Extending the Social Model of Migration and Incorporation to Include Migrant Occupational Communities: The Case of Ghanaian Nurses

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Department of Sociology
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Abstract

The flow of skilled migrants to Canada has increased significantly over recent decades. Considerable research has focused on explaining skilled migration and economic incorporation outcomes, with a focus on economic factors. This qualitative dissertation examines how skilled workers come to the decision to migrate to Canada, and how they navigate the skilled economic incorporation process and challenges that emerged along the way, with a focus on the social forces influencing these processes. To do so, the dissertation drew on the early social migration model advanced by Massey and his colleagues (Massey et al. 1987; Massey et al. 1993), but extended this model by analyzing the influence of the migrant occupational community among skilled migrants.

The project primarily draws on 18 interviews with Ghanaian nurses of varying ages, seniority levels and types of nursing training who migrated to Canada. The analysis revealed key social processes, within both the migrant residential community and what this dissertation has termed the ‘migrant occupational community’, which influenced skilled migration and incorporation. The migrant residential community had a generally positive influence on skilled migration perceptions and aspirations through a local culture of migration, as well as on migration decision-making via general information on better living conditions transmitted via migrant residential networks, similar to that predicted in the early social model.
The migrant occupational community also had an importance influence on skilled migration. The migrant occupational culture influenced skilled migration perceptions and aspirations in positive and negative ways, while migrant occupational networks influenced migration decision-making by providing information and encouragement related to occupational conditions and opportunities abroad. The migrant occupational community played an even more significant role in shaping the skilled incorporation process, primarily via migrant occupational networks and to some extent migrant occupational associations, which helped navigate the numerous steps to skilled incorporation to resume the nursing profession.

This dissertation makes two contributions. First, and primarily, it extends the early social migration model to include the migrant occupational community found among skilled migrants. Second, this project moves beyond an analysis of skilled migration and incorporation outcomes, to an in-depth analysis of the processes of skilled migration and incorporation, in line with Massey’s holistic social migration model focused on low-skilled migration, as well as a growing number of skilled migration studies.¹

¹ The views expressed by the author do not necessarily reflect the views and policies of the Government of Canada.
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Chapter 1
Introduction

The flow of skilled migrants to Canada has increased significantly over the past few decades. Most skilled migrants enter the country through the economic class, and more specifically, the federal skilled workers sub-class (Picot and Sweetman 2012: 3; Citizenship and Immigration Canada 2011, as cited in Picot and Sweetman 2012: 31). In the 1980s, the number of federal skilled workers arriving in Canada hovered around 50 000. In 2014, that number was projected to triple to roughly 164 000 - or 63% of all immigrants to Canada (Citizenship and Immigration Canada (CIC) 2013; CIC 2012:3). Skilled workers can also immigrate to Canada through the family class; however, their skills are not evaluated through the points system (Islam 2003:12-13). Thus, the number of migrants who possess higher level skills coming to Canada is likely even larger than these formal figures (Kofman and Raghuram 2006:293-294).

This significant increase in skilled migration to Canada typically elicits the following questions: why do skilled workers migrate to Canada? What factors or conditions lead some to successfully incorporate into the economy, while others do not? Considerable research has focused on explaining these skilled migration and incorporation outcomes. This dissertation, however, focuses on unraveling the processes that lead to these outcomes. Specifically, this project examines how skilled workers come to the decision to migrate to Canada, and how they navigate the skilled economic incorporation process, as well as the challenges that emerge along the way, with a focus on the social forces influencing these processes.

The critical questions of why skilled workers move, and which factors impact their successful economic incorporation, have historically been answered within the labour migration and

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1 The economic class is made up of the following categories: Canadian experience class, federal skilled worker class/Quebec skilled worker program, entrepreneurs, self-employed, investors, provincial nominee program, and live-in caregivers (Citizenship and Immigration Canada 2011, as cited in Picot and Sweetman 2012:31).
2 These figures include both the principal applicants from the federal skilled worker class (whose skills are systematically evaluated through Canada’s points system), as well as their spouses/dependents (whose skills are not systematically reviewed).
3 The term incorporation has been chosen to describe the process of entering the skilled labour market, in line with Portes and Borocz’s (1989) emphasis on the influence of broader social structures on immigrant incorporation, rather than focusing on individual efforts and skills and a homogenous path of integration into the receiving society.
incorporation literatures. The dominant theoretical approaches within these fields of study are the neoclassical economic and human capital perspectives. As Massey et al (1993:434-436) outline in their review article, the neoclassical approach highlights the primarily economic factors at both the micro and macro levels (i.e. expected wage differences, labour supply/demand) that push migrants to leave their home countries, and pull them towards certain destination countries (Borjas 1990: 7-15). The human capital approach, within the skilled incorporation literature, highlights micro-level economic factors (i.e. individuals’ skills, education, work experience) as critical influences on skilled economic incorporation outcomes (such as Hum and Simpson 2004:50; 57; Aydemir and Skuterud 2005:668). Over time, however, these approaches have been significantly criticized. In particular, as Hondagneu-Sotelo (1994:5-7) and others have argued (Boyd 1989; Massey et al 1994:709; de Haas 2008:9-11), both approaches fail to adequately consider how influences beyond the economic realm, such as political, historical, social and cultural forces, can also significantly shape migration and incorporation.

One alternative to these dominant economic models is the social migration model. This theoretical approach focuses on socio-cultural processes influencing migration and incorporation, and has evolved over time. A key theoretical contribution within this broader literature is Massey’s social process model of migration and incorporation, which was originally developed based on the experiences of low-skilled migration and incorporation and/or rooted in a residential community context (Massey et al. 1987; Massey et al. 1993; Massey et al. 1994). The constituent elements of this early social model of migration will be discussed in detail in chapter 2, but a brief definition of it is warranted here. This dissertation defines Massey’s early social model as one that primarily analyzes how the migrant residential community - made up of a culture of migration, migrant networks and migrant associations - shapes migration and incorporation. It also includes later analyses of gendered culture, networks and associations (among low skilled migrants) and how these can affect migration and incorporation, even though not all gender and migration scholars use the term ‘social model’ (Hondagneu-Sotelo 1994). This social approach to analysing migration and incorporation has more recently been extended to skilled workers through discussions of professional networks, and cultures of migration (Hagopian et al. 2005; Ryan 2008; Raghuram, Henry, and Bornat 2010; Ronquillo 2010; Kiou
and Bailey 2014). However, much of this research has not yet formally been extended to Massey’s early social model.

This dissertation focuses on extending the theoretical claims of the early social migration model to include a community context found among skilled immigrants, the migrant occupational community. To do so, it draws on recent research analysing the social aspects of skilled migration and incorporation, insights from the occupational community literature, as well as findings from this project. Specifically, chapter 2 synthesizes key tenets of social migration and incorporation theory with the concept of occupational community from the occupations literature. In doing so, it proposes the concept of the migrant occupational community, which is defined as individuals who share an ethnic /racial and/or immigrant status, and belong to the same occupation that itself has a history of migration. The key socio-cultural elements within this community include: a migrant occupational culture, migrant occupational networks, and/or migration occupational association.

The second manner through which existing theory is extended is by holding it up against a relevant empirical case (Burawoy 1998:16). This dissertation uses the case of Ghanaian nursing migration for this purpose, since it has been taking place for several decades (Institute of Statistical, Social and Economic Research at the University of Ghana 2003, as cited in Bump 2006) and therefore allows for an examination of sustained social processes. Drawing on the migration and incorporation experiences of this group of skilled workers, chapters 4-6 analyse the validity and consistency of the early social migration model by comparing its main theoretical tenets to this dissertation’s findings. Overall, this project contributes to our understanding of the diverse social mechanisms underlying skilled migration and incorporation processes, and highlights how to extend the early social model by including the migrant occupational community.

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5 Although not all these skilled migration studies explicitly reference Massey’s early social model or reference their findings in relation to his model as a key objective of their work (a key exception here is Ali (2007)), their discussion of social influences on skilled migration and incorporation contributes to the development of a broader social model of migration and incorporation.

6 Skilled is here defined as individuals with a post secondary education, in this case in nursing training.
This qualitative dissertation is based on two data sources. The first, and primary, data source consists of in-depth interviews with Ghanaian nurses in Canada. The second consists of participant observation in the Ghanaian nursing (and broader Ghanaian) community in two Canadian provinces\(^7\) (at various points between 2009-2015). The researcher attended a few meetings by a migrant occupational association in which Ghanaian nurses participated, and an event within the broader Ghanaian community. To clarify, a Ghanaian nurse is here defined as an individual who was raised in Ghana and has completed any level of nursing outside of Canada. The data were analyzed through a thematic analysis approach, which involved looking for clusters of themes or patterns of evidence, in particular in relation to the migrant occupational community, and then evaluating these themes against key tenets of the early social model of migration. More specifically, I assessed the early social model’s claims about the influence of the *migrant residential community on low-skilled migration and incorporation processes* (while also considering how this model has expanded since its emergence in the literature), against the influence of the *migrant occupational community on skilled migration and incorporation processes*.

### 1.1 Research Problem

The labour migration literature has historically been dominated by neoclassical economic approaches. Over time, however, this neoclassical perspective has been significantly criticized. Historical-structural scholars in the 1970s and 1980s began to propose that a wider range of macro economic, political, and historical factors impact both migration and incorporation processes (Sassen 1988:9-10, 186-188; Portes and Walton 1981:29-30, 64-65, 188-191). As Massey outlines in his review of migration theories, the historical structural perspective - in particular world systems theory - argued that as capitalism extends beyond core nations (i.e. colonial powers) to peripheral areas (i.e. former colonies), core nations exploit developing countries for their raw materials, land, and workers, and consequently stimulate international labor migration flows (Massey 1990a:15-16; Massey et al. 1994:721-723).

\(^{7}\) The specific provinces are not mentioned in order to maintain the confidentiality of the project participants.
In the 1980s and 1990s social migration scholars began to critique both the historical structural and neoclassical economic/human capital approaches. These scholars suggest that the neoclassical approach ignored how social categories (such as gender, race, and class) and social processes (such as networks and culture) can significantly shape migration and incorporation, as well as how (im)migration flows are sustained over time (Boyd 1989:639; Hondagneu-Sotelo 1994:4-5). Second, they suggest that the macro historical structural perspective largely reduced migrants to pawns pushed around by structural forces (Hondagneu-Sotelo 1994:187). Alongside similar research proposed by other social migration scholars, Massey outlined a process-oriented social model that highlighted how meso level socio-cultural processes had a significant impact on migration and incorporation. These social processes can be grouped into the concept of a ‘migrant residential community’ to facilitate analysis. For the purposes of this dissertation, its core components include: a culture of migration, migrant social networks and migrant associations, within residential areas characterized by significant migration (Massey et al. 1987:140-147; Massey et al. 1994; Massey and Kandel 2002).

Gender and migration scholars later expanded this social model even further. Massey et al.’s (1987) original study of Mexican primarily low-skilled workers migrating to the United States primarily focused on men due to their dominance in this period of migration, that is the late 1970s/early 1980s (Matthei 1996:41-42). Soon after, gender and migration scholars began to explore the negotiations and conflicts between men and women within low-skilled migrant households, and shone a light on the unique dynamics of (Mexican) women migrant networks (Hondagneu-Sotelo 1994:187-192). As Pessar (1999) outlines in her review article, these insights challenged the unified household (and broader migrant residential community) model, and underlined how gender inequalities and interests can lead to different networks and migration/incorporation outcomes between men and women (Pessar 1999:585-587).

1.2 Critiques of the Social Model of Migration and Incorporation

The influence of key social processes on migration and incorporation, in particular migrant networks, has been explored in different contexts since the inception of this early social model. However, applications of this model as a whole (such as analyzing migrant culture alongside migrant networks) have virtually only focused on low-skilled migrants and/or have been rooted in a migrant residential community setting (e.g. Massey et al. 1987; Hondagneu-Sotelo 1994;
Fussell and Massey 2004; Ali 2007; Fussell 2010; Garip and Asad (forthcoming)). It therefore remains less clear whether these particular social processes are relevant, or manifest themselves in the same way, among migrants with other skills levels or in other community contexts outside the local residential setting - a question asked of the empirical data in chapters 4-6. Similarly, while the inclusion of gender in the social migration model was an important contribution, until recently little attention had been paid to how gender might operate differently among skilled vs. low-skilled migrants. A small, but growing, number of studies though have now begun to analyze the migration and incorporation experience of skilled women (Purkayastha 2005; Yeoh and Willis 2005; Ryan 2008; Meares 2010). However, many focus on the influence of (unequal) gender relations within the household on skilled migration decision-making and skilled incorporation. Consequently, there does not appear to be much research using the insights of the early social model as a whole, that is examining the influence of the culture of migration, (gendered) migrant social networks and migrant associations, to develop a more holistic understanding of the social influences on skilled women’s migration and incorporation within, and importantly beyond, a migrant residential community context.

The lack of a comprehensive process-oriented social model in skilled migration and incorporation research has, in fact, led to the continued influence of push/pull approaches in this field, despite the latter’s limitations. For instance, several studies and reviews of skilled worker migration (such as doctors and nurses) simply list a standard set of discreet, static individual preferences motivating skilled migration decision-making, often noting the frequency with which each is mentioned by the respondents (Campbell 2001:157-166; Kingma 2001:209-210; Khadria 2004:19-32; Adkoli 2006:49-50). Along the same lines, a significant number of studies on skilled immigrant incorporation focus on static measures of human capital as the primary (or among the most critical) factors shaping immigrant incorporation (Hum and Simpson 2004:50, 57; Aydemir and Skuterud 2005:668; Picot and Sweetman 2005:22).

A few more recent skilled migration and incorporation studies, however, have explored social-influences in more depth, such as migrant cultures, networks or associations (Saxenian 2002:25-29; Ali 2007; Raghuram, Henry, and Bornat 2010:631-632; Kōu and Bailey 2014:116-117). These are in the minority though, and often either briefly discuss social processes in their analysis or fail to sufficiently analyse how these work together to shape skilled migration and incorporation. Other studies adopt a quantitative approach focused on the correlation between
socio-cultural factors and migration intentions/labour market outcomes, or note their frequency among other disparate push/pull factors (Wuliji, Carter, and Bates 2009; Khadria 2004:19-32). Consequently, social processes are often discussed as another isolated variable, instead of being connected to a coherent and comprehensive social model of skilled migration and incorporation.

1.3 Research Contribution

In order to extend the early social model (typically focused on low-skilled migrants and/or within a migrant residential community), this dissertation analyses the influence of social processes contained within the *migrant occupational community* on skilled migration and incorporation. More specifically, this study analyzes whether, and if so how, the migrant occupational community influences skilled migration and incorporation, using the case of Ghanaian nurses. The analysis also takes into account how the migrant occupational community works alongside other well-theorized forces influencing migration and incorporation, i.e. the migrant residential community, as well as influences at the individual and structural levels, such as immigration policy and racism. Following Hondagneu-Sotelo (1994: 97) who considered social relations and networks within families and communities as operating at the meso or intermediary level, this dissertation considers the culture, networks, and associations involved in the migrant occupational community as operating at the meso-level.

This analysis does not attempt to disprove other skilled migration and incorporation theories by suggesting that social processes represent the most significant influence on skilled migrants. Rather, it highlights *how* social processes within a migrant occupational community have some influence on skilled migration and incorporation; and in doing so, underscores the need to extend the early social model to include migrant occupational communities found among skilled migrants.

Ghanaian nurses are a relevant case from which to develop an extended social migration model, which can encapsulate migrant occupational communities among skilled migrants, for several reasons. First, Ghana has experienced considerable health worker migration to the United Kingdom (and more recently North America, including Canada) over the past few decades (Canadian Institute for Health Information (CIHI) 2005, as cited in Labonté, Packer, and Klassen 2006a:5; IOM 2009:5). This case study therefore illustrates the influence of social processes (within a migrant occupational community) on sustained skilled migration and incorporation,
which may be found among other skilled migrants from other sending countries (for a longer discussion of the case selection, see pages 65-67). Second, given that most Ghanaian nurses are women, this case study permits an exploration of how the social processes underlying skilled female migration and incorporation may differ from both that of unskilled women (traditionally predominant in the social migration literature) and skilled men (traditionally predominant in the neoclassical skilled migration/incorporation literature), an argument set up in chapter 2 and developed empirically in chapters 4-6.

A last contribution of this dissertation is the insight it provides to empirical and policy issues related to skilled labour and migration. There are estimates that Canada will face a shortage of roughly 60,000 registered nurses by 2022 (Murphy et al. 2009:iii). With aging populations and declining birth rates, foreign-trained nurses may help reduce the strain on health systems. Questions remain, though, about these nursing migration and incorporation trends. For instance, why do foreign trained health professionals choose to migrate? Answering this question requires a deeper analysis of how the migration decision-making process unfolds, beyond individual push/pull factors. In addition, as Ogilvie et al (2007:238) point out, there is limited empirical data that moves beyond identifying which factors influence skilled incorporation, to analyzing how skilled workers successfully navigate the skilled incorporation process and its challenges. Given the predicted labour shortages in the health sector, the successful incorporation of immigrant nurses is an important policy issue to understand in more depth.

In order to answer these key questions on skilled migration and incorporation, this dissertation primarily focuses on processes. More specifically, it analyses how skilled migrants come to the decision to migrate, how they plan their migration, as well as how they subsequently navigate skilled economic incorporation through two process-oriented concepts: the skilled migration decision-making process and the steps to economic incorporation. By primarily analysing the processes through which skilled immigrants migrate and incorporate, rather than focusing on their ultimate migration and incorporation outcomes\(^8\), this dissertation contributes to broadening

\(^8\) Koku and Bailey (2014) represent another example of this process-oriented approach in skilled migration and incorporation research.
current understandings of skilled migration and incorporation and continues the social process tradition of Massey’s early social model.

1.4 Overview of Chapters

This dissertation is organized into seven chapters. Following this introduction and a discussion of this project’s research contributions, the second chapter delves into social migration and incorporation theory focused on low-skilled migration and migrant residential communities. It then draws on elements from the occupational community research to illustrate how skilled migration may also be influenced by a commonly overlooked community context - the *migrant occupational community* - composed of a migrant occupational culture, migrant occupational networks, and/or migrant occupational association. The chapter also outlines how other influences at the individual level and structural levels (i.e. large scale institutions and processes, such as government policy or racial inequality) play an important role in shaping skilled migration and incorporation. The third chapter outlines the key research questions and concepts used to examine the social processes within the migrant occupational community, and then foregrounds the proposed extended social model of migration and incorporation that guided this analysis (a more fleshed out description is provided in the conclusion chapter). This extended model is based on the dissertation’s own findings, as well as a synthesis of the early social migration model, more recent skilled migration and incorporation research, and the occupational community literature. The chapter concludes with the key methodological aspects of the study, notably sampling, recruitment, data sources, analysis and limitations, as well as a more detailed rationale for a case study of Ghanaian nurses.

Chapters 4-6 are the main empirical chapters of the dissertation. The fourth chapter illustrates how structural inequalities can spark an aspiration or desire to migrate among both lead and dependent migrants. A culture of migration, rooted in a migrant residential and/or migrant occupational community, tended to influence *skilled migration perceptions and aspirations* through a shared history of migration, the widespread prevalence of migration, a general awareness of stories of better working and/or living conditions abroad, and a subsequent normalization of migration among community members. However, other stories about the costs, delays and challenges of incorporating abroad circulating back home could also negatively influence skilled workers’ interest in migrating.
Social processes then influence *skilled migration decision-making*. Skilled workers who organise their own migration draw on migrant social networks, from the migrant occupational community and the migrant residential community, to obtain information about where and how to migrate. However structural conditions, namely recruiting employers and a favourable immigration policy for skilled workers, play a key role in translating a positive migration aspiration into a skilled migration outcome. In contrast, the decision-making of skilled dependent migrants is primarily influenced by their spouses, who are considered here to be one part of the migrant residential community at the family level (as elaborated in Chapter 2). However, favourable immigration policy for dependents or family immigrants also facilitates the final migration outcome. Overall, structural conditions play an important role in sparking a desire to migrate, and facilitating the final migration outcome, for skilled workers. They are typically insufficient, though, on their own to lead to migration outcomes without the facilitating role of social processes throughout the skilled migration process.

The next empirical chapter, focused on skilled economic incorporation in the host country, analyses how the migrant occupational community (primarily via migrant occupational networks) provides occupational information and emotional support that help skilled immigrants pass through the steps to skilled incorporation, as well as manage obstacles that emerge along the way. The last empirical chapter focuses on the skilled incorporation process once immigrants enter the workplace. It illustrates how the migrant occupational community can facilitate skilled immigrants’ adjustment to a different occupational culture, as well as challenges with colleagues within the workplace, again through the provision of advice and emotional support. It also briefly explores how some skilled workers stay connected to their migrant occupational community in the home country via migrant occupational associations and networks in the host country, illustrating the significance of the migrant occupational community context.

Each of these empirical chapters provides insight into how the early social model should be extended to include the migrant occupational community among skilled (im)migrants by highlighting when, where and how this community influences skilled migration and incorporation. Bringing together the empirical findings on the influence of the migrant occupational community presented in chapters 4-6, the conclusion more explicitly analyzes these data vis-a-vis the key tenets of the early social model. The conclusion also briefly touches on the implications of an extended social model of migration and incorporation for immigration policy,
namely insights into social avenues for assisting skilled immigrants in better navigating the skilled incorporation process.
Chapter 2
Literature Review: The Need for an Extended Social Model of Migration and Incorporation

This chapter reviews empirical and theoretical literature on migration and incorporation in order to make the case for an extended social model of migration and incorporation. It begins by outlining broad trends in skilled migration to Canada, and then focuses on nursing migration from the developing world to Canada. The next section reviews general economic incorporation trends among skilled immigrants in Canada, and then focuses on immigrant nurses’ incorporation into the Canadian nursing labour market. These two sections provide important context for the ensuing analysis and begin to demonstrate the underdevelopment of a comprehensive social model that adequately includes skilled migration and incorporation, particularly as it applies to nursing migration and incorporation.

The last major section describes the early social model, and outlines its primary focus on what is here labeled the migrant residential community, and traditionally low-skilled migration and incorporation. It also outlines recent studies adopting a social migration approach in their analysis of skilled migration and incorporation, and synthesizes their findings in relation to Massey’s early social model. Drawing on this recent research, the occupational community literature, as well as its own data, this dissertation proposes to extend the early social model by incorporating the migrant occupational community context – a task described in more depth at the end of this chapter.

2.1 Skilled Worker Migration to Canada

Canada is a large immigrant receiving nation of economic and family immigrants, as well as refugees. Historically Canada’s immigration system was restrictive to certain minority groups. In the mid-1960s Canada moved away from this model and developed the points system. This system removed racial and ethnic background as admissibility criteria and shifted the emphasis to human capital attributes, such as language ability, age, and education (Challinor 2011). The model was modified in the 1970s with the creation of three classes of immigrants: independent applicants who would be evaluated based on their human capital, and two other categories - family class immigrants and refugees (Challinor 2011).
Over the past few decades Canada has considerably increased its focus on economic skilled immigrants, in part by making humanitarian and family class migration less of a priority (Challinor 2011). Notably, the 2001 Immigration and Refugee Protection Act (IRPA) increased the emphasis on education, language and skills for admissibility (Challinor 2011). In addition, the federal government has increased its focus on temporary migrants over time (Sharma 2001: 419; Goldring and Landolt 2012:5-7; Boyd 2014). For instance, it recently introduced new skilled recruitment programs for temporary migrants, such as the Provincial Nominee Program (Picot and Sweetman 2012:19). While these migrants are initially brought over temporarily, provincial and territorial governments can nominate them for permanent residence if they have been in the province for at least roughly twelve months, or are applying to immigrate from abroad (Picot and Sweetman 2012:22; Goldring and Landolt 2012:6; Government of Saskatchewan 2015; Citizenship and Immigration Canada (CIC) 2015a). More targeted temporary skilled migration schemes also exist. For instance, nursing professionals abroad have been recruited and brought to Canada via recruitment campaigns where employers sponsor them to work in Canada for a set period of time (Pulse 2008).

These policy and program interventions have impacted the composition of immigrants to Canada. Notably, roughly half of the immigrants to Canada in the mid 1980s were brought in via family sponsorships (Challinor 2011). By 2011 though, less than 25% of permanent residents had entered through this channel, and over 60% had entered as economic immigrants (Citizenship and Immigration Canada 2011, as cited in Picot and Sweetman 2012:31). As a reminder, economic immigrants are primarily composed of skilled workers and provincial nominees, and include principal applicants as well as their spouses and dependents (Picot and Sweetman 2012:31). A significant number of immigrant women enter Canada as spouses/dependents in the economic class, and consequently do not have their skills systematically evaluated. For instance, Banerjee and Phan’s (2013b:1-2, 12) analysis of Longitudinal Survey of Immigrants to Canada (LSIC) data found that the majority of immigrant women in the LSIC sample were skilled (i.e. had a professional/managerial occupation before migrating), but only 25% were principal applicants in the skilled worker class (another 45% of

9 Of particular relevance to this research study are the subcategories of the economic class, in particular federal skilled workers and provincial nominees (Picot and Sweetman 2012:31).
the sample were dependent applicants within the skilled worker class). The other major category through which spouses and dependents immigrate to Canada is the family class. Permanent residents who are in Canada can sponsor their spouses, children and parents/grandparents. Once again, the skills of those sponsored through the family class are not evaluated (Phythian, Walters and Anisef 2009:366). Consequently, the skill level of women immigrants sponsored through the family class is overlooked.

Alongside changes in the types of immigrants, there have also been changes in the main migrant-sending regions to Canada. In the mid 20th century, over 60% of immigrants to Canada originated from the UK and Europe. Since the 1990s Asia and the Middle East have significantly surpassed Europe as the main sending regions to Canada (Statistics Canada 2010, as cited in Challinor 2011; Statistics Canada 2013). In addition, the number of immigrants to Canada from other non-European sending regions has also increased. For instance, the percentage of immigrants originating from Africa almost doubled from 2001 to 2006, increasing from roughly 6% to nearly 11% (Statistics Canada 2010, as cited in Challinor 2011). Despite this growing trend, as Wong (2000:46-47) notes there is a relative paucity of empirical and theoretical research on skilled African immigrants to Canada, and in particular female skilled African immigrants. This gap in the literature is particularly surprising given increases in skilled women’s migration from this region. For instance, the general emigration rate among female skilled migrants from West Africa increased from roughly 17% to 32% between 1990 and 2000 (Docquier, Lowell and Marfouk 2008:23-24). These trends suggest a change in migration decision-making among these skilled female migrants. A notable field of research on skilled female migrants, however, is the migration of nurses - a field of study outlined in more detail below.

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10 Only principal applicants are evaluated by Canada’s points system; however, they can receive additional points based on their spouses’ credentials (Picot and Sweetman 2012:30).

11 Although Canada has been recognized as a leader in gender-based analysis (GBA) in immigration due to its commitment to GBA at the federal level, Boucher (2007:398) notes these efforts have primarily focused on highlighting specific gender issues in Canada’s skilled immigration model, rather than systematic inequalities. Consequently, there may be gender inequalities in the skilled immigration system that are being overlooked.
2.2 The Migration of Nurses from Developing Countries to Canada

Nurses from developing countries have long migrated to the developed world in search of better opportunities. Canada is a destination country for these nurses, with immigrants representing roughly 7-8% of the Canadian nursing workforce in 2011. The total number of foreign trained nurses in Canada could, in fact, be even larger given that these figures only represent those employed in nursing (Canadian Institute for Health Information (CIHI) 2013, as cited in Canadian Nurses Association 2013a:6). Since the mid 20th century, a growing number of nurses have come to Canada from the developing world. In addition to labour shortages post-WWII and the emergence of a public health care system in Canada that increased the demand for nurses, governments also played a role in the migration of nurses from the developing world (Calliste 1993:87-89). For example, Canada changed its immigration policy in the 1950s to permit the entry of a limited number of Caribbean nurses (Calliste 1993:87-89). At the same time, North America became a major destination for Caribbean migrants as the UK government increased restrictions on their entry (Thomas-Hope 2001:5-6).

The situation changed in the 1980-1990s. There were health sector cuts across Canada and the removal of nursing from the list of employable professions for immigrants (Health Worker Migration 2010). Notably, the number of foreign-trained nurses in Canada dropped from 10% in 1985, to roughly 6% in 2000 (Health Worker Migration 2010). Once the nursing labour sector began to expand again in the early 2000s (Health Worker Migration 2010), the main sending region of immigrants to Canada had shifted to Asia. For instance, in the early 2000s the Philippines had become the largest source country for foreign-trained registered nurses in Canada (CIHI 2004, as cited in Little 2007:1342). This shift was likely related to the removal of explicit racial barriers in Canada’s immigration policy in the 1960s (opening up the number of source countries), increased selection criteria in the Government of Canada’s immigration policy (i.e. higher levels of human capital), and the adoption of skilled emigration as an economic policy among certain country governments, notably the Philippines (Ronquillo 2010:10-11; Health Worker Migration 2010).

Another region sending a smaller, though gradually increasing, number of nurses to Canada is Sub-Saharan Africa (SSA). Labonté et al (2006a), for instance, note that between the 1990s and
early 2000s there was an increase in the number of nurses trained in Nigeria and Ghana coming to Canada. Although the numbers remain small on the whole, notably the data identified roughly 50 Ghanaian nurses in Canada by the end of the review period, these figures nevertheless represent a doubling of the number over this period (CIHI 2005, as cited in Labonté et al 2006a:4-5).12 Furthermore, the data likely underestimated the total number of SSA nurses in Canada since it only included those who were licensed or registered in Canada, and a considerable number of foreign-trained nurses are unable to enter their profession (Labonté et al 2006a:5). The authors, for instance, cite one estimate that more than half of foreign-trained nurses are unsuccessful in the pursuit of their occupation in Canada (Jeans et al. 2005, as cited in Labonté et al 2006a:5).

A considerable portion of the literature on nursing migration from the developing world takes a macro-level descriptive approach. For instance, some studies adopt a demographic approach and outline broad skilled migration trends from different regions of the world (Clemens and Pettersson 2008; Docquier et al. 2008). Other scholars have highlighted the negative impacts of these skilled migration flows on sending country institutions and living conditions (Kingma 2001:210; Labonté, Packer and Klassen 2006b). In particular, many suggest that nursing emigration results in a diminished ability to provide health services, difficulty achieving the health-related Millennium Development Goals, and lost training costs (Dovlo 2007:1382; Kingma 2007:1282, 1286). These studies outline important trends and societal consequences related to nursing emigration. The often macro-level focus of this research does little though to illuminate how skilled migration occurs. As Kofman, Raghuram and Merefield (2005:16) suggest, among studies on ethical recruitment and the brain drain from the developing world, “…few studies have explored the actual experiences of migrant nurses”.

This dissertation will examine skilled migration by focusing on the process through which Ghanaian nurses decide to migrate, taking into consideration influences at multiple levels of analysis, i.e. individual, community and structural, and how these work together to contribute to a final migration outcome. This process-oriented approach compliments the dominant macro-

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12 Ghanaian nurses in Canada are also part of a larger immigrant group. Over 29,000 respondents reported a Ghanaian ethnic origin in the 2011 National Household Survey, and nearly 17,000 were first generation immigrants to Canada (Statistics Canada 2014).
level discussions in the nursing migration literature by contributing to a more comprehensive understanding of the skilled migration process.

2.3 Challenges in the Economic Incorporation of Skilled Immigrants to Canada

Canada has admitted roughly 250,000 new immigrants annually over the past several years. More than half of these are economic immigrants (CIC 2011, as cited in Picot and Sweetman 2012:31; CIC 2015b). According to the LSIC (2003), the vast majority (90%) of skilled worker primary applicants find work in their first two years in Canada. However, less than half find a job in their desired occupation (Statistics Canada 2005:7-9). More broadly, roughly 80% of all working-age immigrants find work in their first two years in Canada (Statistics Canada 2005:9). Notably, the majority (74%) of those who do not find employment during this period are women, of which a significant number are spouses from the economic or family categories (Statistics Canada 2005:10).

Immigrants to Canada have traditionally taken roughly 10-15 years to achieve earnings and employment rates nearing those of Canadian-born workers (Frenette and Morisette 2005:237). More recent immigrants though are taking longer to achieve these outcomes (Frenette and Morisette 2005:245-246). Cohorts arriving in the 1980s and early 1990s experienced a larger initial earnings gap (relative to Canadian-born workers) and higher unemployment rates than earlier immigrant waves (Frenette and Morisette 2005:245-246; Aydemir and Skuterud 2005:665), with the exception of immigrant women in the top earnings quartile whose rates have remained stable over the past few decades (Frenette and Morisette 2005:244-245). Although there was improvement in the late 1990s, immigrants arriving in the 2000s again generally experienced a decline in their economic status relative to the Canadian-born, particularly with regards to earnings (Picot and Sweetman 2012:6). More recent research on Canadian born white and visible minorities using census data also finds that the earnings gap between these groups has persisted over the past several decades (Pendakur and Pendakur 2011:8). In particular, black and African black women saw no improvement in their earnings, relative to white Canadians, between the mid 1990s and mid 2000s (Pendakur and Pendakur 2011:21). While the causal mechanisms shaping these earnings gaps likely differ between foreign and native-born visible
minorities in Canada, the persistent earnings gap between even native-born white and visible minority Canadians suggests a negative racial impact in the labour market.

How can we explain these trends? A general consensus has emerged around a key set of factors negatively affecting the employment and earnings outcomes of skilled immigrants including: limited (or no) Canadian work experience; a lack of acceptance/recognition of foreign credentials and especially foreign work experience; a growing number of educated Canadian-born workers (i.e. increasing competition for jobs); bias among employers and professional bodies; as well as challenges with language proficiency (Statistics Canada 2005:10; Reitz 2001:601-602; Picot and Sweetman 2005:22-23; Picot and Sweetman 2012:7-8).

These factors not only have a negative impact on the ability of skilled immigrants to enter the host labour market, but also on their longer-term incorporation trajectories. Labour market pathways research has shown that differences in early incorporation trajectories can shape later employment outcomes and contribute to economic differences among immigrants (Fuller 2011:8; Goldring and Landolt 2012:27). This work highlights the importance of taking a process-oriented approach that considers how early immigrant employment experiences can affect future employment and job quality outcomes. However, as Fuller (2011:43-44) notes, there is a need for more research into which pathways lead to occupational attainment, rather than predominantly focusing on which paths improve general wages and job quality. This dissertation attempts to fill that occupational gap by outlining the path through which some foreign-trained nurses attempt to navigate the skilled incorporation steps into the Canadian nursing labour market, as well as where and how others fall off this path.

2.4 The Economic Incorporation Challenges of Immigrant Nurses in Canada

A growing number of studies have begun to analyse the incorporation experiences of foreign trained nurses in key destination countries, such as in Europe and North America, contributing to a better understanding of the challenges they face, as well as how to facilitate their adjustment to new workplaces. Building off Murphy’s (2008:4-5) overview of this research, some discuss macro-level issues (among other issues) influencing immigrant nurses’ incorporation, such as the effects of colonialism and/or broad challenges in immigrant nursing incorporation (Murphy and McGuire 2005:27-28; Kolawole 2009:11-16). A few others adopt a more grounded approach
focusing on immigrant nurses’ subjective experiences of the incorporation process, as well as the disconnect between their expectations of the process and its negative impact on their confidence and adjustment to the workplace (Murphy 2008; Sochan and Singh 2007:133-135; Blythe et al. 2009:206-207). Much of these studies and reviews focus on foreign-trained nurses in the United States (Diciccio-Bloom 2004; Yi and Jezewski 2000), Europe (Ribierio 2008; Likupe 2006) and Australia (Hawthorne 2001).

A small, but growing, field of research has begun to focus on the experiences of immigrant nurses in Canada, with a particular focus on the myriad challenges they face in the incorporation process. For instance, the Canadian Nurses Association funded a 2005 study on the challenges faced by foreign-trained nurses (both registered nurses and registered practical nurses) in their efforts to join the profession in Canada drawing on diverse sources and stakeholders - including surveys of regulatory bodies, employers, government officials as well as interviews with foreign trained nurses. The study identified the following key obstacles in immigrant nurses’ incorporation process: difficulties gathering documentation from their source country (i.e. transcripts, record of employment) and having these recognized; challenges related to the licensing exam (i.e. format, psycho-social content); absence of support networks post-migration; language and communication difficulties in the workplace (i.e. nursing terminology); and the total costs involved which can surpass several thousand dollars for the nursing application, exam, registration and language course expenses (Jeans et al. 2005:38-45). Overall, this study identified a number of important technical, socio-cultural and financial challenges that make it difficult for foreign-trained nurses to begin resuming their profession in Canada, let alone obtain equivalent employment. However, since these challenges were presented in a largely additive fashion, how they combine together to push the nurses off the incorporation path remains unclear. How social and other forces combine to limit, or facilitate, skilled incorporation is a major question of chapter 5 in this dissertation.

A few qualitative studies provide more in-depth knowledge of the emotions immigrant nurses experience throughout certain key incorporation points. Notably, Sochan and Singh (2007) undertook interviews with a dozen foreign trained nurses (from diverse developing countries) in Ontario who were enlisted in bridging/upgrading programs with the goal of becoming RNs to illustrate the credential recognition and licensure process from the perspective of the nurses involved. Their study revealed a deep sense of confusion among the nurses regarding how to
navigate the credential recognition process, and frustration and disillusionment with the upgrading/bridging programs they were required to pursue (Sochan and Singh 2007:132-134). Furthermore, the return to school left the women feeling vulnerable about their abilities as nurses, and contributed to a questioning of their professional dignity. This in-depth study illustrated how immigrant nurses live through the downgrading experience early on in their incorporation path, but its findings were generally limited to a few early incorporation steps.

Two recent qualitative studies take a more comprehensive approach by exploring the total incorporation experience of foreign nurses in Canada. Drawing on interviews with 17 immigrant nurses in Toronto (from Europe and Asia), Murphy (2008) proposes a four stage process of incorporation into registered nursing: initiating the journey (i.e. registration process), competing for employment, immersing in practice (i.e. experiencing new nursing practices), and aspiring to professional possibilities (i.e. career mobility, and further training). The nurses experienced “tensions” within each of these processes - such as language challenges and limited support from other nurses, as well as “relaxations”- such as cultural and religious networks and supportive teachers in upgrading programs (Murphy 2008:204-206). Murphy’s study therefore provided insight into how foreign-trained nurses navigate the entire skilled incorporation process, highlighting both the challenges as well as supports they drew on. However, her study was limited to employed nurses within the Toronto region, thereby overlooking why and how some immigrant nurses fall off the incorporation path, defined here as resuming their nursing profession in Canada.

A few other research papers also focused on the challenges foreign nurses face incorporating into the Ontario nursing sector, from the credential recognition process to workplace adjustment. Drawing on interviews with roughly 40 nurses, Blythe et al (2009)’s findings echoed earlier studies on the challenges foreign nurses encounter, such as difficulties gathering the necessary documents, language and cultural problems related to the content of the licensing exam, and unfamiliar technology and workplace communication skills (Blythe et al 2009:206-207). The authors also provided concrete suggestions for how to overcome these challenges, such as the importance of initial workplace orientation, and the need for additional resources for foreign trained nurses in order to illuminate the incorporation process and its requirements (Blythe et al 2009:207-208). Similarly, Murphy and McGuire (2005:29) proposed developing orientation/support programs that include applied language training, theory and practice
connections, links to training and employment opportunities, as well as psychosocial, economic and personal support resources. Bourgeault and Neiterman (2013:95-99) analysis of the incorporation challenges experienced by internationally trained nurses also highlighted the utility of bridging programs for navigating clinical and cultural gaps in Canadian nursing practice for skilled immigrants. However, the authors underlined how these programs often face financial constraints and are not widely available across the country (Bourgeault and Neiterman 2013:103-104). Overall, these studies provided important recommendations for how to assist immigrant nurses in overcoming challenges in their skilled incorporation process. Yet much of the recommendations focused on employer or government-led interventions, rather than meso-level networks or communities, which have been highlighted as a useful facilitator in the low-skilled incorporation literature.

A last weakness in current Canadian scholarship on immigrant nurses’ incorporation is the limited recent research on how racial inequalities affect their incorporation process. This is particularly surprising given that racial inequality in the Canadian nursing sector has a long historical precedence. Prior to the mid 20th century, non-white immigrants were only able to enter the country under ‘special arrangements’, or approval from the Immigration Minister, in order to limit ‘coloured immigration’ (Calliste 1993:88-89). Even after immigration policy restrictions lessened post WWII, black Caribbean nurses were admitted under different immigration requirements relative to other skilled immigrants (Calliste 1993:94). For example, the hospital offering these foreign nurses a position had to be notified of their ‘racial origin’. Moreover, prospective Caribbean nursing migrants needed additional nursing qualifications relative to their white counterparts. On a broader level, Calliste (1996) describes the numerous coalitions (i.e. Coalition for Black Nurses, Nurses and Friends Against Discrimination) and social movements that emerged in the 1980-1990s to raise awareness about racial discrimination in the Ontario health care system. The author also outlines complaints brought by black nurses to the Ontario Human Rights Council regarding systemic racial discrimination in their hospital (Calliste 1996:382-384). This important qualitative research highlighted longstanding systemic racism in the Canadian nursing workplace faced by visible minority immigrants and non-immigrants.

More recent research on the health care sector in Canada has emphasized the need for a further nuanced understanding of systemic racial discrimination in workplace hiring/adjustment. For
instance, Ogilvie et al (2007:234) highlight a study that illustrates continued prejudicial tendencies in the Canadian health care sector. Esses et al (2007) asked participants to evaluate applicants for a health care position who were born and educated in either Canada, the UK or India - all with equivalent qualifications. The applicant trained in India received the least positive evaluations. Notably, the researchers assessed subtle prejudices among the participants prior to the evaluation and found that only participants with prejudicial attitudes gave negative evaluations to this applicant. The authors also cite their own research (Ogilvie et al. 2000) on minority nurses in Edmonton, which found that the quality of foreign nursing training was often questioned by Canadian-born nurses. Notably, Canadian nurses were more trusting of the professional knowledge of a nurse from Vietnam who completed her nursing education in Canada but had no clinical experience, compared to two nurses trained in Hong Kong with over ten years experience in Canada (Ogilvie et al. 2007:235). Along the same lines, Ronquillo’s (2010:78-80) analysis of immigrant Filipina nurses in Canada described racialized experiences in the workplace among some respondents, such as feeling like an outsider and sensing the need to prove themselves as competent professionals to their nursing colleagues.

Das Gupta’s (2009) larger study of nurses\textsuperscript{13} confirms this perception of racism within the nursing workplace, and that these perceptions vary between groups. Her 2001 survey of over 500 nurses in Ontario found that 43\% of Black/African-Canadian nurses felt their race/colour/ethnicity affected their hiring, compared to roughly 50\% of South Asian and 23\% of Asian nurses. Larger differences between these groups emerged in other areas (Das Gupta 2009: 85). Notably, 58\% of Black/African-Canadians felt their race/colour/ethnicity had affected their relationships with colleagues, relative to only 48\% of Asian and 27\% of South Asian nurses (Das Gupta 2009:76-77). Similarly, roughly 58\% of Black/African-Canadian nurses felt their race/ethnicity/colour affected their relationships with their patients, relative to roughly 30-35\% among Asian and South Asian nurses (Das Gupta 2009:77). In terms of earnings differentials across groups, Buhr’s (2010:218) analysis of 2001 Census data found differences in earnings among foreign trained registered nurses in Canada, relative to those trained in Canada. Notably, nurses trained in the United States and Western Europe experienced a wage penalty of less than

\textsuperscript{13} Note – Although a proportion of this study’s sample included foreign-trained nurses, the size of the proportion was not clear.
5%, while nurses trained in Africa experienced a 9% penalty. These studies highlight the continued presence of racism and differential treatment in Canadian nursing, as well as the need to understand the distinct experiences of different immigrant nurses, specifying where and how this racial discrimination emerges in the skilled incorporation process.

To summarize, the research on immigrant nursing incorporation in Canada underscores the following key challenges: the cost and length of time involved in the incorporation process (i.e. application, exam, registration fees); lack of information on how to navigate this process; absence of support networks post-migration; challenges in obtaining the necessary documents from the home country; limited recognition of credentials and particularly foreign work experience; challenges with the licensing exam; difficulties adjusting to the new workplace in terms of terminology, new equipment and practices; as well as racial discrimination (Murphy 2008:204-205; Sochan and Singh 2007:132-134; Bourgeault and Neiterman 2013:95-99; Jeans et al. 2005:38-42; Ronquillo 2010:78-81).

A key weakness of many of these nursing studies is that they provide a general description or list of the challenges immigrant nurses face. As a result, there is limited understanding of how these challenges arise, how they come together to shape the incorporation process as a whole, and how foreign-trained nurses attempt to overcome them (an important exception here is Murphy’s (2008) in depth study on nursing incorporation, tensions and supports). Without additional research in this area, the situation will largely remain that “internationally educated nurses are the ‘forgotten nurses’ in the [Canadian] health care system, largely because so little is known about them” (Murphy and McGuire 2005:26).

This dissertation focuses in-depth on whether, and if so how, a group of foreign-trained nurses successfully pass through the skilled incorporation process, and how they navigate any challenges that emerge along the way, by using an extended social model of migration and incorporation that includes the migrant occupational community. In so doing, the dissertation moves beyond a descriptive classification of incorporation challenges, to a more process-oriented understanding of when, where, and how skilled (im)migrants encounter these challenges, how some are able to overcome these barriers and how others are not, with a particular emphasis on the influence of social processes within the migrant occupational community.
2.5 Theoretical Approaches in the Migration and Incorporation Literature

One of the main theoretical frameworks in the migration and incorporation literature is the social model. This social framework was originally developed out of the experiences of low-skilled migrants (Mexican rural immigrants) and has emphasized networks, associations and culture at the level of the community, family and friendships. In the following section I outline the main tenets of this early social model of migration and incorporation, as well as how the associated field of research has expanded over time. While much of this research has historically focused on low-skilled migration, an increasing amount of studies in the skilled literature is exploring the influence of migrant social networks and cultures of migration on skilled migration and incorporation. However, few use the insights of the social model as a whole, that is the influence of the culture of migration, migrant social networks and migrant associations, in an in-depth way to understand skilled migration and incorporation. Furthermore, much of this work in both the low and high skilled literature assumes, rather than illustrates, the specific mechanisms of influence associated with these social processes (as argued by Garip and Asad (forthcoming, 8)). This dissertation proposes to use insights from this more recent research analyzing social influences on skilled migration and incorporation, as well as the occupational community literature, to further extend the social model of migration by analyzing how the migrant occupational community as a whole (i.e. migrant occupational culture, migrant occupational networks, and migrant associations) influences skilled migration and incorporation.

2.6 Theories on the Social Nature of Migration

Several theories exist in the social migration literature. I primarily discuss the following: a) the networks theory of migration, b) the cumulative causation of migration (an evolution of Massey’s early social model), and c) the gendered social migration model, due to their emphasis on meso-level social factors influencing migration. Taken together, these theories set out social processes within what is as usefully labeled as the *migrant residential community*. The concept not only allows for an analysis of the whole, but also the impact of the migrant residential community’s individual constituent elements in this empirical analysis. In addition, this heuristic facilitates comparisons between Massey’s early social migration model and this project’s findings (as well as its synthesis of research analyzing social influences on skilled migration and
incorporation, and relevant occupational community literature), in line with the extended case method approach.

2.6.1 Networks Theory of Migration

The networks theory of migration posits that connections between migrants and non-migrants increase the chance of international movement since they decrease the costs and risks of migration (Boyd 1989; Massey 1990b:69-70). For instance, prospective migrants can rely on connections to migrants in other countries to provide information about strategies to migrate (i.e. technical and legal advice), job opportunities, as well as financial and emotional support (Hammar et al. 1997, as cited in Meyer 2001:93; Massey 1990b:69-70). Consequently as Meyer (2001:94) notes, “in providing the ideas and opportunities of migration to individuals, networks in fact make them migrants. As such, they are more than mere instruments. They are components and determinants of the migration process.” In particular then, migrant social networks play an important function in facilitating the decision-making process of prospective migrants.

2.6.2 Cumulative Causation of Migration Theory

The cumulative causation of migration theory emerged from Massey’s earlier work on the social process model of international migration (Massey et al. 1987). Briefly, the latter illustrated how migrant social networks and associations sustain widespread primarily low-skilled migration and incorporation in a residential setting, while also taking into account the influence of structural conditions (i.e. economic inequalities between countries) in triggering migration. Massey’s theory of the cumulative causation of migration drew on this earlier work, but expanded the scope of social processes that influence (low-skilled) migration and incorporation, as well as clarified the different levels of analysis involved, as detailed below.

The cumulative causation of migration theory is primarily centered at the community-level, but also references key changes at the individual level that emerge through migration (Massey 1990a). Specifically, the more that an individual is involved in migration, the more that his/her motivations and interests become oriented toward additional migration as a result of exposure to new cultures, opportunities and material choices. In addition, the more ties that migrants develop in the source country through repeated migration, the easier future moves become through the former’s provision of information and assistance (Massey et al. 1994:733). Shifting to the
community level, the cumulative causation of migration argues that the local community context also impacts migration dynamics. Essentially, the theory predicts that over time individual migration flows come to influence the context in which migration decisions are developed, in a way that promotes further migration (Massey et al. 1994:733-734). It identifies several components of the local/residential community context that increase this likelihood of migration. These include, among others, a culture of migration and migrant social networks at the community level (Massey et al. 1987:139-147; Massey et al. 1994:734, 737-738). Each of these components is described in more detail below.

A key element within the migrant residential community influencing the cumulative causation process is a culture of migration. As Ali (2007:39) notes, a clear definition of the culture of migration has not been formally established in this literature. Building off his working definition, this dissertation suggests that a culture of migration is primarily composed of a history and prevalence of migration within a community setting, as well as the local stories, values, and ideas that promote or normalize migration. Massey et al (1993:452-453) outline that as the frequency of migration increases in a given locale over time, it changes local values and norms in ways that encourage future movement among community members. Stories about prospects and living conditions abroad proliferate throughout the community via widespread migration. Non-migrants then begin to desire the opportunities provided by migration (Kandel and Massey 2002:981-982). Migration in such communities, in fact, often becomes a ‘rite of passage’ to elevate members’ social and financial status (Massey et al. 1994:738). As such, it

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14 Massey et al (1994:734-737) outline a few other community-level components involved in cumulative causation. These include: community income distribution, the distribution of local landholding, and the organization of agrarian production. The first refers to migrant households that obtain additional revenue via remittances from relatives abroad, which enhances their purchasing ability relative to non-migrant households. This additional purchasing power sparks an interest among non-migrant households to move in order to access the same opportunities. The distribution of local landholding and organization of agrarian production refer to the tendency for land to increasingly become concentrated among migrant households who often use it for investment rather than labour. If these households do use the land to farm, they tend to use more advanced farming technology that require less physical labour, which can distort the labour market and increase pressure to migrate. This dissertation has focused on a few aspects of cumulative causation (the culture of migration and migrant networks), rather than all potential mechanisms involved in this larger process, in order to tease out in detail their connection to the migrant occupational community. Future studies could explore the relevance of community income distribution and remittances on skilled migration by obtaining more systematic data in this regard, within both the migrant residential and migrant occupational community contexts. However, the distribution of local landholding and agrarian production would arguably be less relevant to the focus of this study – skilled workers and the migrant occupational community.
eventually becomes ingrained in the community’s repertoire of acceptable - even expected, behavior (Kandel and Massey 2002:982; Ali 2007:39-40). While not all members of a migrant community will desire to migrate, these conditions contribute to a cultural context within the community where individuals are more likely to develop a positive perception and aspiration to migrate without having migrated themselves and/or necessarily having a direct connection to other migrants (Ali 2007:55).

A second key component of a migrant residential community that influences the migration process, in particular the decision to migrate, is migrant social networks. As discussed, migrant social networks facilitate migration by providing relevant information about living and working conditions abroad, as well as financial and social support/resources that reduce the risks involved in organizing the move, finding work, and adjusting to the host country (Boyd 1989:641-642; Poros 2008:1617). This information and social support increase the likelihood that individuals will shift from having a migration aspiration, to making the decision to migrate (Massey et al. 1993:448-449). The decision to migrate, however, not only impacts the prospective migrant in question. Individual migration decisions increase the likelihood that others will migrate through community-level effects (Massey et al. 1994:734). Specifically, “each new migrant reduce[s] the cost of subsequent migration for a new set of friends and relatives”, which increases migration within the community through the growing number and reach of migrant social networks (Massey 1990a:8).

Overall socio-cultural changes, that is the development of a culture of migration and the growth of migrant social networks caused by repeated migration flows, alter the social context in which individuals view migration and the process through which they decide to migrate in ways that fuel additional movement. This process of cumulative causation will be referred to, from this point on, as the early social migration model. Importantly, Massey et al (1993:448) underscore that the early social migration model more accurately describes how migration is sustained, rather than how it is initiated. He points to other key theoretical models, such as neoclassical economic models and world systems theory, to explain the initiation of migration from an area. In his view, the conditions that create the original migration flows can differ significantly from those that perpetuate movement, which often involve social conditions and institutions “that arise in the course of migration” (Massey et al 1993:448). Given that this thesis focuses on social influences that take time to emerge in community contexts characterized by migration, it will
focus on sustained skilled migration flows from Ghana to Canada, rather than explaining how these flows were originally initiated.

The early social migration model has thus far primarily been applied to low-skilled migrants and/or within migrant residential community contexts. In addition, many studies that test the main social processes outlined in this model tend to focus on whether, and how much, the culture of migration or migrant social networks predict migration (Fussell and Massey 2004; Bohra and Massey 2009; Fussell 2010). There has been relatively less analysis of when, and how, these specific social components are most influential throughout the migration decision-making process. Notwithstanding a few exceptions (Garip and Asad forthcoming; Kandel and Massey 2002), much of the empirical work on migration either “assumes, rather than shows, the mechanisms of social influence” in the migration process, and/or only focuses on one of these mechanisms at a time (Garip and Asad forthcoming: 8). The latter authors, for instance, identified three mechanisms through which migrant social networks influence migration decision-making: social facilitation (information provided by networks that reduces the costs and risks of migrating); normative influence (networks contribute to a normative influence to migrate); and network externalities (networks contribute to institutionalized resources, such as coyotes, to facilitate migration). Their study found that the vast majority of migrants were influenced by social facilitation, while a significant number were also influenced by normative influences transmitted through networks. Network externalities were found to be the least influential relatively speaking. Notably, they still influenced more than half of the migrants’ decision-making process in the study’s sample of Mexico-US migrants (Garip and Assad forthcoming: 23-24). Interestingly, nearly all the migrants were influenced by at least two of these mechanisms at once, and for roughly one third all the mechanisms worked together (Garip and Assad forthcoming: 24). Building off this work, this dissertation aims to move beyond identifying what social mechanisms are involved in migration, to analysing how a few of these key social mechanisms relate to each other, and at which stages in the skilled migration process they emerge.

Transnational scholars, it should also be mentioned, geographically extended the social migration model. This research broadened the scope of the discussion to include transnational social networks, identities, as well as economic, religious and political practices stretching across borders, to form one shared transnational social field (Rouse 1991:13-17; Levitt 2001). A variety
of different research sites have been proposed for transnational projects - such as individual
every day activities, to residential communities (like the early social model), to families, and
ethnic groups (as outlined in review articles - Faist 2004:335-338, as well as empirical research
Parreñas 2005; Portes, Guarnizo and Haller 2002). This dissertation will extend the scholarship
further by analyzing the migrant occupational community stretching across borders.

2.6.3 Gendered Migration

A number of gender scholars point out that much of the migration literature historically
portrayed women as occupying the domestic sphere, while male migrants dominated the public
sphere (Pessar 1999:578-579; Hondagneu-Sotelo and Cranford 1999:105-106; Boyd and Grieco
2003; Ryan 2008:454). Consequently, women were assumed to be dependents or non-
participants (i.e. left behind) in the migration process, and their experiences were generally
considered to be secondary or peripheral (Hiller and McCaig 2007:458). Shortly after the
emergence of Massey’s work, some scholars began to explore the gendered dimensions of the
process of migration. Gendered relations within families were emphasized especially in the early
foundational scholarship in this area, with a few exceptions (such as gendered employment
networks, which are discussed in a later incorporation section of this dissertation).

A notable contribution was Hondagneu-Sotelo’s (1994) research on how gender relations within
the home influence migration networks and outcomes. In her in-depth analysis of low-skilled
Mexican migration to the United States, Hondagneu-Sotelo (1994:39) identified three distinct
family migration patterns: a) family stage migration - migration begins with the husbands, and
then the rest of the family joins; b) family unit migration - the entire family moves together; and
c) independent women and men migrants without families. These migration patterns were shaped
by different sets of gendered power relations and norms within the family and broader
community. Traditionally, social relations within the family, and a culture of migration within
the household and/or broader migrant residential community, tended to facilitate migration for
men - but made it more difficult for women - both in terms of available migrant resources and
decision-making processes (Hondagneu-Sotelo 1994:96-97). For instance, Mexican male
migration was often seen as a “patriarchal rite of passage” among members of the local
community. A large and long-standing web of male migrant networks was therefore accessible
for prospective male migrants to fulfill these cultural expectations. However, Hondagneu-Sotelo
(1994:96, 189-192) found that these migrant social networks were at times exclusionary towards low-skilled women.

Household migration decision-making was also impacted by gender influences. The author found that many men in her sample chose to cross the border with little consideration of their wives’ points of view, particularly in cases of family stage migration (Hondagneu-Sotelo 1994:94-95). However, Hondagneu-Sotelo (1994) noted that these trends began to change as women gradually challenged gender norms and developed their own female migrant networks to facilitate their move. Nevertheless, prospective female migrants in her sample often had to bargain with their husbands or fathers to pursue their migration ambitions (on their own or to join their husbands abroad), particularly when their families were characterized by traditional patriarchal authority. Thus, unequal gender relations within low-skilled households led to unequal migration decision-making between men and women (Hondagneu-Sotelo 1994:87-90).

Other research confirmed the significant influence of gender relations on low-skilled (internal and international) migration decision-making and routes. For instance, a few studies described the presence of conflict, negotiation and divisions in migration decision-making along both gender and generational lines in lower skilled households (Grasmuck and Pessar 1991, as cited in Pessar 1999:583; Hoang 2011:1453-1454). Overall, these scholars demonstrated that gender was not simply another variable to include in a statistical model. Rather, it represented “… a set of social relations that organize immigration patterns” (Hondagneu-Sotelo 1994:3). In addition, this gender and migration scholarship challenged the conception of a unified household (and local community), and demonstrated how gender inequalities can lead to different migrant networks, cultures, and decision-making processes between low-skilled migrant men and women. In order to recognize the extension of the early social model to include family-level gendered processes, this dissertation considers family-based gender inequalities, and the family networks that are shaped by them, as part of the *migrant residential community*.

Studies have begun to also explore the migration experiences of skilled women. The dearth of analysis on skilled women migrants up until the early-mid 2000s is related to several trends. As several scholars have argued (Kofman 2000:45-46; Raghuram 2004a:304-305), skilled migration research has traditionally depicted women migrants in a dependent or supportive role. In addition, as Kofman 2000 (52-53) and others point out (Yeoh and Willis 2005:212), the skilled
migration literature largely focused on male-dominated sectors linked to the knowledge economy, and a definition of skill centered on scientific and technological professions. As a result, occupations in more women-dominated professions, such as teaching and nursing, have often been considered semi-skilled and the migration experiences of women in these occupations consequently received relatively less attention (as outlined in Kofman 2000:53; Kofman and Raghuram 2006:282-283). However, research suggests the influence of gender on skilled migration appears to operate in complex ways that are both similar, and dissimilar, to low-skilled migration and warrant further analysis.

Available research on skilled women migration, for instance, suggests that women’s social networks can influence migration decisions. For instance, Ryan’s (2008:463-468) analysis of Irish women who migrated to the UK after WWII to train as nurses found that women networks (composed of both nursing and non-nursing friends and family), strongly influenced their decision to migrate by providing encouragement, information about nursing training opportunities, as well as support to facilitate their move. The author did not though meaningfully explore why some of these nurses drew on both personal and professional networks in their skilled migration process. Ronquillo’s (2010:60-62) analysis also found that fellow Filipina registered nurses shared information about specific employment opportunities abroad and recruitment programs. Overall, the few available studies suggest that skilled women’s networks can shape skilled migration decisions, but the dearth of data in this area requires further research to strengthen these claims.

Skilled migration decision-making is also influenced by unequal gender relations within the family. A number of studies suggest that the profession of male partners in skilled couples often determines whether a family migrates or not (Man 2004:140; Ackers 2004:198; Raghuram 2004b:172; Yeoh and Willis 2005:215). This can especially be the case when skilled women’s incomes are supplemental, and their spouses are older and more experienced (as noted in Eich Khrom 2007:80). This trend though can vary along educational lines. Notably, Swain and Garasky’s (2007:167-168) analysis of migration outcomes among married couples in the United States found that as wives earn more relative to their spouses, husbands are more likely to opt against migration that would have significant costs on the household. However, the influence of education on the likelihood of migration is significantly stronger when the husband has a higher level of education, relative to the same situation for wives. The authors therefore suggest that
skilled couples may continue to privilege their husbands’ employment prospects in migration decision-making.

Other studies highlighted the strong influence that family members, besides spouses, can have on skilled women’s migration decision-making. Ronquillo et al’s (2011:269-272) analysis of Filipina registered nursing migration, for instance, described how some families strongly encouraged the migration of their daughters in order to access better opportunities for the family abroad. Ryan’s (2008:465-466) analysis of Irish women nursing trainee migrants found a more mixed picture with some parents encouraging their daughters to move, and others trying to stop their plans – often when their daughters were the first migrants of the family, and when there were no personal networks available abroad. In the latter case, some prospective women migrants worked around their disapproving parents by applying to hospitals abroad without their parents’ knowledge/consent, or by recruiting others to help convince their parents (Ryan 2008:465-466). Thus the family unit, as well as the unequal power relations within it, can have a significant influence on skilled women’s migration decisions and their ability to exercise their migration preferences. While the previous section illustrated social influences on women’s skilled migration, the next section outlines social influences on skilled migration in general. While much of this skilled research has not been formally related to Massey’s early social model (a key exception is Ali 2007), their findings are relevant to extending this model to skilled migration. This dissertation therefore synthesizes these various social influences underlining skilled migration, as well as draws on this project’s own data, in order to extend the social migration model by including the migrant occupational community.

2.6.4 Social Influences on Skilled Migration

More recent studies have focused on social influences shaping skilled migration more generally. Two key social mechanisms discussed in this body of research are a culture of migration and professional networks among skilled migrants. While many articles did not specifically identify how, and where, in the skilled migration process these social mechanisms were most influential, that is whether on migration perceptions/aspirations or the decision to migrate, this dissertation has more explicitly teased out these findings (where possible) to better inform the analysis. For instance, Hagopian et al (2005:1755-1756) described a culture of migration among Ghanaian and Nigerian physicians that developed around a shared migration history, as well as professional
networks (i.e. faculty who migrated and returned) who served as successful role models to their medical students. While the authors suggested these social influences encouraged physicians to migrate, the study only briefly discussed these findings. Raghuram, Henry and Bornat (2010:631) also described a “socio-cognitive community” among South Asian immigrant doctors, in which migration to the UK had become a norm (or indicator of success) among these professionals, positively shaping their skilled migration perceptions and aspirations. These authors also noted that access to migrant professional networks, composed of South Asian doctors in the UK, influenced prospective migrants’ decision to migrate to the UK (Raghuram et al. 2010:631). Thus, the socio-cognitive community familiarized migration to its members, and migrant professional networks guided their aspirations towards a specific destination country. In addition, Ronquillo’s analysis of Filipina nurses’ oral histories of migration to Canada highlighted the positive influence of a culture of migration among nurses, that is an expectation or widespread desire to migrate, on these skilled workers’ migration perceptions and aspirations (Ronquillo et al. 2011:266-268). Nowak’s (2009) work on migration perceptions among Ghanaian nurses also briefly suggested that the considerable level of emigration among nurses from Ghana could be related to a type of occupational culture of migration, which in turn may influence their views of migration. Choy’s (2010) research on the longstanding history of migration from the Philippines to the United States, as well as the influence of the country’s racialized colonial past with the US on nursing migration and incorporation flows, further highlights the importance of considering socio-cultural elements in skilled migration and incorporation research.

Kōu and Bailey’s (2014) research on skilled Indian migrants in the Netherlands and United Kingdom similarly described how a culture of migration positively shaped skilled migration aspirations through the influence of a migration norm or expectations. In addition, the authors highlighted the role of social and professional networks in shaping the migration decisions and paths of prospective skilled migrants by sharing information about local conditions, professional opportunities and contacts in the migration destination country (Kōu and Bailey 2014:121). Notably, the study also underlined how social resources are not sufficient for migration. Immigration policies can restrict the ability of skilled workers to use their social resources to move across borders (Kōu and Bailey 2014:114).
Two last articles also discussed the influence of a culture of migration on skilled migration, however, their analysis appeared rooted in the broader migrant residential community. Specifically, Ryan’s (2008) analysis of nursing emigration from Ireland to the United Kingdom in the mid 20th century mentioned the presence of a culture of migration within broader Irish society into which the nurses were pulled (Ryan 2008:461-462). Similarly, Ali’s (2007:54-55) in-depth analysis of the culture of migration among prospective skilled migrants in India underscored how it familiarized migration and made the behaviour normative (even celebrated) among skilled residents within Hyderabad in India (i.e. their migrant residential community).

Overall these studies on the social influences of skilled migration provide important insights into how a culture of migration and migrant social networks have a generally positive influence on skilled migration perceptions and aspirations by contributing to a migration norm or expectation, and on skilled migration decision-making by providing information about working conditions and opportunities in specific migration destination countries, respectively. Some of this research has analysed the presence of a culture of migration and/or professional networks across skilled workers as a broad group (Ali 2007; Kōu and Bailey 2014), while others have focused on a single occupational group (Hagopian et al. 2005; Ryan 2008; Raghuram et al. 2010; Choy 2010; Ronquillo et al. 2011). This dissertation draws on the occupational community literature to further examine how social processes influence the migration and incorporation of skilled workers who are members of an occupation (and arguably by extension an occupational community) characterized by migration. In addition, analysis into how these social processes (i.e. a culture of migration and migrant networks) work together to influence skilled migration in a more exhaustive fashion is warranted. The next phase of the skilled migration process is skilled incorporation. Consequently, a brief review of social theories of incorporation is provided below.

2.7 Theories on the Social Nature of Immigrant Incorporation

Key social theories of immigrant incorporation are discussed separately below in order to clearly outline key terms. After this section, I primarily use the term social migration model to refer to both the social process of migration and incorporation, following Massey et al (1987) who do not draw a division between these two interrelated processes. Numerous sub-fields exist in social incorporation research. This section focuses mainly on social networks and incorporation research. It also reviews later work on gendered incorporation (at the level of the household,
labour market and government policy), as well as racialized incorporation (at the level of the
labour market and government policy), due to their relevance to this case study of Ghanaian
nurses.

2.7.1 Social Networks and Incorporation

Massey and his colleagues propose key social factors that can facilitate incorporation into the
host country. These include, among others, migrant social networks and migrant associations
(Massey et al. 1987:256-261). Other scholars have also suggested that migrant social networks
are an essential social factor in the (low-skilled) incorporation process (Boyd 1989:651-652;
Hondagneu-Sotelo 1994:198-200). As discussed, migrant social networks are generally
described as sets of personal ties linking migrants, former migrants and non-migrants through
family, friendship and community networks (Massey et al. 1993:448). Newly arrived immigrants
with access to migrant social networks in the destination country can receive
psychological/emotional support, as well as information on local services and references that

Other research has found that low-skilled immigrants not only draw on co-ethnic networks to
find employment, but also to improve their working conditions. For instance, Mitra’s (2012:79-
81) study found that Punjabi taxi drivers drew on co-ethnic networks within this labour market to
by-pass rules and conditions that limited their returns. Lastly, migrant social networks can be
further strengthened, and/or multiplied, in migrant voluntary associations and clubs that bring
new and existing immigrants together on a regular basis (Massey et al. 1987:261). These
associations can provide a social support system attuned to the particular racial, ethnic and
linguistic needs of immigrant groups, needs which non-ethnic associations may fail to address
(Owusu 2000:1176). It should be noted that other research has outlined how migrant social
networks can have negative influences on incorporation, such as exploitation through network

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15 Massey’s early social model of migration provided a detailed assessment of the process of migration, and to a
lesser degree the different dimensions of incorporation (i.e. personal, social and economic) among largely low-
skilled migrants that takes place over time (and often over multiple migration trips). However, his incorporation
analysis focused more on the differing extent to which these migrants settle permanently abroad (Massey et al.
1987). This project distills relevant elements of his analysis of the social processes underlining economic
incorporation (specifically securing employment) among low-skilled immigrants. Later extensions of his early social
model (Massey et al. 1993; Massey et al. 1994) focused mostly on the social processes underlining migration.
recruitment (Villar 1992:394; Cranford 2005:391-393), limitations on personal freedom, gender inequalities embedded within the networks, or excluding outsiders (Portes and Sensenbrenner 1993:1338-1344). Thus depending on the circumstances, these connections can become a resource or disadvantage to their members.

The ethnic enclave model expanded beyond (co-ethnic) migrant social networks by providing a full social model of incorporation focused on the ethnic economy. For example, Portes and Wilson’s (1980) research on Cuban incorporation to the United States in the 1970s found that immigrants leveraged their language and ethnic networks to gain privileged access to ethnic markets within their co-ethnic migrant residential community (i.e. ethnic enclave). These socio-cultural resources led to mobility opportunities for members of the Cuban community, relative to opportunities in the secondary sector (Portes and Wilson 1980:314). However, other research found that the ethnic economy mostly benefited pioneer Cuban immigrant entrepreneurs and their offspring, since later cohorts had difficulty building networks with earlier Cuban arrivals (Portes and Shafer 2006:33). This ethnic enclave model provided a coherent analysis of how socio-cultural forces can shape economic incorporation, particularly among pioneer immigrants. Since the model only focused on immigrant entrepreneurs within ethnic enclaves, its findings are less relevant for skilled immigrants whose work/profession can take them outside their migrant residential community (i.e. ethnic enclave).

A relatively limited field of research has examined how social processes influence the skilled incorporation process. Available studies find that migrant professional networks can assist new immigrants in navigating the steps to employment in the host country. For instance, Purkayastha’s (2005:188-191) study of skilled Indian women immigrants in the US suggested that access to networks of native-trained and ethnic doctors is one of their key resources for obtaining information on employment opportunities. Similarly, Kǒu and Bailey’s analysis of highly skilled Indian immigrants in Europe found that immigrant professional networks in the destination country were key to obtaining “…valuable inside information on a particular labour market sector” (Kǒu and Bailey 2014:117), such as learning about job opportunities and contacts with potential employers. Alongside migrant professional networks, other research has found that new skilled immigrants contact ethnic and professional associations to ease their incorporation (Saxenian 2002; Stewart et al. 2008). For instance, Stewart et al’s (2008) analysis of formal supports for immigrants in Canada finds that most new immigrants first contact peers,
and then turn to professional and ethnic organizations, for such information as employment opportunities and support for improving their language skills (Stewart et al. 2008:139).

A few studies, however, suggest that the influence of social processes (notably migrant social networks) on skilled incorporation is less positive when it comes to obtaining commensurate incorporation outcomes. For instance, Sanders, Nee and Sernau’s (2002) study of Asian immigrants in Los Angeles suggests that immigrants (roughly half of whom had a college education) employed in the wider (non-immigrant) labour market provided important information and assistance about job opportunities to new immigrants. Access to these ethnic networks enabled new immigrants to gain insight into additional employment opportunities, rather than being restricted to the ethnic economy. However these ethnic networks tended to direct new immigrants, at least initially, into low status and low skilled jobs (Sanders et al. 2002:298). Notably, this relationship only held when the employee and employer were of a different ethnicity, since immigrants tend to be more self-reliant when obtaining employment within their co-ethnic economy (Sanders et al. 2002:306). Since having access to ethnic networks did not have a significant impact on finding jobs of higher occupational status outside the ethnic economy, the authors suggested that immigrants’ interpersonal networks may not be helpful in acquiring better quality and more senior positions, perhaps given the latter’s limited breadth (Petersen, Saporta and Seidel 2000, as cited in Sanders et al. 2002:300-301). In other words, if ethnic networks do not include members in powerful or high-end labour market positions, and instead are concentrated in lower-skilled labour markets, the information or support provided by such networks are more likely to facilitate obtaining lower quality work.

Raghuram et al’s (2010) analysis of the influence of ‘socio-cognitive networks of the profession’ on skilled immigrant labour market access in the host country also found little evidence of a positive relationship. Migrant professional networks facilitated access to lower-level positions for South Asian migrant doctors in the UK, i.e. junior positions in their profession. ‘Patronage networks’, which typically involved non-migrants, were often needed to actually secure these junior posts, as well as later career mobility in the more desired specialties (Raghuram et al. 2010:631-632). Access to the latter networks, though, was often mediated by racist attitudes. These studies therefore suggest that co-ethnic professional networks can assist in finding employment in the wider labour market, but not always of a high quality or commensurate nature, if these networks are concentrated in lower quality work.
Poros’ (2001; 2008) research moved beyond analyzing the composition of networks and their impact on migration and incorporation, and instead emphasized how the ‘configuration of ties’ can shape the influence of migrant social networks. Her research outlined four types of migration streams based on their network formation: solitaries (which involve no migrant social networks), chains (involving interpersonal networks, i.e. family or community), recruits (consisting of organizational networks) and trusties (i.e. overlapping interpersonal and organizational ties typically involving entrepreneurs) (Poros 2001:245-247). These distinct configurations of ties influence individuals’ ability to migrate, where they migrate, and their incorporation process differently (Poros 2001:245-247). As an illustration, some organisations encourage the migration of skilled professionals and provide assistance to facilitate this process (Poros 2008:1617). However, these ties alone cannot ensure commensurate employment as a result of regulations related to education and certification. In contrast, while some initial low-skilled labour may initially be recruited via business or organizational ties (i.e. recruits), future low-skilled flows (and employment) are often mediated through interpersonal ties (chain migration) since there are few labour market entry requirements (Poros 2001:247). The author, though, overlooks the possibility of migrant occupational networks not tied to a specific organization, and how an “occupational configuration of ties” may also shape migration and incorporation in unique ways.

Salaff, Wong and Greve’s (2010) analysis of Hong Kong migrants (both high and low skilled) also highlighted the different resources and dynamics within business, professional and family-related networks, and how these were often split along class lines. In particular, the authors illustrated how business and professional families were influenced by networks (or structures) that promoted or familiarized migration, such as connections to business contacts or colleagues abroad (Salaff et al. 2010:218-219). However, these professional networks were not always able to secure commensurate employment abroad.

Overall, migrant social networks appear to impact the skilled incorporation process in both positive and negative ways. On the one hand, they can provide skilled immigrants with information about job opportunities, but this does not often result in direct commensurate employment, arguably due to accreditation issues and/or discrimination. Even after the necessary accreditation steps have been undertaken, these migrant social networks can channel skilled immigrants into under-employment if the information (or contacts) they provide are concentrated in lower-level work in their profession. Building on these insights, this dissertation suggests the
influence of the migrant occupational community as a whole, that is the migrant occupational culture, networks and associations, as well as how these elements work together throughout the skilled migration and incorporation processes, warrants further analysis.

### 2.7.2 Gender and Incorporation

The gender and incorporation literature also highlights the importance of social processes on incorporation. A considerable amount of this research thus far has focused on low skilled women and work. The main contributions of this body of research have generally been to illustrate that: 1) the process of getting a job is often determined by gendered networks that channel low-skilled women into gendered employment, such as domestic work; and that 2) low-skilled women tend to find work more easily than their husbands, enhancing their status and financial autonomy (Pessar 1999:584-585). As an illustration, Hondagneu-Sotelo’s (1994:198-200) seminal study on Mexican domestic workers demonstrated how they draw on networks with fellow Mexican women domestics to obtain information about job openings, and how to perform job tasks in the host country. Matthei’s (1996:42) article echoed these findings, outlining several studies where immigrant women initially find employment through female family and friends, often in low-skilled work. More broadly, this research also illustrated the importance of analysing the process of incorporation, that is how low-skilled women found work, rather than only focusing on static labour market outcomes.

Employment in the host country generally provided immigrant (particularly low-skilled) women with greater financial security and a sense of authority in their household, relative to the situation in their home country (Hondagneu-Sotelo 1994:194-195; Grasmuck and Pessar 1991, as cited in Pessar 1999:584-585). These economic changes, at times, resulted in a positive renegotiation of household gender relations, such as a revised division of labour. However, as Hondagneu-Sotelo (1994:195-196) found in her study, some male spouses reacted negatively to their employed wives’ new resources and status and desired to return to Mexico, in part because their own economic and power status declined due to racism and challenging job prospects for low-skilled (often undocumented) immigrant men in the United States. Along similar lines, Espiritu’s (1999) review of research on Asian immigrant families in the United States found that low-skilled immigrant women secured work more easily, relative to their husbands, due to increased demand for low-skilled female work in host countries. Yet their husband’s difficulties in finding work,
and subsequent loss of status, sometimes led to resentment and conflict within the family (Espiritu 1999:642-643). Overall, the gender and incorporation scholarship showcased how gender inequalities in the household, as well as gendered networks and labour market demand in the host country, can have important - though often uneven - influences on the incorporation experiences and outcomes of low-skilled immigrant women.

A growing, but relatively smaller, number of studies examine how gender dynamics influence the incorporation of skilled women. Gendered networks and norms influence the incorporation process for skilled immigrant women in both similar and dissimilar ways to their low-skilled counterparts. In terms of the steps to incorporation, gendered norms and relations within the home can contribute to an uneven distribution of childcare and household responsibilities among skilled men and women, making it difficult for skilled women to undertake the laborious work of rebuilding their careers in the host country (Meares 2010:477-479). Gendered norms can also contribute to a feeling or expectation among skilled immigrant women to privilege the needs of their children and husbands over their own incorporation process (Iredale 2005:163; Ho 2006:503-505). As an example, one study found that skilled women were praised for staying (and supporting) the household, rather than their economic contributions (Yeoh and Willis 2005:219-220). Within this gendered context, it is not surprising that immigrant men’s careers tend to also be privileged in skilled households. This decision is also typically related to men’s perceived better employment prospects relative to women’s, which is linked to the former’s often higher education and work experience (Ribierio 2008:82; Banerjee and Phan 2013b:2). The costs of re-building a career in a host country can also lead to privileging one (often the husband’s) skilled immigrant’s profession in the household, rather than pursuing both at the same time (Iredale 2005:163). George’s (2000) analysis of women nurses migrating from India to the United States, and subsequently sponsoring their husbands, highlights an important exception to these trends. Notably, this women-led migration contributed to mixed changes in gender and class relations within their households, as well as the broader community. Finally, at a broader level, structural inequalities, such as difficulties getting credentials recognized and lack of affordable and available childcare, exacerbate these incorporation challenges for skilled women immigrants (Ho 2006:503, 508).

Some studies have examined how skilled immigrant women attempt to obtain employment, despite these gendered barriers. A few such studies have focused on the formal avenues through
which women try to enter their professions in the host labour market, and how the associated labour market outcomes are often gendered. McCoy and Masuch’s (2007:202) institutional ethnography of skilled immigrant women in Calgary, for instance, found that bridging programs assist with obtaining employment in their field of work, but generally at a lower-level (i.e. underemployment). Similarly, Creese and Wiebe’s (2012:69-70) analysis of the economic incorporation of skilled African immigrants in Vancouver also found that most settlement agencies channeled female respondents into initial low-wage precarious employment, if any. Interestingly, skilled men were often channeled into manual labour (since this sector did not require verifying credentials or language abilities), while the women were directed to low-skilled care work, low-skilled white collar work (i.e. clerical or service sector), or encouraged to return to school to pursue additional training if they could not find work due to barriers related to Canadian experience, credentials and/or accents (Creese and Wiebe 2012:62, 65-66). Thus, this research illustrated the gendered avenues through which skilled immigrants can obtain employment through formal channels.

Skilled women immigrants, however, at times combine both formal and informal strategies to obtain employment. As an illustration, skilled African immigrants in Creese and Wiebe’s (2012:66-69) study supplemented their incorporation efforts (through settlement agencies) with more personalized strategies. For instance, the authors described individual employment strategies pursued by female skilled immigrants to improve their mobility, such as searching for employment in the public sector or companies with anti-racist labour policies to avoid racism, pursuing additional ‘Canadian based’ education to improve their prospects in the host country, or opting for self-employment. Similarly, Liversage’s (2009:136) study of skilled female Eastern European migrants revealed three main strategies these women adopted to try and enter the Danish labour market: making use of their immigrant status to obtain a job provided by the government; returning to school in their current field or a new one; or returning home. These incorporation studies provided important insights into how skilled women migrants actively develop strategies to enter a new labour market. However, they did not pay sufficient attention to the social supports these skilled immigrants may have drawn on to help navigate these challenges.

A few studies have filled this gap in the literature by examining how skilled women immigrants draw on migrant social networks to navigate challenges in the skilled incorporation process. For
instance, Salaff and Greve (2004:157-159) discussed how Chinese female professionals turned to their migrant residential community in Canada (even bringing over parents for assistance) alongside new networks (i.e. neighbours) to assist with childcare responsibilities. These social resources, relatively smaller than what they had in China, were often insufficient though to enable their full re-integration into the workforce (Salaff and Greve 2004:160). Other research has examined how skilled immigrants differentially make use of professional networks along gender lines. For instance, Ribierio (2008:82) described differences in how skilled women, relative to men, made use of migrant social networks to navigate the professional re-certification process. While men drew on the support of mostly fellow male migrants, skilled women migrants drew on diverse (largely women) networks in their community, such as fellow workers, employers and residential community members. More in-depth research is needed to confirm how skilled women may use different migrant social networks, in diverse ways, relative to their male counterparts throughout the skilled incorporation process.

Access to migrant social supports, however, may not be sufficient in navigating women’s skilled incorporation process. Aure (2013:283) highlights the importance of non-migrant networks, and their provision of localized or ‘place-specific knowledge’, in helping skilled women immigrants translate their skills in ways that make them attractive in the host labour market. Several studies underscore the difficulty women immigrants face in ‘activating’ their skills and knowledge in host labour markets. For instance, Riaño and Baghdadi’s (2007:180) research on skilled immigrant women Switzerland found that few women were able to translate their substantial skills and experience into commensurate and regular employment in the host country. However, the authors underscored that migrants’ class, ethnicity and gender could take on “positive or negative roles” depending on the local context, i.e. ethnicity and foreign language skills became advantageous when knowledge of different cultures were in demand in immigrant communities (Riaño and Baghdadi 2007:180-181).

Williams (2007:364) also highlights the different forms of knowledge for immigrants and how these vary based on context. These forms of knowledge include: **embrained** knowledge (i.e. generic skills and cognitive abilities); **embodied** knowledge (i.e. practical thinking rooted in context-specific physical experience); **encultured** knowledge (i.e. shared meaning based on a local understanding); and **embedded** knowledge (i.e. rooted in specific systems, cultures and groups). The author further suggests that encultured and embedded knowledge are rooted in a
specific social setting, and consequently are more difficult to transfer across contexts/countries (Williams 2007:365). Although Williams (2007) does not specifically focus on immigrant women, Kofman (2012:74-75) draws on his work to suggest that many occupations that rely on more encoded (or embedded/encultured) forms of knowledge are regulated and feminized. Thus, skilled immigrant women’s possession of knowledge and skills does not always ensure they can “activate them” in the host country. Along similar lines, Kofman and Raghuram (2005:150-151) note that state actors play an important role in managing such labour markets, such as health and education sectors, through their involvement in immigration and credential regulations. Thus, analyses of skilled women’s migration and incorporation, particularly when the latter involves women-dominated occupations, must take into account the influence of these broader structural conditions, alongside social processes.

The gendered challenges skilled immigrant women face trying to enter their professions, i.e. steps to incorporation, can also impact their labour market outcomes. For instance, skilled women’s delayed incorporation efforts can lead to skills atrophying or the need to retrain. In fact, many studies suggest that migration has a negative impact on skilled women’s career outcomes, often resulting in deskilling or downward mobility – at least initially (Salaff and Greve 2004:155; Purkayastha 2005; Meares 2010:479). Kofman (2012:69-70) outlines two main labour market outcomes from this deskilling: a) skilled migrant women frequently work in sectors outside their specialty area/training, and b) they are underemployed, that is employed below their training or qualification level within their occupation. This de-skilling though is not always linear. Meares’ (2010:479) analysis of the incorporation of skilled female South African immigrants in New Zealand demonstrated that skilled female immigrants often transition back and forth between the domestic and professional spheres as a result of underemployment and laborious gendered responsibilities in the home. Illustrative of an exception to this trend, Kōu and Bailey (2014:119-121) note that some skilled dependent women made sense of their migration from India to the UK in a more positive light since the move enabled them to discover a new country, pursue additional studies abroad and/or obtain independence from their extended family. Notwithstanding some negative impacts on their career upon arrival, the skilled women strove to highlight the benefits of migration. This study’s focus on a single immigrant group, migrating from India to Europe, may not be representative of skilled women’s experiences of the incorporation process more generally.
Quantitative Canadian immigrant incorporation research confirms unequal gendered incorporation outcomes. Fuller’s (2011:32) analysis of LSIC data from the early 2000s, for instance, found that roughly a quarter of immigrant women obtained continuous full-time employment immediately upon entry in Canada, relative to nearly 50% of immigrant men. In fact, exclusion from the labour market was the most common pathway for immigrant women in her study, relative to different degrees or pathways of employment, i.e. study, delayed, redirected employment, self employment, partial integration (i.e. long periods of part-time dependent employment), or quick entry into full-time continuous employment (Fuller 2011:36).

Overall, many of the challenges skilled immigrant women face are influenced by gender inequalities at multiple levels of analysis, such as unequal gender responsibilities in the household as well as structural obstacles in the host country, i.e. limited recognition of foreign training/knowledge or experience, particularly in regulated women-dominated professions (Raghuram and Kofman 2005:151). While similar gender inequalities also negatively influence low-skilled women’s ability to work by increasing their level of work and responsibility in the home, the additional incorporation steps that skilled immigrant women must navigate arguably creates an additional burden. In terms of incorporation outcomes, skilled women immigrants often experience a decrease in occupational status in the host country as a result of gender inequalities within the home, coupled with structural challenges. This stands in stark contrast to the probable financial gains/outcomes suggested in the low-skilled gender and incorporation literature. While the latter suggests that women networks can be a key facilitator in low-skilled migrant women’s incorporation process and labour market outcomes (Matthei 1996:42; Hondagneu-Sotelo 1994), additional research is needed to further explore what type of networks might help skilled women throughout the incorporation process as a whole.

2.7.3 Race, Ethnicity and Incorporation

Canadian labour market research has confirmed race as an important dimension of stratification. A large scholarship examines whether ethnic and racial groups experience more limited labour market opportunities and outcomes relative to Canadian born non-visible minorities. For instance, Pendakur and Pendakur’s (2011:8) recent study on Canadian-born visible minorities found a persistent earnings gap between whites and visible minorities. In particular, the earnings gap persisted between Canadian born visible minorities and non-visible minorities in the 1990s,
and the divergence did not meaningfully shrink during the study period (1996-2006). The differentials tended to be larger for men; however, significant gaps remain among women, particularly for Black and African women, relative to non-visible minority Canadian-born women (Pendakur and Pendakur 2011:21). In an earlier article, the same authors found that Canadian-born visible minorities were under-represented among high earners and over-represented among those with lower earnings. Pendakur, Pendakur and Woodcock (2006:15-16) therefore suggest that visible minorities in Canada face obstacles to achieving higher-paying jobs (i.e. glass ceiling), and are more likely to be clustered in lower-paying work (i.e. sticky floors). Relating these findings back to the social networks and immigrant incorporation research (Sanders et al. 2002:298), migrant social networks among skilled immigrants at times can contribute to negative incorporation outcomes by providing information and contacts in lower-level work (where they are often, at least initially, concentrated).

Racialized obstacles in the steps to skilled incorporation have also been noted. For instance, numerous studies have found declining returns on foreign work experience, and persistent challenges in foreign credential recognition, among skilled immigrants in Canada. Some suggest that these obstacles to immigrants’ entry into their professions reflect a form of racism or discrimination in the Canadian labour market (Teelucksingh and Galabuzi 2005:29; Bauder 2003:702).

Others also argue that the significant increase in temporary and/or probationary worker programs represents another form of exploitation in the Canadian labour market. For instance, a sizable body of research has examined the live-in caregiver program in Canada, and suggested that the strict live-in requirements, and length of time immigrants must work before they can apply for permanent residency, can create conditions that lead to exploitation by employers, such as unpaid overtime (Bakan and Stasiulis 1997:121-122). Another type of temporary migration scheme is the Provincial Nominee Program. This program enables provincial governments and employers to nominate certain temporary residents (both skilled and low-skilled) for permanent residence. Yet as Goldring and Landolt (2012:8-9) point out, their pathway to permanent residence is not guaranteed. Drawing on a qualitative and quantitative study of over 300 migrants in the Greater Toronto Area, the authors propose a “chutes and ladders” model that allows for the possibility that migrants may shift between authorized temporary categories, to unauthorized situations, and back again. They also highlight that migration entry categories do not only
determine how migrants enter a country, but also “establish workers’ legal rights in the labour market” and the stability of their socio-economic status in the immediate and longer term (Goldring and Landolt 2012:15). For instance, employers can take advantage of workers with a precarious status by harassing them and denying wages (Goldring and Landolt 2012:25). Regarding longer-term impacts, the study revealed that precarious/temporary status can negatively impact the type and quality of work that immigrants can secure in the future (Goldring and Landolt 2012:27). Thus, temporary/probationary employment programs can provide an opportunity for immigrants to enter a country, but can constrain their potential employment outcomes over the long-term.

Overall, low-skilled incorporation research has demonstrated how gender and racial inequalities intimately shape the incorporation process. These insights have largely been incorporated into the social migration model, with the particular contribution of highlighting how migrant social networks can assist low-skilled migrants in navigating these barriers. However, this type of synthesis is relatively underdeveloped in the skilled incorporation literature, with some exceptions. Notably, some studies have demonstrated that some skilled immigrants draw on professional migrant networks to assist them in navigating challenges related to the skilled incorporation process, yet these networks are less able to facilitate a commensurate incorporation outcome due to their concentration (at least initially) in lower-level work. This dissertation builds on this work by considering how gender and race influence the incorporation experiences of Ghanaian immigrant nurses in Canada, as well as whether (and if so how) social influences (i.e. migrant social networks and associations) within their migrant occupational community impact their ability to navigate gendered and racialized challenges throughout the skilled incorporation process.

2.8 Extending the Early Social Migration Model: Migrant Occupational Communities in Skilled Migration and Incorporation

The social migration model originated in the study of low skilled migration. More recent studies have found an influence of migrant residential networks, professional networks (or what I call migrant occupational networks), and/or a general culture of migration on skilled migration and incorporation (Hagopian et al. 2005; Ryan 2008; Raghuram et al. 2010; Ronquillo et al. 2011;
Kōu and Bailey 2014). In order to further develop our understanding of the role of occupationally-oriented social influences on skilled migration and incorporation, this section draws upon a concept in the occupations literature - the occupational community - that brings together a variety of socio-cultural forces influencing the lives of skilled workers within a profession. This literature review identifies three socio-cultural elements mirroring those found in the social model of migration – the influence of culture, networks, and associations. Synthesizing these insights, the dissertation uses the concept of a *migrant occupational community* to facilitate its analysis and proposed extension of the early social migration model.

An occupational community traditionally refers to a group of workers belonging to the same occupation who share an occupational culture and develop networks with members of their occupation that extend beyond the workplace (Van Mannen and Barley 1982:12; Sandiford and Seymour 2007:214-215). An occupational culture is primarily composed of a common training/education and occupational language, as well as shared work ethics and values related to the occupation. For instance, individuals within an occupation will be familiar with certain terminology that would seem foreign to those outside the community. This shared vernacular and training creates a common foundation between occupational members that distinguishes them from the rest of society and reinforces connection or attachment to the community (Van Mannen and Barley 1982:19-25).

The occupational culture can also help instill a sense of identity to members of an occupational community. In this context, a member’s skills and expertise related to performing their occupation represent an important source of status and pride (Blauner 1960:484, as cited in Williams 1986:248; Van Mannen and Barley 1982:18). For instance, some professionals come to define their personal identity based on their membership in an occupation. As Van Mannen (1979) suggests, “…for members of occupational communities at least, occupational identities are typically presented to others with some pride and are not identities easily discarded for they are central to an individual’s self image” (Van Mannen and Barley 1982:18-19). Thus, in practicing their profession, many occupational members derive more than just a livelihood - they develop a sense of satisfaction, identity and worth (Van Mannen and Barley 1982:34-35).

Importantly, boundaries between occupational communities are generally neither geographic in nature, nor limited to membership in the same organization/firm (Salaman 1971:389-390; Lee-Ross 2004:86). Rather, they are set by the members themselves based on shared understandings.
and identities related to the occupation (Salaman 1971:393-394). Put simply, “the occupation itself is the reference group; its standards of behavior, and its system of status and rank guide contact” (Blauner 1960:483-484, as cited in Williams 1986:244).

A second key constitutive element of the occupational community is occupational networks. These networks can provide access to practical resources for employment mobility, such as technical guidance, mentoring and tips about job opportunities or partnership offers from other members (Kunda, Barley and Evans 2002:251, 257; Saxenian 2002:26-29). Another, perhaps even the primary, resource provided by network members is emotional support, in particular a feeling of belonging and social support through shared challenges and experiences (Sandiford and Seymour 2007:214-216; Korcyniski 2003:65-66). Lastly, the third constitutive element is occupational associations. These institutions can strengthen occupational networks, and reinforce the identities and values shared within the occupational community, through regular interactions and the provision of additional resources (Saxenian 2002:25-27; Kunda et al. 2002:257).

Themes in the occupational community literature have shifted over time. As Sandiford and Seymour (2007:209-210) outline, when the concept first emerged in the literature it initially focused on working class occupations in the industrial sector. Research in the 1960s continued the focus on traditional working class sectors, but also expanded to professional occupations in the service sector. A guiding assumption of research at the time was that workplace relationships within the occupational community could replace more traditional communities in providing a sense of belonging, purpose and community (Sandiford and Seymour 2007:210). After the 1970s, the prevalence of the concept decreased in the literature as research moved away from industrial sectors, which was the traditional focal area of this body of research (Sandiford and Seymour 2007:210).

Some scholars have re-introduced the occupational community concept to analyse workplace relations and cultures in today’s burgeoning service industry, as well as the expanding number of professions. These studies largely find that occupational communities continue to emerge today, and that they have similar constitutive elements and functions as those outlined in earlier studies, namely providing members with a sense of identity and values through their participation in a distinct occupational work culture, as well as contacts and technical and emotional support

Another important contribution of more recent studies has been an analysis of potential divisions between, and within, occupational communities. For instance, Sandiford and Seymour (2007:217-218) found that male and female pub workers made sense of the poor treatment they received by customers in different ways. Male workers emphasized the value of their work in the wider community, while some women perceived themselves as belonging to a low-status occupation in which customers looked down on them. This suggests that members of the same occupational community can have different perceptions of the value or worth of their community along gender lines. Similarly, Korcynzski’s (2003:67) analysis of communities of coping among customer service representatives in four call centres revealed that women service workers were more likely to experience and report abusive customers relative to their male counterparts. As a result, their “communities of coping” tended to be dominated by women. Once again, this research suggests that members of the same occupation can experience their work, and make use of their occupational community, in different ways along gender lines.

Divisions can also emerge along geographic lines between occupational communities. In his analysis of occupational communities among railway men and architects, Salaman (1971:389-390) proposed that a ‘local’ occupational community is primarily rooted in the local environment when occupational members’ experiences, interests and loyalties are rooted in the same workplace – particularly when the work (i.e. schedule) restricts their ability to develop relations with those outside the workplace, such as the case of railway men (Salaman 1971:404-406). Cosmopolitan occupational communities, on the other hand, are not geographically constrained. Instead, members of these communities have a more generalized view of their occupation, its boundaries and applications, such as with architects who work in different locations but are connected by their membership in the same occupation across geographic borders (Salaman 1971:397-398).

These studies have shown divisions within low-skilled occupations, or between low and high skilled occupations. We might also expect divisions within a single skilled profession, perhaps along geographic or native-born/immigrant lines, in today’s globalised world with significant levels of skilled migration. Few studies, though, have examined whether (and if so how)
occupational communities might play different roles, or have different dynamics, when they serve migrant professionals. For instance, how might an occupational community influence the migration and labour market incorporation of skilled migrants within a specific profession? How might its nature and role differ to address the needs of foreign-trained professionals? Would the potentially different needs of members within the same profession, but belonging to different racial or ethnic groups with occupational training rooted in different country contexts, contribute to divisions within an occupational community in the host country? Alternatively, could the different social locations of professionals represent a resource?

The occupational community literature has traditionally reduced workers to their occupational identity, overlooking how ethnicity and immigration status may help skilled immigrants incorporate into their professions in the host country. A key exception is Saxenian’s (2002:25-29) article on Chinese and Indian engineers in Silicon Valley, which outlines how the former developed ethnic occupational associations to share skills (i.e. business, technical and English language) and capital to create technology firms, largely in reaction to their exclusion from the mainstream technology community. Building off this work focused on ethnic professional associations in the private sector, this dissertation seeks to examine the potential influence of migrant occupational communities as a whole on skilled migration and incorporation in the nursing sector.

2.9 Concluding Synthesis of Relevant Literatures

A synthesis of the occupational community literature, and the social migration and incorporation literature, has revealed three key socio-cultural elements that shape the experiences of community members: culture, networks and associations. Regarding the first, a culture of migration emerges within residential communities after long-standing emigration. Specifically, stories of better living and working conditions abroad spreads throughout a local community over time, as well as a normalization or expectation of this activity. As a result, the culture of migration can contribute to a more positive perception and aspiration among members of a migrant residential community. This insight was originally (and extensively) developed based largely on low-skilled migration flows. However, this conception of the culture of migration within a migrant residential community does not capture how an individual’s membership in a migrant occupational community can also shape their migration and incorporation. A few more
recent studies have briefly referenced a type of culture of migration among skilled migrants (Hagopian et al. 2005; Raghuram et al. 2010; Kõu and Bailey 2014), where a widespread awareness of stories of better working conditions contributes to an expectation and/or desire to migrate. Although these studies provided insights into possible migrant cultures among skilled migrants, they have either mostly remained at the descriptive level, briefly touched upon this social mechanism, been rooted in the migrant residential community context, and/or not tapped into the rich theoretical insights of Massey’s social model of migration. This study’s discussion of a migrant occupational culture therefore draws on elements from this empirical skilled migration research, the early social migration model, as well as the occupational community literature, in order to more deeply consider how this social mechanism influences skilled migration perceptions and aspirations among members of a single occupational group.

Migrant social networks represent a second key element in the social migration and incorporation literature. A longstanding literature has established that for low-skilled migrants these networks can provide information, as well as financial and emotional resources, to facilitate the migration process and direct access to employment in the host country. They can be networks rooted in residential network ties, or in an informal/formal association, such as a volunteer association or club. However, later research illustrated how unequal gender relations within the household can constrain women’s ability to successfully migrate and incorporate without the use of their own – often women dominated – networks. Other studies within the skilled incorporation literature have also suggested that professional networks can provide members with information about where to migrate based on labour market opportunities. Unlike low-skilled incorporation processes, it is unlikely that this information will directly result in a job in their occupation since skilled professionals must first navigate the steps to becoming licensed in their profession, and only then can they enter into competitive hiring processes, all the while navigating structural barriers. Furthermore, since many immigrant professionals are (at least initially) under-employed, migrant occupational networks may be concentrated in low-quality work, which increases the likelihood that new skilled immigrants obtain information about work in low-quality work sectors.

A growing field of research on gender and skilled migration also notes that unequal family/household responsibilities can negatively impact skilled women’s agency in household migration decision-making and career prospects. In addition, arriving in a host country with
either a dependent or lead immigrants status can have significant implications in the incorporation process for high skilled immigrant women (Banerjee and Phan 2013b; Purkayastha 2005). Whether and how skilled women might make use of different social supports to navigate these barriers remains less clear, relative to the low-skilled literature. Lastly, the occupational community literature, for its part, also suggests that occupational networks can provide a sense of belonging and emotional support to fellow members based on shared experiences and challenges in the profession. This assistance can be provided through informal networks or via more formal associations through regular and scheduled interactions.

Drawing on these elements of both the low and high skilled migration literature, as well as research on occupational communities, this dissertation proposes that the migrant occupational community has an important influence on skilled migration and incorporation. More specifically, the ensuing empirical chapters will analyse whether, and if so how, the migrant occupational community as a whole (that is migrant occupational culture, networks and association), alongside the migrant residential community, influences skilled migration and incorporation. This extended social model is elaborated in the next chapter.
Chapter 3
Research Design and Methodology

I begin this chapter by summarizing the key conceptual research questions and terms used in this dissertation, as well as outlining its guiding theoretical framework. I then review the main methodological aspects of the study, notably sampling, recruitment, data sources, analysis and limitations, as well as a rationale for the research design.

3.1 Research Questions

The key conceptual research questions are derived from a synthesis of social migration and incorporation literature, and the occupations research. The first research question addresses the skilled migration process, i.e. the development of skilled migration perceptions and aspirations, migration decision-making and the actual move. To explore the social processes shaping skilled migration, I bring together key social processes within the migrant residential community (extensively developed in primarily low-skilled research through the early social migration model), growing research in the skilled literature focused on social aspects of skilled migration and incorporation, as well as the occupational community (extensively developed in the occupational community literature, but with less meaningful reference to migrant status).

I suggest that the migrant residential community is not the only type of community through which skilled workers can be influenced. The early social model illustrated how a residential community characterized by migration can shape migration perceptions and aspirations through a local culture of migration. A few recent studies of skilled migration have also identified a type of culture of migration among certain groups of skilled migrants (Hagopian et al. 2005; Raghuram et al. 2010; Ronquillo 2010; Kōu and Bailey 2014), where a widespread awareness of better working conditions contributes to an expectation to migrate. However, these studies remain in the minority, often do not advance a clear and detailed definition of this culture of migration, and/or tend not to analyse in-depth how this migrant culture relates to a specific occupational group. Drawing on this research from both the low and high skilled migration literature, as well as the occupational community literature, I suggest that a migrant occupational culture (composed of one or more of the following elements: a shared migrant occupational language, education/training, values, history of occupational migration, workplace standards, as
well as a general awareness of how these differ relative to nursing abroad) may influence nurses’ perception and aspiration to migrate, leading to the following question:

**CQ1- Are skilled migration perceptions and aspirations influenced by the migrant occupational community? If so, how?**

I also draw on social migration literature to explore the second stage of the skilled migration process, that is making the decision to migrate and the actual move. Generally, early research using the social migration model identified gendered migrant residential networks as the primary social influence on low skilled workers’ migration decision-making and ultimate outcome by providing information and assistance that reduce the risks and costs involved. A growing amount of skilled migration research also highlights the influence of migrant social networks on skilled migration decision-making through encouragement and information on employment opportunities and skilled migration channels (Ryan 2008; Ronquillo 2010; Kōu and Bailey 2014). Pulling together these insights from both the low and high skilled literature, I therefore suggest that alongside gendered migrant residential networks, the migration-decision making process of skilled workers might also be influenced by migrant occupational networks (within a migrant occupational community) through the information they provide, as well as the associated reduction in costs and risks. I therefore ask:

**CQ2- Is skilled migration decision-making influenced by the migrant occupational community? If so, how?**

The third conceptual research question is rooted in my synthesis of key insights from social incorporation literature discussing the influence of migrant residential communities, and other structural influences outside the migrant residential community (such as racial inequalities) on incorporation, as well as the occupational community literature. This diverse research suggests that social supports within certain communities, i.e. gendered migrant social networks and associations within the migrant residential community, as well as occupational networks and associations within the occupational community, facilitate the economic incorporation and mobility of community members by providing relevant information and emotional support. Similarly, a developing field of skilled research also notes how (ethnic) professional networks and associations among skilled immigrants can assist in obtaining information about
employment conditions and contacts in the local labour market (Purkayastha 2005; Stewart et al. 2008; Raghuram et al. 2010; Kõu and Bailey 2014). Drawing on these diverse literatures I suggest that migrant occupational networks and associations, within the migrant occupational community in the host country, might also influence the skilled incorporation process of skilled immigrants by providing relevant technical information and emotional support to navigate the numerous steps to skilled incorporation (including a skilled incorporation outcome), and therefore ask:

CQ3- Is the skilled incorporation process influenced by the migrant occupational community? If so how?

Overall, the findings from these three research questions promise to contribute to the development of an extended social model of migration and incorporation that takes into account diverse meso-level influences, including the migrant occupational community, alongside well-theorized structural and individual forces.

3.2 Key Concepts

The key terms and concepts used in this dissertation are defined below: Ghanaian nurse, migrant occupational community, migrant residential community, skilled migration process and skilled incorporation process, by synthesizing conceptual ideas from the social migration and incorporation literature, as well as relevant occupational community research.

1- Ghanaian nurse

A Ghanaian nurse is here defined as an individual who was raised in Ghana and has pursued nursing training. The latter generally range from registered nurses with a degree/diploma in Nursing, to community health nurses, to a variety of auxiliary nurses with shorter training periods (Munjanka, Kibuka, and Dovlo 2005:10, 43; Bohmig 2010:149).16 Essentially, a Ghanaian with any level of nursing training is described as a nurse, though his/her level of training is noted where possible. This dissertation had a particular interest in recruiting participants who obtained their nursing training in Ghana. However, the primary researcher

16 Note: more detail is provided on the different nursing training categories in chapter 5.
encountered some difficulty in recruiting participants with this training history. In addition, the researcher was also introduced to a number of Ghanaians who migrated to the UK, and later trained as nurses. Given the extensive historical migration from Ghana to the UK (IOM 2009:5), and the number of respondents with a stepwise migration path to Canada, respondents with UK-based nursing training were ultimately included in the sample. Furthermore, this broader sample provided noteworthy insight into certain shared incorporation challenges between those respondents trained in Ghana and the UK, as well as shared interest in their Ghanaian nursing community in Canada. These insights underscore the strength in the flexibility of qualitative methods.

2- Migrant occupational community

A migrant occupational community refers to individuals sharing an ethnic/racial background, and/or migrant status in the same occupation characterized by extensive migration who are exposed to one or more of the following: a) migrant occupational culture; b) migrant occupational networks; and/or c) migrant occupational association in the host and/or home country. These three social processes/elements within a migrant occupational community are derived from a synthesis of the research on occupational communities, the early social migration model, more recent skilled migration and incorporation research, as well as data from this project. Each of these elements is described in detail below:

2a) Migrant occupational culture

A migrant occupational culture is here defined as including one or more of the following elements: a shared migrant occupational language (i.e. occupation-specific terminology), education/training, values (i.e. a sense of respect/identity related to their occupation), history of the occupation (members’ shared knowledge and familiarization with their occupation’s migration history), and/or standards of workplace behavior, conditions and performance, as well as a general awareness of how these differ relative to nursing elsewhere, within an occupation characterized by migration.

-> Example: A component of the migrant occupational culture could include a shared history of migration among nurses in Ghana. The history of migration among Ghanaian doctors would not be included in this definition since this history stems from a separate occupation.
2b) Migrant occupational networks

Migrant occupational networks refer to ties between individuals sharing the same ethnic/racial background and/or migrant status, and belonging to the same occupation characterized by extensive migration. In the instances where these migrant occupational networks overlap with migrant residential networks, they are still considered to be migrant occupational networks.

- For example, a migrant occupational network could consist of two sisters living in Ghana who are also nurses, or a Ghanaian nurse in Canada who stays in touch with a fellow nurse in Ghana. However, a network involving two Ghanaians who do not also belong to the same occupation are not included in this definition of a migrant occupational network.

2c) Migrant occupational association

A migrant occupational association refers to a formal (non-union) collective that brings together members of the same racial/ethnicity and/or immigrant status, belonging to an occupation characterized by significant migration to discuss issues relevant to its occupational members, such as difficulties in the workplace.

- For example, the main objectives of a migrant occupational association can include to support and promote its immigrant community in the host country by using members’ occupational skills, strengthen their occupation/sector in the home country, as well as support the professional mobility of occupational members in the host country. Association members can meet on a regular basis to organize events in support of these goals, such as fundraising evenings to send proceeds to institutions related to their occupation in their home country, and provide a space for occupational members to share information, advice and support. These bodies can also host formal websites or blogs describing their work and activities, as well as constitutions setting out their purpose(s) as an association.

3) Migrant residential community: The migrant residential community is here defined as including: a culture of migration, migrant residential networks and/or a migrant association, bringing together elements of Massey et al (1987:169-171) and later elaborations (Massey et al. 1993; Massey et al. 1994). The concept can refer to the migrant residential community at the family (household) or local community level.
4) **Skilled migration process:** The skilled migration process here consists of skilled workers’: a) perceptions and aspirations to migrate; and their b) migration decision-making and ultimate migration outcome. Drawing largely on the extensive work of Massey and his colleagues (Massey et al. 1987; Massey 1990a; Kandel and Massey 2002) who analysed social influences largely on low-skilled migration within a migrant residential community, this project modifies many of the key social influences and elements identified in their analysis and applies them to a migrant occupational community among skilled migrants:

4a) **Skilled migration perceptions and aspirations**

Skilled migration perceptions refer to the development of attitudes and understandings of migration (i.e. positive, negative, neutral or mixed) among skilled workers. Skilled migration aspirations refer to the potential desire or interest to migrate.

4b) **Skilled migration decision-making and ultimate migration outcome**

Skilled migration decision-making includes choosing the specific destination city/country, identifying how to migrate to the preferred destination, as well as the final decision to migrate and successful move across borders.

5) **Skilled incorporation process:** This project focuses on the economic dimension of skilled immigrant incorporation. The skilled incorporation process therefore is defined as including: a) the steps to skilled incorporation, and b) a skilled incorporation outcome, i.e. the first and/or final employment outcome.

5a) **Steps to skilled incorporation**

Informed by Murphy’s (2008) process-oriented analysis of skilled incorporation, this dissertation analyses the following steps to skilled incorporation to capture skilled immigrants’ process of incorporating into the Canadian nursing labour market: getting credentials recognized, upgrading, organizing/taking licensing exams, undertaking job searches, and navigating the norms and expectations of the nursing workplace in Canada.

5b) **Skilled incorporation outcome**
This project proposes a typology of skilled incorporation outcomes drawing heavily on the work of Riaño and Baghdadi (2007:172-173) in their analysis of skilled immigrant women’s labour market outcomes in Switzerland. Their study included a typology of three possible outcomes: not in the labour market; employment below skills; and employment according to skills. In addition, the authors further differentiated short vs. long term employment within the latter two categories. This project uses a similar typology and also recognizes the instability of short-term employment for skilled nursing immigrants via temporary work agencies, as the former are often associated with lower job quality - such as low pay, little benefits and complex power relations between their de facto and de jure employer (Kalleberg et al. 2000:272-274)\(^{17}\). The following skilled economic incorporation outcomes are therefore used for this analysis:

- **Positive economic incorporation**: employed according to nursing educational/certification level directly with an employer.
  - i.e. if a Ghanaian nurse was trained as a registered nurse (RN) and obtained an RN position directly with a hospital in Canada

- **Downward economic incorporation**: employed below nursing educational/certification level and/or via an intermediary, such as a temporary work agency.
  - i.e. if a Ghanaian nurse was trained as a registered nurse, and obtained a paraprofessional nursing position - such as a health care aide, via an intermediary.

- **Blocked economic incorporation**:\(^{18}\) not in the nursing labour market
  - i.e. if a Ghanaian nurse is unable to find any nursing employment in Canada and subsequently opts out of the nursing labor market altogether, or turns to a lower-level non-nursing job, i.e. a minimum wage worker.

Notably, this approach to analyzing incorporation does not consider a single, static labour market outcome. Rather, it examines the path these nurses undertake to obtain a positive economic incorporation outcome over time. While some may obtain a positive outcome in their first job, others navigate a longer road of obstacles and opportunities to shift along the skilled

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\(^{17}\) Some articles on nursing agency work have outlined certain positive attributes related to agency work, including higher pay in certain circumstances (Grinspun 2003:69) and greater flexibility in schedules (Manias et al. 2003:274). However, immigrant nurses with few other options may have a different perception of the costs and benefits of agency work. Moreover, most of the respondents in this project who used a temporary work agency were in the early stage of incorporation as paraprofessional nurses and/or obtained work in long term care homes. The latter have been associated with low salaries and low work satisfaction (Buhr 2010:222; Redfoot and Houser 2008:262-263).

\(^{18}\) Blocked economic incorporation here does not refer to the blocked mobility thesis, which suggests that immigrants may turn to self-employment, rather than wage-labour, when faced with barriers in the host society labour market (Li 1997:105). Rather, it refers to being out of the nursing labour market, and obtaining a lower-level non-nursing job. No respondents indicated being self-employed in this study.
incorporation continuum to a positive incorporation outcome, and still others do not shift along the continuum and remain blocked. In so doing, this project takes a process-oriented analytical approach to skilled economic incorporation that can include multiple labour market outcomes for a single nurse’s work history.

Finally, information on the quality of nursing employment will also be discussed where possible, namely whether the work position was in a nursing area in which the respondent had developed expertise through additional training or years of experience, and whether the position was part-time or full-time. The latter is a common indicator of precarious employment in the work literature (Vosko, Zukewich, and Cranford 2003:2) However since this information was not obtained systematically across respondents, it will be provided where available.

3.3 Theoretical Framework: Description of an Extended Social Model of Migration and Incorporation

This dissertation’s major proposed theoretical contribution is its refinement of the early social migration model to include the migrant occupational communities of skilled (im)migrants drawing on its own findings, as well as a synthesis of the early social migration model, more recent skilled migration and incorporation research and the occupational community literature. Its secondary, more empirical, contribution is to identify specific social influences at the occupational level shaping skilled migration and incorporation. These refinements, based on the extended case method approach, permit an extension of the early social model, and provide additional insight into the social nature of skilled migration and incorporation.

The proposed extended social model of migration includes both outcome and process-oriented concepts. For the outcome variable, the analysis is of the degree of incorporation into the Canadian (nursing) labour market. For the main process-oriented concepts (i.e. skilled migration decision-making and the steps to economic incorporation), the analysis considers how skilled migrants come to the decision to migrate in the home country, as well as how they navigate their skilled incorporation in the host country. This interpretive model does not represent a set of hypotheses tested in this research project, rather it served as a heuristic guide throughout the analysis. It draws on the work of other migration scholars that focus on process-oriented or trajectories research, in order to analyse migration and incorporation experiences over time and space (Murphy 2008; Fuller 2011:19-20; Goldring and Landolt 2012:16-18). As Ho (2011:126)
underscores, “turning the analytical lens to migration strategies and trajectories reveals a breadth of migrant experiences exceeding the optic of studying migration only in terms of visa types, occupational statuses, or life stage snapshots”, and allow an identification of the strategies they choose at key inflection points that shape their evolution.

The proposed extended social model addresses the skilled migration process beginning in the home country, as well as the skilled incorporation process in the host country. In terms of the former, the model considers how skilled workers’ perceptions and aspirations of migration can be influenced by their migrant occupational community, which consists of one or more of the following constitutive elements – 1) migrant occupational culture and/or 2) migrant occupational networks in the home country. Each of these elements can negatively or positively influence skilled workers’ migration perceptions and aspirations. For instance, the migrant occupational culture might stimulate positive perceptions of migration by spreading a shared awareness of stories of better nursing conditions abroad based on a long-standing history of nursing migration, and contribute to a desire to migrate among nurses. The analysis also considers the possibility that other influences shape skilled migration perceptions and aspirations, such as socio-cultural elements within the migrant residential community (i.e. family, neighbours) or migrants’ own knowledge (i.e. human capital) or experience of working/living conditions abroad.

Assuming the development of positive perceptions and aspirations to migrate, the analysis turns to the second aspect of the skilled migration process. Specifically, whether, and if so how, the migrant occupational community facilitates skilled migration decision-making and the ultimate migration outcome. For instance, migrant occupational networks with peers abroad may provide information on which cities to migrate to and/or specific routes to take (i.e. where and how to migrate), which helps cement skilled migration decision-making. The analysis also considers the possibility that access to the migrant occupational community can negatively influence skilled workers’ decision-making. For instance, migrant occupational networks abroad may not provide useful information in terms of where to migrate. In addition, other factors may work against the influence of the migrant occupational community. For instance, immigration restrictions may block attempts to migrate, despite information shared by migrant occupational networks. Thus, the proposed extended social model of migration takes into account influences at multiple levels of analysis to fully understand the complexity of the skilled migration process.
Assuming an eventual decision to migrate and successful move across borders, the analysis then shifts to the host country and the skilled incorporation process. Similar to the skilled migration process, the question is whether and if so how the migrant occupational community facilitated the skilled incorporation process in the host country. For instance, a recently arrived Ghanaian nurse in Canada may rely on information obtained from a migrant occupational association to assist with getting her credentials recognized, i.e. a step in the skilled incorporation process. The analysis also considers the possibility that access to the migrant occupational community can negatively influence skilled immigrants’ incorporation. For instance, migrant occupational networks may only provide information on low-skilled nursing jobs, such as personal care worker jobs, which would result in a downward incorporation outcome. Given this dissertation’s focus on the migrant occupational community as a whole, a summary of its constitutive elements (and the relationships involved) that emerged from this study, as well as a synthesis of relevant research from the skilled migration/incorporation and occupational community scholarship, are outlined in Figure 1 below. The information in Figure 1 foreshadows the findings discussed in more detail in subsequent empirical chapters and the conclusion.19

19 Note: the dashed lines indicate the possibility of overlap between these social processes. For instance, the migrant occupational culture can be transmitted through migrant occupational networks, and migrant occupational networks can be involved in migrant occupational associations.
Figure 1 – Outline of Constitutive Elements of the Migrant Occupational Community in an Extended Social Model of Migration and Incorporation

Case Study – the Migration of Ghanaian Nurses

Ghanaian nurses represent a useful case study for extending the social model of migration and incorporation to include the migrant occupational community. The rationale for the case study method, coupled with a review of the history of Ghanaian skilled nursing migration and the incorporation literature related to nursing immigrants in Canada, substantiate this claim.

3.4 Rationale for Qualitative Case Method Approach

The primary theoretical aim of this dissertation is to extend the early social migration model to include the migrant occupational community found among skilled (im)migrants. The secondary (more empirical) aim is to use this case study of Ghanaian nurses to identify additional social influences relevant to skilled migration and incorporation. While it is difficult to generalize the findings of case studies to a population, they contribute to theory building in two key ways. First,
case studies allow for an in-depth engagement with empirical research and theory. Instead of focusing on generalizing to a population, a case study examines in-depth the validity and consistency of a theory by comparing the research findings from one case to existing theoretical frameworks – or what Burawoy (1998:16, 26) calls ‘extension of theory.’ In this dissertation, the theoretical approach to which the empirical comparison is made is the early social model of migration, synthesized and outlined in the previous chapter. Such case studies enable an examination of the mechanisms underlying theoretical frameworks and can help develop new insights into existing concepts and hypotheses. In this instance, the dissertation analyses the influence of the migrant occupational community vis a vis the early social model framework, by drawing on its own data, the occupational community literature, as well as more recent research analyzing social aspects of skilled migration and incorporation research.

This dissertation does not, however, attempt to disprove other skilled migration and incorporation theories by suggesting that social processes represent the most significant influence. Rather, it illustrates the processes through which the migrant occupational community in particular works alongside other well-theorized structural influences (such as inequality between nations and immigration policy) and meso-level forces (such as social processes within the migrant residential community), and suggests why the migrant occupational community must be acknowledged in an extended social migration model. This process-oriented approach to extending theory is more suited to the strengths of qualitative research.

The second manner in which this case study contributes to extending theory is that its in-depth qualitative data permits an exploration of issues that cannot be adequately analysed using large samples and quantitative methods. More specifically, the typical foci and data used in much of the skilled (im)migration research – such as national or regional level data on migration flows, individual push/pull factors, as well as labour market participation rates and earnings of skilled (im)migrants relative to the native born population - are insufficient for understanding the social processes of skilled migration and incorporation. The norms, meanings, networks and communities involved in skilled migration and incorporation can best be analysed through in-depth qualitative case study analyses of specific groups.
3.4.1 Ghanaian Skilled (Nursing) Migration

Ghana is a developing country located in Western Africa. Spread across ten regions, the country’s population hovers around 26 million (World Bank 2014). After achieving independence from Great Britain in the late 1950s, Ghana experienced periods of economic and political instability. The Ghanaian government then sought financial aid at various points from the 1960s to the early 1980s from the International Monetary Fund and World Bank (Boafu-Arthur 1999). To receive this aid, the government was required to cut its overall expenditures (Wong 2000:49; Oppong 2001:357-358). For instance, the country’s health budget was cut roughly between 20-35% during this period (Pacific Asia Resource Centre 1993:4). Some scholars have suggested that the difficult socio-economic conditions, and underfunded public institutions, that resulted from these measures influenced the high rate of health worker emigration over the past few decades (Ageyi 2007:3, 6; Oppong 2001:357-358, 363). Notably, the percentage of nurses/midwives leaving Ghana remained at roughly 20% from the 1990s to early 2000s. The number of emigrant nurses considerably decreased in the mid 2000s but rebounded to some extent in the late 2000s, although reliable and updated figures are difficult to obtain (Bump 2006; Ministry of Health 2005, as cited in Awumbila et al. 2008:11; Piller 2011:13, 30).20

The country remains donor-dependent today, however, its economy has been improving. For instance, real GDP growth averaged 4.7% in the late 1990s, while a decade later it averaged over 6% (Institute of Statistical, Social and Economic Research (ISSER) 2008, as cited in Awumbila et al. 2008:3). In line with these trends, the prevalence of poverty has significantly declined in the past several years - dropping from roughly 50% in the 1990s, to 28% in 2007 (Ghana Statistical Service 2007, as cited in Awumbila et al. 2008:4). Furthermore, life expectancy has increased from under 50 in the 1970s, to 61 in 2012 (United Nations Children’s Fund (UNICEF) 2013).

20 Note – a recent BBC article referenced significantly lower figures of Ghanaian nursing emigration in 2013 (107 nurses left) relative to the early 2000s (i.e. 700 in 2004). However, the figure climbed again in 2014 (192) (Darko 2015)
Public spending (largely from donor funds) in the Ghanaian health sector has also increased. However, actual government spending on this sector (roughly 4-5%) in the 2010s still failed to meet the 2001 Abuja Declaration, where African Union members committed to increase healthcare expenditure to 15% of their annual national budget (Baidoo 2009; World Bank 2015). It should be noted, however, that the government has attempted to improve working conditions in this sector. In the late 1990s, the Ministry of Health introduced the Additional Duty Hours Allowance (ADHA), with the goal of better compensating health workers for overtime hours and heavy workloads (Antwi and Phillips 2011:6). This action was later replaced by the Health Salary Structure, which gave nominal wage increases to all health workers based on task evaluations. However, inflation alongside the loss of the ADHA resulted in the total earnings of some workers to decline (Antwi and Phillips 2011:7). Notably, 50% of Ghanaian nurses working in public institutions in a 2005 survey felt their incomes were insufficient to meet their needs, with only about a quarter able to save a portion of their monthly income (Quartey, Anarfi and Agyei 2010:16-17). Faced with these challenging working conditions and wages, it is not surprising that more than half of the respondents indicated they had considered emigrating (Quartey et al. 2010:18). While more recent information suggests nursing pay has improved in Ghana and contributed to a reduction in nursing emigration, the need for better remuneration to temper migration continues to be underscored (Darko 2015). The long-standing trend of nursing emigration within the Ghanaian nursing occupational community therefore may represent an avenue for some nurses to resolve dissatisfaction with their living and working conditions.

Data from the early 2000s reveals that the top three receiving countries of Ghanaian nurses have been (in descending order): the United Kingdom, United States and Canada (Clemens and Pettersson 2008:9). Research from the mid 2000s confirms that Canada remains one of the top destination countries for Ghanaian nurses, behind the United Kingdom and United States (Pillinger 2011: 12). The neoclassical economic approach might suggest that Ghanaian nurses are attracted to Canada because it provides better wages and benefits relative to the sending country. However, some scholars suggest the restructuring of the nursing sector in Canada in the 1990s and 2000s has led to de-skilling and a decline in job quality in this sector (Bakan and Stasiulis 2003:108). Nevertheless as the above figures suggest, Canada has been a destination country for Ghanaian nurses. Given these discrepancies, diverse influences at multiple levels of analysis must be taken into account to provide a ‘realistic explanation’ of African migration.
This dissertation focuses on the influence of meso-level social processes, within the migrant occupational community, on the sustained migration of Ghanaian nurses to Canada, while recognizing that such skilled migration is also influenced by wider structural forces, such as government policies and individual motivations. Qualitative research is particularly relevant for this type of inquiry, given that it enables the researcher to focus on the intersections between individual migrant decisions, sociocultural forces, and the wider structures in which the former operate (Raghuram 2004b:164).

3.4.2 The Economic Incorporation of Racialized Immigrant Nurses in Canada – The Need for an Up Close and Targeted Analysis

Several scholars have suggested that visible minority immigrants and Canadians experience a difficult incorporation process into the Canadian nursing sector (Das Gupta 2009; Bakan and Stasiulis 2003; O’Brien-Pallas and Wang 2006; Tregunno et al. 2009, as cited in Walani 2015:67). In fact, some propose that a racial hierarchy exists in the health workforce, where white women perform more administrative work, black women perform lower-skilled work, and Asian women are situated in the middle with work that requires more training (Bakan and Stasiulis 2003:128-129). These differences across racialized groups underscore the importance of focusing on specific groups’ incorporation experiences in more depth. As Das Gupta (2009:117) argues, each group has a different relationship and history with the majority (white/European) population in Canada, which can lead to unique racialized relations in the workplace. By focusing on a single African immigrant nursing group in Canada with a history of migration that has received less attention in the nursing literature - Ghanaian nurses – this dissertation fills a gap in empirical knowledge. However, it also extrapolates the broader processes underlying these nurses’ skilled incorporation, so that this case study can inform the broader skilled incorporation literature.

3.5 Sampling and Recruitment Techniques

3.5.1 Rationale for Sampling

The main purpose of this project is to refine the early social migration model. Purposive sampling, rather than random representative sampling, was therefore used. To clarify these terms, the objective of random sampling is to test existing hypotheses by analyzing representative samples of a population to infer broad generalizations. In contrast, purposive
Sampling focuses on a specific group to obtain rich, in-depth data for process-oriented theory building or refining (Hesse-Biber and Leavy 2005:61, 70). This dissertation purposively sampled a group of skilled migrants exposed to a migrant occupational community in order to obtain in-depth information about the social processes underlying skilled migration and incorporation that have been overlooked by the early social model. The objective was to reach a saturation point with the data in order to get sufficient insight into the topic of a migrant occupational community and its influence on skilled migration and incorporation.

3.5.2 Overview

The total sample consisted of 18 nurses (14 women, 4 men) of varying ages, seniority levels and types of nursing training. The majority arrived in Canada between the 1980s and late 2000s, either as lead (8) or dependent (10) migrants. The former led their own migration to Canada, while dependent migrants either accompanied, or were brought over, to Canada by their husbands/fiancés. All the migrant nurses came to Canada as adults, ranging roughly from mid/late 20s to 40s/50s at age of arrival. The sample also included nurses with a range of incorporation outcomes, i.e. from blocked to positive incorporation. Furthermore, several nurses navigated different incorporation outcomes throughout their settlement in Canada. These differences across respondents, as well as over time in the lives of each individual nurse, ensured variation in the outcome incorporation variable. This type of rich analysis also enabled an understanding of the process of incorporation, rather than focusing on a single, static incorporation outcome. Finally, a few supplementary interviews were also conducted with Canadian-trained Ghanaian nurses. Given that the focus of the dissertation is on nurses who trained outside of Canada and their skilled migration and incorporation process, these interviews served as reference material on the migrant occupational community.

The sample is largely made up of Ghanaian nurses residing in Western and Eastern Canada, as well as a few from Central Canada, given that the majority of (employed) Ghanaian nurses in Canada reside in these regions (CIHI 2005, as cited in Labonté et al. 2006a:5). Since the project was not restricted to one locale, more than one migrant occupational community was analysed. This approach provided richer detail on whether, and if so how, the former influences skilled migration and incorporation. In addition, the data revealed that a significant number of respondents first moved from Ghana to the UK (where several trained as nurses), and then later
to Canada. The basic demographic, professional and migration details of the nurses in this sample are outlined below:

**Table 3.1 – Respondents’ Basic Demographic and Migration Information**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Training Location</th>
<th>Type of Nurse</th>
<th>Migration Channel</th>
<th>Regional Destination</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>United Kingdom (UK)</td>
<td>Registered Nurse (RN)</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana</td>
<td>RN, midwife</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana</td>
<td>RN</td>
<td>Lead</td>
<td>Central Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana</td>
<td>RN, midwife</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>UK</td>
<td>RN</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>UK</td>
<td>RN</td>
<td>Lead</td>
<td>Western Canada</td>
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<tr>
<td>M</td>
<td>UK</td>
<td>RN</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>UK</td>
<td>RN</td>
<td>Lead</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana, UK</td>
<td>RN, midwife</td>
<td>Dependent</td>
<td>Central Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana</td>
<td>RN, midwife</td>
<td>Dependent</td>
<td>Eastern Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>UK</td>
<td>RN</td>
<td>Dependent</td>
<td>Western Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana</td>
<td>RN, midwife</td>
<td>Dependent</td>
<td>Eastern Canada</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Ghana, UK</td>
<td>RN, midwife</td>
<td>Dependent</td>
<td>Central Canada</td>
<td></td>
</tr>
</tbody>
</table>

21 In order to ensure the confidentiality of respondents, their arrival location in Canada has been identified at a regional level.
3.5.3 Overview of Data Sources

3.5.3.1 Ethnographic Participant Observation

This dissertation primarily draws on data gathered from in-depth interviews. Supplementary information was also obtained via ethnographic participant observation. Specifically, the primary researcher attended a few meetings of a migrant occupational association\textsuperscript{23}, and an event within the broader Ghanaian community, at various points between 2009-2015. While formal analysis and notes were not systematically undertaken, this ethnographic research enabled a deeper understanding of the relationships between these Ghanaian nurses, the types of events they organize through their migrant occupational associations, key activities within these events, as well as their motivations for participating in Ghanaian nursing events, and general Ghanaian social gatherings. Furthermore, listening to (and interacting) with Ghanaian nurses during these events contributed to developing a more valid understanding of the experiences, meanings and perspectives of this migrant occupational group (Prus 2005:15-17).

\textsuperscript{22} Although it was not explicitly clear which type of nurse this respondent was, based on her years of training the primary researcher deduced her training was equivalent to a registered practical nurse.

\textsuperscript{23} Due to the relatively small size of these Associations, their title and location have not been provided in order to maintain the confidentiality of participants in this project.
3.5.3.2 In-depth Interviews

The interviewing process primarily took place between Fall 2009 – Fall 2012 and involved Ghanaian nurses living in Canada. Several follow up interviews and informal discussions were also undertaken up until 2015 either in person, on the phone, or by e-mail. These semi-structured interviews focused on the migration and economic incorporation of the Ghanaian nurses, including retrospective questions about participants’ migration perceptions and aspirations while living in Ghana (as well as in other destination countries), their skilled migration decision-making process which contributed to their eventual migration to Canada, and the details of their skilled economic incorporation process in Canada (see Annex 1 for interview guide). There were few exclusion criteria, only that the participants had pursued nursing training (in any country outside Canada), and were raised in Ghana. There were no age limits, nor was a minimum level of job experience or minimum time spent working in the nursing profession (in Canada) required, since the focus was on the skilled migration and incorporation process as a whole – i.e. not only positive economic incorporation in nursing employment. Women nurses were primarily interviewed, as they predominate in this occupation. However, the project did not restrict the sample to women, given the presence of Ghanaian men in certain nursing specialties. Lastly, in an earlier stage of the project, interviews were conducted with Ghanaians who trained in Canada. However, as the research evolved to focus on skilled migration and incorporation, the former interviews were only used as reference material. Permission was obtained from the University of Toronto Research Ethics Office to undertake the research project. For the purposes of confidentiality, all participants in this research have been given pseudonyms.

3.5.3.3 Recruitment Techniques

The dissertation relied on numerous recruitment techniques to ensure a sample with both variation and depth. One avenue of recruitment was contacting members of different migrant occupational associations. The Associations provided their consent to contact their members. Notably, a specific set of participants was not contacted, but rather the membership more generally.

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24 Two respondents did not explicitly mention being born or raised in Ghana, but since they both completed their nursing training in Ghana, called Ghana home, and/or did not mention living in any other countries, it was assumed they spent a considerable period of time in Ghana before migrating to Canada, and thus were eligible for the study.
A second recruitment technique involved drawing on community leaders. Notably, the primary researcher made contact with a few professors from different universities in Canada who agreed to assist in recruiting participants by providing referrals to Ghanaian nurses, or general recruitment advice/suggestions. One of these professors also put the primary researcher in touch with an active member of the Ghanaian community in his province, who facilitated introductions to nurses at his church and the broader community. During these events, the primary researcher discussed the research project with prospective participants to gauge their interest and later followed up by email and/or phone. A third technique involved contacting various nursing training colleges, immigrant centres and/or agencies, and describing the purpose and topic of this dissertation. Their assistance was then requested to recruit participants.

Snowball sampling was also used, alongside these formal recruitment strategies. Thus, peers or friends were asked if they were connected to any Ghanaian nurses. Project participants were also asked if they could recommend others who might be interested in this project, which provided a significant number of additional participants. This snowballing technique likely also established a greater sense of trust with potential participants, since the latter’s participation came with an introduction from the previous interviewee (Cornelius 1982:392). Furthermore, snowball sampling ensured, by design, that networks were part of the sample. However, formal techniques also ensured that all the nurses in the sample were not directly connected to one another. Overall with both formal and snowball recruitment techniques a diverse sample was obtained, whose experiences touched on different skilled migration routes to Canada, as well as various steps and outcomes in the skilled incorporation process.

3.5.3.4 Limitations and Observations

Potential barriers in this recruitment process included the primary researcher’s social location as a white, financially-secure Western woman in graduate school, as well as a non-nursing status. However, the research design attempted to minimize the impact of her social location in several ways. First, the primary researcher mentioned to some potential participants that several members of relevant migrant occupational association(s) in different parts of the country had participated in the project. She also mentioned spending time in Ghana conducting preliminary research to underscore interest and commitment to this case study of Ghanaian nurses. As Cornelius (1982:391) suggests, spending time in the home community of interviewees
contributes to breaking down social barriers between the researcher and participants by enabling common topics of discussion, such as food and politics. Common discussion points in general also help to build rapport and familiarity with the participants (Nagra 2011:25-26). The interview schedule was also pilot-tested with a few key informants before starting formal data collection to help ensure cultural appropriateness.

Despite these efforts to minimize barriers with the target population, the recruitment of participants involved some difficulty. Many Ghanaian nurses were supportive and appreciative of the project and the interest in their migrant occupational community. Others, however, appeared more reticent to discuss their personal experiences with a researcher from outside their community. To overcome this obstacle, the primary researcher benefited from the assistance of a few key informants who facilitated introductions with others within the Ghanaian nursing community and shared insights into particular nuances and points of view within the community – a well known strategy in the qualitative research literature to bridge social distance (Berg 2004:145-146). In retrospect, spending more time immersed in this migrant occupational community in Canada would likely have further assisted in minimizing these barriers by making prospective participants feel more comfortable with the project, as well as enhancing understanding of potential areas or issues of concern for the research participants.

Finally, in order to ensure that project participants had a chance to learn about the findings and provide feedback, a few key informants were contacted in the later stages of the project to share and discuss relevant findings, as well as thank them for their support and participation. While this project cannot fully grasp the lived realities and challenges faced by these nurses given their unique migration and incorporation journeys, it was the hope of the primary researcher to provide participants with new insights on their experiences (Miller and Glassner 2004:132). Lastly, the primary researcher benefited tremendously from meeting these dedicated professionals, and learning about their strength and resilience as they navigated the skilled migration and incorporation process.

3.6 Data Analysis

First, a thematic analysis approach was used to examine the data for this dissertation. This process began with conducting a few interviews, reviewing them for recurring topics, and then returning to the field for additional interviews. Once all interviews were conducted, each
transcript was reviewed several times. Quotes appearing to contain similar content were given the same code. Generally, the main codes that emerged related to: the key components of the skilled migration process (i.e. types of migration perceptions and aspirations, various pathway/routes of migration); the steps of the skilled incorporation process (such as successes/challenges with foreign credential recognition, licensing exam, finding employment and adjusting to their new workplace); as well as the diverse influences (such as the migrant occupational community) shaping these key processes. The data were analysed and organized thematically, looking for clusters of themes and relationships emerging from these codes. This phase of the data analysis process was facilitated by N-Vivo software.

These themes were then evaluated against the early social migration model, whose key tenets were outlined in the previous chapter. More specifically, the project assessed the early social model’s claims of the central influence of the migrant residential community on primarily low-skilled migration, against questions about the influence of the migrant occupational community on skilled migration, drawing on its own data as well as insights from more recent research on social aspects of skilled migration and incorporation, and the occupational community literature. The dissertation also considered other influences (such as structural conditions) on skilled migration and incorporation, drawing on the logic of necessary and sufficient causes where relevant (Ragin 2000:89-92). The objective here was not to test which factors had the greatest influence on a static migration or incorporation outcome, but to outline how multiple influences worked together to shape overall skilled migration and incorporation processes. Furthermore, drawing on Ribierio’s (2008:84) qualitative analysis of immigrant nurses in Portugal that focused on how inequalities were perpetuated with their native-born counterparts, this dissertation also focused on how patterns/challenges emerged and were sustained, rather than their extent or strength.

Several detailed theoretical memos were also written to facilitate evaluating this data against the key claims in the early social migration model. Quotes were selected from the interview data to support claims in this dissertation. The researcher has used [...] to indicate where quotes were cut or edited to avoid repetition, reduce unclear interview segments and/or focus on conceptual clarity. In addition, the project consulted diverse migration and incorporation research from European, North American and African sources to “ensure there is no silencing of voices” (Kolawole 2009:16), and to compare its findings with those of scholars from diverse regions. As
other scholars suggest, comparing results between this project’s data and that of other researchers in the same field represents an important method of confirming the validity of current theoretical models (Alonso-Garbayo and Maben 2009:4).

The last phase of analysis moved from evaluating the project’s themes and concepts against the early social migration model, to then refining and extending this theory following Burawoy’s (1998) approach. Specifically, a comparative analysis of this dissertation’s findings, relative to the parameters of the early social migration model (focused largely on low-skilled migration and/or the migrant residential community), identified unrecognized key processes. The following conceptual modifications are therefore proposed, as they would facilitate a greater inclusion of the experiences of skilled (im)migrants in an extended social migration model: the influence of the migrant occupational community on the processes of skilled migration and incorporation, as well as the at times intersecting relationship between the migrant residential and occupational communities in these processes. These modifications are expanded upon in the upcoming empirical chapters.
Chapter 4
The Skilled Migration Process

This chapter analyses the skilled migration process through several stages – beginning with the development of a perception and aspiration to migrate, to deciding to migrate and the actual skilled migration outcome. At each stage, the analysis emphasizes how key facilitating conditions and constraints (at the individual, structural and in particular community levels) combine to influence an individual’s movement along the skilled migration path.

This chapter finds that an important influence on skilled workers migration aspirations is occupational interests, where the desire to migrate is fueled by perceived better occupational opportunities (i.e. more nursing jobs) and working conditions abroad (i.e. nurses receive more respect). Alongside these professional interests, skilled workers also aspired to migrate based on individual interests (i.e. linked to a general desire to earn additional revenue) and family interests (i.e. a desire to provide higher living standards for one’s family), similar to the migration aspirations outlined in the low skilled migration literature. Although most respondents (both lead and dependents) shared one (or more) of these diverse migration aspirations, they were generally not sufficient to lead to a decision to migrate. A more complex decision-making process was involved, which involved multiple levels of analysis.

The skilled migration decision-making process among lead migrants was generally triggered by unsatisfying structural conditions (i.e. working conditions, living standards). However exposure to a culture of migration, from either their migrant residential or occupational community, helped skilled workers become aware of alternatives abroad and feel more familiar with migration, which generally contributed to a more positive perception and/or aspiration to migrate. These structural and meso-level community conditions alone, though, were typically insufficient to motivate respondents to initiate migration. Skilled workers tended to shift from having a migration aspiration to making the decision to migrate when poor structural conditions and exposure to a migrant community were coupled with a lifecycle change, such as finishing their education. At this point, lead migrants require reliable information about where and how to migrate, which some obtained through migrant occupational networks. In their absence, some nurses turned to migrant residential networks to obtain general information about living conditions in prospective destination countries or their own research. When it came to lead
migrants actually undertaking the move, structural opportunities (i.e. employer facilitated migration channels and favourable skilled immigration policy) enabled this outcome.

The skilled migration process began in a similar fashion for dependent migrants. Challenging structural conditions sparked an interest in migrating, and exposure to a migrant residential and/or occupational community, in particular the culture of migration within both these communities, primarily strengthened positive migration perceptions and aspirations. However, one aspect of what this dissertation considers to be part of the migrant residential community, gendered family relations/networks\textsuperscript{25}, emerged as most salient in skilled dependent migrants’ decision-making. Notably, not all dependent migrants were strongly motivated to migrate. Nevertheless, unequal gender relations within the migrant family, coupled with favourable immigration policies for family reunification, resulted in these skilled women’s dependent migration.

4.1 The Skilled Migration Process to Canada

The beginning stage of the skilled migration decision-making process was similar for both lead and dependent migrants moving to Canada. In particular, the nature of their skilled migration perceptions and aspirations, as well as the types of influences shaping them, were comparable. Consequently, the skilled migration perceptions and aspirations of lead and migrants are discussed together in the next section. However the next phase of the skilled migration process, i.e. skilled migration decision-making and their actual migration outcome, will be discussed separately given the significant differences between these two groups.

4.1.1 Skilled Migration Perceptions and Aspirations

Each of the lead migrant nurses described aspirations to migrate to Canada for personal and/or professional reasons. In terms of the latter, many of the lead migrants described an active or latent interest in migrating for perceived better nursing conditions outside the UK or Ghana, such as higher nursing pay and more respect for nurses. In terms of family interests, all the married respondents with children described a desire to provide better living conditions for their current (or future) children by moving. Most dependent migrants, for their part, either had a positive

\textsuperscript{25} See Chapter 2 or full definition in Chapter 3.
view of their migration or at least had mixed views. For some, their positive perception related to an interest in better life opportunities for themselves and/or their family.

A few others highlighted their specific interest in better occupational opportunities abroad, i.e. more nursing employment options and better working conditions. Thus, even though these dependent women did not organize their own migration, several were interested in the economic and occupational opportunities they (and their families) could access through their sponsorship abroad. But how did these nurses, both lead and dependents, develop these migration perceptions and aspirations?

4.1.2 The Influence of the Migrant Occupational Community on Skilled Migration and Perceptions and Aspirations

Membership in a migrant occupational community with a longstanding culture of migration primarily had a positive influence on the migration perceptions of most lead and dependent migrants. A primary avenue through which this migrant occupational culture was visible was through a general awareness of stories of nursing opportunities abroad. As these respondents illustrate, it was fairly common knowledge among Ghanaian nurses that there were better nursing conditions abroad:

Ah no. I like, like generally you would say, that the general notion in Ghana is that nurses are better paid in... paid overseas as compared to Ghana or in Africa [...] I kind of had a fair idea about, I knew that the conditions of working were different from what they were in Ghana. Like in terms of the equipment and stuff like that (Middle aged female nurse, Participant 4)

I think it was, anybody that could get opportunity to go, cause you want to better yourself because nurses are, I don’t know if you have the chance to to interact with nurses there, like the pay is really, like they do a lot and it’s not, you’re not really respected, you know, for what you put in. So a lot of them get frustrated, so their passion isn’t there (Middle aged female nurse, Participant 10)

Another middle aged dependent nurse explains how while she was in Ghana she ‘had heard’ that nurses in other countries experienced higher levels of pay and respect, even though she had never lived abroad:

Umm, did I have expectations, I don’t know what, as it was, I had heard that nursing outside Ghana or abroad or whatever, they are respected more, they get more pay that sort of thing. So you have those those ah expectations, but the other thing was umm, the fear, afraid of okay, what am I going to encounter? This, when I’m here, I’m familiar with my surroundings, and then I’m going to a place that none of my family members are there. So it was, I don’t know, that was, as I said, you are paid well, you are respected, that was the other, the the basic thing, but anything else was, I’m going to just try and see what happens (Middle aged female nurse, Participant 5)
In a similar vein, a middle aged dependent registered practical nurse explained that she simply knew nursing conditions would be different abroad (in Canada), even though she had never been there:

*I know, I know, though, though I hadn’t been here but we know, things [in nursing] wouldn’t be that equal as to back home and this place, because in any case I know money wise I know they can provide so many things that we can’t provide back home, and things like that* (Older female nurse, Participant 14)

While not all the respondents were familiar with specific differences in nursing between Ghana and their destination country (i.e. Canada or UK), or between the UK and Canada, several mentioned a general awareness of better nursing working conditions and/or general desire to migrate for better nursing opportunities abroad.

Social migration scholars have traditionally focused on social processes within *migrant residential communities*, such as how a culture of migration affects consumer desires, schooling plans, marriage interests and status in ways that increase future movement among community members (Kandel and Massey 2002:1000-1002; Ali 2007:54-55). Recent work in skilled migration research has begun to outline a type of culture of migration among skilled migrants (Raghuram et al. 2010: 631; Kōu and Bailey 2014:121) or within a single occupation (Hagopian et al. 2005:1755-1756; Ronquillo et al. 2011:266-268), that helps normalize the desire to migrate. Building off this work, as well as insights from the occupational community literature about shared standards and a desire for respect and pride among members of an occupational group, this project’s findings provide additional insight into the specific ways in which a culture of migration *within a migrant occupational community context* influences skilled migration perceptions and aspirations. Specifically, the migrant occupational culture can modify perceptions of *occupational* desires and standards in ways that make migration seem like a positive activity to undertake among its members in order to access perceived better nursing conditions abroad.

The prevalence of migration within the Ghanaian nursing profession also likely strengthened this migrant occupational culture. For instance, a few respondents mentioned knowing one (or more) nursing colleagues who had migrated before they had undertaken their own move. Knowing a colleague abroad would likely further contribute to the normalization of this activity and have a positive influence on their perception of migrating. Even simply being aware of the widespread nature of Ghanaian nursing migration can have a reassuring effect, as this nurse describes:
In addition to simply being aware of the widespread migration among many Ghanaian nurses, one female dependent nurse described how migration can even be actively encouraged within the migrant occupational community:

Like people, people will tell you, oh people go, and especially London, especially London, it was very easy for Ghanaian nurses to get to London and start working [...] And most people had families in London, so people said no, it’s easy, you go, you can get a job, it’s easy. Yeah, most people kind of encourage you, no, it’s easy. They’ll say, oh my my friend did this, she’s there – she’s working (Younger female nurse, Participant 16)

Thus, the culture of migration operates in similar ways in both the migrant residential community and migrant occupational community by modifying perceptions and aspirations in a way that increases the likelihood of migration. Yet within the migrant occupational community, these social processes are rooted in an occupational context involving the occupation’s history and prevalence of migration, as well as a widespread awareness of stories of nursing opportunities abroad, which contribute to a normalization or even expectation of migration among its members, and can have a positive influence on migration views.

These positive skilled migration perceptions and aspirations, however, do not necessarily lead to an immediate desire to move. For instance, although this nurse’s migrant occupational culture contributed to her awareness of the occupational benefits of migrating, she did not harbour a burning desire to migrate in order to access these conditions. Rather, she was in a ‘waiting to migrate mode’ should an opportunity arise, as she describes:

[...] it's just the opportunity came. You see, it wasn't like I was so desperate, desperate to travel outside the country, or anything no (Middle aged female nurse, Participant 4)

This nurse’s more latent interest in acting on her knowledge of better nursing conditions abroad reflects a more cautious attitude toward skilled migration. As Ali (2007:55) argues, an analysis of the culture of migration does not typically focus on its direct effect on migration outcomes, but rather its “generalized effect upon the social atmosphere in which certain types of life choices and social interactions occur.” Thus while the culture of migration can have a positive influence on how migration is viewed in general among community members, other considerations were also at play for this (and other) skilled migrants. For instance, educated middle class prospective emigrants can be cautious and risk-adverse since they can risk their
financial security through the migration process. Furthermore, professional prospects can also be unclear in a new country. Thus, they are “[…] often ambivalent about their emigration plans” (Salaff 1997:305).

The influence of the migrant occupational community on skilled migration perceptions and aspirations is, however, not always static. For instance, an older female nurse who was more reluctant about following her husband abroad frustratingly described incorporation difficulties her colleagues faced while trying to work in the US, even needing to return to school before working. Although she only explicitly linked her mixed views on migration with leaving family behind in Ghana, the occupational challenges she had heard about also likely contributed to her reservations about migrating. Arguably, stories about the incorporation difficulties that earlier waves of migrant nurses may have faced are only now being transmitted to nurses back in Ghana. Furthermore, Ghanaian nurses have been able to relatively easily incorporate into the British nursing sector (i.e. without writing the licensing exam, though an adaptation training is required) given the strong British colonial influence on the Ghanaian nursing system. However, this is not the case for foreign nurses in North America, who are required to sit the licensing exam (Quartey 2006:11). Given the growing number of Ghanaian nurses migrating to Canada and the United States, more negative incorporation stories may be seeping back to the nursing community in Ghana via migrant occupational networks. Illustrating this very pattern, one respondent who migrated to Canada more recently described sharing her own difficult incorporation journey with a nursing peer in Ghana:

She [a nursing classmate] thought I don’t want her to come. I said don’t come because you can’t use anything over here, you have to start everything. You have to go through the high school again. So don’t come, don’t even make an attempt to travel. Work over there for your money (Young women nurse, Participant 13)

Her description of the challenges she faced in the foreign credential review process in Canada demonstrate how negative stories can be spread to the migrant occupational community back home.

Stories about the complexity of the skilled incorporation process can also negatively influence skilled migration perceptions and aspirations for prospective migrants. For instance, one respondent described how when she visited Ghana she offered to assist her nursing friends and former peers with their migration interests to Canada. However after describing the multiple steps and costs involved in migrating and being able to practice nursing in Canada, such as
taking the TOEFL language exam and licensing exam, many of those originally interested in making an application lost their motivation. These examples illustrate how the migrant occupational culture can negatively influence skilled migration perceptions and aspirations through spreading stories of challenging incorporation stories and lengthy registration processes back home. While there did not appear to be a strong awareness of incorporation challenges among the respondents themselves before they arrived, should these more trying stories and details about incorporating abroad continue to be shared back home, this situation could change.

Returning to positive influences on skilled migration perceptions and aspirations, a second positive influence was personal migration experience. For instance, a middle aged dependent nurse had previously moved from Ghana to Nigeria, before being sponsored to Canada by her husband. Another nurse had previously led her family’s migration to Nigeria to pursue better professional and economic opportunities and was able to obtain a nursing job in a large hospital there. Notably, when she later accompanied her husband’s migration to Canada, she held a positive view of this new migration experience. Massey’s early social migration model suggests that individual experience in another (more advanced) country changes tastes and aspirations in a way that makes migration more favourable and likely in the future (Massey et al. 1993:452). Consequently, these dependent nurses’ migration to Canada was likely perceived in a more positive light given their prior migration history.

4.1.3 The Influence of the Migrant Residential Community on Skilled Migration Perceptions and Aspirations

The migrant residential community also generally had a positive influence on skilled migrants’ general perceptions and aspirations of migrating, primarily through a culture of migration. For instance, a dependent nurse explained how her husband - who migrated a few months ahead of her to Canada - described a positive portrait of the country while she was still in the UK. He also informed his wife about a need for nurses in Canada, which positively influenced her views of migrating – though she encountered a different reality on the ground, as she explains here:

Note – The focal point of this analysis was the migrant occupational community, and the social processes within it. However, the analysis also took into consideration other social influences, such as those within the migrant residential community. However, a more in-depth analysis was undertaken in relation to the migrant occupational community.
I was really calm. Like my husband had already been there maybe you know like 6 6 months or a little bit more so, and he had described it from England and then you come to Canada. He was excited about it, you know like a new country and a lot to do, they need nurses, they need whatever, but at the time that we, I came, that was the depression for nursing so they were not really hiring (Participant 10)

Thus, the stories this dependent nurse heard about economic and professional opportunities in Canada had a positive impact on her perceptions and aspirations to migrate and join her husband abroad.

Other respondents also mentioned having family members in Canada, and were therefore familiar with the country, likely making the prospect of moving there less foreign and unknown. However, some dependent nurses without family members abroad or without personal experience of migrating expressed sadness over leaving their families in Ghana to join their husbands in Canada, contributing to a more mixed view of migrating. As Salaff et al (2010:118, 220) suggest, close ties to a family with no migration history ground migrants to their home country and can have a dampening effect on migration perceptions and aspirations. Furthermore, such a negative influence may be more acute among those who do not initiate their own migration.

Other respondents did not mention the influence of a local culture of migration on their own skilled migration perceptions and aspirations, but instead described how their nursing colleagues were influenced by such social processes. For instance, one respondent described how nurses in Ghana are interested in migrating because they have family abroad who share stories about their living experiences or whose very presence abroad creates an expectation or hope among their family members they will do the same:

Yeah some of them were interested, especially those who had family umm were interested, because they had a hope to maybe one day to end up here. People with maybe one parent outside the country, has a hope of one day they’ll go outside (Younger female nurse, Participant 16)

Another dependent nurse explained this seemingly well-known pattern within Ghanaian society:

So most of the time it’s when you have a family outside Ghana that is kind of, that motivates you or they can tell you stories that you want to move but that wasn’t in my case, so I came because of my husband (Middle aged female nurse, Participant 5)

Thus the migrant residential community, via the culture of migration, can have a positive influence on skilled migration perceptions and aspirations, as found in the low-skilled migration
literature. However, those who are less exposed to the culture of migration (at the level of the family) may have less motivation to migrate abroad.

In the next section, I explore how both the migrant occupational and residential community also influence the decision to migrate to Canada among lead migrants.

4.1.4 The Influence of the Migrant Occupational Community on the Decision to Migrate among Lead Migrants

Skilled migration typically involves high costs and risks from both the personal and professional spheres. Consequently, to shift from having an interest in migrating to acting on these ambitions, prospective skilled migrants require reliable information about where and how to migrate.

Table 4.1 – Respondents’ Skilled Migration Paths and Marital Status

<table>
<thead>
<tr>
<th>Sex</th>
<th>Migration Trajectory</th>
<th>Training Locale</th>
<th>Marital Status at Emigration to UK</th>
<th>Period of Emigration (to UK)</th>
<th>Period of Immigration (to CDN)</th>
<th>Marital Status/ Children When Arrived in CDN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1 (F)</td>
<td>Ghana-UK-Canada</td>
<td>UK</td>
<td>Single</td>
<td>Early 1990s</td>
<td>Mid 2000s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 2 (F)</td>
<td>Ghana-UK-Canada</td>
<td>Ghana</td>
<td>Single</td>
<td>Mid 1980s</td>
<td>Early 2000s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 4 (F)</td>
<td>Ghana-Canada</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Mid 2000s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 6 (F)</td>
<td>Ghana-UK-Canada</td>
<td>Ghana</td>
<td>Married</td>
<td>Mid 1970s</td>
<td>1990s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 7 (M)</td>
<td>Ghana-UK-Canada</td>
<td>UK</td>
<td>Single</td>
<td>1990s</td>
<td>Late 2000s</td>
<td>Married Yes</td>
</tr>
</tbody>
</table>
A key source filling this information gap is the *migrant occupational community*. Specifically, several lead migrants were made aware of where and/or how to migrate through a dependable channel via their migrant occupational networks. Once presented with a specific and plausible migration path from a trusted source, the nurses began to shift from merely thinking about migration, to making the decision to move. For instance, one male nurse had a strong interest in migrating to the US for better nursing salaries and status (relative to the UK). He planned on putting this information into action after finishing his Masters degree. Despite his interests in migrating to the US to improve his nursing prospects, his application was unsuccessful. At around the same time, an African colleague told him about his plans to migrate to Canada and the nursing opportunities there. Thus, his initial interest in migrating was linked both to unsatisfying nursing conditions in the UK and a migrant occupational culture that contributed to his awareness of better opportunities abroad. This favourable orientation to migrate was then amplified by a lifecycle change (i.e. finishing his graduate studies), which created an opening to make a change.

Some scholars have pointed out that a culture of migration can have a similar influence on prospective movers, however particular life course stages can nudge some further along, or behind, on the migration path (Kōu and Bailey 2014:119). In that vein, this male nurse had recently finished graduate school and was interested in migrating for better nursing conditions.

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27 Although it was unclear from the interview if the respondent was married, he did not clearly mention having a spouse.
However, he was unable to migrate to his preferred destination. At that moment, his migrant occupational network made him aware of another destination that could meet his professional aspirations (i.e. **where** to migrate). As mentioned, middle class skilled migrants with careers (not jobs as found among working class migrants) seek trusted information on migration opportunities and pathways (Salaff 1997:298, 305). Thus, this nurse’s migrant occupational network filled in this information gap, helping to nudge him from having an aspiration to emigrate from the UK, to making the decision to migrate to Canada through an employer recruitment program.

Another nurse who migrated directly from Ghana-Canada followed a similar decision-making process, shaped by her migrant occupational community within a context of unsatisfying structural conditions and lifecycle changes. She held a long-standing latent interest in migrating to access perceived better wages and living conditions for her family, which was common knowledge in her migrant occupational community via the migrant occupational culture. Although she had previously discussed the possibility of migrating with her sister-in-law who was living in Canada (and was a nursing aid), this latent interest was not sufficient. Rather, a confluence of conditions working together shifted this nurse along the skilled migration path and helped her decide to move, as she describes below:

> Umm there there have been occasions where she says oh, umm can we try, we were trying out our options to see we were just discussing whether there would be the possibility of coming to Canada, and whatever means would be available. But actually there was never, we never really uh she never invited me to come over as a visitor or anything, it was just general discussions we we were having and then until this issue [Program] came up and I said okay we will try it [...] So once I finished my nursing program well okay we can try if it works out fine (Middle aged female nurse, Participant 4)

Thus, difficult economic and nursing conditions in Ghana, as well as exposure to a migrant occupational culture, contributed to a latent interest in migrating. However, once she was ready to start a new chapter in her life (i.e. after finishing her nursing studies), and received trusted information about a feasible and specific path to Canada (i.e. **where and how** to migrate via the Immigrant Provincial Nominee Program) from her migrant occupational network, she transitioned from general migration aspirations to making the decision to migrate.

Another male lead migrant followed a similar decision-making process. At the same time as he was noticing worsening economic conditions and job cuts in England in the mid 2000s, his Ghanaian nursing manager in England was in the process of moving to Canada. His manager
advised him to think about migrating to Canada, and called to let him know when recruiters from Canada were coming to the UK, as he describes:

_The economy in Europe was turning really really bad. Lots of job cuts, that kind of thing. So my manager in England, he's in Canada now right, so he was moving over here and advised me that you know what ok, there are good opportunities in Canada for nurses, so think about it, you know_  
(Middle aged male nurse, Participant 15)

Thus, economic challenges in the UK created a general interest in accessing better opportunities elsewhere. However, it was when a trusted colleague made this nurse aware of specific information outlining where and how he could migrate to access better nursing opportunities that helped shift from thinking to acting on his migration aspirations, and his pursuit of a Canadian employer recruitment program.

In addition to informing skilled workers of reliable migration channels, migrant occupational networks also help cement or persuade decision-making. For instance, a lead migrant nurse explained how the Canadian provincial health authority that managed the recruitment campaign in which he participated facilitated virtual migrant occupational networks to encourage nurses in the UK to migrate to Canada. He drew upon these networks to solidify his decision to migrate:

_And uhh, there was also a link from [the employer] with the nurses who are here [in Canada]. We can communicate with them from the internet [...] So yeah, they answered a lot of questions and that made my move very smoothly_  
(Middle aged male nurse, Participant 18)

Migrant occupational networks can also serve a persuasion role alongside their informational role. For instance, this same male nurse (now in Canada) was contacted by a prospective nursing migrant in the UK, through this online migrant occupational networking system, seeking more specific advice, information and assistance in making the decision to migrate, as he describes:

_Once I was here, we were still keeping in touch. He called me 24/7 - how is the place, what to do, this and that. And finally, I told him that, listen don't hesitate, don't waste time because, things are changing. So he made a quick move and left the UK, when he came here, we met again, we sat down, we talked_  
(Middle aged male nurse, Participant 18)

Migrant occupational networks, however, do not only emerge through employer institutions. As mentioned earlier in this chapter, some lead migrants were influenced by their own migrant occupational networks. A few others described being contacted by former colleagues or nursing friends (in Ghana or the UK) about getting more information on working in Canada, what to expect, and/or how to migrate as a nurse. Thus in addition to confirming Poros’ (2001:245-246, 248) work on the facilitating influence of organizational ties on skilled migration, this study
expands this research as some respondents drew on their own migrant occupational networks (outside a particular organization, but within their migrant occupational community) to facilitate their skilled migration decision-making. Thus, a singular focus on organizational ties overlooks migrant occupational networks rooted in a migrant occupational community, rather than a specific organization.

Overall, migrant occupational networks can provide detailed information on the relative occupational benefits in the destination country, as well as emphasize the best time and place to migrate. This information helps persuade prospective skilled migrants to shift from merely having an aspiration to migrate (at some point), to putting a migration plan into action. This detailed analysis of just how migrant occupational networks influence skilled migration decision-making extends the social migration literature by providing a deeper understanding of when, how, and in what ways this social mechanism shapes the skilled migration decision-making process, in concert with other influences, such as the migrant occupational culture within the migrant occupational community.

### 4.1.5 The Influence of the Migrant Residential Community on the Decision to Migrate Among Lead Migrants

The migrant residential community also emerged as influential on the skilled migration decision-making process, often when connections to the migrant occupational community were absent. Notably, all the female lead migrants (each of whom was married with children) held a strong interest in migrating to Canada to provide a better future for their children, and/or improve their professional prospects. Without any direct migrant occupational networks channeling information about where and how to migrate, their skilled migration decision-making was primarily influenced by their migrant residential networks. For instance, one middle aged female nurse already had a prospective destination in mind (Canada) because of her husband’s desire to join his relatives there. However, it was not until she was getting concerned about raising her family in the UK that she began to seriously consider migrating, as she describes below:


Yeah. Yeah because, well most of his [husband] cousins are there anyways [...] So umm he's always been thinking that he'd like to end up in Canada one day, he'd like to end up in Canada one day, and I don't really know anybody here. I didn't, even have the slightest idea of the geographical location of Canada, you know. The ummm, after I've done, I did my nursing I worked for a while, I think it was [in the mid 2000s] that ummm he was, he was showing more interest in Canada and Britain was, at the time was getting really bad, especially I think when you have kids, then you start thinking about safety and where to raise kids. Yeah, and I think that's when I began showing interest because it was very difficult, with our kids there, because every time kids go to school or you see in the news that
some kid is being stabbed, because of bullying, or you know if the kid is too smart in class so you know they were targeted. So as young parents, of course, we were really contemplating whether it was a good place to bring the kids up (Middle aged female nurse, Participant 1)

Thus, reflecting on her life stage (i.e. raising her family), coupled with being unsatisfied with her current living conditions, triggered a desire to change her life circumstances. At this point, she already had a country in mind via her husband’s interests (i.e. where to migrate), and subsequently made use of her migrant residential networks in Canada\textsuperscript{28} to set up a visit and solidify her interests in migrating. Once she had decided to move to Canada, another migrant residential network provided her with general advice on how to migrate more quickly. Specifically, a Ghanaian friend (non-nurse) who had already migrated to Canada recommended securing a job prior to migrating in order to facilitate the process. Following this advice, she successfully applied to an online hospital job advertisement which brought this nurse, and her family, to Canada.

Another nurse had a similar decision-making process shaped by unsatisfying structural conditions and lifecycle changes, and to a lesser extent her migrant residential network. Her migration aspirations were driven by dissatisfaction with her career prospects in the UK and feeling a sense of getting older. At that point, she began to visit recruitment fairs hosted by foreign health authorities (i.e. US). Although she discovered she did not have the necessary educational requirements to move to the US, she was eligible to apply for Canadian nursing jobs. Around this time she noticed a job advertisement for a Canadian nursing position in a nursing magazine. At that point, her migrant residential network (in this case a Canadian who had immigrated to the UK) influenced her decision to migrate there. Since she was good friends with this Canadian already, the country had already made a positive impression on her, as she noted “she’s a very nice lady, the Canadians must be good. So that was my reference so I applied and I got hired” (Participant 6). Thus poor occupational prospects, amplified by a lifecycle change (i.e. a sense of getting older), pushed this nurse to seek migration options. Once she found a desirable pathway to Canada (i.e. hospital position advertisement), her available social ties (i.e. migrant residential network) had a positive influence on her decision to migrate, though the extent of this influence was unclear.

\textsuperscript{28} Note – this involved the respondent’s husband’s cousin in Canada. It was assumed that her husband’s cousin was not born in Canada (and likely was Ghanaian), although this was not explicitly mentioned in the interview.
Not all lead migrants mentioned migrant residential networks shaping their decision to migrate to Canada. However, the migrant residential community did have an indirect influence on the skilled decision-making process of a few lead migrants, primarily through a culture of migration. In one case, a male lead migrant was looking for better economic opportunities and living standards outside of the UK for himself and his future family, and began conducting research online about prospective destination countries. Notably, his wife and some family members were already living in Canada. Once a change in his life course occurred, in that his wife was expecting, he fast tracked his migration plans and pursued an employer recruitment program for nurses in Canada through a nursing magazine advertisement. Since he was generally aware of the living conditions in Canada based on his migrant residential community, he felt more secure pursuing an employer recruitment program. Furthermore, there was a history of migration within his family and his own life experience, which likely further helped to normalize migration as an option to access better opportunities. Overall, unsatisfying structural conditions, amplified by a lifecycle change (i.e. a child on the way), pushed this nurse to seek migration options. Through his own research on reliable skilled migration pathways, and his familiarity with Canada via the culture of migration within his migrant residential community, he secured his move.

Another nurse’s experience echoes the influence that the culture of migration can have on skilled migration decision-making, particularly in the absence of direct migrant social networks. After migrating to the UK as a single nurse for better professional and economic opportunities, this nurse later found it difficult to cope with the increasing cost of living and child care with her three young children, as she notes:

Yeah so, uhhh I chose to come here because the living in England was becoming a little bit more economically harder and getting more expensive and I had three children like, uhh spacing, not too much spacing between them[...] a year ½ apart each of them and working was becoming very very difficult economically, especially I mean yeah. So ah, yeah so I went on the internet trying to move to somewhere else that would be cheaper (Middle aged female nurse, Participant 2)

During this period (i.e. late 1990s) in the UK, the Royal College of Nursing began to advocate for a substantial increase in pay for its members, bolstered by surveys indicating that pay was the most important factor likely to retain nurses in the British nursing sector (British Broadcasting Company (BBC) 1998). Within this context, a decreasing number of nurses were entering the profession. The situation worsened in the 2000s as the National Health Service (the UK’s public health care sector) faced a multi-million pound deficit (Guardian 2007). In addition to these
financial difficulties, this nurse also mentioned she was concerned about racial issues her children may later face in the British labour market. Research funded by the British government confirms significant employer bias against job applicants with African and Asian names in various sectors and cities across England, despite their having British education and work experience (Syal 2009). Overall then, challenging economic and working conditions, combined with a shift in her life cycle (i.e. raising several children) pushed this nurse to more seriously consider migrating. Without any migrant networks (either occupational or residential) in Canada to turn to for suggestions on where and how to migrate, she relied on her own research. She was soon drawn to Canada by the perception of a relatively smooth incorporation process, given that English was an official language and she had heard the country was multicultural.

How did this nurse come to feel confident in leading her family’s migration to Canada without the information and guidance of any migrant social networks? Notably, she migrated from Ghana-UK as a single young nurse, and her family had a long history of migration. Thus while she did not use migrant social networks to cement her decision to migrate to Canada, a culture of migration within her family and her own life experience likely made this activity seem less risky, as suggested by the early social migration model. This sense of ease came through in her reflections of how she felt about migrating to Canada and any racial problems she might face there, “I was thinking that if I was able to move in England and live in England, what’s England different from Canada? It’s the same thing” (Participant 2). Furthermore, a migrant occupational culture within Ghanaian nursing, where she trained and worked before migrating to the UK, likely further contributed to her positive perception of migrating. Notably, Ali’s (2007:40) in-depth study of the culture of migration in an Indian city among both skilled and low-skilled communities confirms the importance of the culture of migration, at times alongside and at times without networks, in promoting migration. Consequently, migrant social networks may not be a necessary condition in (skilled) migration decision-making, if a culture of migration is present, perhaps particularly within multiple communities, i.e. a culture of migration within the migrant residential community and migrant occupational community.

These findings highlight the influence of social processes, particularly the migrant residential community and migrant occupational community, on skilled migration decision-making for lead migrants. While more recent research has outlined the influence of professional migrant networks on skilled migration through their provision of information about employment
opportunities and contacts in the destination country (such as Ronquillo 2010; Kōu and Bailey 2014) this project contributes to this scholarship by highlighting the importance of analyzing migrant social networks from within both the migrant residential and migrant occupational communities. Notably, the type of information transmitted through these two communities can differ. While migrant occupational networks provide information on where to migrate and/or specific occupational channels to facilitate skilled migration, migrant residential networks suggest more general strategies of migrating, i.e. securing work in the host country while still abroad. While both facilitated skilled migration pathways in a similar way (where and how to migrate), the type of information exchanged differed between the two communities.

4.2 Dependent Migration to Canada

The dependent migration stream to Canada was the most common migration pathway in this sample (likely related to the large number of female respondents). The 10 female nurses within this stream accompanied or followed their husbands/fiancés abroad29. Most were in their late 20s or 30s when they migrated, with a few older female migrants sponsored in their 40s or 50s. Only one of these dependent nurses was trained in the UK, while the rest trained and/or worked in Ghana before joining their husbands abroad (either first to the UK and then to Canada, or directly to Canada from Ghana or Nigeria).

29 Note – although there is a definitional distinction between family reunification and spouses who accompany the family’s principal applicant in their migration application, I did not identify any relevant specific patterns between the two groups of nurses that would analytically justify keeping them separate for the purposes of this analysis of dependents. Furthermore, women sponsored under either category were dependent on their husbands financially and socially, given their spouses’ primary status (often with employment already secured in Canada) and/or prior living experience in Canada. Consequently, I use the term dependent migrants for all nurses, i.e. both those who accompanied their husbands to Canada (a few dependent respondents) and those who were sponsored by them via family reunification (the majority of dependents).
Table 4.2 – Respondents’ Skilled Migration Paths and Marital Status

<table>
<thead>
<tr>
<th>Sex</th>
<th>Migration Trajectory</th>
<th>Training Locale</th>
<th>Marital status when arriving in UK (or other country)</th>
<th>Period of Migration (to UK or other)</th>
<th>Period of Migration (to CDN)</th>
<th>Marital Status/Children when Arrived in CDN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 3 (F)</td>
<td>Ghana-UK-Canada</td>
<td>Ghana, UK</td>
<td>Married</td>
<td>Late 1980s (UK)</td>
<td>Mid 2000s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 5 (F)</td>
<td>Ghana-Canada</td>
<td>Ghana</td>
<td>N/A</td>
<td>N/A</td>
<td>1990s</td>
<td>Married No</td>
</tr>
<tr>
<td>Participant 8 (F)</td>
<td>Ghana-Canada-UK-Canada</td>
<td>UK</td>
<td>Married</td>
<td>Information not available</td>
<td>1990s</td>
<td>Married Information not available</td>
</tr>
<tr>
<td>Participant 9 (F)</td>
<td>Ghana-Canada</td>
<td>Ghana</td>
<td>N/A</td>
<td>N/A</td>
<td>1990s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 10 (F)</td>
<td>Ghana-UK-Canada</td>
<td>Ghana</td>
<td>Married</td>
<td>Late 1980s (UK)</td>
<td>Early 1990s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 12 (F)</td>
<td>Ghana-Nigeria-Canada</td>
<td>Ghana</td>
<td>Married</td>
<td>1980s (Nigeria)</td>
<td>1980s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 13 (F)</td>
<td>Ghana-Canada</td>
<td>Ghana</td>
<td>N/A</td>
<td>N/A</td>
<td>2000s</td>
<td>Married Yes</td>
</tr>
<tr>
<td>Participant 14 (F)</td>
<td>Ghana-Nigeria-</td>
<td>Ghana</td>
<td>Single</td>
<td>1980s (Nigeria)</td>
<td>Late 1980s</td>
<td>Married Information not</td>
</tr>
</tbody>
</table>

30 The respondent did not mention having children in the interview, but the question was not specifically asked.
Migrant women’s dependent status has typically resulted in their experiences being seen as passive, and therefore peripheral in the skilled migration literature, as highlighted by several gender and migration scholars (Ryan 2008:454; Kofman 2012:75-76; Aure 2013:277). This dissertation therefore unpacks how these women skilled migrants make sense of their dependent migration, their involvement in household migration planning (i.e. any negotiations that took place) and final migration outcome. In so doing, the study attempts to return agency and voice to these skilled women’s migration experiences.

4.2.1 The Influence of the Migrant Residential Community on the Decision to Migrate among Dependent Migrants

The decision-making process for dependent migrants differed significantly from that of lead migrants. Few nurses mentioned any explicit discussion to migrate to join their husbands abroad, or discussions about reservations they had. One exception highlights the nuances that can take place in skilled household migration discussions. This case involved a young female dependent nurse who had significant concerns about the professional risks associated with migrating. Specifically, at the time her husband sponsored her abroad she had not yet finished the nursing bond of service Ghanaian nurses who receive a government allowance must complete. Consequently, she was nervous about the incorporation difficulties this might cause in Canada and raised these worries with him. Despite these concerns, she did end up migrating to join her husband before completing her service. Notably, this was the only nurse who explicitly mentioned this type of discussion with her spouse.

This relative absence of negotiation within the household may reflect what Hoang (2011:1451) describes in her article on gender and low-skilled migration as the “patriarch’s power in

| Participant 16 | Ghana-Canada | Ghana | N/A | N/A | 2000s | Married | No |
| Participant 17 | Ghana-Canada | Ghana | N/A | N/A | 2010s | Married | Yes |
household decision-making” being “taken for granted”, and the priority of his career within the family. In this context, even if the women had reservations they would likely defer to the hidden (or taken for granted) authority of their spouses, as found in other studies of dependent skilled female migration (Yeoh and Willis 2005: 215; Ackers 2004:199). A middle aged respondent who twice left her nursing/midwifery career to follow her husband’s career path across multiple countries also illustrates this pattern:

Yeah I did initially [work at a hospital in the UK] and then I had to leave and join my husband. So wherever my husband was, my husband is a [doctor]. So wherever my husband worked, I worked [...] It is, it’s really, it’s really really, unsettling really (Middle aged female nurse, Participant 3)

Despite palpable frustration with her professional sacrifice, this nurse did not mention trying to negotiate these moves with her husband. Similarly, another dependent nurse’s migration experience reflects a similar pattern:

Oh I I came because of ahh my husband was her Dad, so that was what brought me here. I didn’t have any, I didn’t know anybody and I I wasn’t planning on moving away from Ghana because I had nobody, all my family my brothers and sisters are back home (Middle aged female nurse, Participant 5)

As Hoang underlines, power involves “[…] people’s capacity to define their own life choices and pursue their own goals, even in the face of opposition from others, and to the capacity of an actor or category of actors to override the agency of others” (Kabeer 1999:438, as cited in Hoang 2011:1454). The limited discussion of migration reservations suggests unequal power relations within some of these skilled migrant households. These findings highlight the importance of not “presuming consensual decision making in migrant households with inherent conflicts of interest” (Bruegel 1996:235, as cited in Ackers 2004:191), even if negotiations or conflict over these differing interests are not explicit (Ackers 2004:192).

The transnational nature of many dependent nurses’ marriages may have further strengthened a potentially unequal power dynamic in the household. Most of these women left their nursing careers in Ghana to either join their husbands who had already moved to pursue work/studies abroad, or start married life abroad with their new husbands whom they met while visiting Ghana, but whose residence was elsewhere.31 For those nurses whose husbands were pursuing

31 There were a few exceptions, including a nurse who followed her husband to Canada through his refugee application and a few who accompanied their husbands in immigrating to Canada.
opportunities abroad, foreign career and educational postings are often seen as an opportunity for the husband (and household) to improve their livelihood, and “hence something to be grasped” (Yeoh and Willis 2005:215). Furthermore, women have been found to acquiesce to their husbands in household decisions over migration since they are socialized to put family goals ahead of their own goals, also known as the tied-mover pattern (Mincer 1978:771; Ackers 2004:197). Thus, advocating to remain in Ghana instead of seizing an opportunity for the household abroad would likely have been difficult. For the nurses who were newly-wed wives in transnational marriages, they likely had even less authority to negotiate where to live. Since their husbands were already living abroad before they were married, it was likely understood that their wives would join them there – particularly since Ghanaian society, and their own migrant occupational community, are influenced by cultures of migration. Echoing Hondagneu-Sotelo’s (1994:4, 7-8) work on Mexican migrant domestic workers, this project’s findings confirm the importance of hierarchical gendered networks within the family, which in this case influence skilled women’s agency and decision-making.

A final influence on dependent migration operated at the structural level through a favourable policy environment. Specifically, Canada’s immigration policy provided a clear path through which these dependent migrants could be brought over by their husbands who were either already living in Canada, or had been accepted as the principal applicants to Canada. As mentioned, immigration policies can act as barriers or facilitators in the skilled migration process (Kōu and Bailey 2014:117-118). Thus, the timing of the sponsorship (i.e. for several shortly after getting married), coupled with a favourable immigration policy context, may have made it more difficult for the female spouses to object/negotiate their husband’s migration plans for their new lives. Overall then, the migration decision-making process for skilled dependents was strongly shaped by their migrant residential community (i.e. gendered family relations), within a favourable immigration policy context that facilitated dependent migration.

4.3 Conclusion: The Social Nature of the Skilled Migration Process

Skilled workers perceptions and aspirations to migrate, their decision to migrate, as well as their eventual migration outcomes, are shaped by a confluence of influences at the individual, community and structural levels. Building off insights from more recent empirical studies
analyzing certain social aspects of skilled migration (such as Hagopian et al. 2005; Ryan 2008; Ronquillo 2010; Kōu and Bailey 2014), this dissertation provides an in-depth account of just when and how the migrant occupational culture and migrant occupational networks influence the skilled migration process within a migrant occupational community context. In so doing, this project extends the early social migration model by illustrating how these social mechanisms operate not only within a migrant residential community, but also within a migrant occupational community, to influence skilled migration. For lead skilled migrants, the process typically begins with unsatisfying structural conditions (i.e. rising cost of living, poor working conditions) and a culture of migration within the migrant occupational and/or residential community, which typically strengthens awareness of better economic and/or professional opportunities abroad, and makes migration seem like a more positive and feasible option to undertake. This sense of dissatisfaction is often amplified by a lifecycle change (i.e. having children, getting married, finishing training/studies), which strengthens the desire for change or at least creates more openness to change. At this point, prospective lead migrants require a plausible migration opportunity that outlines where and/or how to migrate. This information is often supplied by migrant social networks (either residential or occupational), or in their absence through individual research.

At a broader level these findings also speak to the need to extend the early social migration model to include the migrant occupational community, given its influence on the skilled migration process. First, the migrant occupational culture contributes to the development of an expectation or familiarity with migration through the history and prevalence of occupational migration, and spreading stories about working conditions and opportunities, which generally shape skilled migration perceptions and aspirations in a positive way. Second, migrant occupational networks transmit information on when, where and/or how to migrate in a way that secures skilled careers abroad and help cement migration decision-making. Notwithstanding the importance of these social influences in facilitating the skilled decision-making process, structural conditions (i.e. employers, and favourable skilled immigration policies) tended to enable actual skilled migration outcomes. This emphasis on the structural level contrasts with some low-skilled social migration literature, which emphasizes the role of migrant residential networks in facilitating both the migration process and outcomes (Massey et al. 1987:170-171,
However, this migration path is often pursued by undocumented migrants with less attachment to a specific occupation.

Overall, a culture of migration and migrant social networks often represent key facilitating conditions for the skilled migration process, but they are not sufficient for the move to occur. For most lead migrants, the combination of unsatisfying structural conditions and a culture of migration (within their migrant occupational and/or residential community) fostered a strong interest in migration, alongside migrant social networks, which guided their decision about where and/or how to migrate. These conditions then set the stage for a positive migration decision, which then intersected with facilitating policies and employer recruitment efforts, to lead to a skilled migration outcome. The migrant residential community (at the family level) took on a more influential role in dependent migration. Some dependent migrant nurses (particularly those with a personal or family history of migration) had a generally positive view of migrating in order to access better opportunities for themselves and their family, related in part to the culture of migration within both their migrant residential and migrant occupational communities. A few though also had some concerns about migrating, particularly those with an established career in their home country and/or no prior personal/family migration experience. However, unequal gender relations within the family resulted in these women migrating for the benefit of the household, alongside a favourable immigration policy in Canada.

Gendered hierarchies of migration decision-making within family relations are a well-known trend in the low-skilled migration literature. This field of research tends to describe conflicts between migrant husbands and wives left behind seeking to join them or have them remain home, or wives wishing to stay in the home country in order to retain their more middle class lifestyle (Hondagneu-Sotelo 1994:56-75; Grasmuck and Pessar 1991, as cited in Pessar 2005:5). In contrast, this dissertation demonstrates that in addition to wanting to remain with their family, some reluctant skilled female migrants also wish to remain in their home country to pursue their careers, rather than risk their profession through dependent migration.

This dissertation therefore makes the case for expanding the early social model by illustrating the diverse (and at times conflicting) social influences at play within skilled migration. Since both the migrant residential and occupational community have a distinct role in shaping the skilled migration process, the two contexts cannot be conflated. Each merit inclusion in an extended
social migration model. In the next chapter, I examine in-depth how these same social processes, alongside influences at the individual and structural levels, influence the skilled incorporation process.
Chapter 5
The Skilled Incorporation Process: Paths to Employment in Canada

This chapter analyses the key incorporation steps immigrant nurses must navigate to try and obtain nursing employment in Canada, i.e. foreign credential recognition, upgrading requirements (where necessary), nursing licensing exam, job search/application, and finally a skilled incorporation outcome, in order to identify the diverse influences on the skilled incorporation process. It identifies the constraints these nurses faced throughout the skilled incorporation process, as well as the resources they draw on to try and overcome them. By qualitatively analyzing how obstacles and successes emerge, this chapter illustrates the social process of incorporation among Ghanaian nurses, as well as how and why the early social migration model should be extended to include the influence of the migrant occupational community among skilled migrants.

The analysis suggests that skilled immigrants rely on social supports, particularly migrant occupational networks within the migrant occupational community, to navigate the steps to skilled incorporation. However, the ways in which lead and dependents experience the skilled incorporation process as a whole, and make use of these social supports along the way, differ in several respects. Specifically, a dependent migrant status set these nurses (all of whom were women) on a more challenging incorporation path since they only tended to begin the steps to skilled incorporation once they arrived in the host country, and then often navigated gendered inequalities in family relations, as well as racialized discrimination in the host country labour market. In contrast, lead migrants began their skilled incorporation process before they even set foot in the host country, often finding an employment position while still abroad. The influence of a migrant’s mode of entry has been researched in meaningful depth by a few others (Purkayastha 2005; Fuller and Martin 2012: 179-180; Banerjee and Phan 2013a), however the area requires further analysis. This chapter will take a comprehensive view by analyzing how both lead and dependent nurses navigate all the steps to skilled incorporation.

As outlined in Chapter 3, I analyze the pathways toward the following skilled incorporation outcomes:
- *Positive economic incorporation:* employed according to nursing educational/certification level directly with an employer
- i.e. if a Ghanaian nurse was trained as a registered nurse (RN) and obtained an RN position directly with a hospital in Canada

- Downward economic incorporation: employed below nursing educational/certification level and/or via an intermediary, such as a temporary work agency.
- i.e. if a Ghanaian nurse was trained as a registered nurse, and obtained a paraprofessional nursing position such as a health care aide, via an intermediary.

- Blocked economic incorporation: not in the nursing labour market
- i.e. if a Ghanaian nurse is unable to find any nursing employment in Canada and subsequently opts out of the nursing labor market altogether, or turns to a lower-level non-nursing job, i.e. a minimum wage worker.

While these definitions will be used as core guiding points, the data analysis revealed a more complex picture, particularly within the positive incorporation outcome category. Although respondents could obtain a positive outcome by obtaining an equivalent nursing position with a direct health care employer, their ability to fully exercise their skills was also influenced by the quantity of work (i.e. full time, part time), and/or whether they were working in a sub-sector in which they had developed experience or expertise, i.e. such as labour and delivery in a hospital setting. These nuances within the broad incorporation outcome categories underscore the contribution of this dissertation’s qualitative approach through which the varying quality of economic incorporation for skilled immigrants clearly emerges, despite the technical outcomes.

In order to understand whether, and if so how, these nurses achieve a given incorporation outcome, we must understand the type of nursing jobs available in both Ghana and Canada. To this end, the following sections briefly describe the structure of the nursing profession in Ghana and Canada (with an emphasis on two provinces of relevance to this project – Ontario and British Columbia). They also briefly outline the midwifery profession in Ghana and Canada to situate

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32 Seven respondents pursued midwifery training in Ghana, alongside their nursing training. Three of these respondents arrived in Canada shortly after midwifery was formally institutionalized in their province, while four others arrived in Canada before midwifery was formally recognized in their province as a profession. Furthermore two of these respondents worked for a significant period of time as nurses in the UK despite their midwifery training from Ghana, and applied for nursing positions in Canada as lead migrants when they moved there after living and working in the UK. Given that this dissertation focused on the nursing profession, and that virtually all the respondents were working as nurses in Canada, a systematic examination of their experiences as midwives was not pursued. Consequently, it is only briefly referenced in this thesis.
the respondents who acquired this training in Ghana alongside their nursing training\textsuperscript{33}, which is not uncommon in Ghana.

5.1 The Nursing Profession in Ghana

Professional nursing emerged in Ghana in the late 19\textsuperscript{th} century (Donkor and Andrews 2011:219). During this period, British nurses were brought over to provide health care for the colonists. Over time, the British staff hired local male orderlies to assist with more basic care work, i.e. bathing and wounds (Donkor and Andrews 2011:219, Bohmig 2010:63). Up until the mid 20\textsuperscript{th} century, all senior nurses in the country were white ‘colonial sisters’ (Donkor and Andrews 2011:219; Opare and Mill 2000:938).

In recognition of the need for more qualified local nurses in the health care system, and more standardized nursing training, the quality of training was enhanced in the 1940s (Bohmig 2010:63-64). A key development was creating the category of State Registered Nurses (SRN). After training for three years, successful candidates were awarded an SRN certificate (Agyepong et al. 2002:2216). The program was modeled on General Nursing Training in England. In fact, reciprocity was established between this nursing training in Ghana and England (Kissieh 1968:207). Since Ghana did not have a post-basic nursing training facility until the 1960s, nurses who were interested in teaching nursing or a higher level administrative position at the time had to study abroad, typically the UK (Bohmig 2010:69).

The size of the nursing workforce, however, remained modest into the mid 20\textsuperscript{th} century. This was likely related to the limited number of nursing training colleges offering SRN training in Ghana (Opare and Mill 2000:938), as well as low salaries (Bohmig 2010:66). Two additional categories of nurses were then developed in the late 1940s to increase the health workforce: Qualified Registered Nurses (QRN) and Qualified Mental Nurses (QMN). The training was roughly 3 years in length, less detailed relative to SRNs, and based largely on an apprenticeship model (Bohmig 2010:66). Furthermore, this training was only recognized locally. Consequently, QRN\textquotesingle s could not travel abroad to pursue higher level training (Bohmig 2010:66).

\textsuperscript{33} Note – the author has attempted to provide as accurate a representation as possible of the evolution of nursing and midwifery training in Ghana. However, numerous and updated sources to verify the information were not always available.
Following Ghana’s independence in the late 1950s, the government commissioned a large scale review of nursing training. The objective of the review was to update the curriculum and better reflect local needs rather than the British model. The SRN training consequently became more comprehensive in nature, including a larger emphasis on health prevention and public health. In addition, to increase unity across the nursing workforce and training, QRNs were phased out in the 1960s (Bohmig 2010:67). However, the increasing workload on SRNs led to the creation of a new practical nursing category - enrolled nurses (Bohmig 2010:68). These nurses were meant to fill urgent hospital needs, until a sufficient number of SRNs passed through the full training system (Bohmig 2010:68). Their training was shorter and less complex, and they worked under the supervision of SRNs (Bohmig 2010:68-71). This class of nurses was also terminated in the 1980s (Bohmig 2010:68). During this period, a cadre of community health nurses was created to fill health care needs in more remote areas. These nurses pursued a two year training, focused largely on maternal and child health as well as basic care (Global Health Workforce Alliance 2008:7; Agyepong et al. 2002:2216).

Another modification to the nursing workforce involved the creation of Health Care Assistants in the early 2000s. This category of workers was created to assist on the wards and help alleviate the shortage of nurses (Bohmig 2010:149). Typically, HCAs are young and have finished secondary school but are not yet able to pursue full nursing training, due for instance to lower grades or financial constraints (Bohmig 2010:149). Their original training consisted of six months in school, and two months of practical work in the hospital. In 2005, however, the persistent shortage of nurses on the ward decreased the training period to 7 weeks and a 2 week practicum to more rapidly increase the number of HCAs in the workforce (Bohmig 2010:149).

Returning to the SRN training, a few additional changes were made in the latter part of the 20th century. A one year internship/rotation was added to the SRN curriculum to increase practical experience for nursing students (Bohmig 2010:69). In addition, the training provided by nursing training colleges (NTC) became known as the ‘registered general nursing diploma programme’ in 2000 (Bohmig 2010:69). Finally, in the 1980s a bachelor degree in nursing was developed at the University of Ghana (Bohmig 2010:70). The length of training was 4 years for direct entry from secondary school, and 3 years for registered nurses with a diploma (Opare 2012). This university training was more theoretical in nature than the diploma training offered at the NTCs (Bohmig 2010:70).
5.2 Midwifery in Ghana

The first midwifery training maternity school was created in Accra (the capital of Ghana) in the late 1920s. The training was three years in duration, following secondary school completion (Bohmig 2010:63; Opare 2012). The fields of midwifery and nursing were subsequently brought together in the mid-20th century. Specifically, midwifery training became a post-registration course for women who trained as either State Registered Nurses or Qualified Registered Nurses, once the latter nursing categories were established in Ghana (Bohmig 2010:71; Opare 2012). The duration of midwifery training for both was initially 18 months. This was later reduced to 12 months for SRNs (once a 3-month midwifery training was included in the SRN curriculum). QRNs continued the 18 months midwifery training, but this was terminated in 1970 (Hussein et al. 2007:82-83). Traditionally, a trained midwife had the status of ‘nurse/midwife’. However, the midwifery program did not offer in-depth nursing training. Consequently, these nurse/midwives did not have the same status as professional nurses (i.e. SRNs) and could not be promoted to ward administrators. In contrast, SRNs were eligible for promotion to ‘ward sister’ three years after their training. However, since midwifery was a pre-requisite for senior nursing positions, it was essential to career advancement for nurses in Ghana (Bohmig 2010:71; Opare 2012).

There are three types of midwifery training available in Ghana: a) 1 year post-basic SRN training program; b) a 2 year post-basic Enrolled/Community Health Nursing Training Program (certificate); and c) a 3 year direct-entry midwifery program (diploma) targeting secondary school graduates (Hussein et al. 2007:82).

5.3 The Nursing Profession in Canada

There are generally two broad categories of nursing in Canada: 1) registered nurses (RN) and registered psychiatric nurses (RPN); as well as 2) licensed practical nurses (LPN) or Registered Practical Nurses (Bramadat and Chalmers 1989:725; Health Force Ontario 2013; Health Canada 2006).\(^{34}\) The former undergo longer professional training and perform a wider scope of work activities than LPNs or Registered Practical Nurses. All nurses in Canada are regulated by

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\(^{34}\) Though less common, other types of nursing include: nurse practitioners (registered nurses with a masters degree from a nurse practitioner program), and employed student nurses (students who are enrolled in a nursing training program working in a health-related workplace) (College of Registered Nurses of British Columbia 2016).
provincial and territorial nursing colleges. These bodies determine the requirements for entering the profession, as well as workplace ethics and duties (Canadian Nurses Association (CNA) 2007:1).

Historically, nursing training programs have varied from hospital-based diploma programs, to diploma and degree-based programs in colleges and universities. In terms of registered nursing, the first official diploma program was developed in an Ontario hospital in 1874. This model subsequently spread across the provinces (Pringle, Green and Johnson 2004:15). Following several studies on the future of the nursing profession in the 1950s, the CNA recommended moving all nursing diploma programs into colleges from hospitals (Pringle et al. 2004:16-17). Consequently, two year college diploma programs began to spread across the provinces. This transfer did not occur at the same time. For instance, the Ontario government announced in the 1970s that diploma programs would move from hospitals to colleges, while the BC government retained both college and hospital diploma programs until the 1990s (Gerhard et al. 1994, as cited in Meyer, Williams, and Murphy 2009:7; Dick and Cragg 2003, as cited in Pringle et al. 2004:17). Alongside this increase in the number of college nursing programs, the number of university nursing programs also began to increase (Health Canada 2006). Until relatively recently, both college diploma (typically 3 years in length) and university nursing graduates (typically 4 years) could sit the licensing exam to become registered nurses in Canada (Pyper 2004:6). In the 1980s, Canadian professional nursing associations began to consider a four year baccalaureate university degree in nursing as the basic educational requirement (McQueen and Grenier 1993:1016). After a gradual implementation, in 2005 all new entrants into registered nursing in Ontario and British Columbia needed a baccalaureate in nursing degree (Meyer et al. 2009:7-8; Pringle et al. 2004:17-19). This is not the case, however, for Registered Psychiatric Nurses. The entry to practice requirements for these nurses remain at both the diploma and degree level (Registered Psychiatric Nurse Regulators of Canada 2014:2).

Note, this was also the case for RNs in Saskatchewan (Pringle et al. 2004:24).

Under these new requirements for RNs, roughly five nurses from the sample may have encountered difficulties. However, two did not make it through the credential recognition process because they either did not begin this review process, or could not obtain the necessary documents from Ghana to even begin the process. Thus, they did not face these new entry requirements. The remaining three nurses did not mention any difficulties having their credentials recognized, or needing to take any upgrading related to these entry requirements.
It is important to note that registered nurses who obtained a college nursing diploma prior to 2005 were not required to upgrade their training to continue to work as a nurse. In other words, only new applicants to registered nursing in Canada must meet the requirement of a university-degree in nursing (Canadian Nurses Association 2013b). Thus, foreign-trained registered nurses coming to Canada after 2005 with less than a university degree in nursing may need to pursue upgrading courses to meet the new requirements. The amount of upgrading needed is determined by the respective provincial nursing association, which assesses to what extent immigrant nurses’ training meets the standards of Canadian nursing training.

Licensed practical nursing (LPN), the second category of nursing in Canada, emerged with the need for additional health human resources following a shortage of registered nurses in the post-WWII period (Pringle et al. 2004:24). The objectives of licensed practical nurses were to provide care to patients and complement the work of registered nurses. The types of positions and titles within this broad category have varied considerably over time, including: nursing aides, nursing assistants, nursing auxiliaries and attendants (Pringle et al. 2004:24). In the mid 20th century, the training was roughly six months long, split between training and supervised practice in a clinical setting (Pringle et al. 2004:25-26). As hospitals became more dependent on the work of these nursing assistants, LPN programs spread across the country (Pringle et al. 2004:26-27).

Ontario and British Columbia both increased their LPN requirements over time. In 1981, LPN training in Ontario increased from 6 months to over a year, recognizing that gaps were emerging between current certificate programs and the skills required in changing nursing workplaces. By 2005 all new applicants for Licensed Practical Nursing required a two year diploma from a community college as the basic educational requirement (Pringle et al. 2004:28-30). In the case of British Columbia, licensed practical nursing education emerged in the 1950s. Over time, LPNs were required to pass a national exam to obtain a license (Pringle et al. 2004:27). In the next two decades, a longer college-based training program was introduced that shifted responsibilities from tasks and skills, to more complex nursing practices (Pringle et al. 2004:29). 36 Another

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36 Note: The training requirements for LPNs have also increased over time in Saskatchewan (Pringle et al. 2004:24-30). Currently, they must complete a two year diploma program (Saskatchewan Association of Licensed Practical Nurses 2012)
A considerable number of midwives in Canada are foreign-educated as a result of the small number of midwifery training programs in the country, and its relatively recent institutionalized status in Canada. The main paths for professional incorporation of foreign-educated midwives for the provinces of interest in this dissertation include:

- a 1-year part-time bridging program (offered in Ontario – the International Midwifery Pre-Registration Programme), after which graduates are supervised until they meet the number of delivered births required by the College of Midwives of Ontario to be fully registered (typically a 6-12 month process); and the

- Multi-Jurisdictional Midwifery Bridging Project\textsuperscript{38}, which places applicants into a general stream (7 months full-time training where midwives participate in online courses and can

\textsuperscript{37} Numerous terms are used for this cadre of workers that are setting dependent, but also synonymous. These include: health care aide, nurse/nursing aide, and personal support worker (PSW) (Berta et al. 2013:25-26). Health care aides and nurse aides typically refer to workers in a health care setting, such as long term care homes. In contrast, PSWs can work in a health care setting or private home setting. Those who work in private home care are typically unregulated (Ontario Network for International Professionals Online (ONIP) 2016). Health care aides are also present in Saskatchewan and have a similarly broad occupational description. Alongside the terms above, they can also be referred to as continuing care assistants (Lum, Sladek and Ying 2010:1-2; Health Canada 2012:14)

\textsuperscript{38} This program has generally replaced the Prior Learning Assessment (PLA) process in the late 2000s. The PLA included a portfolio to determine if the candidate was eligible to take the written and clinical exam. After passing the
choose courses locally available), as well as a short placement (available in BC and Saskatchewan) (Bourgeault et al. 2011:370-371).

The next section analyses the process through which Ghanaian nurses arriving in Canada try to enter the nursing profession, and the successes and challenges they experience along this skilled incorporation path. It begins with an analysis of dependent nursing immigrants, whose largely negative incorporation experiences illustrate the (often gendered) challenges these skilled women immigrants faced at both the family and structural level.

5.5 The Negative Skilled Incorporation Process

Virtually all the dependent nurses (8 of 10) initially experienced either a blocked or downward incorporation outcome upon entering the labour market in Canada. Most were eventually able to obtain a positive incorporation outcome at the time of this research study, while a few could not move past blocked economic incorporation, that is they remained outside the nursing labour market or had a lower-level non-nursing job. The following section outlines how these immigrant nurses transitioned (or not) through the key inflection points of the skilled incorporation process, discusses the social supports that assisted (or were absent) throughout this process, and explores how their mode of entry shaped their incorporation process as a whole. In so doing, this chapter examines why and how some nurses remain in a blocked or downward incorporation outcome, and how some manage to shift to a positive incorporation outcome. An analytical approach rooted in the professions literature could have provided additional insight into how some of the challenges experienced by foreign-educated nurses attempting to incorporate into a regulated profession may relate to issues of professional autonomy and control. This dissertation drew more heavily upon the occupational community scholarship as it enabled an in-depth analysis of occupationally-oriented social processes influencing both skilled migration and incorporation.

exam, the individual pursued a training path based on the specific provincial practice requirements. The program was available in Quebec, British Columbia and Manitoba (Bourgeault et al. 2011:370-371).
5.5.1 The Challenges of Dependent Migration and Skilled Incorporation

All the nurses who migrated to Canada as dependents were women. Rather than moving for a job, these dependent nurses migrated to either reunite with their new spouses (who had come to Ghana to marry them, i.e. family reunification), or accompany their husbands who had found work or study opportunities abroad (i.e. spouses of primary applicants). For the purposes of this research, I collapse the two categories into dependent migrants as these women were largely dependent (socially and financially) on their spouses after arriving in Canada given that not one had secured employment before arriving in Canada.\(^\text{39}\) Half of the dependent respondents moved directly to Canada from Ghana, while the rest arrived in Canada along a stepwise migration path, i.e. first to Nigeria or the UK, and then to Canada.\(^\text{40}\) In addition, virtually all the dependent immigrants trained as nurses in Ghana before migrating to Canada, with one exception who trained in the UK.

5.5.2 Arriving in Canada through Dependent Migration: Starting from Scratch

Many dependent nurses were eager to begin the skilled incorporation process shortly after arriving in Canada, in the hopes of resuming their careers as quickly as possible. The first incorporation step involved getting their foreign credentials assessed. To begin the credential review process, nurses must gather the necessary documents (such as transcripts, record of employment/practice, nursing registration) from their original nursing training college, licensing body and former employers, and submit them to the relevant nursing body in the destination country.\(^\text{41}\) This seemingly simple transaction can become an arduous task. First, the assessment

\(^{39}\) Note – although there is a definitional distinction between family reunification and spousal migration, I did not identify any specific patterns between the two groups of nurses that would justify keeping them separate analytically for the purposes of this analysis. Furthermore, women sponsored under either category were dependent on their husbands financially and socially, given their spouses’ primary status (often with employment already secured in Canada) and/or prior living experience in Canada. Consequently, I use the term dependent migrants for all nurses, i.e. both those who accompanied their husbands to Canada and those who were sponsored by them via family reunification.

\(^{40}\) Note - one dependent nurse first migrated from Ghana to Canada, then to Europe, and then returned to Canada.

\(^{41}\) The following requirements are typically involved in an application for licensure from a foreign trained nurse: completing a form and payment of assessment fee; assessment of nursing education transcript and confirmation of graduation from a registered nursing educational program; passing the licensing exam; verifying good character from the licensing authority where applicant practised in the last five years; evidence of ‘fitness to practice’; references from past employers; ‘currency of practice’ involving recent completion of a nursing education program.
of these documents (at several hundred dollars) represents a costly sum for many new immigrants. Second, delays in obtaining these papers can further complicate the skilled incorporation process. For instance, several dependent nurses faced delays of several months or more. These delays were generally the result of nursing bodies and former employers in Ghana taking a long period of time to send the necessary verification documents, and/or complications resulting from the nursing bond in Ghana (further explained below). During this waiting period, the nurses’ incorporation path was stalled and led to significant frustration since they did not anticipate these hold-ups, as this middle-aged female nurse explains:

*Oh no I didn’t know that. I thought as soon as I come, oh maybe 6 months or so, I’d get settled down, and then I’d start my work. Oh God. Then I had to deal with [college of nurses] - bring this, bring this paper[...] and the time it comes from home, it’s like 6 months after, so you still have to wait (Participant 9)*

Despite these delays, most of the dependent nurses eventually obtained the documents needed to assess their credentials.

The nurses relied on diverse social supports to successfully navigate this first incorporation step, in particular migrant occupational networks and to a lesser extent migrant residential networks. Regarding the latter, a few were guided through the credential review process by their skilled immigrant husbands who contacted the relevant provincial nursing body to learn how their wives could enter the profession - often before the nurses had even arrived in Canada. Others were put in touch with Ghanaian nurses or other Ghanaian health professionals, often via their migrant residential community\(^\text{42}\). These nascent migrant occupational networks guided them through the credential process, such as advising them to contact their provincial nursing body for additional information.

Alongside providing information to help navigate the credential review process, another manner in which migrant occupational networks influenced the skilled incorporation process at this early stage was by providing alternatives to credential recognition delays. For instance, one nurse

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\(^\text{42}\) Note – one of these respondents was connected with a family member of her husband’s who trained as a nurse in Canada; the primary researcher assumed the latter was Ghanaian.
facing such delays opted to pursue a healthcare aid training course in Canada (despite having completed training as a Registered Practical Nurse in Ghana) based on information provided by a family friend’s wife who was Ghanaian and working as a health care aid in her province. Uncertain when she would obtain her credentials from Ghana, and after having already waited for over a year, she opted to pursue this course. While this resulted in a downward incorporation outcome, this nurse’s migrant occupational network provided a means of coping and survival at this difficult point in the skilled incorporation process. Finally, those nurses who did not have access to any migrant social network that could provide information on the credential process largely relied on their own research to identify where and how to begin the review process.

A number of nurses underlined the challenges of navigating the credential review process. A sense of “feeling lost” in the credential review process is echoed in other studies of immigrant nurses in Canada (Murphy 2008:214; Sochan and Singh 2007:133). As both Teelucksingh and Galabuzi (2005:21) and Man (2004) found in their studies of skilled incorporation in Canada, the re-certification process is costly, lengthy, and complicated for new immigrants since “there is a prolonged waiting period, and information regarding re-certification is not easily available, and often couched in vague language” (Man 2004:142). Interestingly, when a few respondents in this study were asked what resources would have been useful to facilitate their skilled incorporation process, they mentioned doing more research on the migration and incorporation experience before moving, as well as having more access to migrant occupational networks.

A few nurses did not stop at simply initiating their foreign credential review, but also tried to enter the health care system and start working at this early stage in the skilled incorporation process. Nurses, however, can only work as paraprofessional nurses (i.e. health care aides or personal support workers) until their full credentials are verified by their nursing body. Consequently, by opting to find work so early in the skilled incorporation process, these skilled immigrant women necessarily secured an initial downward incorporation outcome (note - none of the respondents had only trained as health care aides/personal support workers in Ghana or the UK). For instance, one middle aged nurse was interested in working as a nurse soon after she arrived in Canada, but discovered that her options were limited until she obtained all the necessary nursing documents from Ghana. As a result, she opted to begin working as a part-time personal support worker while she waited for her credentials in order to gain some exposure to Canadian health care. Another key consideration in this skilled immigrant’s decision to pursue
work as a part-time personal support worker, and continue this line of work for several years afterwards, was unequal childcare responsibilities in her home. Her husband was pursuing additional education and they had few personal networks, which made it difficult for her to work more than part-time hours with a young child in the home. Thus structural barriers, coupled with unequal responsibilities in the home (or within the migrant residential community at the family level), contributed to an initial downward incorporation outcome for this nurse.

A similar story, involving structural limitations and/or gendered responsibilities in the home, unfolded for other respondents. Specifically, they mentioned obtaining work as health care aides while they waited for their credentials to be assessed in Canada – thus obtaining an initial downward incorporation outcome. Unequal responsibilities in the home were once again discussed for a few of these respondents, as they had children at the time of migrating to Canada.\textsuperscript{43} For instance, one nurse had to initially put her career interests on hold for several months after arriving in Canada while her child was too young to attend day care and her husband looked for work. Once she was able to put her child in daycare, she pursued health care aide work to get exposure to the health care system. Overall, while these skilled immigrant women were able to enter the health care system before getting their credentials recognized, they were only able to secure a downward incorporation outcome at this stage in the incorporation process due to structural barriers, often coupled by unequal gendered responsibilities in the home.

How did these nurses obtain work as paraprofessional nurses? A few relied on temporary work agencies, while others found advertisements for health care aides/personal support workers in the newspaper. Interestingly, the migrant occupational community appears to play a role in recommending, or at least providing information about, temporary work agencies. For instance, one respondent met other immigrant nurses at church who recommended she find nursing work through a staffing agency. Similarly, another respondent described how Ghanaian nurses she met in her migrant residential community suggested using an agency to get exposure to the nursing sector in Canada as a health care aide, and provided the names of a few agencies to try. Arguably then, the mere presence of a temporary work agency is not always sufficient for

\textsuperscript{43} Note – it was unclear whether one if these dependent nurses had children when she arrived in Canada.
immigrant nurses to obtain employment. Instead, the migrant occupational community (particularly migrant occupational networks) works together with temporary work agencies to facilitate immigrant nurses entering a nursing workplace. Notably, research drawing on the Survey of Labour and Income Dynamics in the early 2000s found that visible minority women who are recent immigrants to Canada were 4.5 times more likely to be employed by a temporary help agency than other women in Canada – providing further evidence of the salience of this incorporation pathway among immigrant women (Fuller and Vosko 2008:44).

Another social mechanism within the migrant occupational community that could facilitate nursing job searches is the migrant occupational association. Briefly, this type of association brings together members of the same occupation who are typically immigrants and share the same ethnic/racial status. Although none of the respondents mentioned making use of a migrant occupational association to secure their initial employment, one nurse illustrates its potential utility for other new nurses. Specifically, this older dependent nurse who initially secured a downward incorporation outcome when she arrived in Canada explains how she has tried to assist other Ghanaian nurses enter the workforce. In fact, ad-hoc calls she received from newly arrived nurses contributed to her initial interest in developing a formal migrant occupational association to better respond to these requests:

*Well at the time there were umm more and more Ghanaians coming here and trying to find how to register [to be a nurse] and ah how it is that they will find a job. You know sometimes they get a job before they come here sometimes they don’t. And so a lot of people were calling us, contacting us and umm so umm that’s how the idea came up. It was like, okay, so you know now that you guys know one or two people why don’t you put this together (Older female nurse, Participant 8)*

Thus, the migrant occupational community can provide useful information and guidance to new immigrant nurses trying to enter the nursing sector in Canada via its migrant occupational networks and/or migrant occupational association.

Most of the dependent nurses were able to eventually obtain the necessary nursing documents to successfully move forward with the foreign credential review process. Three dependent nurses, though, were not even able to pass through this first incorporation step due to delays and confusion from Ghana and/or Canada. In one case, an older female nurse chose to delay her skilled incorporation process after feeling overwhelmed with the credential review process. In the absence of migrant occupational networks to assist her in navigating the credential review process, alongside a chronic back injury, this older nurse felt too lost and discouraged to
continue with the process. Her decision to temporarily opt off the skilled incorporation path, due in part to an absence of social support, confirms the suggestions from other incorporation research that newly arrived skilled immigrants are more likely to become disenchanted and/or give up on the incorporation process without access to colleagues, support groups or bridging courses (Canadian Business Resource Centre 2002, as cited in Iredale 2005:163). At the time of the interview, this nurse was outside the labour market altogether.

Structural barriers from the home country were another key factor contributing to an initial blocked incorporation outcome. Formally implemented in the early 2000s, the nursing bond requires that Ghanaian nurses whose training was government sponsored complete a term of service or pay back the training cost before they are given their verification documents (i.e. official transcripts) by the Nursing and Midwifery Council of Ghana (Antwi and Phillips 2011:11; Bohmig 2010:69, 73). Without these documents, they are unable to register (and therefore work) as a nurse abroad since Canadian nursing bodies require that official verification of transcripts, employment record and license registration be sent directly from all the applicant’s prior nursing schools and licensing bodies (National Nursing Assessment Service 2014:5-6). Most Ghanaian-trained dependent nurses were able to obtain the necessary documents as they had either completed their service before being sponsored, paid the remaining balance, or didn’t mention having any issues related to the bond.

These bond requirements do not consider the possibility that some nurses do not actively pursue migration – but instead are sponsored by their husbands abroad before they finish their bond, as was the case for the dependent nurses in question. Once these nurses arrived in Canada, they attempted to begin the skilled incorporation process but faced considerable difficulties. Either their Ghanaian nursing college did not send the requested documents, their former employer claimed to have no record of their previous work experience, and/or the nursing body requested they pay back the cost of their training in order to obtain the desired verification documents. After trying to obtain their nursing documents for over a year, two of these nurses ultimately gave up and opted to pursue re-training in Canadian nursing colleges. It should also be noted that both nurses took up minimum wage jobs (i.e. blocked incorporation outcomes) to supplement

44 Note – one respondent mentioned that nurses who fund their own professional training are not subject to the bond.
their household incomes, either before their Canadian re-training started or during summer breaks from the training program. Other studies on immigrant nursing incorporation in Canada also found that obtaining the required nursing documents from the home country can be a key challenge (Blythe et al. 2009: 205), and often resulted in a request for payment from their former employer and/or educational institution (Jeans et al. 2005:28-29). Although the negative influence of gendered inequalities at the family (and societal or normative) level on female skilled immigrant’s career mobility has been discussed in the literature (Yeoh and Willis 2005:215-217; Raghuram 2004b:170), more attention to how gendered structural conditions negatively influence skilled female immigrants’ incorporation process is also needed.

Alongside the practical consequences of these structural barriers on these nurses’ ability to resume their profession – resulting in a delayed skilled incorporation path and initial blocked incorporation outcome – the respondents also described the *experience* of being unable to pursue their profession after arriving in Canada. Specifically, their inability to practice their nursing profession, conflicted with their professional aspirations and satisfaction, as illustrated by one such nurse who was on the path to re-train as a nurse in Canada:

*Every day I’m sad, because I’m not happy even when I’m going to school, just that - I’m not, I don’t like this school, I like this school - but I’m not happy. Where I am, I don’t like it. Because, whenever I call my my working mates or my classmates back home, they tell me all those stuff, like they wish they would be like me, but they don’t know what I’m going through over here, you know. So I don’t like where I am, right now I don’t like this situation in which I am. I don’t like it.* (Younger female nurse re-training, Participant 13)

Other studies have found that skilled dependent migrant’s dedication to their career is so strong that they are willing to undergo extensive re-training/schooling or even return to their home country to preserve their skilled identity and status (Liversage 2009:132-133). Echoing these sentiments, one of the young nurses who initially faced a blocked incorporation outcome emphasized her commitment to her profession, despite needing to pursue re-training in Canada and supplementary work outside the nursing labour market:

*So yeah it's frustrating, but what what else can you [...] You know, I I can’t push my profession aside and be working at the factory* (Younger female nurse, Participant 13)

In addition to feeling a sense of professional loss through their blocked incorporation experience, two of these nurses also expressed feeling frustrated with the loss of their financial independence. For instance, the same younger nurse explained that she would not have migrated to Canada had she known she would lose her profession and financial independence:
But if I had known that I wouldn’t get anything to do, I wouldn’t have come. Because I wouldn’t have left my job, to come and stay here, yeah. I didn’t know at that time that was going to happen. I wouldn’t have done that because even if I get there, before anytime I like, and I have my money, I can come over here and visit him (Younger female nurse, Participant 13)

Furthermore as Ackers (2004:191) notes, this situation may not be temporary for dependent migrants. A focus on their husband’s career path may “tip the balance” further in this direction over the medium-term, as financial contributions to the household shift over time in favour of their spouses. At a broader theoretical level, these feelings of professional and financial loss contrast with the early gender and low-skilled migration literature which found that immigrant women’s gains in gender equity lead most to desire settling in the destination country, while men’s loss of status pushed them to return (Pessar 1999:587; Hondagneu-Sotelo 1994:195-196). Interestingly, the experiences of skilled immigrant women who lose their professional status appear to resemble the negative incorporation experiences of low-skilled male migrants. Given the emphasis on the importance of occupational identity for members of an occupational community as highlighted within the occupational community literature (Van Mannen and Barley 1982:18-19; Williams 1986:248), the findings of professional loss and frustration among these skilled immigrant women are additionally substantiated. This further highlights the importance of the occupational level of analysis for skilled immigrant women, outside the household or family realm.

One exception to this pattern of blocked incorporation for nurses who could not obtain nursing documents from Ghana involved a nurse with work experience in the UK. This nurse was sponsored by her husband from Ghana to the UK shortly after finishing her nursing training. She upgraded her training once she moved to the UK in order to practice as a registered nurse there, and later trained and worked as a midwife in the UK. Roughly two decades later, she was sponsored by her husband to Canada, where he found a new job. In order to practice nursing in Canada, she needed to obtain verification documents from nursing bodies in both the UK and Ghana stating she had trained and registered as a nurse in both countries. While obtaining these documents from the UK was not a problem, she encountered significant difficulties when she contacted the relevant bodies in Ghana despite having paid the remainder of her nursing bond, as describes below:

I went through a terrible time when I moved ummm to Canada. Yeah. Because I had to bring in all verification letters from wherever I had trained which in a way was unfair, because in my case I left as soon as I qualified, I did only a few months there I did not have any training in terms of consolidating my training and went to UK where
they did my verification and kind of put me through an adaptation course for half, or maybe a quarter of my training, and then I started practising there. Canadians will not accept only the UK verification and were demanding umm verification from Ghana. I had to travel all the way to Ghana. I had left the country over how many years, [X] years that time and they wanted me to go and bring the verification. I wasn’t even on their register, things have changed. They were asking me to pay $22,000 U.S. dollars to be able to get that verification and I said well I will then use that money to go pay to train as a chef (Middle aged female nurse, Participant 3)

Despite obstacles from the nursing body in Ghana, this nurse was able to negotiate with her provincial nursing body in Canada and resume the incorporation process. Why was she able to do so, while the other two dependent nurses could not? Notably, the latter nurse trained and worked for several years in the UK as both a nurse and midwife, before moving to Canada to join her husband. Her extensive work and training in the UK may therefore have had a positive influence on her discussions with the provincial nursing body, given that location of education can become a marker of “distinction” or discrimination (Collins 1979:11-12, as cited in Bauder 2003:702). In other words, the location of training can either facilitate access to the labour market or can make this process more difficult for immigrants (Bauder 2003:702). It is also possible that the requirements of the nursing colleges in this regard vary across the provinces, as this nurse was living in a different region of the country relative to the other two dependent nurses who faced similar credential problems.

Overall, many of the nurses faced delays or confusion in learning how to navigate the credential review process in the host country. Migrant social networks, both migrant occupational networks and migrant residential networks, provided useful information for who to contact and how to navigate the process. Identifying the key players and documents needed to pass through this first incorporation step was often a complex and confusing task. One older female nurse without any relevant migrant social networks, in fact, temporarily opted out of the incorporation process altogether after feeling overwhelmed. This suggests that professional skills alone are not sufficient to even start the skilled incorporation path. Rather, skilled migrants often require relevant migrant social networks to assist them in navigating the credential review process.

This information alone, however, was not always enough to advance along the skilled incorporation path. A few nurses were unable to complete this first incorporation step due to structural barriers (i.e. the bond) from their home country. This reflects broader patterns identified in the literature about challenges in the early stage of skilled incorporation. Notably, roughly 40% of foreign trained nurses who began the nursing incorporation process in Ontario never become registered nurses or registered practical nurses (College of Nurses of Ontario
2005, as cited in Kolawole 2010:18). The data from this project also revealed that immigrant nurses do not always experience a linear incorporation path. Rather, they pursued employment in the nursing sector even before their credentials had been assessed, often in order to gain some exposure to the Canadian health care system. Interestingly, the migrant occupational community (via migrant occupational networks) at times appeared to guide immigrant nurses to temporary employment agencies, which enabled them to get their foot into the nursing sector in the host country, even though it resulted in a downward incorporation outcome.

5.5.3 Upgrading and Additional Training

The next skilled incorporation step involved completing any upgrading or language tests the provincial nursing body identified as necessary to reach an equivalent level of training relative to Canadian-trained nurses. Only one Ghanaian-trained nurse mentioned needing to undergo an English proficiency test (i.e. TOEFL), perhaps since she was the only one who migrated with her husband as a refugee. Her experience again suggests that the entry migration status with which one enters Canada shapes skilled immigrants’ incorporation path. Though frustrated by the request since English is an official language in Ghana, this middle aged female nurse was determined to pursue her career and began to study for the exam, as she notes:

We got a place of our own and at that time I went to the College of Nurses to let them know that I’m in the country and I’m interested to continue with my profession, what do I have to do and so they said in the first place I have to take the TOEFL[...] English exam, and I was wondering - Ghana is a commonwealth country, and the medium of instruction there is English, and even I remember in the elementary schools you couldn’t even speak your own language, you’d get punished (Middle aged female nurse, Participant 12)

Nursing upgrading or refresher courses were another point on the skilled incorporation path for some dependent nurses. A few were required to upgrade or refresh their nursing training by their provincial nursing body, likely due to perceived discrepancies in their nursing training relative to that available in Canada or an extended period outside of nursing practice. Two other respondents, who ended up re-training in Canadian nursing colleges due to difficulties obtaining the necessary documents to have their Ghanaian training recognized (as discussed above), also had to pursue upgrading due to perceived differences in their secondary school training and pre-requisites for nursing training in Canada.

Although pursuing these upgrading courses delayed the nurses’ path to employment, at times they developed social supports in these sites of downward mobility that facilitated their
incorporation experience. For example, one of the nurses who pursued high-school upgrading courses (in order to re-train in a Canadian nursing college) met another Ghanaian nurse in these courses. Reflecting warmly on the moment when they first met, this nurse underlines the emotional benefits of sharing similar incorporation experiences with a fellow Ghanaian nurse, with whom she later became friends:

Actually it, it was so funny, I met her when we were doing upgrading, and ummm we were learning biology. And the teacher said something, it’s something everybody would know if you were a nurse, but it wasn’t too obvious for those who hadn’t gone through any process, any nursing process, so, the teacher said it, and she’s like oh my God, I can’t, I can’t imagine the number of times I’ve learned this thing, and I’m like – you understand, where did you learn it. So she was like oh I went to nursing school in Ghana, and I was like oh my God me too, so we both shared our experiences, and we became friends (Younger female nurse, Participant 16)

Another respondent explained how she connected with other helpful nurses in a nursing refresher course. These experiences provide a more nuanced depiction of downward or delayed incorporation for skilled immigrants. Although all the dependents who pursued upgrading or refresher courses obtained an initial downward or blocked incorporation outcome, or at the very least delayed incorporation, this experience was not entirely negative. Some respondents connected with other (immigrant) nurses in these sites of downward mobility, which eased their challenging incorporation experience.

5.5.4 Navigating the Nursing Exam

Once the nurses’ foreign credentials were verified and any necessary upgrading was completed, the next step on their skilled incorporation path was the nursing licensing exam. As a reminder, 7 (of the 10) dependent nurses successfully moved along the skilled incorporation path to this next step. At this point, foreign-trained nurses can work in the nursing sector under a temporary permit and registration (from the College of Nurses) with a graduate nurse status – which requires that they have access to registered nurses for guidance and refrain from certain activities/responsibilities, while they prepare for the licensing exam.\textsuperscript{45} Several respondents

\textsuperscript{45} Graduate registered nurses can work in an RN position under certain conditions. In particular, they must have access to registered nurses for guidance and cannot lead a unit (College of Nurses Ontario (CNO) 2013). In addition, they can only work in the facility which has offered them employment.

Note, the terminology seems to have shifted over time and can differ across provinces. For instance, while many of the respondents used the term ‘graduate nurse’ this status is now referred to as temporary class status in Ontario (CNO 2013), provisional registration status in BC (College of Registered Nurses of British Columbia 2015), and graduate nurse in Saskatchewan (Saskatchewan Registered Nurses Association).
described the difficulty of this exam, with particular reference to its context-specific content, as these two nurses, one registered nurse and the other a registered practical nurse, outline in detail:

*Actually I had to write my exam twice because the the Canadian exam is quite different from what we write, back in Ghana we write essays[...]. But over here it’s more social. It’s not it’s not by it’s not the actual answer, it’s what you, and it’s a cultural thing and how will people feel or what’s the right answer, what's the sense, and if I haven’t lived here yet I don’t know how you guys will respond to the same thing. I might just go to A, B, and C, you might all be right. But from a Canadian perspective, you know like maybe C might be better but I don’t have that option because I don’t know* (Middle aged female nurse, Participant 10)

*So the exam was, looking like a little bit ah ah different like, different from what you have studied. Thinking that you are coming to meet the things you studied from the book, but this one is uh uh mostly like psychological questions, things like that* (Older female nurse, Participant 14)

Echoing Sakamoto’s (2013) work on the professional and cultural barriers involved in skilled incorporation, the format and content of the nursing exam appears to require familiarity with not only the technical, but also the socio-cultural aspects of Canadian nursing. Similar issues have been raised in other studies on immigrant nursing incorporation in Canada (Jeans et al. 2005:40; Blythe et al. 2009:206), such as the difficulty of a multiple choice exam for those who do not have much experience with the format. Acquiring this type of socio-cultural knowledge can be difficult for newly arrived immigrant nurses.

Some dependent nurses passed the nursing exam on their first attempt.⁴⁶ A condition that appeared to facilitate a successful exam outcome for some nurses was taking a course that exposed the nurses to the Canadian health care system, and helped increase their familiarity with Canadian nursing terminology, equipment, and care practices. Some nurses took these courses before they wrote the exam, while another took them after having been unsuccessful on the first attempt. As one middle aged dependent nurse explains, she opted for a longer exam preparation course because it included an in-hospital component where she could gain exposure to the Canadian hospital work setting, which differed from the nursing working conditions in Ghana:

The 7 month [course] is you have to go to the hospitals, the nursing homes and all those things and then kind of get experience of things that they use and how they work with. So that was another thing that helped me in the sense that I got to see something that I had read in books and have never set eyes on and you got to practise with those things and then got familiar with those things. So that was, that is another thing, over there in Ghana they don’t have it, they try to improvise you know the end result is the same, but you don’t have, you study, you have to kind of keep the the the names of those instruments in mind like you improvise, improvise this into something else, so the challenge is

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⁴⁶ One of these nurses did not explicitly mention if she had passed the exam on the first try. However, she passed the exam and did not mention any difficulty in doing so, so she was not probed further. The primary researcher therefore assumed she passed on the first attempt.
to come here and then the thing is staring right in front of you and you don’t know how to use it (Middle aged female nurse, Participant 5)

A few nurses, interestingly, were advised to take this type of course through migrant occupational networks. In addition, these networks could also provide study tips for the exam. While two of these nurses developed these migrant occupational networks through their church, another met immigrant nurses in her temporary nursing workplaces while working as a health care aide. However, these courses did not always ensure a successful exam outcome (as discussed in a later section).

Gendered responsibilities within the migrant residential community (at the family level) were at times an obstacle to fully accessing these resources. Many dependent women respondents pursuing the licensing exam had young and/or several children when they arrived. While only a few explicitly highlighted unequal household/family responsibilities as a significant influence on their skilled incorporation process, those who volunteered this information strongly underlined this barrier. For instance, one middle aged female respondent highlighted the challenges she faced in making her incorporation process a household priority. At the time she was preparing to write the licensing exam, her husband was pushing to move their family to a different city. However this nurse’s desire to resume her career was so strong, she was willing to demand her career take priority despite the costs for her relationship, as she describes:

He wanted us to move to [another city] and I said I can’t do that. I am just, just getting my nursing stuff together. I think I had just finished the upgrading and was waiting to write the exam [...] You’re building a life, and we are here and I’m kind of getting settled and you have just finished and you don’t have any job. So at least let’s give it a shot here. But no, that wasn’t it, so he packed up and left (Middle aged female nurse, Participant 5)

As Kofman (2012:71) notes in her review of gender and skilled migration in Europe, skilled women’s need to re-certify may be seen as less of a priority in families with unequal gender relations. In addition to trying to push her professional incorporation onto the list of household priorities, this respondent also had to navigate uneven childcare responsibilities during this early stage of the incorporation process. As she describes, being solely responsible for child care in her marriage made it very difficult to study for the licensing exam:

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47 Although the specific influence of unequal family responsibilities on the skilled incorporation process was not systematically explored in interviews, several respondents brought up this issue on their own when describing their incorporation experiences and the challenges involved.
I was getting ready for my exams I needed someone to hold her and then at some point when he finished at [University] and he was doing some, what do you call it correspondence course, so he was home all the time but yet, I get up in the morning and I had to go and look for a daycare to take her so that I can go to school. He wasn’t ready to take care of her. So I had to take a bus all the way down, we lived on [X], up on the hill there all the way down to [X] to take her to daycare there and then take a bus to [my college], so you’re always rushing, rushing, rushing, always late for class and all those things and after school, you’re thinking, I’m going to school from 8 till 3 or 4, you pick her up from school, no I’ll come from school, go and pick her up and bring her home and it was, it was just too much (Participant 5)

Not only did she receive limited childcare assistance from her spouse, but she did not have family networks in Canada to assist her, which she noted would have been available in Ghana. Other gender and migration research also documents the difficulty of managing household responsibilities without family networks, alongside attempts to enter the labour force in the host country (Ho 2006:504-505; Man 2004:145). Although this nurse did ultimately pass the licensing exam on her first attempt, she explains that this early period in the incorporation process was so difficult she likely would not have been able to do it again, “So it was, it was tough, so when I, I remember when I finished my exams I said I don’t know whether I’ll pass or not, I don’t know if I have the stamina to go and try it again so I don’t know, it’s taken a toll on me. So thank God, at least, I did it once, and then that was it” (Participant 5). Reinforcing this point from another perspective, another dependent nurse mentioned that there were nursing exam preparation courses available in a location several hours away from her home, but she was unable to take on this commitment with her childcare responsibilities at the time. Consequently, she did not end up taking an exam preparation course and was unsuccessful at the exam on her first attempt. Thus, gendered household relations (within the migrant residential community at the family level) can have a negative influence on the ease with which skilled female immigrants move along this skilled incorporation step.

Another manner in which these nurses could gain exposure to the Canadian health care system was through (temporary agency) work in the nursing sector. As mentioned, a few nurses had already begun to work in the nursing sector as paraprofessional nurses (i.e. health care aides or personal support workers (PSW)) while they were waiting to get their credentials recognized. Once their credentials were recognized and they were eligible to sit the licensing exam, their status shifted to a graduate nurse. Another dependent nurse waited until this point (i.e. after credentials were recognized) to try and find work, which allowed her to enter the labour market as a graduate nurse.
Two conditions appeared to influence the respondents’ ability to obtain nursing work after getting their credentials recognized\(^{48}\): their gendered household responsibilities and to a lesser extent, the preference for Canadian experience in the nursing labour market. Regarding the latter, a few respondents described frustrating experiences of being told (or perceiving) it would be difficult to obtain an equivalent hospital job (i.e. a positive incorporation outcome) without Canadian work experience. This scenario is illustrated by a middle aged nurse (who had also trained as midwife in the UK) who tried to obtain an equivalent position soon after arriving in Canada, as she describes:

[…] So and it was just like it was a common you know problem, from place to place to place. Trained as a midwife, I can't work in labour and delivery because I don’t have Canadian experience and you have nurses working there who are not midwives, but that's the Canadian thing, you, nurses do that job, and I'm more qualified to do with them, and yet you can’t even get that of course, because you can’t even get your foot in, you can't you know. So that that initially, I would say the first year wasn’t, yeah it was frustrating (Middle aged female nurse, Participant 10)\(^{49}\)

Faced with this employment barrier, nurses may opt for employment in other areas outside their specialty or in nursing homes (where more basic nursing skills are typically required), as this respondent explains in a general sense:

But I know there are lot of Ghanaian nurses around, but most of them work in the nursing home[…]Um, because you know sometimes you meet somebody and they said oh I’m also a nurse but I work here, I’m also a nurse and I work here, and then they they, an example they gave – what a couple them that I met, you go to a hospital you are not going to be hired, but if you go to the nursing home you have a better chance of being there and as I said you know they're always asking for your employment history. So with, without employment history you can’t get into the hospital as easily as you can with the nursing home. But the demands there, at the hospital, it’s ah much more than in a nursing home (Middle aged female nurse, Participant 5)

Echoing this point, another middle aged female nurse emphasized that nurses who apply directly to an (acute) hospital have a hard time getting a job because they confront the Canadian experience problem. As Bauder (2003) suggests, Canadian experience seems to only be required for desired occupations in the host country, while such experience is not as important for

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\(^{48}\) Note: it was not always clear when in the skilled incorporation process nurses confronted the Canadian experience problem when trying to obtain nursing work, i.e. before or after writing the licensing exam. Nevertheless, it has been included here in order to capture an important challenge experienced by some nurses along the skilled incorporation path, though it may appear in different points along this path.

\(^{49}\) Note: this nurse mentioned she had also considered pursuing midwifery in Canada but was unable to do so. While it wasn’t explicitly clear in this passage if she was referring to having Canadian experience in midwifery or nursing, since she only passed the licensing exam and obtained work in nursing, the primary researcher assumed the passage referred to nursing.
occupations that are less desired by Canadian born professionals, such as nursing homes in this case. The author therefore argues that “if Canadian experience is not a valid indicator of performance, then it may be a measure of cultural distinction, with the objective being to exclude immigrants who do not possess it” (Bauder 2003:711).

At a broader level the fact that a few nurses described stories or personal experiences of the “Canadian experience problem” suggests a possible culture of racialized incorporation among immigrant nurses. Put another way, some immigrant nurses appeared to share (or develop) an awareness of the Canadian experience problem, indicating it may be part of a developing collective conscience in their migrant occupational community. Interestingly, some nurses’ awareness of this incorporation challenge may impact their strategies to find employment, steering them towards a more accessible nursing entry point – a nursing home, i.e. where more basic nursing skills tend to be required. This is consistent with McCoy and Masuch’s (2007:191) analysis of skilled immigrant women in Alberta, which found that the women knew they would be unable to get equivalent jobs, and had been informed to look for entry-level positions in their professions. Similarly, Teelucksingh and Galabuzi (2005:27) note that employer requirements of “Canadian experience” often result in foreign-trained professionals leaving their field and a subsequent atrophying of skills. While only a few nurses described this sentiment or awareness, these findings nevertheless suggest a potentially negative dimension of a culture of incorporation within a migrant occupational community. This would represent another contribution to the early social migration model focused primarily on low-skilled migration, whose members do not encounter this type of occupational challenge in the host country.

Another condition influencing the ability of these women to find nursing work, beginning once they arrived in Canada (as discussed in the previous section) and often continuing after the credential recognition process is completed, is gendered household responsibilities. Almost all the dependent nurses pursued a more ‘staggered’ incorporation approach, a situation where female skilled immigrants privilege domestic duties over professional interests when both immigrant parents have careers (Salaff and Greve 2004:155; Ribiero 2008:82; Iredale 2005:162). In such cases, women migrants often put their careers on hold for family stability, such as by taking part-time or casual employment to fit around their family’s schedule, while their husbands
focus on their career (Ho 2006:508; Banerjee and Phan 2013b:2). In the case of these nurses, in order to manage their childcare responsibilities several either stayed home with their children for a period of time post-migration or took on part-time nursing positions before they wrote the licensing exam - either as paraprofessional nurses before having their credentials recognized, or as graduate nurses after passing through the credential review process.

Quantitative incorporation research using LSIC data from the early 2000s confirms that marital status does not impact immigrant men’s employment outcomes. However, married immigrant women were nearly twice as likely to be out of the labour market relative to their unmarried counterparts (Fuller and Martin 2012:165). In addition, women sponsored by their husbands or family were 3 times more likely to be outside the labour market, and 1.5 times more likely to experience initial challenges obtaining work (Fuller and Martin 2012:166). In terms of balancing household responsibilities, immigrant women are more likely to undertake family care and part-time employment than men (Fuller 2011:33). Thus, the presence of young children in the home, and a dependent status, are two conditions that can make it more difficult for immigrant women to fully enter the labour force in the host country.

As mentioned working in the health care sector, even in a situation of downward incorporation or a low quality incorporation outcome, at least exposes immigrant nurses to the Canadian health care system. It does not appear to always be sufficient on its own though to secure a successful licensing exam outcome. For instance, one nurse who obtained paraprofessional nursing work before writing the exam was unsuccessful on her first few attempts at the licensing exam. Another was able to obtain an initial positive incorporation outcome, as she was employed by a hospital according to her nursing education level (as a graduate nurse). However, she did not pass the exam on the first attempt. Notably, she was working in a different nursing specialty area in which she did not have experience – thus a low quality positive incorporation outcome. Interestingly, both nurses mentioned the utility of taking courses to pass the licensing exam. However, these courses may not always be sufficient for passing the exam. At least one nurse seemed to pursue an RN review course while working before the exam, but was only able to pass

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50 It should be noted that there is a higher proportion of part-time workers in nursing relative to other occupations in Canada (CIHI 2003, as cited in Pyper 2004:9).
the exam on her second attempt. Arguably, the length of time with which she was out of the labour market (and then working mostly in long term care homes) may have made it challenging to pass the exam on the first attempt, despite the assistance of the review course. Overall, gendered norms and responsibilities that contribute to women staying within the home, or taking on irregular or non-hospital nursing work, may complicate efforts to pass through this skilled incorporation step.

It should also be noted that one dependent nurse was able to obtain an initial positive incorporation outcome, in part thanks to her spouse. In this case, the nurse was also trained in another health care field and was offered a job as a coordinator in this field (after she had waited roughly a year to settle her children in their new neighborhood). As she explains below, her working background became known in part through the community’s awareness of her husband who was a well-known health care professional in the area:

R: But people had heard that there was a professional in town so the health region decided to find someone to coordinate the whole [health care field] program and that’s how I got my first job. So I got hired as a coordinator, a [health care field] coordinator. And uhh, yeah.

Interviewer: Interesting. So how did they know that you were there?

R: Oh this place is small, it’s a small town and, it's a small town, and my husband is working and everybody knows him and things like that, so yeah (Participant 3)

It is likely that the government’s demand for her specialty, and the town’s limited population, facilitated this nurse’s initial positive incorporation outcome. Furthermore as she notes, the close-knit nature of the community (i.e. a sense of mutual trust and reliance among members) may have also facilitated finding a job in her field without prior work experience in Canada.

Overall, skilled dependent nurses face a number of obstacles in this second key incorporation step (i.e. passing the licensing exam). First, the context-specific content related to Canadian

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51 In the case of another dependent nurse it was unclear whether she took a course to assist with the licensing exam before or after being unsuccessful in passing the exam.

52 Note – this respondent passed through several of the steps to skilled incorporation in the nursing profession in her province, including foreign credential review and passing the nursing licensing exam. However once she passed the exam, she became aware of the possibility of another health care field becoming established in her province, and opted to pursue this professional path given that she was also trained in this field.

53 The specific health care field has been removed to protect the respondent’s confidentiality.
health care issues and practices (rather than objective anatomical content) made nursing exam courses useful in order to become familiar with a Canadian nursing setting, though this was not always sufficient. Some nurses also supplemented this exposure to the Canadian health care system (or in its absence) with assistance from migrant occupational networks, which provided tips, old study materials and/or advice for this difficult content in the exam.

Gendered responsibilities in the home, however, can make it difficult for nurses to access these facilitating conditions. Challenges in other spheres can also exacerbate these difficulties, in line with Purkayastha’s (2005) depiction of ‘cumulative disadvantage’ among skilled women Indian immigrants in the United States. Complex provincial regulations, potential biases in hiring and assessment processes, alongside unequal gender responsibilities within the home, all work together to complicate skilled women immigrants’ efforts to enter their profession. Focusing on the latter, these findings suggest that unequal household relations within the migrant residential community (at the family level) can work against the assistance provided by the migrant occupational community (as well as other available resources, such as formal exam courses), and complicate skilled immigrant women’s progression along the skilled incorporation path.

Despite these challenges, some dependent nurses drew on their migrant occupational community, namely migrant occupational networks, alongside other strategies, to shift from downward to positive incorporation outcomes. The agency of these nurses in persisting through incorporation struggles and set-backs emerges in the next section of the analysis, and highlights the strengths of a qualitative analysis of the steps to skilled incorporation.

5.6 Moving Along the Spectrum to Positive Incorporation

Shifting from a downward to positive skilled incorporation outcome is not inevitable for skilled immigrants. In this section I describe how some nurses made this shift happen, highlighting the strategies and supports they drew on. As a brief reminder, virtually all the dependent nurses (8 of 10) initially obtained either downward or blocked incorporation outcomes. How were some nurses able to shift along the incorporation spectrum from downward to positive incorporation?
Table 5.1 – Overview of Respondents’ Training and Incorporation Outcomes

<table>
<thead>
<tr>
<th>Sex</th>
<th>Type of Training</th>
<th>Duration of Training</th>
<th>First Incorporation Outcome&lt;sup&gt;54&lt;/sup&gt;</th>
<th>Last Incorporation Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 3 (F)</td>
<td>RN (Ghana), Midwife (UK)&lt;sup&gt;55&lt;/sup&gt;</td>
<td>Information not available</td>
<td>Positive</td>
<td>N/A</td>
</tr>
<tr>
<td>Participant 5 (F)</td>
<td>RN/Registered General Nursing, (Ghana) Midwife, (Ghana)</td>
<td>RN/Registered General Nursing, Ghana (3 years, diploma) Midwifery, Ghana (1 year, certificate)</td>
<td>Downward</td>
<td>Positive</td>
</tr>
<tr>
<td>Participant 8 (F)</td>
<td>RN (UK)</td>
<td>Information not available</td>
<td>Downward</td>
<td>Positive</td>
</tr>
<tr>
<td>Participant 9 (F)</td>
<td>RN, Midwife (Ghana)</td>
<td>RN/Registered General Nursing, Ghana (3 years, diploma) Midwifery, Ghana (18 months or so)</td>
<td>Downward</td>
<td>Positive</td>
</tr>
<tr>
<td>Participant 10 (F)</td>
<td>RN (Ghana), Midwife (UK)</td>
<td>RN/Registered Nursing, Ghana (3 years, diploma) Midwifery, UK</td>
<td>Positive</td>
<td>Positive</td>
</tr>
</tbody>
</table>

<sup>54</sup> Note – in the case of a few dependent nurses, they did not explicitly mention the nursing work they later obtained was registered nursing positions as opposed to registered practical nursing (or LPNs). However, the primary researcher assumed they were registered nursing positions based on the respondents’ discussion of passing the nursing licensing exam. Although it is possible they could have opted to pursue the licensing exam for registered practical nurses (or LPNs), it was assumed they passed the registered nursing exam since they did not mention pursuing the licensing exam for registered practical nurses or working as the latter.

<sup>55</sup> Midwifery training in the UK consists of a three year program. However, registered nurses who pursue midwifery can pursue a shorter training period of 18 months (Nursing and Midwifery Council 2015)
| Participant 12 (F) | RN, Midwife (Ghana) | Midwifery, Ghana (direct-entry, 2½ years) RN/ Registered General Nursing, Ghana (3 years, diploma) | Downward | Positive |
| Participant 13 (F) | Community Health Nurse (Ghana) | Community Health Nursing, Ghana (2 year, certificate) | Blocked | Blocked |
| Participant 14 (F) | Enrolled Nurse/ Registered Practical Nurse (Ghana) | Enrolled Nurse, Ghana (2 years, diploma) | Downward | Positive |
| Participant 16 (F) | Registered Nurse (Ghana) | Registered Nurse, Ghana (3 years) | Blocked | Blocked |
| Participant 17 (F) | Registered Practical Nurse (Ghana) | Registered Practical Nurse, Ghana (2 years, diploma) | Blocked | Blocked |

Migrant occupational networks were mentioned as an important support assisting some women in obtaining equivalent, or higher quality, nursing work. For instance, one nurse was able to find work as a registered nurse in a nursing home. Although this was technically a positive incorporation outcome (since she obtained work as an RN), this nurse desired to work in a hospital in her specialty area, that is a higher quality position. A migrant occupational network eventually facilitated her shifting from this RN position in a nursing home to an equivalent hospital position in her specialty area. Others benefited from the employment advice and information shared by their colleagues *once they were in the workplace*. For instance, a middle aged dependent nurse explained how she met another Ghanaian nurse in a long term care hospital where she was doing temporary placement work as a graduate nurse, who recommended an agency where she might have a better chance of obtaining a placement in an acute hospital. After contacting this agency, she was successfully posted in an acute hospital as a graduate
nurse. She later benefited from the advice of a non-immigrant nursing colleague who informed her of a part-time, permanent job opening in the hospital, which she later obtained. Thus, while her migrant occupational network was not able to directly secure her an equivalent position, the network provided her with a strategy for how to access higher quality employment, i.e. recommending an agency that enabled her to access (temporary) work in a hospital, rather than long-term care, where she eventually secured a position.

A few other nurses emphasized the importance of simply being in a hospital setting and having access to employers, apart from the (migrant) occupational networks that can develop in the workplace. As one older female nurse explains, she sent in her application to one of the hospitals where she had been working as a registered practical nurse through an agency. By this time, she felt the managers had gotten to know her, which facilitated her successful application to a full-time casual position in that hospital at her level of training. Another nurse mentioned that a temporary employer in one of the long term care homes where she had worked as an agency nurse made her aware of a casual opening in the workplace, and encouraged her to apply. This echoes findings from a study on skilled female incorporation in the US, which found that having the opportunity to become known to employers is key to being considered for a more permanent or equivalent position if you are a foreign trained professional, “… otherwise, coming from outside… [they] would have had no chance” (Purkayastha 2005:188).

It is also noteworthy that several dependent nurses experienced multiple labour market transition points before obtaining a positive skilled incorporation outcome in a higher quality nursing position. This confirms the findings of other incorporation studies, which found that it is common for migrants to experience several jobs early in their incorporation path, since they are eager to transition out of jobs that are not commensurate with their training or experience (Fuller 2011:15, 31-32; Sanders et al. 2002:285-286). As mentioned, one dependent nurse shifted from being an RN in a nursing home to a hospital position based on a tip from another foreign-trained nurse (that is a migrant occupational network), but it began as a temporary position and she later applied for a permanent position in the unit. Another nurse shifted from a part-time hospital position not in her specialty area to a part-time position in her specialty area, but at a lower level of expertise. Along similar lines, another nurse worked several years part-time as a personal support worker, and then shifted to a part-time community registered nurse for the same organization (after passing the licensing exam), in large part due to childcare responsibilities.
After several years in community nursing, she was able to shift to a part-time hospital position based on her own research (which eventually transitioned to full time), but the latter was not in her area of expertise.

Most nurses who made use of temporary placement agencies also experienced multiple incorporation point trajectories. For instance, one respondent initially obtained health care aide positions in mostly long-term care hospitals via agencies, and then got a permanent part-time position as a graduate nurse while preparing for her exam in an acute hospital. It later transitioned to a full-time position. Another nurse had a particularly staggered incorporation process that dragged on for two years. Beginning as a health care aide, then working mostly in long term care homes through a placement agency, she eventually shifted to a casual registered nursing position in a long-term care home (a positive incorporation outcome), and finally a higher quality position in an acute hospital, which was her preferred destination.56 As a reminder, nurses who begin working before their credentials are recognized will necessarily begin with a downward incorporation outcome (i.e. as a health care aide), thereby increasing the number of incorporation points they will pass through to a positive outcome.

Overall these dependent nurses’ experiences underscore the need for a detailed analysis of the skilled incorporation process (rather than first or final outcome) to accurately portray its length and complexity. At a broader level, these findings confirm previous skilled incorporation studies suggesting that junior positions can enable foreign professionals to develop networks and knowledge, which facilitate obtaining better positions later on (Raghuram et al. 2010:632). The crucial distinction though, as Williams (2007:374) points out, is whether these downward incorporation outcomes represent “stepping stones or entrapment”. The data appears to suggest the former, if they are supplemented by social supports - in particular migrant occupational networks - to facilitate mobility between stepping stones. In addition, simply being in a nursing workplace with other immigrant nurses and prospective managers was an important facilitating condition that plugged them into information channels about future (permanent and/or full-time) job openings.

56 Note – it was unclear whether the position this nurse obtained in the acute hospital was casual or permanent at the onset.
The previous sections illustrated how the incorporation experiences of skilled migrants are transnationalized and gendered. Specifically, a dependent migrant status without employment prospects sets these nurses (all of whom were female) on a challenging skilled incorporation path. Most eventually transitioned to a positive incorporation outcome, at times relying on social supports to help move along this path, such as migrant occupational networks. The next section illustrates how lead migrants experienced significantly fewer obstacles in their skilled incorporation process, in large part due to more a more advantageous starting point. Nevertheless, they also drew on social supports, both migrant occupational and migrant residential networks, to try and overcome incorporation challenges.

5.7 The Positive Skilled Incorporation Process

Eight (8) respondents were lead migrants to Canada, i.e. they were the primary drivers of their own (and/or their family’s) migration. Almost all secured a first positive skilled incorporation outcome. Four (4) lead migrants were women who ranged in age from roughly their 30s to 50s, while the other four (4) were younger males in their late 20s to 40s at the time they migrated to Canada.

Table 5.2 – Overview of Respondents’ Training and Incorporation Outcomes

<table>
<thead>
<tr>
<th>Sex</th>
<th>Type and Location of Training</th>
<th>First Incorporation Outcome (^{57})</th>
<th>Last Incorporation Outcome (^{58})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1 (F)</td>
<td>Registered nurse (RN) (roughly 3 years), United Kingdom (UK) (^{59})</td>
<td>Positive (^{60})</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^{57}\) Note – a few respondents mentioned obtaining work as nurses in Canada but did not specifically mention they were registered nursing positions. However, the primary researcher assumed they were registered nursing positions based on the respondents’ discussion of passing the nursing licensing exam. Although it is possible they could have opted to pursue the licensing exam for registered practical nurses (or LPNs), it was assumed they passed the registered nursing exam since they did not mention pursuing the licensing exam for registered practical nurses. In addition, since the Canadian recruitment program through which several of lead respondents migrated only appeared to be recruiting registered nurses, and outlined the need to register with the provincial registered nursing association to pass the needed nursing licensing exam, this further suggests that the positions these respondents initially obtained in Canada were registered nursing positions (i.e. positive incorporation outcome).

\(^{58}\) Note: this refers to last incorporation outcome at the time of the interview.
<table>
<thead>
<tr>
<th>Participant 2</th>
<th>RN/Registered General Nursing, Ghana (3 years) Midwifery, Ghana (1 year)</th>
<th>Positive</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 4</td>
<td>RN, Ghana (4 years)</td>
<td>Downward</td>
<td>Positive</td>
</tr>
<tr>
<td>Participant 6</td>
<td>RN/Registered General Nursing, Ghana (direct-entry, 4 years) Midwife, Ghana (duration not available) Additional studies in health care field (3 years)</td>
<td>Positive</td>
<td>N/A</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Registered Nurse, UK (3 years) Masters in health related field, UK</td>
<td>Positive</td>
<td>N/A</td>
</tr>
<tr>
<td>Participant 11</td>
<td>RN, UK (3 years) Masters in health related field, UK</td>
<td>Positive</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Several lead migrants trained as nurses in the UK, not in Ghana. Most likely followed the Project 2000 nursing training, as this has been the major nursing training program in the UK since the 1980s. This was a 3 year training program that included four branches of nursing in which nurses could specialize: adult nursing, children’s nursing, mental health nursing and learning disabilities nursing (Basford and Slevin 2003: 703-704). Students would register in the specialty nursing area they had pursued (Pringle et al 2004:37). Up until the end of the 1990s, these nursing students would pursue 18 months of general nursing, and then an additional 18 months in their chosen branch or specialty. However after a review in the early 2000s, the curriculum was changed to reduce the general nursing training to 12 months, and augment the training in the chosen specialization (Basford and Slevin 2003: 703-704). As of 2013, this training results in a nursing degree (Willis Commission on Nursing Education 2012:12).

Note – all of these lead migrants initially had a graduate nurse status before they passed their licensing exam, but were able to begin working in their hired position with their direct employers as graduate nurses until they sat the exam. Consequently, they are assigned an initial positive incorporation outcome, even though they were temporarily working with a graduate nurse status. This status would be assigned to any nurse in Canada before they pass the licensing exam.
How did so many of these lead migrants secure a positive skilled incorporation outcome? This section will continue to show how the incorporation experiences of skilled immigrants are gendered and transnationalized, that is the migration status these immigrants have upon arriving in Canada (i.e. either as a lead or dependent migrant) intimately shapes their skilled incorporation process in the host country.

5.7.1 Securing Employment Before Migration – Setting the Path for Positive Incorporation

Almost all the lead migrant nurses followed a stepwise migration from Ghana, to the UK and then to Canada (7 of 8), with only one migrating directly from Ghana-Canada. All but one of these eight nurses secured a job in Canada before immigrating. In fact, several applied for nursing positions through the same employer recruitment campaign targeting nurses in the UK.

The campaign, managed by a group of provincial hospital authorities, targeted registered nurses who had at least one year work experience in the UK and were registered with the UK Nursing and Midwifery Council (regardless of where they originally trained as nurses). Through this program, eligible nurses in the UK could apply for nursing positions in participating Canadian hospitals. If their application was successful and the nurses received an offer of employment, they could apply for a work permit-visa from Citizenship and Immigration Canada. Once they received the work permit, the document could be extended for a maximum of 5 years. In addition, after a probationary period, the nurses could apply for permanent residency through the

<table>
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<tr>
<th>Participant</th>
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<th>Placement</th>
<th>Outcome</th>
<th>Notes</th>
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<tbody>
<tr>
<td>15</td>
<td>RN, UK (3 years)</td>
<td>Positive</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>RN, UK (3 years)</td>
<td>Positive</td>
<td>N/A</td>
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61 Respondents were not systematically asked whether they were lead migrants from Ghana-UK. However, mapping the connection between lead migrant status across stepwise migration, and whether this has an influence on skilled migration and incorporation, could be a fruitful avenue for future research.

62 It was unclear whether three respondents applied to an employer recruitment campaign. However, the primary researcher deduced this was likely not the case for two of these respondents based on the year they arrived in Canada and when the recruitment campaign was launched. However, it remains a possibility that the third nurse migrated through this campaign given her time of arrival.
Provincial Nominee Program, sponsored by their employer. However, the nurses were tied to the hospital that initially hired them for an initial 3 year period. Why did several lead migrant nurses pursue migration and employment in Canada through this targeted recruitment channel and not other avenues?

Both migrant occupational networks and individual research pointed lead migrants toward this skilled recruitment campaign. In terms of the former, one male nurse became aware of the campaign through migrant occupational networks in the UK. Specifically, his former manager (who had recently moved to Canada), got in touch with him and recommended he explore the recruitment campaign. As he notes:

Yes, yes. He he advised me to go to a job fair, cause there were recruiters coming from all over Canada to England, to come and recruit nurses. So when they were coming over, he he gave me a call (Middle aged male nurse, Participant 15)

Along similar lines, a middle-aged female nurse became aware of a skilled migration channel to Canada, i.e. the Provincial Immigrant Nominee Program (PNP), through a migrant occupational network (i.e. her sister-in-law in Canada who is a nursing aide). Thus, migrant occupational networks made these prospective skilled migrants aware of a reliable process through which they could move to Canada and eventually obtain nursing employment. In the absence of these facilitating conditions, the nurses seemed to rely on their own research— a pattern confirmed in other networks research (Poros 2001:246). This key precipitating event (i.e. securing employment prior to migration) proved instrumental in facilitating their more positive incorporation experience, relative to dependents, as illustrated below.

5.7.2 Beginning the Skilled Immigrant Incorporation Process Offshore

After the lead migrant nurses, still living and working in the UK, were informed they had successfully obtained a job in Canada, they began the process of immigrating. The first step involved getting their foreign credentials recognized, which required sending their nursing training transcripts, employment records and/or registration to the relevant provincial nursing body in Canada. Once their credentials were approved by the provincial nursing body, the nurses

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63 Additional information can be found in the following document (Nurse Vancouver 2009:2-3).
were issued a temporary work permit by CIC and could migrate to Canada to begin their new job with a graduate nurse status, before they passed the licensing exam.

Only one lead migrant experienced delays with the credential recognition process. As a brief overview of their educational backgrounds, two lead migrant nurses had trained as nurses in Ghana, but then worked for over a decade in the UK. The others had migrated from Ghana to the UK in their 20s or so, and then later elected to pursue nursing training in the UK. Consequently, most lead migrants only had to send their British nursing documents to Canada. Notably, only one of these nurses (who in fact was British-trained) faced a delay of a few months with the credential recognition process, which was primarily due to delays with the provincial nursing body in Canada. The general absence of delays among the other lead migrants is likely related to the fact that many applied to a recruitment campaign that specifically targeted foreign nurses – though foreign nurses of a specific kind, i.e. those with British nursing experience/training. It is notable that the dependent nurses who migrated directly from Ghana would not have been eligible to apply for this recruitment campaign, even though their Ghanaian training was also based on the British model. The other lead migrants who moved to Canada (from the UK) outside this recruitment campaign also did not face any credential recognition delays. Similar to the respondents above, this outcome may be connected to the fact these nurses had worked in the UK for several years before applying for nursing jobs in Canada.

Only two lead migrant nurses discussed any upgrading issues. One nurse who trained in the UK and then moved to Canada had to pursue an upgrading course, based on a new requirement by the nursing board in his province. Another lead migrant, who moved directly from Ghana to Canada, was initially asked to write an English test. She was then asked to obtain proof from her training school and workplace that confirmed all her nursing was done in English, a process which delayed her credential recognition. Overall, having worked and/or trained in the UK appears to have been a facilitating condition for a smooth credential review process. This contrasts with the experience of several dependent nurses who were required to upgrade or take an English test based on an assessment of their available foreign credentials by the provincial nursing body in Canada.

Another facilitating condition in these lead migrants’ credential recognition process was the assistance they received from their future employers. A few nurses described how their
employers provided them with the necessary information and contacts for getting their credentials recognized. This eliminated any confusion or delays in having to navigate this process on their own, as this older female nurse notes:

Well when you apply to the, when I applied to the hospital, then the hospital gave me all the information that I needed to register with the uhh, at that time it was called the [College of Nurses]. So I wrote to them and then they said okay you need to do this and that and, you have to get after all this documents and this and that also, and then when you get into Canada you have to do an exam and so, they gave you all, all the information from the [College of Nurses] (Older female nurse, Participant 6)

Thus, securing employment prior to migrating enabled these nurses to receive additional assistance (from their future employers) in navigating this skilled incorporation step.

Another less explicit benefit of securing employment prior to migrating was that lead migrant nurses could begin working right away in Canada. As mentioned, these nurses were required to get their credentials recognized (while still in the UK) before they could migrate to Canada. Once they obtained verification from the provincial nursing body and received their work permit, they could migrate and begin their new position they had obtained prior to migrating as graduate nurses. The skilled incorporation experience of lead migrants, therefore, contrasts significantly with that of dependent immigrant nurses. Since these dependent nurses did not secure employment before immigration, they only underwent the full foreign credential review process after having arrived in Canada. However since they could only work as graduate nurses after their credentials were recognized, those dependent nurses who sought work in the immediate period after immigrating had no other option but to begin their incorporation path as paraprofessional nurses (i.e. a downward incorporation outcome) – in contrast to the lead migrants who could begin working as graduate nurses in their hired positions once they moved to Canada since their credentials had already been assessed upon arrival.

One exceptional case further confirms the utility of securing an employment position before arriving in Canada. This middle-aged female nurse led her family’s migration to Canada through the Immigrant Provincial Nominee Program (PNP), a program run by provincial governments to fast track skilled immigration to underserved areas. At the time, skilled workers could migrate through this program either by employer sponsorship (i.e. securing a job before migrating) OR if they had a family member in the province willing to sponsor them. Crucially, this lead migrant was sponsored by her family, not an employer. Consequently, while this nurse led her family’s migration to Central Canada, the structure of the program essentially provided her with a
dependent migrant status. Since she was sponsored by her relatives, she largely began her incorporation process from scratch after arriving. Not surprisingly then, this lead migrant obtained an initial downward incorporation outcome. While she was waiting for her credentials to be reviewed in Canada, she obtained nursing aide work in nursing homes. She later obtained a part-time RN position in another nursing home once she passed her exam, and eventually managed to shift to a full-time RN position in another nursing home, as gerontology was one of her desired specialties.

In 2012, interestingly, the government modified its Immigrant Nominee Program to require that applicants have a job offer before they migrate to the province (Graham 2012). This also reflects government research, which found that immigrants sponsored by an employer with a job for them in the host country have better economic incorporation outcomes, at least in the immediate term (Citizenship and Immigration Canada 2010, as cited in Picot and Sweetman 2012:26). Overall, this nurse’s experience illustrates the importance of securing employment prior to migrating in shaping skilled immigrants’ incorporation process and outcome.

To conclude, the experiences of the lead migrant nurses illustrate the importance of securing a nursing position prior to migrating in order to facilitate a positive skilled incorporation outcome. Prospective nursing migrants were able to obtain these jobs as a result of a combination of facilitating conditions, i.e. access to migrant occupational networks or individual research in the absence of these networks, an employer recruitment program and favourable immigration policy, as well as their work experience in the UK. The fact that the only lead migrant who obtained a downward incorporation outcome came straight from Ghana to Canada, and was sponsored by her family through the PNP (not an employer), further supports this argument. Despite its importance though, securing employment prior to migrating is not sufficient for obtaining a positive incorporation outcome. Since nursing is a regulated profession, even those nurses who obtained a job before migrating had to pass the licensing exam in Canada before they could secure their position and work as full registered nurses.

Note – this nurse was in contact with the provincial nursing body in Canada to identify which documents she needed to bring from Ghana, but was unable to finish before she moved, and therefore continued tracking down the papers once in Canada.
5.7.3 Arriving on Canadian Soil – Navigating the Nursing Exam

Once foreign nurses’ credentials are reviewed by the relevant provincial nursing body, they are informed of any upgrading they must pursue (based on discrepancies between their training/practice and Canadian nursing requirements). If no upgrading is needed, immigrant nurses are given a time period during which they must pass the nursing licensing exam. As mentioned, all immigrant nurses (whose credentials have been verified but have not yet passed the exam)\(^{65}\) are given the status of graduate nurse.

Several respondents highlighted how challenging the exam was, and some even failed.\(^{66}\) Along the same lines as the dependent nurses, the lead migrants felt sufficiently prepared for the anatomical content (similar in most countries). However, they were underprepared for the more context-specific questions that focused on Canadian health care issues. This middle age nurse who wrote the exam describes the challenge of correctly answering these context-specific questions as an immigrant:

*But here it’s just social, social aspects of it and it’s just a bit of physiology that comes in. So which, yeah, which makes it difficult if you don’t live in Canada then it will be, like if you live in Canada, then anybody who live in Canada can just go take that exam and pass it, yeah because if you know the way the health system runs right* (Middle aged female nurse, Participant 1)

Thus, some nurses developed a sense of frustration with the more socio-cultural elements of the exam, given the disadvantage this creates for immigrant nurses relative to nurses already living in Canada. Notably, the pass rate among foreign-trained nurses taking the exam for the first time was roughly 43% in 2012, while the rate for Canadian trained nurses was more than twice as high at 87%.\(^{67}\) Rather than simply noting these disconcerting trends, this dissertation also highlights how the nurses overcame these exam challenges.

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\(^{65}\) Note – nurses who are required to pursue upgrading are not permitted to sit the licensing exam until they complete this additional training.

\(^{66}\) Note – roughly 6 (of 8) lead migrants passed the exam on the first try. In two cases, it was unclear whether the respondent passed on the first try or not. However, since the respondents did not mention any difficulties with the exam, it was assumed they passed on the first attempt.

\(^{67}\) These figures shift over the year (since applicants can take the exam at various times), however the change is minimal. Notably, the pass rate among foreign-trained nurses remained between 40%-50% throughout 2012, while the rate for Canadian-trained nurses never fell under 80% (Canadian Nurses Association 2013c:4).
Securing a job from abroad, once again, provided several advantages to help prepare for the exam. Specifically, lead migrants employed as graduate nurses had easier access to supports and facilitating conditions, relative to dependents who were not employed right away in hospitals. For instance, an older female nurse who migrated over a decade ago underscored how useful it was to work in a hospital for a few months before writing the exam in order to understand how nursing care is delivered in Canada, as well as the different equipment and some of the terminology:

*I was allowed to work for 6 months with pay and then prepare for the exam which was very good because I got a chance to learn the terminology. You know the English people say things different, going to the bathroom they say *ah the loo* […] Here we say *washroom* and even the medications, the same medication that is called differently when you are in Canada. So I got a chance to learn all those things (Older female nurse, Participant 6)*

Thus, being able to ‘learn on the job’ helped her become familiar with the differences in health practices and terminology. Confirming this point from another perspective, a middle aged female nurse who migrated to Canada explained how she did not work long enough before the exam to gain this type of knowledge, and failed on her first attempt. Notably, she turned to migrant occupational networks in her workplace to assist her with studying, though it was unclear whether she received this assistance before or after her first attempt at the exam. Thus, when structural conditions did not provide sufficient preparation (i.e. insufficient time spent in the workplace to gain knowledge of Canadian nursing practices), this nurse turned to her migrant occupational networks to fill the gap by obtaining advice and guidance from others who have gone through the same experience and faced similar difficulties with the exam.

Several other nurses who passed the exam on their first attempt also made use of their migrant occupational community, namely migrant occupational networks. For instance, a middle-aged male nurse who migrated from the UK described how structural resources (i.e. the tutor recommended by the provincial nursing body) were useful. However, they seemed insufficient to fully prepare him for the nursing exam. Notably, this nurse chose to supplement his workplace experience with group studying sessions involving migrant occupational networks, where they would compare notes and study together. Similarly, a few other lead migrant nurses mentioned pairing up with immigrant nurses (often co-workers) to study together, and/or assist other newcomers pass through this inflection point. For instance, a younger male nurse notes that “oh yeah yeah yeah, I got a lot of help here, ok [from other immigrant nurses]” when it came to studying and passing the licensing exam (Participant 11). Another male nurse who arrived in
Canada from the UK a few years ago mentioned that he has tried to help a few new immigrants by providing them with his old study materials for the exam. Thus, even employed lead migrants benefit from making use of migrant occupational networks to pass through this key inflection point, particularly when other facilitating conditions (i.e. sufficient exposure to a Canadian hospital setting) are lacking.

Finally, one other lead migrant nurse mentioned participating in an employer sponsored support program for immigrant nurses that provided training for the nursing exam, in terms of how to tackle the questions, understand the types of questions, etc. Notably, this respondent was working as a nurses’ aid (and then graduate nurse) in a nursing home at the time, and passed the exam on her second attempt. This outcome may again suggest that the employer supplied exam resources may not be sufficient for immigrant nurses, perhaps especially so when working in a paraprofessional nursing position and/or in a long-term care setting, rather than acute hospital setting.

It is also noteworthy that the female lead migrants in this sample with children did not explicitly mention an unequal division of labour within their households affecting their ability to study for the licensing exam, in contrast to several dependent nurses. Perhaps their lead migration experience contributed to/or reflected more egalitarian gender relations within the home, as has been suggested by other gender and migration scholars within low skilled migrant households (Hondagneu-Sotelo 1994:86-88). In addition, several of the key steps to skilled incorporation where unequal family/household responsibilities were challenging for some dependent skilled women, i.e. getting their credentials recognized and looking for a full-time job, were not an issue for lead migrant women because they had accomplished these steps before arriving in Canada.

5.8 Conclusion: The Social Nature of the Skilled Incorporation Process

The skilled incorporation process is filled with challenges, even for those who obtain a positive incorporation outcome. Mapping this process in detail reveals the key constraints these immigrant nurses face along this path, and conditions that facilitate trying to overcome them. Furthermore, a qualitative approach provides an in-depth understanding of the quality of the incorporation process for skilled immigrants. It also highlights the importance of analyzing intersecting levels of analysis (i.e. individual, community and structural) over time to fully
account for the diverse conditions that work together to shape skilled immigrant’s incorporation experiences (Purkayastha 2005:193).

Attention to the process through which skilled immigrants reach a skilled incorporation outcome can also help explain why some nurses are temporarily diverted from the incorporation path, and how others are able to obtain a positive incorporation outcome more quickly. In particular, the migration pathway through which immigrant nurses enter their new host country intimately shapes their future skilled incorporation pathways. Lead migrants were able to navigate this process more easily since they completed key skilled incorporation steps before even immigrating by securing a job while still abroad. Dependent migrants, by contrast, faced a much lengthier path that is virtually guaranteed to start with downward incorporation if they opt to start working soon after they arrive, since immigrant nurses who do not have their credentials recognized can only work as para-professional nurses, such as health care aides. Thus, dependent nurses begin their skilled incorporation path significantly behind that of their native-born and lead migrant nursing counterparts in the destination country.

Social processes, particularly within the migrant occupational community, emerged as an important facilitating condition throughout the skilled incorporation process. This community provided specific occupational information and guidance during the more technical steps of the skilled incorporation process (i.e. how to get credentials recognized, study tips for licensing exam, and possible employment avenues), primarily via migrant occupational networks. Although the migrant occupational community did not have a direct influence on skilled employment outcomes, several immigrant nurses did make use of migrant occupational networks to facilitate passing through the steps to skilled incorporation – which are a prerequisite for obtaining a positive incorporation outcome.

Lead and dependent migrant nurses appeared to encounter their migrant occupational community in different sites. Some lead migrant nurses have access to migrant occupational networks before they arrive, while others tend to connect with their migrant occupational community once they enter their new position in the workplace. In contrast, some dependent nurses did not have a direct connection to migrant occupational networks when they first arrived in Canada. Those who did benefit from these networks early on in the skilled incorporation process had a friend/family member who either was a nurse or knew a fellow immigrant nurse. Some also met
other immigrant nurses once they had progressed along the skilled incorporation path or in sites of downward mobility, i.e. in upgrading courses, or temporary work placements through agencies. This research therefore illustrates that a migrant occupational community can be found in more traditional locations - such as nursing workplaces - as well as in sites of downward mobility for those experiencing a more challenging skilled incorporation path.

This study also illustrated how the migrant occupational community can play both similar and dissimilar roles for lead vs dependent skilled immigrants. For instance, leads and dependents shared challenges related to the socio-cultural elements of the nursing licensing exam, and often turned to their migrant occupational community, particularly migrant occupational networks, for assistance. However, dependents also experienced particular challenges in the skilled incorporation process related to credential recognition and obtaining equivalent nursing employment in the host country, and at times made use of their migrant occupational networks to get information and guidance to help address these particular challenges.

The migrant residential community (at the family level) had a more complex influence. Some dependent nurses relied on their partner’s assistance to navigate the steps to skilled incorporation, particularly in terms of gathering initial information about getting credentials recognized or job openings. In addition, the migrant residential community played an important role in connecting some immigrant nurses to their migrant occupational community. As other networks scholars have suggested (Poros 2001:246), the migrant residential community often lacks connections to organizations that can channel migrants into their occupations at a level equivalent to their prior employment. Consequently, those involved in ‘chain migration’ often experience underemployment in the host society, unless interpersonal ties can connect the migrant to organizational ties (Poros 2008:1618). The latter trend was present among some dependents, whose husbands – often skilled husbands – connected them with relevant nursing bodies. At other times, unequal childcare and household responsibilities made it difficult for some dependent skilled women to move through the skilled incorporation steps.

These gendered findings contrast with some key claims in the gender and low-skilled incorporation literature. In particular, the latter has outlined several positive benefits low-skilled women can experience through migration facilitated by migrant residential networks, i.e. becoming employed, earning their own income and therefore gaining relatively more
authority/independence in their household (Hondagneu-Sotelo 1994:194-195), alongside remaining challenges in the household as well as discrimination in broader society. However, skilled female dependents often lose many of these benefits (which they had prior to migrating) once they face the difficulties involved in the skilled incorporation process. Thus, the mixed gains discussed among low-skilled women immigrants (Espiritu 1999:642-643; Pessar 2005:14-16) are also apparent among skilled dependent women immigrants, though the type of gains/disadvantages differ along skills/occupational lines.

To conclude, this dissertation illustrates that structural categories (i.e. migrant status and whether or not immigrants have nursing employment secured in Canada before migrating), as well as access to migrant social networks (migrant residential networks to some extent, but in particular migrant occupational networks), have a significant influence on whether, and how easily, skilled immigrants can navigate the skilled incorporation process and obtain employment in their profession. Furthermore, these facilitating conditions are impacted by other intermediating influences, such as gendered inequalities in family relations within the migrant residential community, as well as racialized discrimination in the host country labour market. These findings therefore underscore the need to take into account multiple levels of analysis. While the early social model does take this type of nuanced process-oriented approach, this model must be expanded to include the influential role of the migrant occupational community to adequately account for the diverse social influences involved in skilled incorporation. Furthermore, the migrant occupational community and migrant residential community can at times complement, and at other times conflict, in terms of their impact on the skilled incorporation process. Their unique influences strengthen the importance of including both community contexts in an expanded social migration model.

This chapter examined the key steps to incorporation that skilled immigrants must navigate to obtain employment, as well as the struggles they faced and how they attempted to overcome them along the way. These challenges do not end once the nurses obtain a skilled incorporation outcome - whether downward or positive. Rather, the importance of a process-oriented analytical approach that carries on into workplace (rather than finishing with skilled incorporation outcomes) clearly emerges. In the next chapter I focus on the post-employment incorporation process in more detail, the types of obstacles skilled immigrants faced throughout this process, and the facilitating role of social supports, especially within the migrant occupational
community, in the form of a migrant occupational culture, networks, and associations, in helping the nurses adapt to these workplace challenges.
This chapter analyzes the incorporation experiences of skilled immigrants after they enter a nursing workplace. Many studies assign a positive incorporation outcome to skilled immigrants once they obtain employment - particularly equivalent employment or equivalent earnings relative to either their home country, the native-born in their host country, or earlier waves of immigrants (Hum and Simpson 2004:56; Aydemir and Skuterud 2005:668-669). Following the approach of more recent incorporation scholars (such as Murphy 2008:246-247, Bourgeault and Neiterman 2013), this dissertation proposes that the incorporation process continues after skilled immigrants enter a workplace, even when they obtain equivalent employment. Without analyzing these post-employment experiences, the skilled incorporation literature overlooks key challenges faced by those who obtain employment (even those who obtain a positive incorporation outcome), and crucially, how they attempt to overcome these challenges.

This analysis finds that immigrant nurses experience difficulty in adjusting to new nursing care practices, terminology, and working conditions in Canada, which represent elements of the nursing occupational culture in Canada. It also confirms the presence (and/or perception) of latent and explicit racism in the nursing workplace, as found by previous studies (Calliste 1996; Ogilvie et al. 2007:234-235; Das Gupta 2009). Given these findings, the skilled incorporation story is incomplete without an analysis of skilled immigrants’ experiences both pre-and-post employment. This chapter also analyses how skilled immigrants draw on social supports (particularly within the migrant occupational community via migrant occupational networks and associations) to assist them in managing these workplace adjustment challenges. The migrant occupational community, however, does not only influence skilled immigrants’ relationship to their new workplace in the host country. It can also facilitate connections and activities in the broader nursing sector in the home country, in order to fulfill transnational occupational desires among some skilled immigrants. An analytical approach rooted in the professions literature could have provided additional insight into issues of autonomy, control and boundary maintenance related to the incorporation of immigrant nurses into the Canadian nursing workplace, as well as the influence of stakeholders involved in overseeing this profession, such
as the state and nursing bodies, on this skilled incorporation process, given the prominence of these issues in the professions scholarship, as outlined by Gorman and Sandefur (2011). In order to retain the analytical focus on both skilled migration and incorporation processes though, the migrant occupational community concept was used as the primary guide for this analysis.

The previous chapters illustrated how skilled workers’ migrant entry status, whether they are lead or dependent migrants, shapes their migration and early incorporation process. Migrant status no longer has as meaningful an influence once skilled immigrants enter the workplace. At this point, their shared migrant and racial status appears to supersede the influence of their migrant status alone. As a result of these similarities, the workplace adjustment experiences of the lead and dependent nurses are discussed together.

6.1 Obstacles in the Workplace Adjustment Process among Skilled Immigrants

6.1.1 A New Occupational Culture in the Workplace

After obtaining a position in the health care sector, immigrant nurses often navigate occupational challenges related to their new workplace. A key challenge that emerged from the data was adjusting to a new occupational culture, which included differences in equipment, technology, nursing terminology, care practices and ways of thinking in Canadian nursing relative to their home country (or prior country of residence). For instance, a few nurses mentioned the difficulty of adjusting to new equipment and technology in their Canadian nursing workplace. Although their imported nursing textbooks in Ghana depicted diverse nursing equipment and technology, the nurses had not actually physically seen or used some of this equipment since it was not available in their country. Thus, when they migrated abroad it took time to familiarize themselves with these new workplace conditions. For instance, a middle aged dependent woman nurse who trained in Ghana describes the challenge of transitioning from reading about this equipment in theory, to using it in practice abroad:

Uumm during, like back home, you don’t have like the nursing did, I I figured you know did give us a good training, they taught us well, but we had to improvise a lot with the instruments that we need and all those things. We don’t have them. So it’s all improvise so the difficult part of me being here was, you see the thing, you’ve heard it and you’ve read it in the book, but you have never seen it physically, you know. It can be described, some, a few of them can see pictures of it, but most of them you don’t. So that was the the most difficult thing that I would say I’ve experienced, getting used to using those ah IV poles and pumps and all those things (Middle aged female nurse, Participant 5)
In addition, the nurses also had to learn the language, care practices and ways of thinking in Canadian nursing. For instance, a few nurses mentioned having to learn different names for medication in Canada relative to the UK or Ghana. The challenges these nurses faced in adapting to the new occupational culture in Canada are confirmed by another large study on immigrant nursing incorporation in Canada. This research found that “subtle differences of the Canadian [health care] system” are difficult to learn - even among nurses from similar training styles and who are fluent in English (Jeans et al. 2005:41). Along the same lines, Duff et al’s (2000:49) study of new immigrants participating in a long term resident care training in Canada found that immigrant health workers can have difficulty picking up the subtle differences between official terms used in textbooks, and the colloquial terms used in the nursing workplace by their colleagues and patients.

Another aspect of the Canadian nursing occupational culture to which the nurses had to adjust was different care practices, or how nursing is practised. Two middle aged female nurses, one who moved directly from Ghana to Canada and the other who first migrated to the UK and then Canada, describes these differences in nursing practice in more detail:

*And then here too, nurses do more, when I say more - like more assessments, than back home. Back home, we don't do much assessments there, we only rely on doctors' orders. Once in a while when there's no doctor then you play the role to assess a little bit. But every order comes from the doctor - every order. But here you have to do more, more you know, more assessments and everything, before the doctor comes, or you report it* (Middle aged female nurse with work experience in Ghana, Participant 9)

*I think when I moved to Canada I found that the Canadian nurses actually do much more than the nurses in England. For instance um, when you're working in England, you you the nurse do not assess the the patient's breathing - like chest, listening to the patient's chest and abdomen. When I got to Canada, you have to do it. You learn how to do it. They have videos in the workplace - so I took the videos home and I sit down and watch, and of course in the textbooks they expect you to know. So I think they are trained to know how to do it* (Older female nurse with work experience in Ghana and the UK, Participant 6)

Thus, the nurses had to adjust to new/additional workplace responsibilities and divisions of labour. This supports other recent research on the challenges immigrant nurses face in the workplace by Ronquillo (2010:73-74) and Bourgeault and Neiterman (2013:90), particularly in terms of ‘cultural competency’ vs clinical competency, and adjusting to the different style/practices of nursing in Canada. A general expression used by a few nurses to describe these differences in nursing language and care practices was ‘thinking like a Canadian [nurse]’. This nurse, who migrated from Ghana, trained as a nurse in the UK and then moved to Canada, illustrates this thinking in more detail based on her experience in Canadian hospitals:
In my case I did a lot, I’m like - “in England we don’t do it this way, in England it’s not like that”, you know because it’s all frustration, right? So it makes you think, how can it be done like the way it’s done in England, but because you are frustrated you are not stopping to think, you are in a different country (Middle aged female nurse, Participant 1)

Williams’ (2007:364-365) four types of knowledge can help make sense of this shared sentiment among the nurses. Embrained knowledge is derived from more generic skills and cognitive abilities, while embodied knowledge reflects practical thinking rooted in physical experience and ‘learning in doing.’ Encultured knowledge involves shared meanings based on a common or local understanding/socialization, while embedded knowledge is tied to contextual factors and rooted in specific systems, cultures and groups – often work related. Williams (2007:365) asserts that encultured and embedded knowledge are ‘place-specific’, that is rooted in a specific social setting or environment. Alongside other migration studies that have applied William’s typology (Aure 2013:280), this dissertation finds that immigrant nurses often find it difficult to acquire encultured and embedded nursing knowledge in the host country. While their embrained nursing knowledge is more easily transferable, i.e. general anatomical knowledge, this study further confirms the importance of recognizing the different types of knowledge required for successful skilled immigrant incorporation.

Previous research by occupational scholars, notably Van Mannen and Barley, also provides insight into why and how adjusting to these new types of nursing knowledge can be difficult for skilled immigrants. These authors suggest that when individuals become members of an occupation they must learn a “… set of codes that can be used to construct meaningful interpretations of person, events, and objects commonly encountered in the occupational world” (Van Mannen and Barley 1982:20). Applying this insight to the present case study, immigrant nurses must learn a new occupational culture rooted in the Canadian nursing context. For these nurses, ‘decoding’ this workplace culture (i.e. ways of thinking and doing in Canadian nursing) is particularly challenging given its dynamic nature and varying levels of formal support to gain this knowledge. However, learning the new occupational culture is arguably a necessary step for immigrant nurses to keep their jobs by successfully performing their profession in their new workplace.

Overall, a key obstacle in the nurses’ workplace adjustment process involved learning a new occupational culture, i.e. different working conditions, the terminology, care practices and ways of thinking rooted in the Canadian nursing context. Further complicating this adjustment process
was the demeaning treatment some nurses received from both their colleagues and patients during (and after) their initial transition period.

6.1.2 Encountering Racism in the Nursing Workplace

A particularly difficult challenge in these skilled immigrants’ workplace incorporation process was latent and explicit racism. One form of perceived latent racism in the workplace was feeling disrespected by colleagues because of a lack of familiarity with the Canadian nursing culture. For example, a female nurse who trained in the UK described how colleagues simply assume foreign-trained nurses do not have equivalent nursing knowledge and/or are not fully trained when misunderstandings arise, rather than it being largely an issue of different nursing terms and care practices, as she describes below:

[...] Some of the nurses just assume that foreign nurses don’t have a clue about patient care because we don’t even know how to do a chest assessment. That fact is that we have chest physios whose job are solely chest assessment for patient at risk. Or even some of them will remark they don’t even know how to spell properly. Because the nurses do not understand our system of working, they fail a couple of nurses on their orientation shifts and thought they were unsafe to practice. It all comes back to the different care delivery systems (Middle aged female nurse, in an e-mail follow up, Participant 1)

Another middle aged female nurse who trained in Ghana and moved directly to Canada describes a similarly demeaning experience with nursing colleagues, i.e. her general (non-immigrant) occupational community. For instance, after having her credentials recognized and passing the licensing exam, she was unfamiliar with certain nursing instruments. Rather than reaching out to assist her, she sensed her colleagues questioned her professional skills and credibility, as she describes below:

And so it was difficult in the sense that she says she’s a midwife, then how come she doesn’t know, kind of ah dampens your spirit a bit, kind of pulls you back it’s like, you know, it shakes your confidence, you know what, you know what you’re doing, just that I don’t know this instrument, I don’t know this gadget, it doesn’t mean I don’t know my stuff. But at the, at the at the end of it or what I do, or how I take care of my patients, is the one that determines you know how much I know. But to everybody else you know nothing, and you claim to be this, so in their minds you are a fake, you are claiming to be something that you’re not. And that is another challenge and then you pass by and they’re talking behind your back (Middle aged female nurse, Participant 5)

68 Note – the primary researcher assumed this passage referred to an acute hospital setting at which point the respondent was working as an RN (rather than long term care setting) given the reference to instruments and equipment which likely would not have been a problem in a nursing home setting where she was working for a period of time before becoming an RN.
Thus, immigrant nurses can experience skills discounting, i.e. “the devaluing of educational and occupational experience, of immigrants […]” (Ogilvie et al. 2007:234) and differential treatment within their own occupational community. These findings have also been outlined in other studies. For instance, Calliste’s (1996:371-372) earlier research on the workplace experiences of African Canadian registered nurses in Canada found that while Caucasian nurses who made mistakes were assisted to improve their practice, visible minority nurses were not helped, were treated condescendingly, or were required to perform at a higher standard than their non-black colleagues. Similarly, Murphy’s (2008:147, 151-152) study of foreign-trained nurses in Ontario described instances where these nurses experienced ridicule from their colleagues when they were unfamiliar with certain instruments, terminology, or phrases. In the same vein, Ronquillo’s (2010:78-79) research on registered nurses trained in the Philippines and living in Canada described a need for the immigrant nurses to prove themselves to their Canadian colleagues. Notably the nurses in Ronquillo’s study, as well as several nurses within this sample, did not specifically use the term racism to describe these experiences. However, some immigrant nurses develop their own ways of expressing racialized experiences since they “[…] may not always be willing or able to explicitly use the language of race, racialization or discrimination […]” (Ronquillo 2010, as cited in Ronquillo et al. 2012:20). Arguably then, this type of demeaning treatment from Canadian nursing colleagues can at best be described as an inability or unwillingness to identify with immigrant nurses’ experiences and needs in the workplace adjustment process, or at worse as latent racism.

The social or professional distance between the Ghanaian nurses and their Canadian nursing colleagues may also reflect what Van Mannen and Barley (1982:13-15) describe as “self-imposed boundaries” within an occupational community. As a reminder, an occupational community refers to a group of individuals within the same occupation who typically share an occupational culture and develop networks with members of their occupation that extend beyond the workplace (Van Mannen and Barley 1982:12; Sandiford and Seymour 2007:214-215). Importantly, occupational community boundaries are generally not geographic in nature, or limited to membership in the same organization (Salaman 1971:389-390; Lee-Ross 2004:86). Rather, they are set by the members themselves based on shared understandings and identities related to the occupation (Salaman 1971:393-394). A few studies though using the occupational community framework, for instance, have found differences within occupational communities
along gender or geographical lines (Salaman 1971:389-390; Sandiford and Seymour 2007:217-218). In that vein, this dissertation suggests that immigrant nurses whose different training, language and racialized experiences separate them from the majority of occupational community members may also perceive themselves to be outside the community’s boundaries.

Why do we see these divisions within the broader nursing occupational community? Bechky’s (2003) work on misunderstandings between occupational communities may assist in understanding this outcome. In her study of communication difficulties between engineers, technicians and assemblers working for the same company, Bechky highlights the challenge these groups experience when trying to communicate as a result of their specialized language, training and work conditions/practices. She proposes that these communication problems are the result of decontextualization, which refers to the “context-based use of different concepts to talk about the same object” (Beckhy 2003:320). A similar process of decontextualization may be underway between some non-immigrant and immigrant nurses in the Canadian nursing workplace, given differences in language, training, and type of nursing practices across countries. This may result in communication difficulties between the two nursing groups, resulting in the perception of boundaries, and the creation of divisions between them.

It is important to note that not all the respondents described these types of divisions. In fact, a few discussed developing friendships with some Canadian-born nurses or doctors, even those who had experienced racialized incidents with other nurses or patients. Nevertheless, nurses from several provinces highlighted these experiences of exclusion. Thus, there is evidence of overall patterns of exclusion from the general (non-immigrant) nursing community in Canada in this study, in line with findings from other nursing incorporation research in Canada which found similar divisions within the nursing community in certain provinces, such as Ontario (Das Gupta 2009:76-77).

Another manifestation of perceived latent racism in the workplace was frequent questioning of some nurses’ accents from both their colleagues and patients. One middle aged female nurse - who trained in Ghana, worked in the UK and then worked as an RN in Canada for several years - explained that she is still frequently asked where her accent comes from and where she trained. Once patients find out she trained in a developing country, some would then ask how long she has been a nurse, as she describes below:
Yeah the other ones I found them very funny. Like a patient would come and I will say that, like when I received a patient, I’m working in an acute surgical floor, and I receive a patient from the operating room or something and I’m like trying to admit the patient, like when I first greet the patient - hi I’m X, I’m your nurse today, and how would you like me to call you blah blah blah and then she said oh this this, or he says this then, the first thing he will say - where do you come from? Everybody, where do you come from? Because I was the only black there, right? Oh where do you come from, where is this accent from? […]

Yeah, so where do you come from? Where does this accent come from? Did you train here? And then, and then someone of them will ask me - how many years experience do you have, while you look after them. Where do you come from and how many years experience do you have in nursing? And I say you know what, it’s over 20 something. […] Yeah, oh that one is like continuously, and I’m used to that, you know, I find it interesting. Anyway I like to tell them where I come from. I even go ahead and tell them I trained in Ghana, went to England and did more training in England, worked in England for [X] years, then I came over here and then they go on, where do you come from? It’s like every day, it’s like a song I sing now (Middle aged female nurse, Participant 2)

The fact that this must regularly explain her accent, despite years of work experience in the UK and Canada, suggests that her ‘master status as a foreigner’ remains long after her initial incorporation into the nursing workplace (and her nursing credentials being fully recognized as equivalent), as has been found in other studies on skilled female immigrant incorporation (Purkayastha 2005:190). Similarly, a middle-aged female nurse who trained in Ghana and migrated directly to Canada explained that she sometimes found it difficult to follow conversations because she was not used to the accent here. Rather than trying to understand why she was asking individuals to repeat themselves, she felt her basic understanding of English was being questioned, as she notes:

You know being in a foreign land, you know, you don’t, even though English is our ah ah official language back home, you are not used to the accent or the way, the faster way people speak here, so it’s a struggle to come in and then have to go through all this and to take time someone says something, and then you have to let them repeat couple of times. And it’s not that you don’t understand the language but it’s you know it’s faster, that is not my first language. You know, so these are all some of the things, they consider you are from Africa, Africa in general, you know nothing. That is one thing (Middle aged female nurse, Participant 5)

Although it wasn’t clear if this nurse was speaking in a more general sense, or within a workplace setting, her frustration was clear. As Das Gupta (2009:71) suggests in her analysis of visible minority nurses in Ontario, accents can become a way to differentiate individuals for ridicule or ‘negative assessment’. However, some might suggest that language facility can be integral to successful nursing incorporation and safe nursing practice (Ogilvie et al. 2007:228). As a result, potential language comprehension concerns or questions may be justifiable among Canadian-trained colleagues and/or patients. Yet, the fact that these Ghanaian nurses are from a country where English is the national language (and the language of instruction) suggests comprehension is not the main issue. An alternative explanation is that this repeated questioning
of where, and how long, the nurses trained (based on their accent) may reflect latent racism. Notably, Creese and Wiebe’s (2012:65-66) analysis of skilled immigrants found a similar pattern, particularly among women seeking white collar service jobs, which require strong English skills. The women described being treated by prospective/current employers as if their language skills were inferior, despite coming from countries where they had been educated in English. The authors therefore suggest that assumptions about language capabilities often reflect stereotypes about immigrants’ abilities that are “…mediated through [their] accent and racialized [bodies]”, suggesting a process of racialization rather than an objective review of skills (Creese and Wieber 2012:65).

A few nurses also experienced more explicit forms of racism, alongside these various manifestations of latent racism. For instance, two nurses described encounters with patients who refused to be cared by them because they were black or because of their accents. These negative workplace experiences left both professional and personal impacts. For instance, a middle aged female nurse described a racial incident that occurred shortly after she arrived in Canada, after her nursing credentials as an RN from Ghana had been fully recognized by the respective provincial body in Canada. Not only was she unprepared for the racial incident, but her employer did not have sufficient policies and resources to support employees in this type of situation, as she describes here:

_‘I had this patient that I was looking after, so I went to him and I introduced myself that morning and I started you know, doing everything, you know we do what we call the ‘head to toe assessment.’ So, I assess him, he was really really feeling so uncomfortable. I was trying to make him relax and chat with him, and I was finding it so difficult with him for some reason. So afterwards I went back to the nurses station and was doing my charting and writing all my notes, and I saw this patient come out through the corridor crying, really really in tears, surrounded by two of the nurses, obviously I am the only black nurse, those two nurses were actually Canadian white nurses, and he was talking to them and I wasn’t sure. So I was trying to interrupt - oh that’s my patient why is he crying, obviously I was very anxious because I found him very tense and not relaxed. So the nurse came into the office and then she told me - X you know what, can I look after Mister so so and so, and I said no he’s my patient why do you want to look after him. You have your four patients and I have my four patients, that would give you five patients and I have three, that’s not fair. So yeah I’ll just keep him and you keep your patients, and she was finding me very reluctant to tell me the reason, and then she eventually she has to say it - that the patient said, he is a racist and he has never had a black person touch him[…]’_

_Uhhh he is crying because he doesn’t want me look after him anymore[…] He was a Canadian. And then I felt, then I felt all these gooseflesh on myself. I, I didn’t know how to handle it because I’ve never had this experience. And I said so what, should I just give him to that patient. I, I was thinking in my mind, should I let my, my colleague take him? And I said no. What if all the nurses on this floor, all thinking to myself, what if all the nurses on this floor were black - what would he have done? Yeah and I am thinking what if you were very ill and you are dying and I’m the only person to help you? I’m thinking all these different things, and I’m thinking is it fair on my other colleague, white nurse, to take him? No, it’s not. Should he be allowed to just choose which colour looks after him?_
So I said - you know what, okay, let's get on to work. I'm still very very upset right now but I'm trying hard not to get upset, I want to just work. So let's swap the patient, take mine - one of, him, and I'll take one of yours - to be fair on you, not to have 5 patients while I have 3 patients, so then we did that for that shift. Then the following day I phoned in sick because I didn’t sleep all night. I sat there thinking about the whole thing, I was feeling uncomfortable - should I go back to [previous sending country]? (Participant 2)

Since this nurse had only recently arrived, she felt an urge to return to her sending country in order to avoid future racial encounters in Canada. Her colleagues’ differing reactions (some trying to quietly avoid the situation by swapping patients, and others urging her to take a stand and confront the patient’s racism) also left the nurse feeling confused and uncertain of how to react. She later tried to draw on available workplace resources (i.e. union) for assistance based on the advice of a colleague, but found her representative provided unhelpful advice that would not solve the situation:

I remember when the thing happened I called our union rep [...] and said this is what, cause one of the girls said you know what- call the union and see what she says. So when I called the union and I was like crying, you know what she told me, she’s said she’s also a foreigner [...] And she’s had patients spat on her feet and she just clean it and started working so I shouldn’t get bothered about that. She told me that. [I: Wow] I know. So is this how we gonna live our life?

Rather than taking her union representative’s advice to ignore this racist treatment, the nurse refused to accept these working conditions. Instead, she insisted the administrators in her workplace develop policies to address this type of incident. Thus, this respondent addressed a gap in available structural resources (i.e. formal policies) by demanding a new set of institutional processes. Notwithstanding her courageous response, this experience negatively influenced her skilled incorporation in two key ways. First, she chose to remain a bedside nurse (rather than try to rise through the management ranks), in part because of this racialized incident:

The nursing wise I didn’t, I wasn’t thinking of going anywhere differently, but just remain in my nursing job - the same - until I retire. Ummm although I did have that expectation to become like a whole big manager or something instead of just bedside nursing, but that changed, for some reason ahhh I think I should concentrate on my children, educating them and also the reason why it changed was also because of that experience that I had with that man, the racial thing. And I was thinking oh there’s no way I think I can go everywhere, if they will not allow me to touch, then how can I, like manage all Canadian nurses, saying what to do and not to do. So I changed my mind, I said okay, I'm not doing any further training, I’m just going to stay and do my nursing as I am and then finish (Middle aged female nurse, Participant 2)

This experience also influenced her feelings of inclusion into broader Canadian society. As described below, she still does not feel fully accepted in Canada even though several years have passed since the racialized incident:

Uhh yeah I don’t know why I felt [previous sending country] was more homely. I think I was accepted and I lived in [previous sending country] as my own place rather than here for some reason. I don’t know if it’s the experience
that happened with that man, or it’s because there is less black people here (Middle aged female nurse, Participant 2)

As Grant and Nadin (2007:159) found in their study with Asian and African skilled immigrants in Canada, racism and undervaluing of foreign credentials/work experience are key barriers to developing a strong sense of Canadian identity. This discriminatory treatment makes it difficult for immigrants to identify with a destination country that does not seem to accept them. This feeling of exclusion or isolation was also shared by other nurses. For instance, one respondent mentioned that in her previous workplace in the UK, colleagues would spend time and develop friendships with each other. This made her work life less isolating and more rewarding. In contrast, there were fewer attempts from workplace colleagues in her province (in Canada) to develop a connection. This limited connection to colleagues in a new workplace contributed to strong feelings of loneliness, which made the skilled incorporation process more straining, as she notes below:

R: [...] because in the UK we actually socialize a lot, that’s another thing. So people can, even if you’re struggling, people will want to know your your background, will want to know you’ll be more, invite you out, you know.

I: The other nurses you mean?

R: Yeah, yeah. But here, it’s not like that, you just come to work and you go your separate ways unless it’s Christmas, then people will probably organize. Whereas in the UK, every month, that’s always, we get paid every month, anyways so there’s always, like I was organizing our outings when I was in the UK, you know, yeah. So with that, you get to meet people, you click with people, but here it’s just work and home. So if you don’t meet anybody you click with or anybody that can, you can connect with or that can actually advise you, you know, then you go home and you’re alone facing your four walls and that becomes really stressful if you don’t have any family (Middle aged female nurse, Participant 1)

Another manner in which some nurses felt excluded was the small number of black nurses in their workplace (relative to not only Ghana, but also the UK). This limited presence of black nurses in the workplace again underlined their minority status:

So when I came to my hospital, I was the only black on my floor as compared to England where there were like 10 of us on the floor (Middle aged female nurse, Participant 2)

I find there are little cliques you know, and me being, although everybody’s nice, me being the only black African, I felt out of place because I have nobody to click to, to cling to. You know what I mean? (Middle aged female nurse, Participant 1)

Thus, the nurses’ minority status further contributed to feeling out of place in their new workplace or even outside the boundaries of their general (non-immigrant) occupational community. Overall, adjusting to a different occupational culture (such as new workplace conditions, care practices and terminology), latent and explicit racism, and feelings of loneliness,
all represented significant obstacles in these nurses’ incorporation process after entering the workplace. The next section explores how these nurses overcame these challenges.

6.2 Resources to Facilitate the Workplace Adjustment Process Among Skilled Immigrants

6.2.1 The Migrant Occupational Community and Workplace Adjustment Process

Many skilled incorporation studies focus on identifying and explaining the challenges immigrants face, and propose general recommendations to address these obstacles (such as Ogilvie et al. 2007, and Sochan and Singh 2007). A strength of this dissertation is its focus on how skilled immigrants themselves attempt to overcome these incorporation challenges in practice. In so doing, this study highlights skilled immigrants’ agency within these broad incorporation trends.

One nurse was able to adjust to the skilled incorporation process by gaining experience through different moves within Canada. She was therefore able to gain knowledge and familiarity with the skilled incorporation experience over time. More specifically, after first being sponsored to Canada by her husband (and then several years later moving to another Canadian province), she underlined how she had become accustomed to Canadian health care system and developed the “Canadian way of thinking”, a concept discussed in an earlier section, which facilitated her second skilled incorporation experience:

_Gosh, it’s just like night and day. And I don’t know whether it’s maybe as time went by, you know coming to [Canadian province] was my first introduction to Canada, so I’m getting to know the culture and getting to know the people you know, and then being introduced to the nursing, and you know things rub off on you. So maybe I hadn’t much thought of it from [Canadian province] then coming here, you’re coming with a different attitude - you’ve already been in Canada for 10 years [...] so I’m coming with a different attitude here, I’m coming maybe with a bit more Canadian experience (Middle aged female nurse, Participant 10)_

Others drew on their migrant occupational community to try and overcome these differences in occupational cultures. For instance, a few nurses explained how fellow immigrant nursing colleagues offered to assist in learning Canadian terms for medications and nursing routines more generally. One older female nurse describes such a scenario:

_I happened to work with one lady who is from England and just because I was coming from England, she was most helpful, she kind of schooled me through all the differences of medications, the drugs the umm umm routines that are very different from England to here, cause she knew both sides. So she was most helpful and ah supportive because if you are a stranger too you know, people are not always quite sure about you, so she kind of put in a good word_
for me all the time and was friendly, would invite me and you know it really helped a lot (Older female nurse, Participant 6)

A few studies on skilled incorporation have noted that general English language classes are often insufficient to meet the needs of foreign-trained professionals (Man 2004:145). This respondent’s experience shows how migrant occupational networks can fill this gap.

Migrant occupational networks can also provide more general assistance when it comes to incorporating into new workplace conditions and a different occupational culture. For instance, a middle aged female nurse in Eastern Canada explained how a fellow immigrant Ghanaian nurse proactively approached her in their hospital, and offered to assist her during the initial transition period to the workplace when she was still preparing for the nursing licensing exam, in terms of answering any questions she might have and where to find things, etc.

Another illustration of the support function of the migrant occupational community is its provision of professional support. For instance, a middle aged dependent nurse explained how many immigrant nurses have approached her for assistance. These nurses felt comfortable talking to her and asking questions, arguably because she had been through a similar skilled incorporation experience. In the same vein, another male nurse explained how he tries to assist new immigrants by providing advice on how the system works, mobility and team dynamics. Without this relevant social support, immigrant nurses may feel discouraged and opt off the incorporation path. For instance, one middle aged women nurse explained that she knew several foreign colleagues who migrated to Canada from the UK. However, they eventually opted to move back after being unable to adjust to the new working and living conditions in Canada. Notably, she underlines that if she had connected with these nurses earlier, she may have been able to convince them to remain in Canada:

I am because you know sometimes I think, because of uhh, for me, I like helping people because I know I struggled to get to where I am and I always think other people will struggle the same way. So if I can actually tell them to stop thinking like they’re in Britain and think Canadian, they will, yeah, they will their life will be much easier. Because, which is, you know I sort of reflected on my own experience, you know, and then what helped me get through it. So if I can speak to them sooner, then and then they can start making those changes, and applying them to their own day to day life. That will make their life a lot easier[...] Cause a lot of people before I got to them, it was too late. And actually about 4 of them have left. 4 people have gone back to the UK, yeah. (Middle aged female nurse, Participant 1)

Another middle aged female nurse describes a similar scenario, where a foreign-trained (Black) nurse in her city had such a difficult time in her workplace, she chose to move to another city:
Yeah, I know that there is an [African] nurse, but she doesn’t work here. She works, she goes all the way to [larger city]. As I said, I think she probably did, well not probably, she did do some grad nurse jobs here before she she passed her exams, and things didn’t go well and that was around the time that we had just come here, and I I didn’t hear good good news and umm yeah I saw it myself too, well not to me ahhh because there was another East African or South African girl here and yeah she’s gone too. And I mean the [first African] lady said quite a lot [...] Yeah she, yeah she was, so she chose to go to [a larger city] instead. And I don’t blame her [...] Oh yeah, it’s more Metropolitan and I think, people are uhh kinda open to, to things (Middle aged female nurse, Participant 3)

Thus, immigrant nurses without access to relevant social supports (i.e. migrant occupational networks) to assist them in coping with skilled incorporation stresses may be more likely to give up on the skilled incorporation process in their current locale, and opt to try again elsewhere where they might be a more diverse (and receptive) population, or more social support available. Similarly, Blythe et al’s study on immigrant nurses in Canada found that those who cannot adapt to their new workplace environment (i.e. new equipment, care practices) generally left (Blythe et al. 2009:207). However, the authors provide little suggestion as to what type of resources, or conditions, would assist these nurses with this challenge. This analysis suggests that social supports, particularly the migrant occupational community via migrant occupational networks, can make a difference among immigrant nurses in helping to overcome skilled incorporation challenges among those experiencing either positive or negative incorporation outcomes.

The support function of the migrant occupational community in the adjustment process is not only recognized by its members. External actors (i.e. employers) also draw on this community to provide assistance to new immigrant nurses. For instance, a few female nurses were approached by their employers to assist new immigrant colleagues settle in, as illustrated below:

*Oh yeah, no actually they, I didn’t talk of volunteer but then you know I realized every time somebody new comes in, and sort of struggling, they [management] always refer them to me. They call me and say oh, actually we’ve got a few people that have come and they seem to be struggling, do you mind umm meeting them and talking with them. So that’s how I became that gateway (Middle aged female nurse, Participant 1)*

*So what happened is that this friend of mine, that lady I said who was in the recruitment office that I spoke to [...] and when the nurses comes, uhh the black ones among them, she [woman from the recruitment office] tells them, oh get the, she calls me and asks me if she should give my number to them because they are all like, oh they don’t know anybody, things, and if I can help them settle. And I said yeah sure, I didn’t mind. So she gives my name to everybody[...], speak to [me] she will help you, you know find a place to live and how where you can get African food from and things like that (Middle aged female nurse, Participant 2)*

Thus, external actors (i.e. employers) can interact with migrant occupational networks to create a more formal method of helping foreign-trained nurses adjust to their new lives. Although it was not always clear whether this assistance focused on incorporating into the workplace and/or new city, arguably immigrant nurses brought together would discuss issues related to both. In
addition, the fact that some employers specifically chose to connect immigrant nurses together highlights the perceived utility of migrant occupational networks in facilitating the skilled incorporation process from individuals both within, and outside, this community. On a broader level, the fact that employers are fostering migrant occupational networks demonstrates a recognition that skills and human capital alone are insufficient to ensure a positive incorporation process.

A few nurses also mentioned the utility, or their interest in, their migrant occupational association, another element of the migrant occupational community, for support as they adjusted to their new workplace environment and destination country\(^{69}\). For instance, one respondent described being able to meet other Ghanaian nurses via the association:

*So then I went, and then they were having a picnic, they want to do, the same picnic they will do next week. So when I went, then I joined up, after all look - this is a new country. I'm not really too much into that kind of stuff but I did join. And uh so, just to network, and get to know some Ghanaians [...] Other, other Ghanaian, other nurses who have moved here [...]* (Middle aged nurse, Participant 11)

Another nurse, who only connected with a migrant occupational association a few years after arriving in Canada, described how connecting with other nurses who had been through similar experiences would have been helpful when first arriving:

*And you know, and the the first thing here, you know you come in, oh you've got to pass those exams, if you don't pass, you know you've got to stay at home, umm you know, how you gonna survive? That kind of thing. I mean if you had that network that people that you can talk to, people can reassure you, that kind of thing, I think you know - it would, it would have done a whole lot of good* (Middle aged nurse, Participant 15)

When probed further the respondent noted that having that support from other nurses (outside of work) would be useful, wherever the nurses came from. Arguably though, an association bringing together immigrant nurses would foster more shared experiences relative to nurses more generally.

These associations also host social events to further promote a sense of inclusion among members. For instance, a middle aged nurse who experienced a strong sense of loneliness when first arriving in Canada explains how the migrant occupational association plans to organize social events to ensure new Ghanaian nurses do not feel isolated:

\(^{69}\) In this section discussing the migrant occupational association, information related to the gender of respondents has been omitted due to the relatively small size of these associations and potential confidentiality concerns.
Bringing members together on a regular basis through formal associations/groups facilitates these exchanges and strengthens connections between these Ghanaian nurses, as Horowitz (1985:56-57) suggests occurs within traditional occupational communities through formal associations. A nuance of these migrant occupational associations is that one of their potential areas of influence is assisting in navigating the skilled incorporation process, such as creating a feeling of belonging among new immigrants who may feel excluded from their general non-immigrant occupational community.

Another possible influence of the migrant occupational association is its professional development function. This can range from providing information about career development, to nursing best practices, as suggested by these two nurses when probed:

*We just got a got a [migrant occupational association] yeah [I: Yes], here, yeah. So now that’s an avenue we can connect people to, like when we meet each other, we discuss that and there are meeting days and, so when we go, when we will meet, when over there, we can, we talk about our issues facing us (Middle aged nurse, Participant 14)*

*Um, at least you know that you are not alone, in in this profession. Secondly, you can have ideas, you know how to go about umm maybe problems at work, how to go about it, who to speak to, what to do first (Middle aged nurse, Participant 18)*

Why do these migrant nurses feel the need to turn to, or interest to create, a migrant occupational association to address these workplace adjustment and mobility needs? As mentioned, differences in nursing practice, terminology and thinking can result in decontextualization, which in general refers to the “context-based use of different concepts to talk about the same object” (Bechky 2003:320). Bechky proposes to bridge these divisions by developing common ground around workplace tasks that help create shared contexts. Through this process, workers can develop a “shared understanding” of the issue/concept being discussed and its context (Bechky 2003:320-321). The above data suggests that more experienced Ghanaian nurses who have developed the ability to “think like a Canadian nurse” can serve as this ‘bridge’ for newly arrived Ghanaian nurses, since they have an understanding of the language, culture and practices in both types of occupational community contexts (i.e. in the host and home countries). However as Williams (2007:370) suggests, even obtaining this type of encultured and embedded knowledge in order to assist migrants move from “the status of ‘stranger’ to that of ‘friend’” may be
insufficient. Social categories, i.e. along racial or immigrant lines, can prevent further rapprochement between new nurses and “within-group members”. Notably, this dissertation suggests that immigrant nurses may create their own migrant occupational community to respond to their needs, rather than wait and be accepted by all “within-group members” in their broader occupational community.

Existing nursing research highlights the need for formal training programs that introduce foreign-trained nurses to the culture, terminology and practices within the Canadian nursing workplace (Murphy and McGuire 2005:29). While this type of program might be useful, it overlooks the presence of a community already undertaking this role – the migrant occupational community - which provides insight into what strategies migrants themselves have devised to address their specific needs. Although a few studies have mentioned the presence of ethnic professional associations, such as Man’s (2004:146) brief reference to Chinese Professionals Associations in Canada and Saxenian’s (2002:25-29) description of Chinese and Indian occupational associations in Silicon Valley, such studies remain limited. This case study therefore contributes to building a more in-depth understanding of the nature, role and influence of both migrant occupational associations, and the broader migrant occupational community, in the skilled incorporation literature.

6.2.2 The Migrant Residential Community and Workplace Adjustment Process

A final resource that some nurses turned to facilitate their workplace adjustment process was their migrant residential community. Interestingly, there were instances where the migrant occupational community intersected and complemented the migrant residential community to respond to the needs of new immigrant nurses. On the one hand, a few nurses explained how the migrant occupational community (either migrant occupational networks and/or the migrant occupational association) was an entry point for getting to know the broader Ghanaian residential community, such as where to locate the local embassy, ethnic food shops, etc. On the other hand, the migrant residential community also at times provided access to networks and resources to help build up the migrant occupational community. For instance, an older nurse explains how these two communities can support each other:

So when there’s anything happening with a Ghanaian cultural group we are invited. And so one day the group of nurses decided they were going to do this and they started asking- do you know any Ghanaian nurses and of course
then give your name and phone number so they phone you, they’re trying to start this thing would you like to come and then, so I went a couple of times and that’s how I got involved (Older nurse, Participant 6)

Similarly, a middle-aged female nurse was able to develop migrant occupational networks through her migrant residential networks (at the family level), and was then able to feel less isolated in her new province. After arriving on her own in Canada, before her family joined her, she didn’t know any other Ghanaians and reached out to a family member living abroad:

[...] So my sister then was talking to a friend of hers who is a Ghanaian in America and she was telling her about me and that friend told my sister that, “oh I know about another Ghanaian nurse in [city] and she gave the name and the phone number to my sister and my sister called me and I called her, and she and her husband happened to have come from [Ghana]as well, and the husband apparently knew my brothers and he told me but I didn’t know him, so now we are very close friends(Middle aged female nurse, Participant 2)

Only one nurse explicitly mentioned the migrant residential community as having a distinct influence on her workplace adjustment process. This middle aged female nurse underlined her family’s support during the struggles and rejection of this period, noting “I am blessed to have my [family] here with me and I look forward to coming home to them every day that is how I coped with my frustration” (Participant 1). She also notes that members of her migrant residential community (i.e. other non-nursing Ghanaians) get together on a monthly basis to watch movies together and have formed a ‘small family’. Thus the migrant residential community can also provide social support to nurses feeling isolated in their skilled incorporation process, though this appears to be less common. Furthermore, it is worth underlining that this nurse was also actively involved in her migrant occupational association. This suggests that the general social support provided by her family (migrant residential community) was perhaps not sufficient, and/or that she derived an additional sense of social and professional fulfillment from her membership in a migrant occupational community. Although some other respondents mentioned being involved in Ghanaian cultural groups in their area or befriending other Ghanaians (non-nurses) in their community, the latter connections did not seem as explicitly linked to the workplace adjustment process.

6.2.3 The Migrant Occupational Community in the Transnational Realm

The migrant occupational community also filled a broad transnational occupational interest among several respondents, underlining the broad scope of this migrant occupational community. Specifically, numerous respondents emphasized their interest in strengthening their occupational community in Ghana despite living abroad. One key avenue through which they
could pursue this interest was via their migrant occupational association. For instance, one of the original members of a migrant occupational association explained that this transnational occupational interest was a key driver for creating an association in Canada, as described in more detail below:

The migration of what - healthworkers from Ghana. My opinions right now is that why do, I don’t blame them from migrating, on the other hand I wish we can stay in Ghana and help our country. Ahh, they ohh, I I wish we can stay in Ghana and help, but on the other hand how can they, if they cannot afford a good living? Umm that’s my problem so, like umm, that’s why I was telling our, [the migrant occupational association] that is that we’ve formed saying that - I’ve got that guilt being trained in Ghana, Ghana is an underdeveloped country where doing my training, we were even paid to do our training because they were taking the English system. The, our allowance, they gave us an allowance, while we were training, it wasn’t enough but at least you can live on it food wise, not clothing but at least you can feed yourself for a month on that money, while we were training. And then they, although it's an underdeveloped country, they still paid us to train and then when we finish, we leave the country it’s so sad. Ummm and then we have learned much more here and why don’t we go back and ummm help them in Ghana (Middle aged nurse, Participant 2)

Similarly, other members of these associations explained how participating in the group filled a desire to strengthen their occupational community in Ghana, an interest they had long held, but some had been unsure how to fulfil:

She [another Ghanaian nurse] said oh, you know it’s um, the association wasn’t that big yet, and she said oh, they just started a small [migrant occupational association] that, you know, and their main goal is to help Ghana, you know. And actually saying that, you know that quickly reminded me of when my mom was in hospital and the picture I saw, right. That has always been at the back of my mind, how can I make a difference. So when she said you know, their their main goal is to form an association and be able to help Ghana, you know, adopt a ward, that’s what made me show interest. And also for my own selfish reasons as well, I’m like ohh so I can have you know other Ghanaians I can associate myself with, so you know (Middle aged nurse, Participant 1)

Umm I, their their their their cause, is a is a noble cause. You know because coming back from Ghana I know what nurses go through. We don’t have a lot of uhh equipment and uhh hospitals are very, how would I say, it’s improving but by that time, hospitals, you have to pay. You know, you have to pay for your bed, you have to pay for your medication, but our association were trying to supply them beds, medication and help and even blood pressure, high blood pressure machines, you know? So when I heard their cause, I said wow, this is very, this is something uhh helpful, if we can extend our help to uhh Ghanaian nurses, or the hospitals there we would ship some few items for them (Middle aged nurse, Participant 18)

Interestingly, several nurses highlighted that they became motivated (or further motivated) to contribute to their occupational community in Ghana once abroad. Specifically, they only seemed to become aware of the level of disparity in the equipment and resources in their host vs home countries once they entered their new workplace, as a few nurses describe below (one who trained in Ghana, and one who trained in the UK but grew up in Ghana):

Just it’s just um, you know when you grow up somewhere you don’t see that there’s so much need there, unless maybe you know you step out of it and then you see from afar and you think oh there’s all this need so, I think I feel privileged in where I am so I just feel as if I need to give back (Middle aged nurse, Participant 8)
Ah it’s my home. It’s my home. I’d like to help more, there are some things, you find, you find that we’re lacking a lot of things that that and if you know it and you help and it’s it’s better. There’s so many things, that when you see, when you see them here, you say oh. It’s it’s an eye opener (Middle aged nurse, Participant 9)

Thus, immersing themselves in their new workplaces and lives abroad prompted action in their migrant occupational community in Ghana. Before that point many did not have a reference point, as this middle aged nurse explains: “now, my experience there was so sad, uhh, anyway to me at that time it wasn’t sad, I just saw, this, because I don’t know anything else to compare it to. So I was just going with the flow” (Middle aged nurse, Participant 2). But once this nurse became aware of these nursing workplace differences first-hand while working in the UK, the respondent committed to contributing to her occupational community in Ghana (and health sector more broadly), as explained below:

So we were working, working and then these patients, I had only been there like six months [in UK], you know training.. started my nursing six months, we were working, and then all of a sudden they called the crash team for this patient who was dying, and you could see all the doctors, anaesthetists, everybody running with this crash cart, pulling it, came - and they revived this patient and I’m like wow! You know, because I was like shocked, screaming - wow, great, good, oh my God. Developed countries is the best, and I’m like wow. And then this friend of mine, her name was X she started crying. I said what are you crying for the patient is up, he is awake, he is almost dead. And I’m like what are you crying for? And then she wiped her face and then she told me, you know what if it was in Ghana this patient is dead. What if that patient in Ghana is my Mom or it's my Dad, he's just dead like that, while he would have been revived here. So that was so tearful, I even became tearful, I went off all of a sudden. So I have to pat her, and hug her and said, oh never mind God’s will one day Ghana will also be like this. So then ahh we stopped crying, then I said oh my God, since then I've had that intention, I have to help Ghana, somehow (Middle aged nurse, Participant 2)

She later became involved in a migrant occupational association in England, which facilitated contributions back to nurses in Ghana. This nurse later became involved in a migrant occupational association in Canada, once she moved there from the UK, to continue this commitment to her migrant occupational community in her home country.

In addition to fostering transnational attachments, these associations can also be involved in transnational occupational activities. As several scholars have pointed out, financial remittances have traditionally received the most attention in the broader literature, i.e. money sent from migrants to their families back home (Faist 2008:21-22; Markley 2011:366). Another type of remittance that emerged from this data involved occupational equipment being sent across borders to improve resources and working conditions in the occupational community. For instance, the migrant occupational associations discussed by the respondents have sent, or have plans to send, hospital equipment and/or instruments back to Ghanaian hospitals.
An additional type of remittance activity in which some nurses engaged is technical remittances, which refers to immigrants transferring skills and expertise to the sending country (Nichols 2002, as cited in Goldring 2004:805). In the case of migrant occupational communities, this can take the form of voluntary health work in Ghana, such as by providing free public health lectures, or plans to eventually return home and apply their new nursing skills in Ghana. Several nurses described their interest in engaging in this type of remittance based on the skills they had obtained living and working in Canada. For instance, a middle aged female nurse proudly explained how she will be able to transfer her new skills and knowledge back home when, or if, she returns to Ghana:

_There are no regrets. Because even if I go home now, whatever I've learned here I'm gonna use it back home and it will be very very beneficial for them, than you know people here, so why not? [...]_ (Middle aged female nurse, Participant 9)

Another nurse explained her interest in potentially setting up a training school for nursing aides in Ghana or a nursing home based on the skills she gained in Canada. A few nurses, however, were less interested in actually practicing nursing in Ghana, largely because they felt it would be too difficult or difference to nurse there.

Some nurses, though, have already tried to engage in this type of transnational occupational activity or knew of other Ghanaian nurses who have done so. For instance, one nurse mentioned a Ghanaian friend in the UK who would teach nursing back in Ghana on short visits. Another middle aged nurse who returns to Ghana every few years described trying to volunteer in a Ghanaian health care setting during a visit back home. Furthermore, this nurse aspires to organize volunteering in Ghanaian hospitals for other members of the migrant occupational association in which she is involved in Canada.

Technical remittances targeting a migrant occupational community, however, are not necessarily as straightforward as those within the low-skilled migrant residential community. For instance, when one respondent tried to volunteer in Ghana, the health care workplace indicated that the nurse would have to go through a series of steps first, such as renewing (and paying the costs of) registration. Another nurse described logistical problems involved in this type of remittance activity, highlighting that she changed specialty areas when she migrated to Canada, and her contacts in Ghana were in her previous specialty. Consequently, she was unsure whether her
current skills were needed, and who to contact in her former workplace to pursue this idea. She describes this scenario in more detail here:

So ah my expertise is kind of limited at where I used to work so that is, but I go there and say hi and talk to them, but I don’t I don’t, I’ve lost all my skill in that field (Middle aged female nurse, Participant 5)

Thus, since skilled immigrants often have specialized technical remittances, their engagement in transnational occupational activities may require more planning and effort than general technical remittances in a residential community setting. Another implication of these findings is that incorporation difficulties in the host country, which result in immigrant nurses having to change specialty areas, can make it more difficult for them to contribute back to the migrant occupational community in their home country.

A potentially negative reception by the migrant occupational community back home can represent another obstacle to technical remittances. A few nurses explained how nurses in Ghana can be critical of immigrant nurses returning home and volunteering back home, as detailed below:

I think that they [nurses in Ghana] didn’t want to be looked down upon. Ahh, they don’t want you to come and work and be telling them this is not done this way or that way, and that is what I found (Middle aged female nurse, Participant 2)

Even though some of the experiences I’ve heard of people going back and trying to help, they were not well received because you still had the nurses at home being resentful of those that have been abroad. [I: Really?] Oh yeah, oh yeah. It’s still, it’s still the same thing about it, the same thing like I just explained to you, [the nurses in Ghana say] who do you think you are, we’ve been here, we know how the system works, you’ve been away, you’ve not.. you know? There’s been a gap, how can you, how dare you come to tell us what to do to make it better [...] (Middle aged female nurse, Participant 10)

This negative reception of technical remittances may suggest another aspect of occupational transnational activities that distinguishes these activities from traditional remittances focused on migrant residential communities. Thus, technical remittances within a migrant occupational community can trigger mixed reactions, which highlights the importance of taking an occupational lens to skilled migration research.

6.3 Conclusion: The Social Nature of the Workplace Adjustment Process

The skilled incorporation process is not complete once skilled immigrants obtain employment, whether or not it is commensurate employment. New challenges emerged in the workplace that
complicated their skilled incorporation process, such as differences in occupational culture in the workplace manifested through different nursing terminology, care practices and equipment, as well as latent and explicit racism. Human capital on its own was often insufficient to meet these challenges. Instead, the migrant occupational community (particularly via migrant occupational networks, and to some extent the migrant occupational associations) emerged as a key support that foreign-trained nurses drew on to cope with obstacles in their workplace adjustment process. In particular, it appeared to fill functions typically provided by the general (non-immigrant) occupational community, in which some did not appear to feel included. The latter traditionally offers assistance, a sense of belonging, and a space in which members develop networks with more experienced colleagues. This analysis shows that an immigrant status can become another type of division within occupational communities, alongside other stratification categories already identified in this literature, such as gender and geographic location of work (Salaman 1971:389-390; Sandiford and Seymour 2007:217-218). As a result, foreign trained immigrant nurses may turn to - or develop - their own parallel migrant occupational community. In other words, they may develop their own migrant occupational networks and migrant occupational associations to obtain occupationally-relevant assistance, a sense of belonging, and support networks.

This strategy aligns with well-theorized trends in existing networks literature, such as when immigrants experience discriminatory treatment from broader society, their commitment or connection to their ethnic residential community becomes stronger (Portes and Sensenbrenner 1993:1336). The contribution of this thesis is to highlight how the migrant occupational community can be another support on which skilled immigrants rely when they experience rejection from their general (non-immigrant) occupational community, especially in the workplace. Furthermore, this chapter has demonstrated that occupational divisions between the general (non-immigrant) occupational community and the migrant occupational community in the workplace highlight another distinct experience in skilled incorporation, relative to the low-skilled migrant residential community. These findings therefore underscore the need for an extension of the early social migration model to reflect occupational challenges in the host country that can emerge during the incorporation process, and the role of the migrant occupational community in addressing these challenges.
The migrant occupational community did not only address workplace adjustment needs in the host country. It also filled a desire to contribute to the nursing profession in Ghana by facilitating occupational remittances. However, technical remittances within a migrant occupational community can be experienced differently than in a migrant residential community context. In particular, complications in transmitting these remittances arose due to licensing issues, relevancy of nursing skills, and negative reactions from members within their occupational community back home. Transnational development activities have been discussed in the skilled incorporation literature. These have traditionally focused on the migrant residential community (i.e. hometown associations, ethnic community associations) or transnational business linkages (Portes 1997:812-813; Orozco and Garcia-Zanello 2009). By focusing on the migrant occupational community, this project has extended this discussion to transnational occupational activities. These activities are not focused on general economic development, but often on the improvement of occupational (in this case nursing) conditions or the broader health sector in their home countries. These findings therefore illustrate the importance of community context in shaping particular forms of transnational activities among migrants. In this case, overlooking the migrant occupational community might ignore these unique processes.

Lastly, this chapter has once again shown how the migrant residential community and migrant occupational community can intersect. Skilled immigrants can draw on the former to connect with their migrant occupational community when they need additional support throughout the steps to skilled incorporation, such as being connected to migrant occupational networks or migrant occupational associations. On the other hand, migrant occupational networks can also provide useful information to facilitate broader incorporation into the migrant residential community in the host country, such as where to locate the local embassy or ethnic food. This data therefore again illustrates the need to expand the early social model to include both communities, including their distinct influences as well as where the two overlap and complement one another in skilled incorporation.
Chapter 7
Conclusion: Extending the Social Model of Migration and Incorporation

Much skilled migration and incorporation research highlights the central influence of economic factors on these two processes. This dissertation, in contrast, focused on when and how social processes also shape skilled migration and incorporation. The analysis drew heavily on insights from the early social migration model, originally developed by Massey (Massey et al. 1987; Massey et al. 1994) and later extended by others (Hondagneu-Sotelo 1994) to analyze low-skilled migration. It also drew on more recent skilled migration and incorporation empirical research that considers social influences, as well as the occupational community literature.

The dissertation found that the migrant culture, networks and associations, embedded in the well-theorized migrant residential community concept from the early social model, were also present within the migrant occupational community. Both types of communities, and in particular the migrant occupational community, acted as intermediating forces that sparked interest in, and then helped facilitate progress along, the skilled migration and incorporation paths. However at times the two communities intersected, and even constrained, this progress. More specifically, the migrant occupational community had an important influence on the skilled migration process for both lead migrants (those who led their own/family’s migration) and dependent migrants (those who followed/were sponsored by their partners), and took on an even more significant role in facilitating the skilled incorporation process. In contrast, the migrant residential community had both a facilitating and constraining influence during the skilled migration and incorporation process, particularly for dependent migrants. Notably, at times gender inequalities within the migrant residential community (at the family level) constrained the assistance provided by the migrant occupational community. These different, and at times conflicting, functions of these two communities illustrate the importance of looking closely at the relationship between migrant residential and occupational communities to ascertain in which contexts they overlap to facilitate skilled migration and incorporation, and when they can run against one another.

This dissertation makes two contributions to the broader migration and incorporation literature. First, this dissertation joins other studies in refining our understanding of how social processes shape skilled migration and incorporation (Hagopian et al. 2005; Purkayastha 2005; Ryan 2008;
Poros 2008; Ronquillo 2010; Salaff et al. 2010; Raghuram et al. 2010; Kǒu and Bailey 2014), alongside traditional economic factors. This study’s extension of this body of research centers on highlighting the influence of the migrant occupational culture, networks and associations (within the migrant occupational community) on both skilled migration and incorporation. In so doing, this dissertation has made the case for extending the early social migration model to include the migrant occupational community found among skilled migrants. Second, this project moves beyond an analysis of skilled migration and incorporation outcomes, to an in-depth analysis of the processes of skilled migration and incorporation, in line with Massey’s holistic social migration model focused on low-skilled migration, as well as a growing number of skilled migration studies (Murphy 2008; Kǒu and Bailey 2014). In so doing, this dissertation has illustrated the complexity of the processes of skilled migration and incorporation, as well as the intersecting influences involved at multiple levels of analysis. Specifically, skilled workers’ migration and incorporation are shaped by factors at: the structural level - through immigration policies and racialized and gendered labour markets; the community level - through migration cultures, networks and associations rooted in both the migrant occupational community and migrant residential community; as well as gendered inequalities within the migrant residential community (at the family level); and finally, the individual level through migration aspirations.

7.1 Skilled Migration and Incorporation: Analysing the Social Dimensions

The dominant theoretical approaches within the skilled migration and incorporation fields are the neoclassical economic and human capital perspectives. The former highlights the primarily economic factors (i.e. wage differences, labour supply/demand) that push migrants to leave their home countries and pull them towards a host country. The corollary for skilled incorporation, the human capital approach, highlights micro-level economic factors (i.e. individuals’ skills, education, work experience) as a critical influence on skilled incorporation outcomes. The objective of many studies that adopt this economics-focused approach is to measure the extent to which isolated factors contribute to the likelihood of a successful migration or incorporation outcome. Such an approach does not explain when and how such factors intertwine at multiple levels to produce a given skilled migration and incorporation outcome. Without this more process-oriented information, which this project obtained through qualitative analyses informed by the early social model of migration, it is more difficult to explain which conditions, inflection
points and supports enable some skilled migrants to successfully migrate and obtain a positive incorporation outcome, while others do not.

An exception to the dominant neoclassical economic and human capital perspectives in the skilled migration literature is gender and migration research that has begun to highlight how gender inequalities within the family can negatively impact female skilled workers’ migration decision-making and incorporation outcomes (Yeoh and Willis 2005:219-220; Ho 2006:503-505; Meares 2010:477-479). However while family level factors (considered here as part of the migrant residential community) are necessary to consider in skilled migration and incorporation, they are not sufficient.

A growing literature has also begun to identify social influences on skilled migration and incorporation that lie outside the family or household, such as professional networks (Ryan 2008; Poros 2008; Raghuram et al. 2010; Ronquillo 2010; Kōu and Bailey 2014). Drawing on the social processes discussed in this more recent skilled migration research, the occupational community literature, as well as data from this study, this dissertation has used the concept of the migrant occupational community – composed of a migrant occupational culture, networks and associations – to bring new insights into the influence of these social processes on whether, and how easily, skilled migrants can make use of structural opportunities to move across borders and obtain equivalent employment in their host country. By outlining these diverse influences throughout skilled migration and incorporation, this dissertation helps to extend the early social model of migration and incorporation to include the migrant occupational community found among skilled migrants.

7.1.1  The Influence of the Migrant Occupational Community in Skilled Migration

A migrant occupational community consists of individuals who share an ethnic/racial and/or immigrant status, and belong to the same occupation that itself has a history of migration. This community includes the following elements: a migrant occupational culture, migrant occupational networks, and/or migration occupational association. Members of the community tend to be exposed to the migrant occupational culture from their home country, which consists of one or more of the following elements: a shared migrant occupational language, education/training, values, history, and standards of workplace conditions and performance, as
well as a general awareness of how these differ relative to nursing abroad, within an occupation characterized by significant migration. Many members of a migrant occupational community also have access to migrant occupational networks and associations. The former networks are composed of individuals sharing the same ethnic/racial background and/or immigrant status, who also belong to the same occupation characterized by migration. Similarly, migrant occupational associations refer to a (non-union) collective that brings together individuals of the same ethnic/racial and/or immigrant status, belonging to the same occupation characterized by migration, to discuss relevant issues to occupational members.

The migrant occupational culture, in particular, influenced skilled migration perceptions and aspirations. Specifically, the shared history and prevalence of migration within the nursing occupation contributed to this activity being seen as more plausible and familiar by Ghanaian nurses. Most respondents were aware of this culture of migration rooted in their migrant occupational community. Those with direct ties to peers abroad or return migrant nurses were exposed to stories about working and living conditions abroad via migrant occupational networks. Many nurses who did not have direct connections to colleagues living abroad described being aware of better occupational and living conditions abroad, as well as the history and widespread nature of migration within their profession, which tended to positively influence their skilled migration perceptions and aspirations by normalizing the activity. However other stories about the costs, delays and challenges of incorporating abroad circulating back home could also negatively influence skilled workers’ interest in migrating. This contrasts with much of the research discussing a culture of migration among skilled migrants, which primarily describes the former as having a positive influence on skilled migration, as in Massey’s early social migration model (Hagopian et al. 2005; Ali 2007; Raghuram et al. 2010; Ronquillo 2010; Kōu and Bailey 2014). Thus, the migrant occupational culture could have both positive and negative impacts on skilled migration perceptions and aspirations, depending on the conditions over time.

Skilled migration decision-making was also influenced by the migrant occupational community via migrant occupational networks, particularly among lead migrants. These networks provided key information on where and when to migrate (i.e. based on nursing labour market conditions abroad), and/or how to migrate (i.e. concrete and reliable channels of skilled migration). Supplied with this trustworthy information, skilled workers were in a better position to shift from
having migration aspirations to deciding to undertake the move. In the absence of migrant occupational networks, some nurses turned to migrant residential networks (i.e. friends and family) to obtain general information about living conditions in prospective destination countries. In addition then to confirming the facilitating role of migrant professional networks alongside other recent studies in skilled migration (Raghuram et al. 2010; Kõu and Bailey 2014), this study provides further insight into the distinct influence of migrant occupational networks relative to migrant residential networks in shaping the skilled migration decision making process. In addition, this dissertation illustrates *when and how* a migrant occupational culture and migrant occupational networks work together to influence different stages of the skilled migration process within a migrant occupational community context. As Garip and Asad ((forthcoming):7-8) argue in their holistic analysis of Mexico-US migration, this type of comprehensive study into how different social mechanisms combine to shape the migration process is limited in the literature.

These social supports were not sufficient, however, to enable an actual skilled migration *outcome* among lead migrants. Instead, structural opportunities that facilitated the skilled migration pathway (i.e. online nursing job opportunities or employer recruitment programs) alongside a lifecycle change together with networks, culminated in their actual skilled migration outcome. Attractive structural conditions alone were also not sufficient to determine skilled migration, given the costs and professional/personal risks involved. For most lead migrants, migrant social networks intersected with facilitating structural conditions to lead to a skilled migration outcome.

The migration process was different for the dependent skilled migration stream. All the dependent nurses in this sample were women, brought to Canada by their husbands. Some of these dependent migrant nurses had a positive view of migrating in order to access better opportunities for themselves and/or their family. Others were less interested in migrating, particularly those with an established career in their home country, and/or no personal or family migration history (i.e. less exposed to a culture of migration within the migrant residential community). However, unequal gender relations within the family resulted in these women migrating for the benefit of the household. Thus the migrant residential community, at times operating through gendered inequalities within the family, was the predominant influence on skilled migration decision-making for dependent migrant women, in contrast to the notable influence of the migrant occupational community among lead migrants.
7.1.2 The Influence of the Migrant Occupational Community on Skilled Incorporation

The skilled incorporation process involves multiple steps and requirements in order for foreign-trained nurses to obtain employment in their profession. Skilled immigrant nurses therefore benefit from those familiar with these requirements who have the skills to assist them. Consequently, instead of only turning to family members or neighbours (i.e. migrant residential community) outside their profession, many skilled migrants also turned to their migrant occupational community to assist them through these skilled incorporation steps. Specifically, migrant occupational networks provided information and guidance through the more technical incorporation steps, i.e. how to get credentials recognized, study tips for licensing exam, and/or possible employment avenues. Some respondents also described what might be called a ‘culture of racialized incorporation’, which consisted of an awareness (developed through personal experiences and/or stories from others) of the difficulty foreign-trained nurses face in obtaining commensurate employment in their field (or an acute hospital) without Canadian experience. This incorporation challenge can shape strategies to find employment, such as steering nurses toward what they perceive to be more accessible occupational entry points, i.e. nursing homes. Thus, a migrant occupational culture can also influence the skilled incorporation path.

Both lead and dependent migrants turned to the migrant occupational community throughout these steps to incorporation. However, the lead migrants were able to complete a few steps prior to migrating (notably credential review and obtaining employment), which facilitated their progression along the skilled incorporation path and an initial positive incorporation outcome, a general pattern found among other studies of immigrant nurses (Bourgeault and Baumann 2011:12-13). In contrast, most dependent migrants obtained an initial downward incorporation outcome, since they started the skilled incorporation process from scratch once they reached Canadian soil. Once they entered the workplace, both leads and dependents faced similar challenges. In this workplace setting, the migrant occupational community - through migrant occupational networks and to a lesser extent migrant occupational associations - provided occupational mentoring and emotional support to assist in overcoming differences in nursing occupational cultures (such as differences in nursing equipment, terminology, and care practices), and exclusionary treatment.
A key contribution of this dissertation, therefore, is the provision of in-depth information on how the skilled incorporation process unfolds and is influenced by the migrant occupational community along the way. While other studies have outlined the influence of migrant professional networks and associations at certain stages of the skilled incorporation process in varying levels of depth (Saxenian 2002; Purkayastha 2005; Raghuram et al. 2010; Kõu and Bailey 2014), this dissertation has outlined in detail how the various elements within the migrant occupational community (i.e. migrant occupational culture, networks and/or association) influence all the steps to skilled incorporation. It is also noteworthy that the migrant occupational community appeared to step in and support the incorporation process of skilled migrants when there was an absence of resources from other actors. For instance, when migrant nurses were not provided with sufficient assistance in finding tutors or courses to pass the licensing exam from general (non-migrant) nursing bodies, such as their provincial nursing body, several turned to their migrant occupational community for additional information and guidance. Along similar lines, when some migrant nurses perceived their general (non-immigrant) occupational community in the workplace as excluding them or felt the desire to obtain or share support, some turned to their migrant occupational networks or migrant occupational association to provide this social support and sense of inclusion. Thus, the migrant occupational community appears to fill in a resource gap when it is not provided by other actors.

The previous sections provided a summary of the distinct elements of the migrant occupational community, and how these influence skilled migration and incorporation. Given that much of the research using Massey’s early social model of migration focuses on low-skilled migrants and/or the migrant residential community, the next section outlines the similar and dissimilar elements of the migrant residential and occupational communities in skilled migration and incorporation, and how these can both compliment and work against each other.

7.1.3 The Intersecting Influence of the Migrant Residential and Occupational Communities in Skilled Migration and Incorporation

Skilled migrants turned to the migrant occupational and residential communities at various, and at times similar, points in the skilled migration and incorporation process. Both communities influenced skilled migrants’ perceptions and aspirations in the early stage of the skilled migration process. Regarding the influence of the migrant residential community, skilled nurses
were exposed to a culture of migration within Ghanaian society that is characterized by high levels of migration. The history of migration in their migrant residential community contributed to this activity being largely seen as a plausible and positive option to pursue. Furthermore, many lead nurses also had family members who had migrated. This prior family experience arguably helped to reduce their perception of risk by making the migration experience seem more familiar. Migrant residential networks also tended to circulate stories of better opportunities and living conditions abroad, representing another influence on skilled migration perceptions and aspirations.

Similar social processes were operating within the migrant occupational community, although the content differed. Notably, the history and prevalence of migration within the nursing profession in Ghana also led to this activity being seen as a less risky or more commonplace activity for many nurses. Furthermore, stories of better nursing working conditions and pay also became widespread within the nursing community over time. Thus, a migrant occupational culture can contribute to a positive perception of migration among skilled workers. However, the information circulating back to Ghanaian nurses is not always positive. Stories about challenges incorporating as a nurse abroad can diminish skilled workers’ interests in migrating. Thus, the migrant occupational culture can shape skilled migration perceptions and aspirations in positive or negative ways, depending on the information being circulated.

The influence of the migrant residential and occupational communities on skilled migration decision-making varied based on lead or dependent migrant status. Some lead migrants tapped into migrant residential networks to obtain general information on living conditions in a desired destination country. However, these networks could not always provide sufficient occupationally-specific information. When available, lead migrants turned to their migrant occupational networks to obtain information on such issues as where to migrate based on relative differences in nursing pay, working conditions and status, as well as concrete avenues to pursue migration as a skilled worker. For lead migrants then, the migrant residential community and migrant occupational community can serve a complementary function by filling in information gaps related to general living conditions and occupationally-specific conditions and migration channels respectively, to facilitate skilled migration decision-making.
The role of these two communities differed significantly for dependent migrants. Several respondents were interested in migrating to access better opportunities for their families and themselves in a general sense and/or related to their occupation. A few skilled dependent women, however, had more mixed feelings about migrating. Nevertheless, their husbands directed their migration to fulfill their own career ambitions or sponsor them if they were already living abroad. Thus the migrant residential community, operating at the family level, played a strong role in shaping skilled migration decision-making for women dependent migrants. These findings illustrate the importance of acknowledging the influence of these two distinct community contexts – the migrant residential community and migrant occupational community – given that one can complement or dominate the other, and shape skilled migration decision-making. Ignoring either of these social processes would provide a narrow depiction of how the skilled migration process unfolds, as well as how and why this can differ for lead and dependent (typically women) migrants.

The relative importance of the migrant residential and occupational communities shifted during the skilled incorporation process. Skilled migrants often turned to their migrant occupational networks and/or migrant occupational association (within their migrant occupational community) as a valuable resource to guide them through the credential review process, the licensing exam, obtaining employment information, and/or coping with new and challenging working conditions in the workplace. Notably, some lead migrants who obtained an initial positive incorporation outcome still faced challenging workplace adjustment conditions, such as racism from peers or patients. The migrant occupational community was thus an important resource for those migrants who, perhaps on paper, seemed to have a positive incorporation outcome, but in practice continued to face difficulties once in the workplace.

There were few instances, in contrast, where the nurses explicitly mentioned turning to their migrant residential community to facilitate multiple steps in their skilled incorporation process. Arguably, the migrant residential community was generally not able to provide sufficient technical and specialized occupational information. Furthermore, significant differences again emerged between the experiences of lead and dependent migrants. For instance, some dependent nurses turned to their migrant occupational networks to obtain information on how to navigate the foreign credential recognition process or avenues to obtain nursing employment. Yet unequal gender relations within the family, such as an unequal division of household labour or
childrearing, made it difficult for some of these women to put this advice into action and pursue their professional ambitions. Furthermore, the gendered unequal decision-making within the family that led some dependent nurses to migrate before finishing their bond contributed to delays and obstacles in obtaining their nursing documents from back home once they reached the host country. Thus, constraints within one community can limit the resources or assistance provided by another, particularly for skilled women dependents as these trends were not prevalent among women lead migrants. This gendered dynamic again highlights the importance of analysing the influence of both the migrant residential and occupational communities in order to fully understand the incorporation experiences of skilled migrant women.

7.2 Extending the Social Model to Include the Migrant Occupational Community among Skilled Migrants

Massey et al’s (1987) original social model of migration provided an important theoretical framework that highlighted how social processes are a key influence on when, why and where primarily low-skilled workers migrate when faced with difficult structural conditions in their home country. More specifically, this research (and later development of it – Massey 1990a; Massey et al. 1993; Massey et al. 1994) outlined how the migrant residential community positively shaped (primarily low-skilled) individuals’ migration perceptions and aspirations through a culture of migration consisting of stories and lifestyles depicting favourable living conditions and general economic opportunities abroad, as well as the widespread prevalence and history of migration within these communities, which normalized this behaviour. Social networks, for their part, facilitated migrants’ ability to cross the border and directly obtain (low-skilled) work soon after arriving in the host country. This model was later further developed by early gender and migration scholars such as Hondagneu-Sotelo (1994), whose analysis illustrated that migrant social networks were neither inherently positive, nor accessible for both men and women. As a result, low-skilled women often resorted to developing their own migrant networks. Although this developed social model of migration has not been formally extended to skilled migration and incorporation, some more recent studies have begun to examine social influences in this field of research, such as professional networks and migrant cultures among skilled workers themselves and/or their migrant residential community (Hagopian et al. 2005; Ryan 2008; Raghuram et al. 2010; Kōu and Bailey 2014). Drawing on these insights into the social influences of skilled migration and incorporation, the occupational community literature, as well
as findings from this study, this dissertation extends the early social model by including the migrant occupational community found among skilled workers.

This next section contrasts the commonalities and distinctions between these the migrant residential and occupational communities in low and high skilled migration in more detail. In so doing, the analysis lays out how the early social migration model, primarily focused on the migrant residential community among low-skilled migrants, would have to be extended to incorporate the findings of this dissertation (see Table 7.1 for an outline of the similarities and differences in social influences across low and high skilled migration).

First, the influence of the migrant occupational culture on skilled migration perceptions and aspirations is variable relative to the low-skilled literature. Specifically, the migrant occupational culture can have a positive or normalizing influence through its spreading of favourable depictions of working and living conditions within the migrant occupational community, and its longstanding history and prevalence within the community. However, stories about incorporation challenges channeled from abroad can also diminish prospective migrants’ interest. These negative influences related to specific professional incorporation challenges contrast with Massey and other’s description of the predominantly positive influence of the culture of migration on low-skilled migration (Kandel and Massey 2002:981-982; Ali 2007 – note a key exception here is Garip and Assad (forthcoming):19-20;24). Thus, the migrant occupational culture can have a nuanced influence on skilled migration perceptions and aspirations depending on the conditions over time, rather than being inherently positive.

Second, skilled migration decision-making represents a complex process involving multiple, and often conflicting, influences from the migrant residential and occupational communities. This complexity contrasts with the more linear process described in research on low-skilled migration. Low-skilled migration has been described as spontaneous, where workers do not “plan their migration months in advance, nor did they necessarily take the initiative to seek out a contact, a social link in the network chain to the U.S.” (Hondagneu-Sotelo 1994:57, 96). Instead, they often quickly react to a tip from a return migrant or family member abroad to jump on an opportunity abroad (Hondagneu-Sotelo 1994:57, 96). Since the professional risks are high for skilled workers, their migration decision-making process is lengthy and involves multiple considerations. Furthermore, their considerations differ in part from low-skilled migrants. Rather
than seeking information to secure any job through a migrant residential network (Salaff 1997:298), skilled workers are interested in finding out about attractive labour market conditions and skilled migration channels that facilitate labour market incorporation into their specific profession. This information is often supplied by migrant occupational networks. Without trusted information and advice from social supports about where and how to migrate as a professional, it is less likely that skilled workers will be convinced to shift from simply having a migration aspiration, to actively planning their migration.

Massey has, however, argued that household migration decision-making is a more complex process that is not taken lightly by (primarily low-skilled) migrants (Massey et al. 1987:173). Yet his focus was on the household economy and its needs, rather than professional considerations. Thus, differences in the type of information prospective migrants seek to cement their migration decision-making exist across low and high skilled migration. Furthermore, Massey (and other scholars using his theoretical model) often focus on the migrant residential community as the primary community context influencing migration decision-making (Kandel and Massey 2002; Fussell and Massey 2004; Ali 2007; Fussell 2010). This dissertation’s contribution is the finding that the migrant occupational community represents another influential community context shaping skilled migration decisions.

The migrant occupational community alone, however, was not sufficient to shift skilled migration decision-making into reality. Structural conditions typically enabled actual skilled migration outcomes among lead migrants. This continued determinative role of structural conditions (i.e. employers, favourable skilled immigration policy) represents another distinction between skilled migration and incorporation, and low-skilled migration that emphasizes the role of migrant residential networks in facilitating migration outcomes despite structural constraints (Massey et al. 1987; Hondagneu-Sotelo 1994). For instance, Massey et al’s (1987:302) study found that the impact of legal status on predicting future migration trips among undocumented Mexican migrants declined as the number of trips increased. Legal status, Massey suggests, no longer acted as a barrier as migrants gained migration experience over time. In contrast, skilled workers require a legal migration channel to fully pursue their professions abroad. Thus, while the information provided by migrant occupational and residential networks help secure skilled workers’ decision to migrate to a specific destination, these social processes are less likely to enable the actual skilled migration outcome among lead migrants. In other words, migrant social
networks could very well be a necessary condition for cementing skilled workers’ decision to migrate, but they are not sufficient for the move to occur. Social networks (notably migrant occupational networks) intersected with facilitating structural conditions to enable a skilled migration outcome, particularly among lead migrants.

Another finding of this dissertation was the type of conflicts within the migrant residential community related to migration decision-making, operating through gendered relations at the family level. On the one hand, many of this dissertation’s findings echo key claims made in the low-skilled gender and migration scholarship. For instance, the latter literature has found that when gender relations are unequal, the family member with more power (typically the man) determines migration decisions for the household, even when disagreements occur (Hondagneu-Sotelo 1994:56-62). A similar pattern was found among a few female skilled dependent migrants with husbands who were professionals and/or had previous migration experience. On the other hand, this dissertation has uncovered a few distinct findings relative to the low-skilled literature. In particular, the latter tends to describe conflicts between migrant husbands and wives left behind seeking to join them, or wives wishing they could themselves (and/or their husbands) remain home for such concerns as strains on the family/marriage while apart, or unreliable remittances while their husbands are away (Hondagneu-Sotelo 1994:56-75; Salaff et al. 2010:155). In addition to wanting to remain with their family, some reluctant skilled female migrants in this sample were less interested in migrating because of a desire to pursue their careers at home, rather than risk their profession through dependent migration. Thus while the unequal and gendered process of decision-making is similar between low and high skilled female dependent migrants, the types of conflicts within the household can differ along occupational/skills lines.

The function of the migrant residential community during the skilled incorporation process also differed from that described in the primarily low-skilled migration literature. In the low-skilled literature, migrant residential networks provide information about job openings, or even secure direct entry into employment in low-skilled sectors that typically offer entry-level jobs (Boyd 1989:652; Hagan 1998:58-59). The incorporation path to employment for skilled workers differs dramatically. The various skilled incorporation steps require technical and occupationally-specific information. Consequently, the migrant residential community alone is arguably unable to provide sufficient assistance and guidance to migrant nurses to pass through all these
necessary steps to employment. As a result, the migrant occupational community (in the form of migrant occupational networks and/or migrant occupational associations) is often turned to as a relevant resource to fill in these information gaps along the steps to incorporation - from foreign credential recognition, to the licensing exam, to obtaining information on job prospects, to adjusting to new workplace conditions and discrimination in the workplace. While the migrant occupational community was not able to help the respondents obtain direct employment, it did facilitate passing through the steps to employment, which is necessary to move along the path to a positive incorporation outcome.

The migrant residential community, in fact, at times had a negative influence on the skilled incorporation process. In contrast to the positive benefits low-skilled women can experience through migration via migrant residential networks (i.e. becoming employed, earning their own income and therefore potentially gaining more authority/independence in their household), skilled female dependents in particular can lose many of these same benefits (which they had prior to migrating) once they face the difficulties of navigating the skilled incorporation process from scratch on Canadian soil as a dependent, with no secured employment in the host country and often with a heavy burden of household and family responsibilities. Although the low-skilled literature has underscored the sometimes contradictory gains women face, particularly in the realm of gender equality in the household (Espiritu 1999:642-643), this dissertation alongside a growing number of studies focused on skilled migration and incorporation at the family level (see Purkayastha 2005; Yeoh and Willis 2005; Iredale 2005; Meares 2010; Banerjee and Phan 2013a) illustrate that skilled female dependents also experience uneven gains in the professional realm during their skilled incorporation process. Overall, while similar gender inequalities (in terms of decision-making and household division of labour) are found in both low and high-skilled migrants households, the consequences of these inequalities on the incorporation process can differ for low vs high skilled women.

A final distinction between the migrant communities dominant among low vs skilled migrants is where and how they are encountered. The social processes within a migrant residential community influence migrants’ daily lives if their family members have migrated, are currently abroad, or if members of their local residential community have a history of migrating. However, the migrant occupational community is encountered in multiple different sites. For instance, lead migrants can encounter migrant occupational networks in their home country workplace when
colleagues are planning to migrate, or in their host country workplace after having migrated. In contrast, dependent migrants often developed migrant occupational networks in sites of downward mobility in the host country, such as in upgrading or exam preparation courses, or in temporary workplaces through agency placements. Given that these two communities are encountered in different locations, the focus on the migrant residential community in the low-skilled migration literature has overlooked how community contexts in other sites influence the incorporation process.

Table 7.1 – Comparison of Social Processes in Migrant Residential Community vs Skilled Migrant Occupational Community

<table>
<thead>
<tr>
<th>Social Processes</th>
<th>Key Impact</th>
<th>Migrant Residential Community with Low and High Skilled</th>
<th>Skilled Migrant Occupational Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of Migration</td>
<td>- influences perceptions and aspirations of migration in positive ways</td>
<td>- migration becomes seen as a more plausible and feasible option to pursue among community members over time through a shared history of migration(^70)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- migration is seen as less risky, and becomes normalized, because of its prevalence within the community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- stories of better living/economic conditions abroad become widespread in the community and have a positive influence on perceptions and aspirations among low-skilled and high-skilled migrants(^71)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- stories of financial challenges have a negative influence on migration perceptions and aspirations among low skilled migrants</td>
<td></td>
</tr>
<tr>
<td>Migrant Social Networks</td>
<td>- facilitate migration decision-making</td>
<td>- provide emotional support related to risks of migration</td>
<td>- provide information about when, where and/or how to migrate through skilled migration channels, and when to migrate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- provide information and support for where, why and how to migrate among low and high skilled migrants* (i.e. how</td>
<td></td>
</tr>
</tbody>
</table>

\(^{70}\) Note – the rows filled in blue denote a similar influence/impact across both types of communities.

\(^{71}\) * Refers to cases where the information applies to both low and high skilled migrants.
<table>
<thead>
<tr>
<th>Migrant association</th>
<th>to cross border, sources of financial assistance</th>
<th>related to occupational labour market conditions/obstacles</th>
</tr>
</thead>
<tbody>
<tr>
<td>- dominate migration decision-making</td>
<td>- unequal gender relations within the family can determine dependent women’s migration decision, despite concerns *</td>
<td>- N/A</td>
</tr>
</tbody>
</table>
| - facilitate passing through steps to skilled incorporation | - provide information on job openings, and strategies to obtain low-skilled work

- provide skilled immigrants basic connections to relevant professional bodies or the migrant occupational community²²

- N/A

- provide source of emotional support or comfort to skilled migrants when they face challenges in the skilled incorporation process | - provide information on job openings, and strategies to obtain work in their occupation

- provide information and tips that help skilled immigrants navigate the multiple stages required by professional licensing bodies, i.e. credential review, licensing exam, etc.

- provide guidance and tips to adjust to new occupational conditions and culture |
| - negatively influence ability to obtain a positive incorporation outcome | - can direct low-skilled migrants into precarious work with exploitative conditions

- unequal gender relations related to the household division of labour and/or childrearing can make it difficult for low and high skilled women migrants to enter the workplace* | - can provide information that directs new skilled immigrants into precarious work, i.e. temporary agency work

- N/A |

- strengthens attachment to migrant community in host and home community | - organize social and recreational events to foster a sense of inclusion and community in the host country based on a welcoming and familiar atmosphere

- provide concrete avenue through which to support the migrant residential/occupational community back home | |

²² The text in italics refers to scenarios where the migrant residential community distinctly influences skilled migration or incorporation.
| - N/A | - provide **professional development advice** in host country |
| - N/A | - organize **occupationally-focused events** in host country |
| - assists migrants navigate incorporation steps and try to overcome incorporation challenges | - provides a **central meeting place** to share general information and low-skilled job openings |
|  | - represents a **central resource** where skilled immigrants can ask for information, guidance, and support related to the various steps to skilled incorporation |

Drawing on the findings from this project, the occupational community literature, as well as empirical insights from more recent research analyzing social influences on skilled migration and incorporation, I highlight the following extensions of the early social model:

- the influence of the migrant occupational community on the skilled migration process via the migrant occupational culture and migrant occupational networks, which can vary based on the information circulating back. This inclusion would expand the social model to include an influential community context beyond the migrant residential community, as well as a more nuanced influence of the migrant occupational culture;

- the positive influence of the migrant occupational community on the skilled incorporation process, in particular through the provision of key informational/technical and emotional resources throughout many of the skilled incorporation steps via migrant occupational networks and/or migrant occupational associations, which expands the social model to include another community context influencing skilled incorporation;

- the (at times) negative influence of gendered inequalities within the migrant residential community (at the level of the family) on skilled migration decision-making and incorporation processes, which extends the early social model’s findings related to gender inequalities among low-skilled women migrants to also include skilled women migrants;

- the complimenting, and sometimes contradictory, influence of the migrant residential community and migrant occupational community on skilled migration decision-making and skilled incorporation steps, which expands and refines the early social migration model to include the dynamics between these two communities;

- the different sites in which the migrant occupational community emerges, including sites of downward mobility, which expands the early social model typically rooted in a migrant residential setting; and

- the strong influence of structural conditions (notably immigration policy and employer recruitment programs) on skilled migration and incorporation outcomes, which expands the early social migration model’s focus on the influence of the migrant residential community on these outcomes.
These findings do not invalidate the early social migration model. Rather, key social processes identified across these community contexts, i.e. culture of migration, migrant networks, and migrant associations, represent general social processes that can produce different outcomes in different situations (Becker 1998:142). In other words, there were similarities in the elements and logic of the social processes underlining the migrant occupational community in skilled migration and incorporation on the one hand, and the migrant residential community in low skilled migration and incorporation on the other. However, different elements also emerged in this analysis that the early social migration model does not consider. As a result of these distinct and intersecting influences, we cannot ignore the migrant occupational community context if we are to understand skilled migration. By including both types of contexts, and analyzing their relationship to one another, this extended social migration model can better account for both low and high skilled migration.

7.3 Policy Implications

Canada is estimated to face a shortage of roughly 60,000 registered nurses by 2022 (Murphy et al. 2009:iii). Moving beyond a discussion of solely economic factors, i.e. human capital, this dissertation outlined the various structural and social influences that combined to facilitate or constrain the ability of immigrant nurses to move along the skilled incorporation path. The nursing bond of service, in particular, had severe consequences on the ability of a few dependent nurses to continue their profession in Canada. While the bond of service was instituted to help address the depletion of health human resources from Ghana, it assumes that nurses who emigrate before finishing their bond do so voluntarily or actively. This was not the case for a few women migrants who were sponsored abroad by their husbands, before they could complete their service. This dissertation has revealed the consequences this bond can have on the professional and personal lives of women who did not initiate their own migration. A reconsideration, or discussion, of how the penalties of the nursing bond are applied to this group of nurses may be merited, and/or how the Colleges of Nurses in Canada manage these types of cases, i.e. what
types of training/verification documents can be accepted to move forward with the foreign credential review process.\footnote{A recent news article (2015) reported that the Ghanaian government has elected to discontinue the nursing bond (i.e. the government funding and required service for nurses), given that a surplus of nurses is being produced and many are training through private nursing institutions. However, the bond scheme will still apply for the next several years until the last cohort to graduate has completed their five years of service (Darko 2015)}

A key contribution of this research was not only its discussion of the challenges these migrant nurses face, but also the strategies and resources they used to attempt to overcome them. A few studies have highlighted bridging programs as a useful resource in this regard (Bourgeault and Neiterman 2013:103; Murphy and McGuire 2005:29). This dissertation has shown that immigrant networks and/or associations between professionals in the same occupation represent another important social support to facilitate navigating the skilled incorporation process. A better understanding of these existing migrant institutions could help expand their reach and impact, as they are currently managed on a largely informal and voluntary basis by nurses who balance multiple responsibilities in their personal and professional lives, around a shift-work schedule, which makes dedicated commitment to these groups more challenging.

7.4 Future Research and Limitations

This dissertation focused on a particular migrant occupational group to tease out in detail the social influences within a migrant occupational community and their influence on skilled migration and incorporation. It therefore represents an entry point for future research to examine migrant occupational communities in other groups characterized by high levels of migration. For instance, this extended social migration model could be used to analyse attitudes towards migration among students intending to study abroad, given the persistent and large numbers of international students today. Rather than making an individual decision, these students may also be influenced by a migrant occupational community. In addition, migrant occupational communities may exist in lower skilled occupations, such as agricultural workers migrating from Mexico and the Caribbean to North America. As another example, the extensive scholarship on domestic worker (im)migration may represent a fruitful opportunity to examine whether and how this group of workers has developed a migrant occupational culture, migrant occupational networks and migrant occupational associations over time, which may influence these workers’
migration and/or incorporation. This research would contribute to a more in-depth understanding of the variety of social influences shaping today’s diverse types of migration. Furthermore, it may help extend current understandings of the migrant occupational community to potentially include both low and high skilled migrants. Another potential analytical extension of the migrant occupational community would be to explore in more depth whether, and if so how, locally trained skilled migrants draw on the migrant occupational community in different ways from those who are trained abroad. This dissertation found a case, for instance, illustrating how an immigrant nurse provided advice to a native-born visible minority nurse on how to manage difficult, even demeaning treatment, in the workplace by colleagues. However, additional research is needed to probe this support in more detail, and examine whether (and if so how) this assistance might differ for immigrants and non-immigrants. Such research would illustrate the breadth of this community and its utility.

This study also found that step-wise migration was prevalent among the respondents. In the case of Ghanaian skilled immigrants, a history of migration from Ghana-UK emerged as a skilled migration pathway of which many respondents were familiar and/or participated in themselves. As Paul (2011:1880-1881) has suggested, some (low-skilled) migrants design a multi-stop migration path to gain the necessary human, financial and social resources to ultimately gain entry to their preferred destination country. While none of these nurses explicitly mentioned intentional long-term stepwise migration plans, their migration history involved several stops over time. Since this dissertation focused on the skilled migration process to Canada, comprehensive information on migration and incorporation was not systematically solicited regarding the respondents’ experiences in the UK. Future research could explore in more depth how the social processes underlining skilled migration shape migration trajectories across multiple countries, and how multi-stop migration might impact skilled incorporation processes in the different countries along these trajectories.

A more detailed assessment of employment outcomes based on a variety of job quality variables, such as temporary/permanent employment and part-time/full-time employment, could also provide valuable information. This dissertation did not obtain systematic information across different job quality variables, and instead focused on the process and paths leading to skilled migration and incorporation. However, connecting these social processes with more specific employment (or incorporation) outcomes would be a useful next step in this line of research.
Furthermore, a longitudinal study with a larger sample could also analyse whether skilled immigrants that enter under probationary schemes (that is, are tied to an employer for a period of time, and/or live and work in the country under a probationary status for a period of time) eventually transition to permanent status and what impact the latter may have on their skilled incorporation process.

Additional research into the relationship between the migrant residential and occupational community is also warranted. This dissertation focused on outlining in detail the social processes within the migrant occupational community. A few instances were identified where these two communities constrained each other, particularly along gendered lines. Future case studies could explore in more depth where and how these two communities complement, and/or constrain each other, along the skilled migration and incorporation paths. More in-depth research on the specific gendered differences between lead and dependent migrants throughout the skilled migration and incorporation processes, as well as the influence of spouses on the ability to navigate these processes (including more detailed information about spouses, such as their occupation) would also generate additional insight into the gendered reality of skilled migration and incorporation. While this study did touch on these issues as they emerged inductively from the interviews, it was not an original focal area of the research and therefore was not systematically investigated or probed in-depth for all respondents. Related to this, the influence of gender norms and relations on the men in this sample was not systematically investigated. Although the two married lead male migrants mentioned discussing their migration plans to Canada with their spouses (as a reminder - none of the dependent nurses were men), the family did migrate and the respondents were able to pursue their desired employment. However, additional details were not probed systematically. Another fruitful avenue of research then would be to probe these issues further with men nursing migrants, perhaps particularly those who migrate as dependents. For instance, George (2000) examined how women-led nursing migration from India to the United States, coupled with variations in nursing occupational culture between the two countries, impacted gender and class relations in different ways within the household and broader immigrant community for these nurses and their spouses. Her extensive study, in both the sending and receiving country, is a rich example of how this type of study can further tease out the relationship between the migrant occupational community and migrant residential community. Lastly, the complex migration stories of a few respondents at times made it challenging to neatly
categorize them as either lead or dependent migrants. Additional detail into how the level of dependence, and avenue of entry, among respondents and their spouses influence skilled migration and incorporation would help to clarify the utility and validity of these categories.

Another fruitful avenue of research would be to analyse groups of skilled immigrants as case studies of professions. Nurses, for instance, are not simply skilled workers - they are part of a highly regulated profession. As a result, issues of control over expert knowledge could be examined in more depth to further understand the context in which skilled incorporation operates (in particular both the formal and informal steps required for skilled incorporation), as well as how the migrant occupational community can influence immigrant nurses’ ability to navigate both types of skilled incorporation steps. In addition, scholars have highlighted that nursing is a gendered, racialized profession, which is impacted by gender and racial stereotypes, as well as inequalities between nursing colleagues, and nurses and patients (Wingfield 2009). Additional research could therefore further explore how the gendered and racialized aspects of this profession can intersect with immigrant status to create unique incorporation experiences that may require different supports, such as the migrant occupational community. This would be in line with Gorman and Sandefur’s (2011) “new ‘underground’ scholarship” of the professions which focuses on understanding differences and variation within professional groups.

Lastly, future research could examine how the influence of migrant occupational communities on skilled migration and incorporation can differ based on nationality. The particular needs, desire and functions of migrant occupational communities could differ based on the historical, political and cultural context in which occupations are embedded. Related to this point, additional research into the influence of the state on the experiences of skilled professionals, as well as their migrant occupational community, could also provide useful insight. This dissertation, drawing on the logic of necessary and sufficient causes, illustrated how the state can shape skilled migration paths and outcomes in a more direct fashion than that outlined in Massey’s early social migration model often focused on undocumented (low-skilled) migrants. Additional research into the influence of the state on the experiences of skilled migrants is merited. For instance, while the Ghanaian government, Ghanaian nursing body and service delivery groups have (until recently) worked together to implement a bond of service for health professionals in part to better manage this migration flow (Antwi and Phillips 2011:11), other countries have elected to promote the emigration of their health workers, such as the Philippines. How these differing contexts can
shape the development and influence of a migrant occupational community would provide deeper insight into this type of community. Overall, this dissertation has provided an entry point for new areas of research using an extended social model to further our understanding of today’s complex flows of migration and incorporation.
7.5 Appendices

Annex 1 – Interview Guide

➔ I’ll start by asking you a few questions about your time in Ghana and moving abroad.

1- Where were you born in Ghana?

2a- Can you tell me why you became a nurse?
   - Is there anything unique about nursing that attracted you, or not?
   - Was working directly with patients a consideration for you, or not?

2b- What type of nursing did you practice?
   - Did you train as a registered nurse, nursing assistant/auxiliary nurse, other?
   - Do you have a B.S. in nursing, a diploma or another level of education?
   - How many years of nursing training did you complete in Ghana (or abroad)? What was the name of the institution where you trained?
   - What were your regular job activities while working as a nurse in Ghana?

3a- Could you tell me about why you became interested in migrating to Canada? And how?
   - Was your interest in migrating related to your professional interests in any way, or not? If yes, how so? What about any nursing advertisements you came across? Or not?
   - Were your interests influenced by any nurses you know, current colleagues, or former colleagues who are now working abroad, or not?
   - What about the Ghana nursing association (if you belong to it) or not?
   - What about the history of migration within your occupation? Your British-influenced training? Or not?

3b- Was your interest in working abroad influenced by any friends, family or neighbours, or not? If so, how? Were any of these friends or family nurses?

4a– Did many of your colleagues migrate abroad, or not?
   - How did you become aware they were migrating? What did you think about this emigration?
   - What were the opinions of your colleagues (in Ghana) about nurses leaving to work abroad at the time?

4b- What were your perceptions of working abroad at that time?
   - Were your perceptions influenced by any nurses you know, current colleagues, or former colleagues who are now working abroad, or not?
   - What about your Ghana nursing association, or not?
   - What about your British-influenced training, the history of migration in your occupation, or not?
   - What about any nursing advertisements you had come across, or not?

5a- What were the opinions of your colleagues when you decided to migrate?
   - Did you experience any criticism of your decision to migrate from your colleagues, or not? If so, could you describe it?
- What about your nursing association (if you belonged to one)?

5b- What were the opinions of your family members/spouse when you informed them you had decided to work abroad? What about your neighbours or local community?
  - Did you experience any criticism of your decision from your community or family, or not? If so, could you describe it?
  - Do you feel women’s migration abroad is accepted in Ghana or not entirely? Why so? In the nursing occupation, do more male or female nurses migrate? Why do you think that is?

6- How old were you when you migrated?

7a- Can you tell me how you came to the decision to migrate abroad?
  - Was your decision to migrate related to your professional interests in any way, or not? If yes, how so?
  - Was your decision influenced by any nurses you know, current colleagues, or former colleagues who are now working abroad, or not?
  - Did your Ghanaian nursing association influence this choice, or not?
  - Did the history of nurses migrating to certain countries (i.e. UK) influence your choice at all, or not? Did your nursing training (based on a British model) influence your choice at all, or not?

7b- Was your decision to work abroad influenced by any (non-nursing) friends, family or neighbours, or not? If so, how?

8a- How did you go about planning your migration abroad? That is, how did you come to choose Canada as your country/city of destination, as well as the specific route (i.e. transportation) and lodgings, used?
  - Were your plans influenced by any nurses you know, current colleagues, or former colleagues who are now working abroad, or not?
  - Did your Ghanaian nursing association influence this choice, or not?
  - Did the history of nurses migrating to certain countries (i.e. UK) influence your choice at all, or not? Did your nursing training (based on a British model) influence your choice at all, or not?
  - Just your own research, or not?
  - Why do you think so many Ghanaian nurses migrate to such a small number of countries?

8b- Did any of your friends, family or neighbours influence this migration planning process, or not? If so, how?

9a- Can you describe the actual move to Canada (or your first destination abroad)?
  - Did you migrate straight to Canada from Ghana, or did you go somewhere else first? What year did you arrive in Canada?
  - Did you rely on any assistance or information from any colleagues (in Ghana or abroad) in the actual move? When you first arrived? Or not?
- What about the migrant occupational association (in Ghana or abroad)? When you first arrived? Or not?
- Did any other resources or factors influence your actual move?

9b- What about assistance from your family or friends in Canada (or whatever the first destination country was) in the actual move? When you first arrived? Or not?
- Did any other resources or factors influence your actual move?

→ Now I’ll ask you a few questions about your experiences here in Canada.

10a- Did you obtain a job in nursing soon after you immigrated or not?

(If not skip to Q11)
- If so, how soon after?
- What kind of nursing employment was it (i.e. nursing assistant, registered nurse)?
- Were you working in a hospital or home care, full time or part time/contract?
- How did you feel about this work?

10b- Can you describe how you actually obtained this first nursing job?
- Did you get the job from your own research (i.e. an advertisement in the newspaper)? Online? Or not?
- Did any of your former colleagues (or other Ghanaian nurses you knew in Canada) assist you with this, or not?
- What about your any nursing associations (i.e. migrant occupational association, the nursing association in your province]) or not?
- Your knowledge of nursing training and nursing culture from your training/work experience in Ghana, or not?
- What about your friends, family, neighbours, or other types of associations, or not?

10c – Can you describe the process you undertook to apply to this nursing job?
- Did you have to get your credentials recognized? Did you have to organize licensing exams or complete any re-training? What about learning how to look for nursing jobs, and/or the nursing workplace culture in Canada?
- Did any of your former colleagues (or other Ghanaian nurses you knew in Canada) assist you with this, or not?
- What about any nursing associations (i.e. migrant occupational association, the nursing association in your province]), or not?
- What about your knowledge of nursing training from training/working in Ghana, or not?
- What about your friends, family, neighbours, or other types of (non-nursing) associations? Or not?
- Just your own research on how to apply for a nursing job, or not?

11a- If you did not find employment in your specific field of nursing, did you find other employment? If so, what kind of work?
- How did you feel about this work?

11b- How did you obtain this first non-nursing job?
- Did any of your former colleagues (or other Ghanaian nurses you knew in Canada) assist you with this, or not?
- What about your any nursing associations (i.e. [migrant occupational association, the nursing association in your province]) or not?
- What about friends, family, neighbours or other types of non-nursing associations, or not? Any other factors?
- Or did you get the job from your own research (i.e. an advertisement in the newspaper)? Online? Or not?
- How long did it take you to find work as a nurse? How did you find this nursing work?

11c- Can you describe the process you undertook to apply for this non-nursing job?
- Did you have to get your credentials recognized? Did you have to organize licensing exams or complete any re-training? What about learning how to look for nursing jobs, and/or the nursing workplace culture in Canada?
- Did any of your former colleagues (or other Ghanaian nurses you knew in Canada) assist you with this, or not?
- What about any nursing associations (i.e. [migrant occupational association, the nursing association in your province])? Or not?
- What about your friends, family, neighbors, or other types of (non-nursing) associations? Or not?
- Just your own research on how to apply for this type of job, or not?

12- If you had difficulty finding relevant employment when you first immigrated, is there anything that would have assisted you in your search for a nursing position? Or not?
- In terms of resources, networks, information from your fellow Ghanaian colleagues? Or not?
- What about from your family or neighbours? From the government? Or not?

13- Are you still in the same job (i.e. your first job)? If not, how did you obtain your current job?
- Did you rely on the assistance of any former/current colleagues in the search for this job, or not? Any Ghanaian nurses who weren’t your colleagues?
- Did you rely on the assistance of your [migrant occupational association], or other nursing associations, in the search for this job, or not?
- What about your knowledge of the Canadian nursing culture, or not?
- What about friends, family, neighbours or ethnic associations, or not? Any other factors?
- Did you get the job from an advertisement in the newspaper? Online? Or not?

14- Could you tell me about your current job?
- Do you work full-time/part-time, temporary/permanent?
- What is your schedule (evening, day shifts)?
- Can you describe your working conditions? Your responsibilities or main tasks?
- Do you receive any benefits?
- Would you mind telling me your hourly wage?

15- How do you feel about your current job?
- Do you have any interest in changing work positions or not?
- Are you satisfied with your wages, schedule, working conditions, patient interaction or not?
16- Can you describe your relations with other colleagues at work – nurses, doctors, etc?
   - Who do you usually go on break with? Eat lunch with?
   - Do you mostly work with Canadian-born nurses, or nurses born outside Canada? Any Ghanaian nurses?
   - Have you ever had difficult relationships with any colleagues, or not? How so?

17- Did you have any expectations about living and working in Canada before leaving? If so, what were they?
   - Were these expectations met or not?

18- If you had the chance to do this all over again, would you have chosen to migrate to Canada? Migrate in general? Why or why not?

➔ Now I’ll ask you a few questions about any connections you have with Ghana, and other Ghanaians here in Canada.

19- Do you spend time (outside work) with other Ghanaian nurses, or not? Do you spend time with other Ghanaians here, or not?
   - How so? Has this changed over time?
   - Do you spend time with other African nurses inside/outside of work, or not? Other Caribbean nurses? How so?
   - Have these friendships ever assisted you in looking for a job? Finding a job? Or not? If so, how?

20- Have you heard of the [migrant occupational association] or not? [It is an association for Ghanaian nurses, where members share their concerns, their experiences, and fundraise for development causes in Ghana] Would you be interested in joining this association? Why or why not?
   - If you are a member, can you describe your experiences in this association?
   - Can you describe the types of activities you participate in through this association?
   - Do any of these activities target your former workplace, training college, and/or colleague? Or not? If so, how?
   - What influence, if any, does this association have on your life/experience in Canada? On incorporating into the nursing sector here in Canada?

21- Do you ever participate in Ghanaian cultural associations here in Canada or not, such as the Ewe association of Ontario? Why or why not?
   - If yes, can you describe your experiences in this association?
   - Can you describe the types of activities you participate in?
   - Do any of these activities target your former workplace, training college, and/or colleagues? Or not?
   - What influence, if any, does this association have on your life/experience in Canada? On incorporating into the nursing sector here in Canada?

22a- Do you personally stay in touch with your home community in Ghana, or not?
   - If yes with whom - your family, relatives, and/or neighbours in Ghana? Can you describe these connections more, i.e. what type of connections are they?
- Why do you maintain these connections? What influence do they have in your life/experience in Canada, if any?

22b- Do you personally stay in touch with any of your former colleagues in Ghana, or not? If so, can you describe these ties in more detail?
  - What about with anyone from your former workplace, former training college, or former nursing association in Ghana? Or not? If so, can you describe these ties in more detail?
  - Why do you maintain these connections? What influence do these connections have in your life in Canada, if any?
  - Have you ever thought about returning to work/live in Ghana (on a permanent or temporary basis), or not? If so, why? Or why not?
  - Have you ever assisted a fellow Ghanaian nurse in migrating to Canada (or elsewhere) or not?

23– Do you have any memory of the conditions of the health care sector in your hometown or not? The facilities, access to services, etc?
  - Do you feel the migration of health care workers is influencing the health sector, or not? If yes, in what ways?

24- Do you think Ghanaians abroad have any role to play in addressing the issue of the migration of health workers, or not? How so?

25- Do you have any final thoughts about nurses leaving Ghana to work abroad? On this topic in general?

26– Is there anything else you would like to discuss regarding your time in Ghana as a nurse, or your time in Canada as a nurse?
  - Your decision to work abroad? How you planned the actual move?
  - Your work experience in Canada as a nurse?
  - Your connections back home?

⇒ I’ll finish by asking you a few general questions.

27- Were you single when you migrated? Are you single now? Do you have children or not?

28- Can you tell me how old you are?

29- Would you mind telling me your yearly income?

30 – Can you briefly summarize the different employment positions you have had since arriving from Canada till now?
  - Roughly how long were you in these positions?
  - How did you move from each of these jobs, i.e. did you rely on the assistance of any friends, colleagues, family, neighbours, and/or associations at any point in these job transitions, or not? Or did you mostly rely on just passing out your CV and applying for individual job openings, or not?
### Annex 2 – Overview of Nursing Training Types in Ghana

#### Table 7.2 – Contemporary Nursing Training in Ghana

<table>
<thead>
<tr>
<th>Type of Nursing</th>
<th>Pre-nursing education</th>
<th>Years of professional training</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (bachelor’s degree)</td>
<td>12 yrs</td>
<td>4 yrs</td>
<td>- 3 year nursing diploma, and an additional year for Bachelor of Science in Nursing</td>
</tr>
<tr>
<td>Registered Nurse (diploma)</td>
<td>12 yrs</td>
<td>3 yrs</td>
<td>- also known as registered general nurse</td>
</tr>
<tr>
<td>Registered Psychiatric Nursing (RPN)/ Registered Mental Nurse (diploma)</td>
<td>12 yrs</td>
<td>3 yrs</td>
<td></td>
</tr>
<tr>
<td>Community Health Nursing (certificate)</td>
<td>12 yrs</td>
<td>2 yrs</td>
<td>- replaced enrolled nurses (2 year, diploma)</td>
</tr>
<tr>
<td>Registered midwife</td>
<td>12 yrs</td>
<td>3 yrs</td>
<td>- new direct-entry program (as of 2007)</td>
</tr>
<tr>
<td>Health Care Assistants</td>
<td>12 yrs</td>
<td>9 weeks</td>
<td>- 7 week training, 2 weeks practical work</td>
</tr>
</tbody>
</table>

Table 7.3 – Specialist nursing training

<table>
<thead>
<tr>
<th>Qualification type</th>
<th>Prerequisites</th>
<th>Duration of education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-basic nurse diploma in various fields (i.e. critical care operating room, psychiatric nursing)</td>
<td>Registered nursing with 3 years of work experience</td>
<td>1.5 yrs</td>
</tr>
<tr>
<td>Post-basic university diploma in nursing education, nursing management</td>
<td>Registered nursing training</td>
<td>2 yrs</td>
</tr>
<tr>
<td>Registered Psychiatric Nursing</td>
<td>Registered nurse training</td>
<td>2 yrs</td>
</tr>
<tr>
<td>Registered midwife (post RN)</td>
<td>Registered nurse training</td>
<td>1 yr</td>
</tr>
<tr>
<td>Registered midwife (post community health nursing)</td>
<td>2 yrs enrolled nurse/community health nursing training</td>
<td>2 yrs</td>
</tr>
</tbody>
</table>

7.6 References


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