nurse and is working in an acute area of health care within the NHS. The major hurdle for this life history subject was a lack of preceptorship to assist her in the transition from student to qualified practitioner. Irrespective of the claims made by the statutory body for nursing, the student experienced little support from qualified staff nurses with the result that she considered leaving the profession. Arguably, the student’s experience is consistent with and representative of the problems all newly qualified staff are faced with in relation to lack of support.

Despite the fact that a lack of preceptorship can be linked to attrition rates in nursing (Morle 1990, UKCC 1990, Ashton and Richardson 1992, Merchant 1992, Bain 1996), few strategies exist to ensure that preceptorship programmes are in place. Whilst the nursing literature advocates preceptorship for newly qualified nurses and in spite of the Government’s apparent commitment to the idea, the life history subject’s narrative suggests a reality in which little preceptorship exists, the consequences of which will be continued high levels of attrition from nursing. In light of the interim findings from the Department of Health’s longitudinal study, which shows that newly qualified nurses expect a preceptorship programme to assist with the transition from student to
staff nurse, it is imperative that NHS employers address this issue as a matter of urgency if the NHS is to retain its staff.

In addition to problems with accessing preceptorship programmes, on completion of nurse training overseas students are issued with work permits for full time staff nurse vacancies. As work permits cannot be transferred to other jobs or other employers, newly qualified overseas nurses find themselves working long hours, often in an unsupported role. The consequences of an inflexible policy, which does not allow flexible working hours, in spite of Government rhetoric (DoH, 1999) adds to dissatisfaction with working life and encourages international nurses to seek more flexible ways of working outside the NHS.

Finally, when discussing returning to Zimbabwe, in spite of the affection the students held for their country and the overwhelming sense that Zimbabwe will always be considered 'home', little enthusiasm was shown for an immediate return on completion of nursing training, irrespective of the many difficulties students faced in the UK. The reason for this reluctance lies in the persistence of the socio-economic problems which pervade all areas of Zimbabwean life. The fact that students are able to keep in touch with families and to read about Zimbabwe in the media, enforces the view that life in the UK, at least in relation to economic stability, is preferable to life at home. A way of reconciling life in the UK with the need to return home was found by one student whose family planned to leave Zimbabwe to live and work in the UK.

It is evident from the students' narratives that most hope to return home in the future, although the time frame varies between individuals depending on their view of how
soon change will come about in Zimbabwe. The life history subjects appear deeply saddened by the situation in Zimbabwe, and speak of a country whose culture and lifestyle are to be envied, whilst at the same time being eroded by the effects of the continuing political situation.

The following chapter considers the implications arising from the life history study in which Zimbabwean nursing students discussed their experience of life in Zimbabwe, life in the UK, and plans for the future. Analysis of the data has highlighted areas to be addressed by educational leaders and managers if they are to fully support and maximise the full potential of overseas students who choose to live, study and work in the UK.
Chapter Seven:

Implications and Recommendations for Educational Leaders and Managers

Introduction

This study has focused on the lived experience of Zimbabwean students who chose to study nursing at one UK University. Using a life history approach (Plummer, 2001), data was collected from interviews with nine pre-registration nursing students, and one former student who is currently working as a staff nurse in the NHS. The data was organised under the themes of 'life in Zimbabwe', 'life in the UK', and 'plans for future', as this reflected the content of the narratives, and aided the analysis. The findings were then sub-divided into categories of education, family life; language; nursing; politics; HIV/AIDS; arriving in the UK; financial implications of living in the UK; social life in the UK; experience of racism in the health care practice setting and the college; career aspirations; and returning to Zimbabwe. These categories provide a framework for understanding the experiences of overseas students studying in the UK and are used to structure this chapter, which discusses the implications of the study and subsequent recommendations for educational leaders and managers.

Education

The Zimbabwean students discussed the experience of being educated in a predominantly catholic boarding school system. Being sent away to school was variously described as both traumatic and character building. All students connected education with life chances, namely access to 'white collar' jobs. However, while early separation from family in order to attend boarding school may enable students to function as independent adults, it does not necessarily equip them with the skills
needed for independent learning. There is a difference between independence in life and being an independent learner. Since the style of boarding school education is directive Zimbabwean students may need considerable support to develop as adult learners.

A number of characteristics may usefully describe the common features of adult learners, for example that they can be expected to assume responsibility for their own learning, and that they may have established attitudes, patterns of thought and fixed ways of learning which can assist them with new situations and ideas (Curzon, 1990). Given the Zimbabwean students experience of a fairly rigid system in which rules and regulations were said to structure the school day, it is likely that attitudes towards learning will be well established, and this may include the belief that learning should be a highly structured enterprise. The consequences of fixed notions regarding learning are that some Zimbabwean students may experience difficulty with the unstructured elements of the pre-registration nursing programme (personal study time, self directed learning) and the amount of learning that is expected to take place outside the formal educational setting.

The UKCC (1999) recommended that the sequencing and balance between theory and practice should promote an integration of knowledge, attitudes and skills. The consequences of this are that pre-registration nursing programmes have seen an increase in clinical practice experience with a subsequent decrease in theoretical input. Students are therefore required to engage in increased periods of independent study in order to meet the requirements of ‘fitness for practice’ (UKCC, 1999). The implications of this are that whilst educators may recognise that adult learners come
from widely varying backgrounds, with each individual having his/her own personal strengths, anxieties and hopes (Daines et al, 1992), these issues are compounded for Zimbabwean students who may struggle with the concept of adult learning in the context of the pre-registration nursing programme.

In light of this it is recommended that overseas nursing students are made aware of the philosophy that underpins nursing courses in the UK, at the point at which they make an application. In addition, support should be available that reflects the individual learning needs of overseas students in coming to terms with the nature of nursing programmes in this country. This may include setting up formal study groups, facilitating formal e-learning opportunities designed to foster independent study, facilitating support groups of Zimbabwean students who are further advanced on the programme, and increased directed study for Zimbabwean students, to assist them in meeting the particular demands of the pre-registration course.

Family Life

Family life plays a central role in the early lives of Zimbabweans and is pivotal to the maintenance of family relationships in later life (Owomoyela, 2002). Although students discussed feeling oppressed by a lack of autonomy to control their day to day lives, nevertheless support from family, both financially and emotionally, appeared to influence their sense of well-being, whilst living in the UK. In spite of the evidence that traditional family life is disintegrating in Zimbabwe due to the politico-economic situation (Musengeyi, 1996), students feel indebted to their families and describe a 'duty of care' to exist whereby they are expected to look after ageing family members.
The implications for Zimbabwean students living in the UK, are that often monies are remitted back to Zimbabwe leaving the students in serious financial difficulty.

Female students described the practice of having help in the home, a deeply rooted cultural practice in Zimbabwe being derived from the notion of caring for and being cared for (Noddings, 1984). The absence of help in the home was said by students to inhibit day to day life, in the sense that time needed for studying and socialising was being taken up by domestic activities. The implications of this are that some students may need support in relation to time management in order to cope with the academic and practical requirements of the nursing programme. In addition, as a consequence of a superficial knowledge of Zimbabwean culture, conversations in which a student indicates a lack of help in the home as the reason for falling behind with course work or non-attendance of practice placements may be perceived by the educator or UK-born student colleagues, as simply an excuse. Misinterpretation of the students’ comments are likely to be due to the fact that having a maid is not seen as a necessity in the UK, being more often associated with social status and wealth.

It is therefore recommended that where necessary Zimbabwean students are assisted to develop time management skills to enable them to meet the academic and practical elements of the nursing programme. In order to recognise the particular difficulties students may have in relation to coping without help in the home due in part to the financial implications of having to remit monies home, educators need to be aware of and sensitive to the particular cultural practices of Zimbabwean students.
Language

English is considered the first language in Zimbabwe and is taught to all school children from an early age in an education system which has adopted the British model (Golby, 1995). However, the two main indigenous languages of Shona, which is more widely spoken, and Ndebele, spoken to a lesser extent, are reverted to during informal settings where Zimbabwean students mix with members of their own cultural group. Membership of the current Zimbabwean Government is drawn exclusively from Shona speaking people, whilst the opposing party draws its membership from Ndebele speaking people. The consequences are that Ndebele speaking Zimbabweans are reported to feel marginalised within Zimbabwean society. Often, a Shona Zimbabwean will not speak Ndebele, and vice versa, either as a result of no exposure to the language, or more likely as a result of tensions between the two groups reminiscent of those existing between Catholics and Protestants in Northern Ireland (Moore et al, 1997). The implications of a lack of understanding on the part of educators who may presume Zimbabwean culture is homogenous, of cultural differences within and between groups, are that tensions may go unacknowledged. As a consequence, students may be placed in positions of conflict, for example during theoretical sessions regarding religion, ethics, and cultural care.

It is recommended that educators are mindful of the very real difficulties overseas students may face in putting aside cultural conflict when exposed to sensitive subject matter in the classroom. In order to achieve this it is necessary that where students are drawn from countries experiencing conflict, for example Zimbabwe, educational managers should ensure that teachers are aware of how cultural conflict between ethnic groups might impact on relationships in the classroom. In order for teachers to
develop culturally sensitive practice, it is recommended that they acknowledge the role they have to play in examining approaches and assumptions, and in challenging racist beliefs and practices (Mason, 2000).

Nursing

Potential nursing students have access to a wide variety of nursing courses in Zimbabwe from a basic pre-registration diploma to PhD programmes (Mapanga and Mapanga, 2000). However, current Zimbabwean nursing students are unlikely to have access to even a minimum standard of clinical experience due to the failing state of Zimbabwe’s health care system. In addition, the British Government’s current recruitment drive has resulted in increasing numbers of qualified practitioners leaving developing countries, including Zimbabwe, to live and work in the UK (Buchan, 2002). The result is that the quality of nurse education in those countries has diminished. The implications of this are that in spite of an ethical recruitment policy, which states that developing countries should not suffer as a result of recruitment, increasing numbers of Zimbabwean students have sought to train as nurses in the UK, to the detriment of their own country. Whilst it would be unethical to deny opportunities to Zimbabweans who wish to study in the UK, by the same token it is unethical to deprive a country of a potential workforce at a time when they are so desperately needed. It is considered vital, if the quality of health care is to improve during a time when the country continues to be decimated by HIV and AIDS (Barnett and Whiteside, 2002), that qualified nurses return to health care practice in Zimbabwe as soon as possible. It is therefore recommended that every effort is made to encourage Zimbabwean students to put their skills, knowledge and expertise into practice in Zimbabwe once the political situation has stabilised. It is further
recommended that the UK Government addresses the problem of recruitment and retention by paying attention to supporting and mentoring existing practitioners, rather than effectively draining the workforce of developing countries.

**Politics**

As previously stated, the UK health service is currently suffering a recruitment and retention problem such that qualified nurses are being recruited overseas. At the same time the political situation in Zimbabwe is such that students have been encouraged to leave the country in order to access nurse education in the UK. In light of claims that the recruitment of nurses from developing countries is unethical, the UK Government has responded by putting in place an ethical policy which advises NHS employers to focus recruitment initiatives on countries in the European Economic Area (EEA) (Buchan, 2002). The implication of concentrating on the ethical recruitment of registered nurses is such that attention is diverted away from the recruitment of overseas nursing students. Potential students have ready access to information regarding studying in the UK, including immigration information, visa requirements, and financial advice (http://www.ucas.co.uk). However, when attempting to enter the UK students reported obstructive behaviour on the part of immigrations officials despite having been offered a university place therefore having a legitimate right to enter the country.

It is recommended that information made available to overseas students should be consistent with policy and practice encountered by students on entry to the UK. Educational managers should take efforts to ensure that overseas students once in
receipt of a university place have all the necessary paperwork to ensure a smooth transition into the country.

HIV and AIDS

HIV prevalence in the adult population of Zimbabwe has been estimated to be 25% (Chifunyise, Benoy, and Mukiibi, 2002), with AIDS related deaths numbering 2500 per week (IRIN, 2003). Zimbabwean students appeared knowledgeable regarding the transmission of HIV, the risk factors, and the relationship between nutritional status and the progression of HIV to AIDS. However, a degree of powerlessness was noted in their narratives, with students citing the cultural practice of polygamy and frequent sexual partners as responsible for the extent of the problem. It is likely given the link between the increase in HIV infection rates in the UK and the rising numbers of African immigrants (Carter, 2003) that at least some of the Zimbabwean students will be HIV positive. The implications for HIV positive students who experience financial difficulty are that they are likely to suffer a poor nutritional intake. As a consequence, HIV positive students are likely to be even more susceptible to opportunistic infections encountered in clinical practice.

The current policy of non-compulsory testing of immigrants for HIV is under review and likely to change in the future given the rise in HIV prevalence in this country (Carter, 2003). Students who request support from occupational health services do so in strict confidence. However, it is recommended that those educators who are responsible for Zimbabwean students are knowledgeable regarding the link between overall health status and progression of HIV to AIDS, and are able to advise students accordingly. Furthermore, it is recommended that educational managers are made
aware that overseas students from countries known to have high infection rates of HIV may need support to manage their health during periods of clinical practice in acute hospital settings.

**Arriving in the UK and Financial Hardship**

The impact of the declining economy in Zimbabwe is such that students who are studying in the UK often have to remit monies home in order to provide support for family members (Summers, 2003). The financial difficulties students suffer as a result are compounded by a lack of consistent information and advice regarding the facilities that UK banks provide for Zimbabwean nationals. The University’s International Website advises students to open a bank account in a branch close to the campus, as they are supposedly used to dealing with overseas students ([www.dmu.ac.uk/study/international](http://www.dmu.ac.uk/study/international)). However, no information is given regarding the type of account students are likely to be issued, the documents they will need or difficulties they might encounter. Students are not made aware that most banks offer only limited facilities to overseas students, which effectively means no access to a cheque book, cheque guarantee card, or overdraft or loan facility. In addition, banks which class Zimbabwe as a sanctioned country will not accept a telephone application and insist on the production of two forms of identification consisting of a passport and a letter from the Home Office. Students who have submitted their passports to the immigration department on arriving in the UK are unable to provide the University with UK bank account details and are therefore unable to access any bursary or loan. The implications of this are serious financial hardship for some students, especially those who are expected to send money home to Zimbabwe.
It is recommended that educational managers who are responsible for admissions are aware of the financial problems Zimbabwean students are likely to encounter during the initial weeks of the nursing programme. Information should be made available to students that accurately reflect the facilities offered by UK banks. Students may need to be advised to bring extra funds into the UK in order to bridge the gap between opening a bank account and being able to access funds from a bursary or loan. Previous Zimbabwean students should be encouraged to support other Zimbabwean students where possible. In addition, students need to be made aware of the Universities Access to Learning fund, which provides monetary support for those who are experiencing serious financial difficulties.

Students studying the Dip HE programme who have been resident in the country for three years prior to course commencement are eligible for the NHS bursary (DoH, 2001), and are more likely to have UK banks accounts in place. It is likely, given the economic situation in Zimbabwe that they will have contributed financial support to their families and will continue to do so throughout the period of their studies. This may result in students having to seek part time work to supplement their income. It is recommended that educational managers recognise the pressure upon Zimbabwean students to engage in part time work at the same time as undertaking pre-registration nurse training. Educators need to develop flexible ways of delivering the pre-registration programme, which will allow for the diverse needs of students who have commitments to supporting family overseas.
Social Life in the UK

Having a network of friends was reported by Zimbabwean students as central to their sense of belonging in the UK. Social circles were seen to vary, being comprised either of other Zimbabweans, or including members of different ethnic groups. However, irrespective of the nature of their preferred social network, students derived support from belonging to an identified mentor group within the School of Nursing and Midwifery.

Mentor groups within the School are designed to offer one-to-one support for a small number of students from a designated personal tutor. The School of Nursing and Midwifery is committed to strengthening and enhancing the role of the personal tutor within the context of the guidelines laid down by the university. Guidelines for the role of personal tutor have been developed around a number of themes including academic progress, monitoring attendance; illness and absence; module choices and career planning; professional requirements for practice; and progress in practice (DMU, 2004). Each mentor group comprises of approximately twenty students drawn from one particular cohort using a process of random allocation. If for any reason, a student is unhappy with their designated mentor group or personal tutor, they can request reallocation to another group within the same cohort.

The implications of the process of random allocation to a mentor group led to some Zimbabwean students experiencing communication difficulties. In the event that a mentor group included both mature Zimbabwean students and younger Zimbabwean students, the cultural practice of respect for older members of society led to communication barriers. A younger Zimbabwean will acknowledge the position of
the mature Zimbabwean who with age gains attentive hearing in communal discussions (Owomoyela, 2002). The implications of having little choice in group membership are that in classroom settings where older and younger Zimbabweans comprise the same group, younger students may feel restricted in their ability to express their opinions and actively participate in debates. It is recommended that when preparing personal tutors for their role, educational leaders and managers include awareness training of how cultural practices impact on classroom activity.

Racism

The experience of racism in health care practice, and to a lesser extent in the college setting, was reported by Zimbabwean students. Racist behaviour in health care practice settings involved qualified nurses perceived to be offering learning opportunities to white students to the detriment of Zimbabwean students. Racist behaviour in the classroom involved lecturers reportedly ignoring the Zimbabwean student in favour of white English speaking students. Mechanisms for dealing with so-called backstage racism (Porter, 1993) in health care practice included ignoring the perpetrator, forgiving the perpetrator, and making it difficult for the perpetrator to operate. Mechanisms for dealing with racism in the classroom saw Zimbabwean students rationalising the behaviour as being due to lecturers having difficulty understanding the students’ accent.

The implications of racial harassment in the workplace are seen in the effect it has on the performance of an organisation by creating a climate of isolation and hostility (Beishon et al, 1995). Similarly, racial harassment in the university affects the performance of the students by creating isolation and hostility in the classroom. In
spite of the fact that students developed mechanisms for coping with racism, in part because of a reluctance to recognise it as such, educational managers and leaders need to have polices in place to address the problem when it occurs. In order to do so, it is recommended that educational leaders take accounts of racism seriously and counter racist behaviour in all its manifestations. This entails having knowledge of policies for dealing with racism in the context in which it occurs.

Career Aspirations

The career aspirations of the Zimbabwean students varied in relation to both choice and location. Students indicated the desire to return to Zimbabwe to specialise in particular areas of health care practice in the belief that having trained in the UK, opportunities for promotion would be enhanced. On the other hand, students who expressed a desire to remain in the UK felt opportunities for promotion were limited due to the size of the NHS as an organisation, and their status within it. However, students did not perceive a lack of opportunity to be specifically related to racist practices whereby ethnic minority nurses are said to be disadvantaged in the NHS (Culley and Mayor, 2001).

The implications of undertaking pre-registration training in the UK are such that should the Zimbabwean students return to Zimbabwe after registration, they are well qualified to work in all health care settings. However, in the UK, in order to specialise in a particular area with a view to promotion, students would need to undertake further training. The financial pressure experienced by Zimbabwean students during the pre-registration programme may preclude them from undertaking further training, requiring them instead to work towards promotion as quickly as
possible. For this reason, Zimbabwean students may decide not to undertake further training on completion of the Dip HE or BSc (Hons) programme.

The experience recounted by the Zimbabwean student upon qualifying as a registered nurse supports the view that a lack of preceptorship for newly qualified nurses is linked to attrition rates. In spite of the statutory body for nursing (UKCC, 1990) and the Government (DoH, 1999) advocating preceptorship programmes, there is little evidence that these are operating in practice. The implications for newly qualified nurses including those from Zimbabwe, is that they find themselves unsupported and therefore unable to cope with the demands of current health care practice, thus increasing their likelihood of leaving the NHS. The policy whereby overseas students are prevented from working flexible hours in spite of Government rhetoric to the contrary (DoH, 1999b), further increases attrition rates from nursing.

It is recommended that educational managers continue to work in partnership with NHS managers to develop flexible routes to learning which take account of the personal circumstances of individual students. Included in this is the need for flexible specialist nurse training and easily accessible preceptorship programmes. This would go some way to addressing more generally the serious recruitment and retention difficulties currently affecting the NHS, as well as increasing support specifically for Zimbabwean nursing students.

Returning to Zimbabwe

On completion of pre-registration nurse training Zimbabwean students indicated no immediate desire to return to Zimbabwe. This was entirely related to the current
political and subsequent socio-economic situation, which served to make life in the UK the much preferred option. The dilemma faced in reconciling separation from family during the period of studying in the UK was solved by Zimbabwean students encouraging family members to join them in the UK as soon as possible. The students’ wish for the future of Zimbabwe is political and economic stability for a country currently decimated by a Government committed to an unworkable land reform policy (Meredith, 2002) and ravaged by HIV and AIDS (Barnett and Whiteside, 2002). The implications of the HIV crisis has been an exodus of young people from the country at a time when the UK Government is actively recruiting workers from overseas in an effort to address a serious staffing problem in the NHS.

It is recommended that educational leaders and managers are sensitive to the issues affecting the lives of Zimbabwean and indeed all overseas students, including separation from family, financial and associated health problems, communication difficulties, and reported experience of racist practice. NHS managers and education leaders need to work together to develop support networks that extend beyond pre-registration nurse training and recognise the valuable contribution overseas students are making to the NHS. At the same time, those responsible for the provision of nurse education need to understand the particular needs of the countries from which overseas students are drawn. Students need to be given every opportunity to support the development and recovery of health care systems in Zimbabwe at the earliest opportunity.
Conclusion

In conclusion, this chapter has reviewed the implications of a life history study, which considered the lived experiences of Zimbabwean students who chose to study nursing in the UK. The findings from the study point to the socio-economic situation in Zimbabwe coupled with the threat posed by the HIV/AIDS epidemic as likely reasons for Zimbabwean students choosing the UK for entry to nurse training. On completion of the pre-registration programme, in spite of a deeply rooted love for Zimbabwe, and serious financial difficulties in the UK, students express no plans for an immediate return.

Students should be given every opportunity to study nursing in the UK. However, the serious exodus of young people from Zimbabwe has come at a time when the country is suffering a serious decline in health care provision due to the socio-economic situation and the HIV/AIDS epidemic. Educational leaders and managers are recommended to work closely with NHS managers in order to find ways of addressing the serious recruitment and retention issues in the NHS, which does not rely on overseas recruitment where it is detrimental to the well being of those countries.

The following chapter summarises the life history study and draws together conclusions for the University, educational leaders, educators, Zimbabwean students, the Nursing and Midwifery Council, and the UK government. The chapter concludes with final thoughts regarding the journey through the research process.
Chapter Eight:

Conclusion and Reflection on the Research Process

Introduction

Interest in the lived experience of student nurses who come to the UK to study pre-registration nurse training began when a routine visit to a clinical practice area led to a 'chance encounter' (Plummer, 2001) with a Zimbabwean nursing student. Routine visits to clinical areas provide lecturers with an opportunity to check achievement of learning outcomes, attendance, and general progress of students undertaking the clinical component of nurse training. However, this particular encounter resulted in a 'fateful moment' (Giddens, 1991), as it gave the opportunity to construct a new way of thinking about an issue, namely the lived experience of overseas nursing students who leave the country of their birth to live and work in the UK.

Chapter One provided a detailed account of the Zimbabwean student's difficulties since arriving in the UK, for example communication barriers and financial problems. The student's experience was compounded by a reported account of racist behaviour in health care practice and in the college setting. Constraints of time and the environment prevented further exploration of issues of obvious concern to the student. The need arose therefore, for a study to address the concerns of this student and others with similar experiences. This resulted in the research study, which aimed to give a voice to overseas students who by virtue of belonging to a minority ethnic group within nursing often find that their voices go unheard (Culley et al, 2001).
The study aims were threefold. First, to describe the experiences of Zimbabwean nursing students studying in one UK University School of Nursing and Midwifery, using a life history approach to collecting data; second, to develop an understanding of the factors affecting Zimbabwean nursing students studying in one UK University that may impact of their future plans for nursing in the UK following registration with the NMC; third, to provide a useful source of information to the International Office within the University in relation to ways in which overseas students may be supported based on their lived experiences.

The Study

Chapter Two set the study in context by reviewing the literature relating to the country of Zimbabwe and its people. Education provision, religion and social custom, health, healthcare and nursing were discussed as these were thought likely to be important contextual factors in the experience of Zimbabwean students. Particular attention was paid to HIV and AIDS owing to the extent to which the disease has affected the country. The current political and socio-economic situation in Zimbabwe was shown to compound the problem of HIV and AIDS due to the relationship between nutritional status and progression of HIV to AIDS (Singhal and Rogers, 2003).

Health care provision was shown to be in a state of crisis, made worse by medical and nursing personnel leaving the country (Kithama, 1998). Consequently, opportunities for nurse training are limited in the sense that clinical experience, access to health care technology, and the quality of nurse education have been adversely affected. The review also suggested that the UK government is engaged in an overseas recruitment
drive in an attempt to address serious staffing problems in the NHS (Buchan, 2002). The UK is consequently seen by Zimbabweans as providing an ideal opportunity for them to live and study abroad, with many choosing entry into nurse training as a legitimate way to enter the country.

Chapter Three considered the methodology for the study, which adopted a life history approach (Plummer, 2001). Life history research provides a way of connecting the lives and stories of individuals to the understanding of larger human and social phenomena (Hatch and Wisniewski, 1995) in a way that other methods do not. Despite the power relationship inherent in the research interviews a number of contextual features suggest the accounts of experiences given are internally valid. First, students provided their own framework within which to reveal experiences to the researcher. Second, where certain issues prompted the researcher to investigate further, for example on policies of UK banks, or Home Office visas on working hours, the reported experiences to which the students referred were confirmed by documentary or official sources. Third, students were quite willing to voice criticisms of the course, the practice settings and on occasions of each other, and to this extent this underscores the authenticity of the accounts.

The social distance of nationality, ethnicity, status, and in some cases gender, renders traditional concepts of reliability less appropriate as a marker of the trustworthiness of the data. However, by noting the effects of this social distance on the interaction, documenting its apparent impact on the interviews, and estimating the effects on the direction and strength of the analysis, the researcher has provided an auditable account of the processes behind the generation of the data.
In order to achieve depth of understanding, relatively few life histories, all drawn from one educational setting have been discussed. This clearly limits the generalisability of the findings in any statistical sense. However, within their own accounts the students refer to the transferability of their experiences to other Zimbabwean nursing students they know. The study also generates analytic generalisations – for example that many of the reported strategies that would help Zimbabwean students would actually help all UK nursing students and could therefore be implemented without the potentially stigmatizing need to frame Zimbabwean nursing students as a special case.

Chapter Four presented and analysed the findings under the broad framework of 'life in Zimbabwe'. Emergent themes from the interviews included education, family life, language, nursing, politics, and HIV and AIDS. A combination of socio-economic factors and the significant threat of HIV and AIDS, combined with a decline in health care provision, were reported as reasons why the students chose to leave Zimbabwe. Colonial ties with Britain, in spite of some current political animosity, coupled with readily available information relating to nurse training made the UK the Zimbabwean students’ preferred destination.

Chapter Five presented and analysed data relating to ‘life in the UK’. Themes in the narratives of students included accounts of arriving in the UK, finances, socialising, and racism. Difficulties in accessing full bank account facilities coupled with having to remit monies home to Zimbabwe led students to experience serious financial hardship. Accounts of racism in health care practice and college settings resulted in
students developing coping strategies consistent with accounts in the literature (Culley et al, 2001).

Chapter Six presented and analysed data in relation to the students 'plans for the future'. Themes discussed within this chapter, included career aspirations and returning to Zimbabwe. The students indicated no immediate desire to return to Zimbabwe in the near future, due entirely to the politico-economic situation. However, should they do so, the perception was that having undertaken nurse training in the UK, opportunities for career advancement would be enhanced in Zimbabwe. A somewhat different view was taken towards career advancement in the UK, in spite of having trained here, in that the size of the NHS was seen to limit chances of promotion.

Chapter Seven discussed the implications of the study and subsequent recommendations for education leaders and managers. In relation to the aims of the study these can be summarised as follows:

**The University**

The University should ensure that all those responsible for recruitment, selection and admission of overseas students including those from Zimbabwe, take account of the particular difficulties students face based on their lived experience. This study has shown that the difficulties encountered are particular to the individual student and are influenced by the country of origin. In this sense, a cover all policy for supporting international students will not suffice. Information regarding admission to the UK should reflect the political context in which the relationship between the UK and the
donor country exists. For example, information relating to the facilities offered by UK banks should be pertinent to the needs of specific groups of students. University websites advising international students should reflect changes in government policies, which may have an effect on students, for example visa requirements, and work time directives.

**Educational Leaders**

This study has shown that students suffer financial deprivation when living in the UK, and that this is compounded when money is remitted home. Students are therefore more likely to undertake part time work in addition to studying. Educational leaders with responsibility for curriculum design need to work in collaboration with NHS managers to develop flexible routes to learning for overseas students undertaking pre-registration nurse training.

Statistics relating to the number of HIV infected adults in Zimbabwe (Carter, 2003) makes it likely that some students studying in the UK will be HIV positive. There is clear evidence for the link between poverty, nutritional status, an increased susceptibility to opportunistic infections, and the progression of HIV to AIDS. Educational leaders need to work alongside occupational health services, within the context of current policy, which advocates non-compulsory testing of immigrants, in order to advise Zimbabwean students on matters of personal health and safety.

**Educators**

Zimbabwean students were shown to have particular needs derived from cultural practice, social custom, preferred language, and ethnic tensions, all of which impact
on relationships within the classroom. Educators should be aware of the existence of
tensions in and between specific ethnic groups where these may influence classroom
activity, for example when delivering sensitive curriculum content such as religion,
ethics, and cultural awareness. Educators need to pay attention to the specific needs
of individuals within designated mentor groups, for example, where older and
younger Zimbabweans, or Shona speaking and Ndebele speaking Zimbabweans
comprise the same group. Measures should be taken to develop the role of personal
tutor to incorporate aspects of cultural awareness. Educators involved with overseas
students need to take a broad view of the concept of adult learning, bearing in mind
the diverse range of educational experience students bring to pre-registration nursing
programmes. Flexibility in supporting Zimbabwean students is advocated that takes
into account individual learning needs. In addition educators need to recognise and
acknowledge reported accounts of racist behaviour in all its manifestations.
Awareness of the existence of and mode of operation of policies to deal with racism in
whatever context it occurs is essential.

Zimbabwean Students

Zimbabwean students need to recognise the importance of supporting each other
while studying in the UK. The lived experience of current students provides a useful
source of information in relation to many aspects of life in the UK, for example
documentation commonly needed, sources of financial support, and maintaining
health and well being. Overseas students should consider developing identified
support networks including the availability of contact telephone numbers. Course
leaders could provide a framework during admission, enrolment and induction to
facilitate this. Aspects of time management have been shown to be problematic for
Zimbabwean students. Therefore, where possible students should be encouraged to support and motivate each other at times when domestic activities impinge on the student’s ability to meet the requirements of the pre-registration nursing course.

The pre-registration course equips the student with the skills required to practice in a variety of health care settings, although some areas of specialist practice necessitate further training if career advancement is desired. Pressure should not be placed on students to return to Zimbabwe on completion of their studies. However, Zimbabwean students should recognise the important contribution they can make to the future recovery of health care provision in Zimbabwe.

The UK Government

Finally, the UK government together with the Nursing and Midwifery Council should take efforts to support newly qualified and existing practitioners working in the NHS. Preceptorship programmes should be put in place as a matter of urgency if attrition rates from nursing are to be countered. A planned programme of recruitment should focus primarily on countries that do not themselves have a problem with health care provision, as opposed to a short term solution involving recruitment from vulnerable countries. The valuable contribution of overseas nursing students to health care provision in this country should be recognised.

Reflections on the Process of Research with Zimbabwean Nursing Students

It is accepted that part of the process of life-history work is that the researcher has a place in the account (Hatch and Wisniewski, 1995). In this section, the author tries to critically reflect on the journey through the research, on the challenges of the life-
history approach, what could have been carried out differently, the dilemmas faced in interpreting the accounts given by the students, and where the partial and working resolutions to these dilemmas leaves the study.

One of the key reasons for selecting life history as an approach is to give a voice to students whose minority status (as students, as migrants, and as members of minority ethnic communities) might otherwise have led to a situation of these voices remaining muted. The process of understanding the students has led the researcher on a journey towards a greater awareness of the contextual problems facing a significant proportion of pre-registration students. For example, when the student who was the original impetus for the study mentioned that she felt trapped in a full-time nursing post, without the flexibility to reduce her hours in order to meet changing family commitments, the student referred to the terms and conditions of her visa. The researcher wondered if the student was mistaken or had misunderstood the situation, but her own enquiries on the Home Office web-site revealed that the student had indeed correctly understood her own situation. This in itself is a cautionary tale about the delicate balance to be struck between adopting a researcher’s scepticism to the validity of the data, and the researcher’s responsibility within a life-history approach to take the perspectives expressed seriously.

During the course of the life history study issues were raised that the researcher was not in a strategic position to address. For example, the students talked about experiences of racism in the college and in the course of their work-place practice on the wards. What the Zimbabwean students experience as direct racism (racist individual behaviour) may in fact be indirect racism. This indirect racism may arise
because qualified nurses in clinical areas do not have awareness that different students (especially from different cultures) may require quite different management in terms of their learning. In the case of Zimbabwean students, an undemonstrative attitude to learning may be perceived by registered nurses as a lack of motivation to learn, leading them to focus attention on other learners who in appearing more assertive may be perceived as more motivated to learn. This created difficulties for the researcher because students are taught about caring and cultural awareness but are confronted with workplace situations where these values do not appear to inform the behaviour of staff in clinical placement settings. The students then feel they are expected to behave in ways that they do not see other nurses behaving. This is a problem for a life-history study because the imperative of the life history approach is to validate the experience of the life history subjects. However, the experience of the researcher was on occasions to feel some unease in accepting that the version told to her was truthful. For example, the researcher is aware that a personal tutor of one life history participant, whose total contact with the student was greater than the researcher's own contact through the process of the life-history interview now views everything the student says with scepticism because the student had attracted the label of a habitual complainer with a poor attitude to work.

On another occasion, a personal tutor reported a life history subject's lack of interest in learning disabilities (the student's chosen speciality). This student was reported to be driving an expensive car bought by his father, a businessman in Zimbabwe who needed a legitimate way to get money out of the country. Yet in the interview the student professed a keen interest in learning disabilities and the need to take back this knowledge to Zimbabwe. This suggests the researcher was unable to persuade at least
some respondents to view her outside of her role as an academic nurse tutor (who would of course expect students to have a positive attitude towards the client groups for whom they would be caring).

Using a life history approach created difficulties in relation to making recommendations for future practice. The methodology can be questioned in that if it relies on accounts that can be demonstrated at some level to be false, then what level of confidence can be place on the recommendations? If a life-history approach is adopted then to some extent an impasse is reached, because on the one hand the life history interview has yielded very rich data, when students are given free reign to express whatever they like. Yet on the other hand issues are raised that need to be verified in order to be sure recommendations for policy and practice are firmly grounded.

There is also the issue of the extent to which recording accounts of Zimbabwean students and then looking at these in their own terms risks over-playing the uniqueness of these experiences compared to other international nurses, or indeed any other student nurses currently undergoing training. In other words because the approach involves no immediate and direct comparisons some experiences might be wrongly attributed to migrant or cultural status, which are actually related to student status.

Reflection on the process of research with Zimbabwean students has culminated in the researcher not so much re-thinking the methodology, as coming to realise the limitations of the approach. Once issues have emerged from the data, then what the
researcher makes of the life-history narrative depends upon what aspect of the account is considered. One cannot derive recommendations from narrative data without some caution because the serious nature of some of the narratives would require at least some cross-validation. For example, accounts of circumstances that the students attribute to racism, may be rhetorical devices to try and claim back some power in a situation in which they feel relatively powerless: or they might actually be based on incidents; or they might be based on indirect racism; or they might be based on other local discriminations (staff nurses discriminating against all students because it gives them some power, and only accepting them after certain rites of passage on the wards). Life-history narratives cannot in and of themselves offer this context to reported experiences.

Consideration needs also to be given to the influence of other data on how a life-history is read. The life-history subjects did not reveal their HIV status to the researcher, nor make their own status the centre of their narratives, yet the researcher has felt compelled to try and make links between the narratives and her own contextual knowledge. There is evidence of the high prevalence rates for HIV in Zimbabwe, so the researcher has felt obliged to consider the possibility that some students are HIV positive and to wonder about the consequences for their health of the reported situations of stress, double workloads and draining of resources for healthy nutrition in order to remit monies back to Zimbabwe.

One aspect of this life-history research that the investigator could have conducted differently would have been to supplement the life-histories with a focus group in order to provide an opportunity for the students themselves to verify their own
accounts (Pope and Mays, 2000). However, the problem with this is that a focus group would implicitly put pressure on an individual student to defend their version of events. For example, the issue with regard to preceptorship was only one student's account: all the other students felt completely supported in practice. A focus group of this kind would have had to be undertaken with great care so as not to skew the data. In addition, using a focus group technique is a different methodology, and would involve Shona speaking Zimbabweans talking to Ndebele speakers, which the research has shown to be problematic for some students in some situations. The fact that tensions exist between these two distinct groups was only highlighted through the process of life history interviewing. Therefore to engage in focus group methodology could be regarded as not taking life-history seriously.

In spite of its limitations, without a life-history approach, the very important issues, illuminated by the methodology, would not have been raised; nor would they have been grounded in lived experiences. However, the recommendations that have been made need to be treated with caution, and are in any case secondary to the main aim of the research, which has been to understand from the point of view of the students themselves the lived experience of living and studying in the UK. As a consequence the researcher herself feels better informed about some of the issues that students under her care face. Furthermore, the issues raised are ones that would never have occurred to the researcher without the experience of listening to the life-histories. One example of this would be that Shona speaking Zimbabweans and Ndebele speakers may experience tensions if expected to engage in debate over sensitive issues.
Finally, the future for these students is that they are likely to remain in the UK for some considerable time, and will probably bring their families to join them in the UK rather than returning to Zimbabwe. Public sector vacancies are unlikely to diminish in the medium or long term owing to the changes in the age structure of the UK population. Zimbabwean students will have to struggle (as do many UK-born nurses) against a system which claims to be flexible in order to get nurses into the system, but which is then inflexible in order to retain those just recruited. The likelihood is that in twenty years there will be a well established Zimbabwean minority group in the UK similar to the Caribbean community who came to the UK in the post war period (Culley and Dyson, 2001). In summary, undertaking life-history research does not provide all the answers, but at least life-histories can help us understand what the issues are, to raise them and to give these accounts a voice and an audience.
Appendix One: Student Consent Form

Study Title:

A study to describe the life history experiences of Zimbabwean students studying pre-registration nursing in a UK University

Name of Researcher: Sue Dyson

I confirm that I have read and understand the information sheet dated January 2003 for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand my educational and legal rights will not be affected.

I agree to audio-recording of a life history interview by the researcher.

I understand that sections of my educational records may be looked at by the researcher where this is relevant to my taking part in the research. I give my permission for the researcher to have access to my records.

I agree to take part in the above study.

Name of Student Date Signature

Witness to Consent Date Signature
(i.e. family member/friend)

I, the researcher (Sue Dyson) have explained the details of the study to the participant

Name of researcher Date Signature

One copy for student; one copy for researcher.
Appendix Two: Student Information Sheet

Study Title:
A study to describe the life history experiences of Zimbabwean students studying pre-registration nursing in a UK University

You are being invited to participate in a research study. Before you decide it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully. Please feel free to ask me if there is anything that is not clear or if you would like more information.

What is the study about?
The study is about the life history experiences of Zimbabwean students studying pre-registration nursing in a UK University. The research aims to describe your experiences within your own frame of reference and cultural context. It is hoped that by understanding the experiences of Zimbabwean students' appropriate ways of supporting students in the future can be developed. The findings from the research study will be forwarded to the Head of the School of Nursing and if appropriate to the International Office for use in developing support systems for other students.

Why have I been chosen?
You have been invited to participate in the research along with all Zimbabwean students currently undertaking a pre-registration nursing course at De Montfort University.

Who is involved in the study?
The study is led by myself, Sue Dyson, from the Faculty of Health and Community Studies at De Montfort University, Leicester. The study forms the dissertation element of the Doctorate in Education (EdD) at the University Of Leicester School Of Education. The EdD is a course of study leading to the award of Doctor of Education and is designed to focus on a particular issue within the field of education. The Doctorate programme is designed to produce work of publishable quality. Findings from research conducted as part of the doctorate programme are disseminated in relevant publications in order to advance the body of knowledge relating to educational concerns, in this case support for international students.

Do I have to take part?
No, the study is entirely voluntary. Whether you choose to take part or not, this will not affect your education in any way and you are free to keep this information sheet. If you decide to take part, you are still free to withdraw from the study at any time without giving a reason for doing so.

What is involved?
You will be asked to take part in a tape-recorded interview about your life experiences and the place of your nurse education experiences in the UK within the context of your life. The interview may last between1-2 hours and will be conducted at Charles
Frears Campus during a time that is convenient to you. The interview will be scheduled to take place outside of classroom contact time in order not to compromise your learning. All arrangements for the interviews will be made in advance in order to minimise any inconvenience to you. I may ask you for permission to use information from your personal records for the purposes of the research. This information will be used to inform the study and will only include details regarding the part of Zimbabwe that you come from (rural or urban). This information is important in understanding the different life experiences of the participants in the study.

What happens to the information?
All the information is confidential. The interviews will be listened to by myself, the researcher, and transcribed (written down in full) Your name and the name of others you refer to during the interview will not be used on the transcript, nor on the label of the cassette tape, and you will be referred to by a letter (A,B,C,D etc). The tapes and transcripts will be securely stored in a locked filing cabinet in a locked University office. A list of respondents will be kept separately under similar secure conditions. All data will be treated in accordance with the latest Data Protection Act. On completion of the study all tapes and transcripts will be completely destroyed.

What if I wish to complain?
Please raise any difficulties or questions in the first instance with myself, the researcher, Sue Dyson on 0116 207 8764 or e-mail suedyson@dmu.ac.uk If you have any major complaints please contact Donna Young, Acting Head of School of Nursing and Midwifery on 0116 2013849 or e-mail dyoung@dmu.ac.uk

What will happen to the results of the study?
A summary of results and recommendations will be made available to you following the completion of the study at the end of 2003. The findings from the research will be forwarded to the Head of the School of Nursing and Midwifery, to the School of Nursing and Midwifery Research Ethics Sub Committee, and to the International Office in order to inform support for overseas students. The research findings may also be published in relevant educational and nursing journals. The completed thesis will remain the property of the University of Leicester as the awarding body of the Doctorate in Education.

Who is organising and funding the study?
The study is organised by myself, Sue Dyson a Senior Lecturer in the Faculty of Health and Community Studies at De Montfort University. The study has been reviewed by the De Montfort University Human Research School Ethics Committee.

Contact for further information
If you are interested in taking part in the study, or would like any further information about the study, please contact Sue Dyson on (0116) 207 8764. Thank you for taking the time to read this information sheet.
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