GUIDELINES TO FACILITATE ADAPTATION IN SOUTH AFRICAN EXPATRIATE NURSES WORKING IN THE KINGDOM OF SAUDI ARABIA AND UPON THEIR RETURN TO SOUTH AFRICA

by

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DECLARATION

I declare that **GUIDELINES TO FACILITATE ADAPTATION IN SOUTH AFRICAN EXPATRIATE NURSES WORKING IN THE KINGDOM OF SAUDI ARABIA AND UPON THEIR RETURN TO SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

27 August 2020

Signature of Student

Date

DEDICATION AND ACKNOWLEDGEMENTS

I would like to dedicate this dissertation to my father, Prof FJ Smith and my mother Hester J Smith who has always motivated me to continue with my studies. Although my father is no longer with us, he has always been a constant pillar of support and love. I could not have done it without both of your love, encouragement and support. Thank you for being with me every step of the way.

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"Never stop learning. For when we stop learning, we stop growing."
Loyal 'Jack' Lewman

ABSTRACT

The purpose of this study was to gain an understanding of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the Kingdom of Saudi Arabia and returned to South Africa. The study aims to develop guidelines to facilitate expatriate nurses' migration and adaptation in the Kingdom of Saudi Arabia and re-adjustment upon their return to South Africa. This study followed a descriptive phenomenological design with three Phases.

Phase 1 explored and described the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the Kingdom of Saudi Arabia; and their adaptation and adjustment when they returned to South Africa. The target population included participants who worked and lived in the Kingdom of Saudi Arabia and returned to South Africa. Sampling included convenient, purposive and snowball techniques. Data collection was done with unstructured phenomenological interviews and analysed using Colaizzi's method.

Phase 2 developed guidelines to facilitate South African expatriate nurses' migration and adaptation to the Kingdom of Saudi Arabia and adaptation upon their return to South Africa. A Nominal Group Technique was used with seven experts (sampled through non-probability, convenient and purposive sampling from education institutions in South Africa). Guidelines were developed from the findings of Phase 1, a literature review and inductive and deductive reasoning.

Phase 3A validated guidelines with seven experts sampled with non-probability, convenient and purposive techniques. Data was collected with an e-Delphi technique and an AGREE tool for validation. Phase 3B ensured stakeholder involvement with an e-Delphi technique. The target population included stakeholders from SANC and the international recruitment agency that was sampled through non-probability, convenient and purposive techniques. Consensus was reached on four final validated guidelines.

KEY WORDS

Descriptive phenomenology, South African expatriate nurse, KSA, migration, adaptation, re-adjustment, culture shock, nominal group technique, e-Delphi technique, AGREE ll tool.

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ABBREVIATIONS

AGREE	Appraisal of Guidelines for Research and Evaluation
AIDS	Acquired Immunodeficiency Syndrome
CHE	Council of Higher Education
CPD	Continuous Professional Development
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
ISIS	Islamic State of Iraq and al-Sham
KSA	Kingdom of Saudi Arabia
MOH	Minister of Health
NEI	Nurse training programmes
NGT	Nominal Group Technique
NHI	National Health Institution
OHSC	Office of Health Standard Compliance
P	Participant
PHC	Primary Healthcare
POPI	Protection of Personal Information
RAM	RAND Appropriateness Method
SA	South Africa
SANC	South African Nursing Council
SANDF	South African National Defence Force
SAPS	South African Police Service
SAPTCO	Saudi Arabia Public Transport Company
SMA	Saudi Monetary Agency
SSA	Sub-Saharan-Africa
STF	Special Task Force
TB	Tuberculosis
TRT	Tactical Response Teams
UK	United Kingdom
UNISA	University of South Africa
USA	United States of America
USASAC	United States Army Security Assistance Command
WHO	World Health Organisation

CHAPTER 1

ORIENTATION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

A comprehensive discussion on the background to the research problem; statement of the research problem; aim of this study; research objectives and questions; significance of this study; theoretical foundation; paradigmatic perspective; and ethical considerations is covered in Chapter 1, which resulted in a lengthy Chapter that could not be shortened despite various efforts. The methodology pertaining to phenomenology as a research approach will be described in Chapter 1 as it will be applicable to all 3 Phases in this study. Thus, Chapter 1 of this study may seem very long to the reader. The reason for this is that the researcher wanted to work inductively, and therefore there is no separate Chapter for a literature review. All literature has been incorporated in the background of this study as to support the problem statement and provide the context. The researcher used more than 200 research articles as well as various relevant research textbooks to complete this study. The 3 Phases will be described as separate Chapters.

As per Li, Nie and Li (2014:314) estimated 77% of all developing countries are facing a nursing shortage and are relying on neighbouring countries to supply this deficit. Mlambo and Adetiba (2017:63) predicted that South Africa (SA) will have an estimated shortfall of 19 000 nurses by 2018 and a serious nurse shortage in African continents, with 70 000 South African nurses working overseas. This predicted nurse shortfalls could be due to an aging population, violence in the workplace, nurse shortages (globally) resulting in high nurse-patient ratios causing burnout due to fast-growing populations (Haddad & Toney-Butler 2019:NP).

These shortages are filled with nurses migrating form underdeveloped countries. Nurse migration streams typically from developing countries to developed countries (Burmeister, Kalisch, Xie, Doumit, Lee, Ferraresion, Terzioglu & Bragadóttir 2019:148). There are certain push and pull factors, which will motivate nurses to migrate from developing to developed countries and will be discussed later in this Chapter. Higher income countries with a stable financial market can also attract nurses (pull factors) from developing countries (Burmeister et al 2019:48).

In this study, the focus will be on emigration referring to South African expatriate nurses leaving SA to work and live in the Kingdom of Saudi Arabia (KSA). SA can be regarded as a developing country whilst the KSA is viewed as a developed country (Mlambo & Adetiba 2017:68). The terms country of origin and destination country (Lagardé & Blaauw 2016:NP) will be used in this study and will be defined later in this Chapter (see Definitions of terms, section 1.6). South African nurses choose to migrate to countries such as Australia, Belgium, France, Portugal, Spain, New Zealand, the United Kingdom (UK) and the United States of America (USA) with the highest numbers in the UK and the USA (Mlambo & Adetiba (2017:68). Most of the nurses are female.

Immigration, whether permanent or for temporary career related reasons, poses challenges and benefits (pull factors) for the nurse emigrant on a variety of domains (including physical, social, mental/emotional and spiritual) (Mlambo & Adetiba 2017:62). Research that documents the adaptation of emigrants in their new countries can be accessed freely – the psychological, social and career challenges faced by nurses who emigrated have however, not been well documented (Pretorius 2018:20). There is a gap in literature regarding nurse migration (guidelines pertaining to preparation and support prior to migration) to KSA and adaptation (support) to KSA, and upon return to SA which this study will aim to address.

Pretorius (2018:20) confirms that immigration is a stressful event for those involved. South African nurses' who worked and lived in the KSA and ultimately returned to their country of origin (SA) might experience many challenges as well as benefits in both destination areas. Stress experienced in the workplace, even more so during migration will influence work productivity and adaptation negatively (Pretorius 2018:21). The KSA is a popular destination for SA nurses due to pull factors that includes mainly financial rewards (Lagardé & Blaauw 2016:NP).

The aim of this study is to gain an interpretation of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and who subsequently returned to SA to live and re-enter the workforce in this country. Understanding their lived experiences of migration and adaptation while working in the KSA and their adaptation upon return to SA can address the existing gap in literature by providing information for the development of guidelines to facilitate expatriate nurses'

migration and adaptation in KSA as well adjustment when returning to SA (labour market and private living).

The following section will provide the background to the research problem.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

During this section, global nurse migration trends will be discussed that include global shortage of nurses; the effects of globalisation on migration as well as reasons for nurse migration (push and pull factors).

1.2.1 Global nurse migration trends

The aspects that will be included in this section is the global picture of nurse migration, push and pull factors that could motivate South African nurses to emigrate to the KSA. The legal and ethical frameworks included in the Constitution of South Africa (ANC Congress 2018:NP) and the position statements and guidelines made by international organisations [International Council of Nurses (ICN) and the World Health Organisation (WHO)] will also be discussed. The South African emigration picture as well as the consequences of migration, including practice and educational standards and the effects on society will also be addressed.

In the following section, the diverse nurse population and the demands of diversity in healthcare populations (a global picture of nurse migration) will be discussed.

- *Diverse healthcare populations*

An effect of globalisation is societies that become increasingly multi-ethnic and multi-cultural (Ladum & Burkholder 2019:29). Along with this, the constant changed diversity in populations leads to altered health needs among individuals (Ladum & Burkholder 2019:29). This changed diversity is challenging the health care systems to deliver affordable, accessible and migrant-sensitive services. Health care professionals increasingly find themselves in a predicament when treating patients with symptoms that are unfamiliar to them or not well understood (Ladum & Burkholder 2019:30). Despite these ever-changing multi-cultural healthcare settings, more international employment opportunities arise to cater for the health needs of diverse patients.

- *International employment opportunities and high demand for nurses*

Nurse migration is a global phenomenon. International nurse migration has always been a reality, but the turn of the 21st century marked more mobilisation opportunities for nurses to work abroad (Mlambo & Adetiba 2017:63). The monitoring of international recruitment of health personnel is crucial, but only a few countries can provide such data. With diverse accumulation of cultures across borders and the high demand for nurses, SA trained nurses might find it easier to migrate to other countries.

International nurses' employment opportunities, liberalisation of healthcare markets, global demographic and social developments are a few concepts that place the migration of nurses in high demand (Mlambo & Adetiba 2017:63). Rapid ageing populations, socio-cultural changes resulting in single households and the breakdown in formerly strong family networks are the trademark of many high-income countries. A global healthcare market justifies the recruitment of nurses from other countries, as it is easier to hire services than to train locally, which in return will increase profits (Lagardé & Blaauw 2016:NP). This shortage of nurses and the global high demand for nursing services place nurses in a beneficiary role where they can choose where they want to work, even if it means leaving their country of origin.

The professional image of nursing, due to the global demand for nurses can have a twofold effect. Firstly, nurses' image can become less attractive because they will be associated with problems in the destination country (Pretorius 2018:98). The professional image of nurses can also be perceived as negative by the destination country when the demands in healthcare are not met despite the additional training received. According to Pretorius (2018:98) a few expected problems can include difficulties in adjustment within the multi-cultural team settings, poor working conditions, lack of training and lack of migrant sensitive staff. The motives to become a nurse no longer conform to professional attitudes, but nursing is rather seen as a mean to escape living conditions and to earn money. Secondly, the migration of nurses can be associated with positive impacts such as learning opportunities and the expansion in the field of transcultural nursing.

With the high demand of nurses globally, a constant shortage of nurses is inevitable especially in under or developing countries.

1.2.2 Global shortage of nurses

It is estimated that each year between five and 10 million people (in general) globally cross international borders to seek employment in other countries (De Haas, Czaika, Flahaux, Mahendra, Natter, Vezzoli & Villares-Varela 2019:886).

Migration of nurses remains a global issue that have a considerable impact on both the country of origin (like SA) and host countries (like KSA) (Al-Nawafleh 2015:221). Regional and international migration aims to restore nursing workforce imbalances but have advantages and disadvantages for the healthcare system (Al-Nawafleh 2015:221). The WHO, in partnerships with nurse education institutions is pursuing the development of a workforce that is migrant and culturally sensitive and includes inter-cultural competence into training of all healthcare professionals (WHO 2018:NP).

The context of the problem involves the KSA and SA settings. These two different settings namely SA (third world or developing country or country of origin) and KSA (first world or developed country or destination country) will be discussed in Chapter 2. South African expatriate nurses migrate to the KSA where they are faced with cultural diversity, language barriers and a religion different form their own. South Africa has witnessed an exodus of skilled nurses (due to financial or work-related aspects) to the KSA for more than a decade. Many South African nurses choose to work in the KSA. Pretorius (2018:22) estimated that currently more than 1 500 South African nurses are working in the KSA. According to Pretorius (2018:22) there are no official or reliable statistics captured on South African expatriate nurses and their migration patterns, which indicates a gap in research data. When these South African expatriate nurses return to SA, they struggle with adaptation upon their return to SA.

Migration benefits the countries of origin (developing country), destination countries (developed country) as well as the migrant (Lagardé & Blaauw 2016:NP). Advantages for the destination country include rectification of the shortage of locally trained nurses and sustainability of the country's health systems. Advantages for the country of origin (for example SA) includes remittances from abroad to aid in its economic development (these expatriate nurses are sending money back to SA to support their families back home whilst working in KSA) (Al-Nawafleh 2015:221).

The constant nurse migration patterns of South African nurses reflect that they will leave the country of origin in a nursing service deficit whilst causing adequate or even surplus service delivery in the destination country. Over the past few decades, there have been cycles of shortage and surplus of registered nurses in many countries. Recent trends of migration have changed tremendously and the situation is severe. Nurse migration will continue to follow the logic associated with the liberalisation of markets and global circulation, implicating that some countries will continue to heavily rely on foreign nurses instead of increasing and building a local sufficient training capacity (Ladum & Burkholder 2019:29).

The dynamics of the 20th to the 21st century nurse migration shows an increasing flow of migrant nurses from African and other global Southern countries to global Northern countries. This is regarded as "a new form of accumulation by disposition" (Labonté, Sanders, Mathole, Crush, Chikanda, Dambisya, Runnels, Packer, MacKenzie, Tomblin Murphy, & Bourgeault 2015:6). The Marxian concept 'Unequal Exchange' and globalisation of nurse migration is used to indicate the disproportionate accumulation of nursing labour in the North and even a greater dispossession in the South (Labonté et al 2015:3). Issues surrounding the global nurse shortage are complex and will last longer than those events previously experienced (Mlambo & Adetiba 2017:62).

International migration of skilled nurses affects countries globally (Ladum & Burkholder 2019:29). The globalisation of nurses could lead to an increasingly interconnected nursing workforce that spans across international borders, structures and systems and processes that needs to deliver healthcare to diverse patients around the world (Ladum & Burkholder 2019:29). During the last decade, there has been an increased focus on the global impact of nurse shortages and the responsibility of nursing education institutions to produce enough high-quality trained nurses (Mlambo & Adetiba 2017:62). Migration can thus be regarded as a key enabler for accessible, inclusive, sustainable socio-economic development (Mlambo & Adetiba 2017:62).

According to Labonté et al (2015:3), a total number of 23 000 African health professionals will emigrate to developed countries every year. This right of freedom is further supported by the ICN who states that all nurses have the right to migrate as a function of choice, regardless of their motivation (ICN 2017:NP). With numerous nurses' leaving their country of origin each year, the global shortage of nurses will not recover. To stop the migration of health workers will be an impossible task as it is an individual's basic human right to

freedom, choices and movement (Mlambo & Adetiba 2017:62). South Africa, as a developing country, could be regarded as a major exporter of nurses (Labonté et al 2015:2). It can be regarded as a benefit that South African expatriate nurses gain international clinical and cultural exposure which can be ploughed back into the nursing profession once they return to SA. The ethical principles stated by the WHO and ICN (right to freedom and movement) support the problem statement in this study that nurses who choose to migrate need to have proper preparation prior to migration and adaptation support during the whole migration process (Mlambo & Adetiba 2017:62).

The following section will address the global shortage of nurses as reflected in terms of the context of this study (KSA and SA).

1.2.2.1 *Nurse shortage in the Kingdom of Saudi Arabia (KSA)*

The KSA has undergone dramatic changes and developments over the past 50 years.

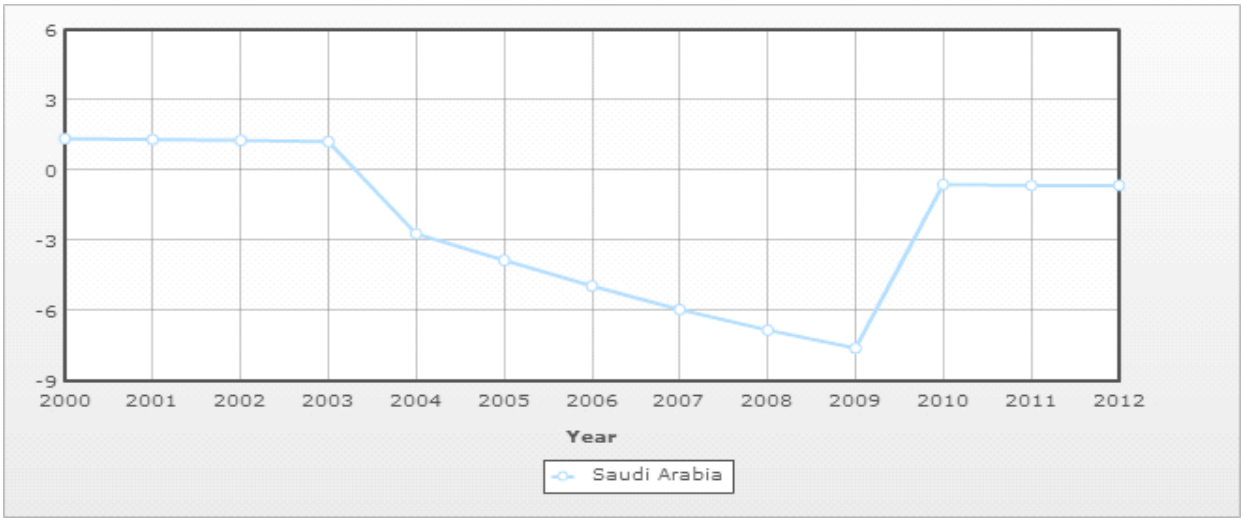

Figure 1.1: KSA Net migration rate [migrant(s)/1,000 population presented on the vertical axis] 2000-2012. The horisontal axis represents the year or timeframe.

Available from: http://www.indexmundi.com

Figure 1 indicates a constant demand to emigrate to the KSA until 2009 where there was a significant decline, but ultimately peaked again during 2010. Figure 1 depicts the number of individuals either entering or exiting the KSA and depicted 1:1000 (1.36 during 2002; 1.32 during 2001; 1.28 during 2002; 1.23 during 2003; up to -3.6 during 2012). This decline in migration patterns could be due to the global financial crisis and recession, which had an impact on migration flows (Labonté et al 2015:7).

The KSA changed from a nomadic society into a more social environment with systems and infrastructures with modern technology (Wazqar, Kerr, Ragan & Orchard 2017:325). It is unfortunate that the environmental changes did not project the increase in the demand for laborers and health care workers. KSA is committed to improve the health of all inhabitants (34.81 million) by providing free and accessible health care services to all (Wazqar et al 2017:328). KSA is only producing 18% local trained nurses and make use of global expatriate nurses to fill the healthcare needs in the country (Albougami, Almazan, Cruz, Alamri, Adolfo & Roque 2020:34). The hospitals expanded and with the extreme shortage of indigenous trained nurses the KSA was forced to recruit expatriate nurses from diverse cultural backgrounds, from as many as 40 countries (Almajwal 2016:192). This recession reduced the number of economic migrants and caused a reduction in remittance dropped which de-motivated individuals who were financially driven to emigrate (Labonté et al 2015:8). There is a constant shortage of nurses in KSA which will support migration of South African trained nurses to fill this gap.

The following section will address nurse shortages experienced in SA.

1.2.2.2 *Nurse shortage in South Africa (SA)*

The nursing shortages in SA will be discussed in terms of emigration statistics, brain drain, the effect of migration on the South African health systems, as well as the reasons for South African nurse migration (push and pull factors). The brain drain effect stemming from South African expatriate nurse migration to the KSA and the effect of migration on the South African health systems will be discussed in Chapter 6. The lived experiences of South African expatriate nurses (data gathered from Phase 1 of this study by means of unstructured phenomenological interviews) with the focus on expatriate experiences gain and implementation thereof upon return to a third world country like SA will be addressed in Chapter 2.

- *South African nursing emigration statistics*

There is a gap in literature on the actual nurse emigration statistics since 2013. Although statistics indicate that there has been an increase in registered nurses (100 323) during 2013 compared to 95 502 during 2012 (SANC 2013:NP), 15% of those nurses will migrate from SA (Labonté et al 2015:2) which will leave the country with 383 nurses per 100 000 population (Labonté et al 2015:2). According to the indicator data (Health Indicators

System 2012) the number of registered nurses in SA increased from 91 011 during 1998 to 124 045 during 2012. During 2010, there was a shortage of 46.3% professional nurses in the South African health sector, while the KSA received 7 288.9 immigrants from SA (Pretorius 2018:21). No recent statistics on South African expatriate nurses residing in the KSA could be found [this lack in evidence was checked and confirmed with the subject specialist at the University of South Africa (UNISA) library May 2020]. According to Labonté et al (2015:2) there are 23 400 healthcare professionals (including physicians) who emigrated to foreign countries.

There is a gap in literature on actual expatriate nurse migrants in the KSA after 2010. According to Labonté et al (2015:12), SA is experiencing a severe shortage in healthcare workers, but there are no specific data available. A sample of 9 743 students from sub-Saharan Africa (4 532 from SA) indicated that four in five students (79%) said they thought about migrating to another country, whilst 35% said they will consider it within six months (Mlambo & Adetiba 2017:62). From this study, it is evident that although countries are training nurses to supply the local healthcare demand, nurses can still choose to migrate to another country.

The following section will address the South African Nursing Council (SANC) statistics and the nurse population demands to cater for the ever-growing diverse South African population.

- *South African Nursing Council (SANC) statistics 2015-2018*

There are no official numbers available from the SANC to indicate the total number of nurses who either immigrate or emigrate from SA. The total number of registered nurses in SA increased from 101 295 during 2006 to 285 704 during 2018 (SANC 2019:NP). It could be argued that these numbers are still not adequate to provide for the fast-growing population in SA. The population increased from 47 391 million during 2006 to 57 726 million during 2018 (SANC 2019:NP). A total number of 66 647 nurses were above the age of 50 years during 2016 (SANC 2016:NP). With this aging nurse population and the higher trends in nurse migration patterns, the South African healthcare system is losing valuable skills and resources when these experienced nurses reach retirement age or choose to leave the country.

Migration of South African trained nurses could be beneficial for individuals and families (referring to financial gain, travel opportunities, improved living standards) or pose a threat to their well-being (when stress, isolation or loneliness are experienced it can cause physical and emotional illness). The following section will discuss the push and pull factors for South African nurse emigration.

- *Push and pull factors towards nurse migration*

Pretorius (2018:21) stated that improved practice and learning opportunities, better salaries and safer personal working conditions are push and pull factors in nurse migration. Push factors are indicators motivating (pushing) nurses to leave their country of origin, whilst pull factors are those attractions offered by the destination country. Push factors as per Thapa and Shrestha (2017:37) include: personal ambition; political conflict; low salaries; curiosity about the destination country; lack of job or career opportunities; low satisfactory work environment; lack of modern facilities; and lack of self-recognition. Push factors are those factors that could motivate South African trained nurses to leave their country of origin (e.g. safety, financial) and pull factors are those motivators attracting these nurses to a destination country like the KSA (e.g. financial and educational gain, travel opportunities). The financial, social, educational, or personal gain might be motivators for South African expatriate nurses to adapt to the KSA environment.

The decision to emigrate to foreign countries include the chance to break traditional reins of family control, experience new environments and the development or improvement of confidence and skills (pull factors towards migration) (Mlambo & Adetiba 2017:62). There is a gap in literature with the focus specifically on migration to the KSA.

Mlambo and Adetiba (2017:68) found that the reasons for South African nurse migration are the poor conditions in health care, including obsolete equipment, heavy workload and job insecurity (push factors towards migration). Despite all these beneficial factors motivating emigration, the South African nurse might never be fully prepared for the challenges he or she might face in the destination country like the KSA (Mlambo & Adetiba 2017:69) as discussed in the next section.

1.2.3 Challenges that emigrants face

Emigration poses many challenges to those involved. Nursing in SA is a predominantly female profession (SANC 2019:NP) which results in the largest number of nursing migrants being female. Female migrants are placing themselves in a vulnerable position when they opt to migrate because they often go to places where there is greater isolation, less protection, contact and support (Ladum & Burkholder 2019:29). The challenges of migration are not just limited to those push factors that contributed to the person leaving their country of origin. Other factors such as the journey to the destination country, adjustment to the destination country, new cultural expectations as well as a different health care system should be taken into consideration (Ladum & Burkholder 2019:30).

Nurses often opt to migrate to countries which they regard as interesting, rewarding or challenging, but are not necessarily psychologically prepared for the challenges they might encounter (Lagardé & Blaauw 2016:NP). As per Bovis, Consolaro, Pistorio, Garrone, Scala, Patrone, Rinaldi, Villa, Martini, Ravelli and Ruperto (2018:6), cross-cultural adaptation refers to individuals experiencing the same phenomenon but in different cultural settings. In this study, the researcher wanted to explore South African expatriate nurses' lived experiences when exposed to diverse cultural behaviours in the KSA and what influence it might have on the adaptation of the expat.

Most expatriate migrant nurses' have no or limited understanding of the Islamic culture which could impede communication resulting in patient dissatisfaction and increased stress levels of the expatriate nurses in the KSA (Al-Yateem et al 2015:205). Most often these non-Islamic nurses experience high levels of stress when exposed to the Muslim patients (inability to communicate, religious variations, different cultural behaviours, beliefs and traditions) and culture shock is likely to occur (Al-Yateem et al 2015:206).

South African nurses who choose to emigrate base their decisions on personal choices and require the assistance of recruitment agencies. These nurses are asked to pay recruitment agencies a fee to find them employment abroad. Some agencies charge nurse recruits up to six month's salaries for making employment information available (Sunam & McCarthy 2016:50). Migrant nurses might be misled by recruitment agencies regarding working conditions, foreign legislation, salaries and the adaptation process in the destination country (Sunam & McCarthy 2016:50).

When these migrant nurses are not well prepared for the diversity and possible challenges, they might face in the destination country it will hamper their adaptation in the new environment. Adaptation in the country depends on every nurse's personal circumstances, cultural orientation and background. Psychological challenges adaptation from inadequate adaptative and adjustment processes can weaken the immigrant's health, causing high levels of emotional and social distress, deterioration in mental health and ultimately challenge their adaptation back into the nursing workforce when they return to their country of origin (Ladum & Burkholder 2019:29). The impact on the destination country might be very challenging when incorporating nurses from a vast variety of diverse cultures into their own healthcare systems (these nurses all come from diverse backgrounds with different training standards and might not be culturally sensitive towards the new culture). This could lead to higher stress levels and poor performance by the expat nurses or even patient dissatisfaction.

The KSA is known to recruit international nurses, especially from SA (Labonté et al 2015:8). These expatriate nurses will be in contact with foreign nurses from diverse cultures, whilst trying to understand and adjust to the diverse the KSA population and environment (Labonté et al 2015:8).

When the South African expatriate nurse enters the KSA, her or his adjustment will be reflected in her or his work standards (Wang 2016:231). There is no specified time-period for cultural adjustment to occur. The South African expatriate nurses' adjustment to the new culture could therefore be linked to her work performance in the KSA (Wang 2016:232). Effective orientation and support of expatriate nurses prior and during the emigration process will improve their adaptation, work performance and enhance patient care standards when working in the destination country.

Nurse migration may have physical, emotional, or psychological effects on the person, which might influence or change their health or individual personalities and can reflect negatively on patient care standards. This study aims to explore if South African expatriate nurses might experience challenges on physical, emotional or spiritual levels as these challenges may cause culture shock.

The following section will describe culture shock experienced during migration.

1.2.4 Culture shock

Wang (2016:231) found that health care workers experience culture shock when they relocate to different environments. Culture shock is defined by Wang (2016:231) as the initial process of adjustment to a strange or unfamiliar environment. It is described as feelings of disorientation that occur when exposed to a new context or culture (Wang 2016:231). South African nurses who opt to emigrate to the KSA who have no experience in dealing with Muslim patients or on how to communicate with these patients are at a high risk to develop culture shock (Al-Yateem et al 2015:206).

There are different methods of coping with culture shock cross-culturally, but expatriate nurses form their own cultural identity by the way they endure culture shock (Al-Yateem et al 2015:206). Culture shock might appear commonly between Western and Eastern country migrations (Wang 2016:231). Absence of familiar aspects including food, cuisine and communication could result in frustration and anxiety experienced by the expatriate nurse (Hirai, Frazier & Syed 2015:440).

Mastering of the new culture contributes to expatriate adjustment (Hirai et al 2015:440). With the high demand for nurses and the attractive opportunities offered by a destination country like the KSA, nurses might be tempted to migrate, leaving their country of origin, SA in the case of this study, depleted of nursing skills and knowledge. Furthermore, when the adaptation and migration process of these expatriate nurses is not supported, it may lead to poor adaptation into the foreign culture.
The following section will focus on the problem statement applied to this study.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The research problem can be explained in twofold. The first part is the gaps in preparation and support prior to expatriate nurse migration. The second part of the research problem is poor adaptation processes (working and living) when these South African expatriate nurses migrate to the KSA as well upon their return to SA.

As indicated by Mlambo and Adetiba (2017:62) an effect of globalisation is that international borders are more open and acceptable towards migration, which is also enhancing the human right towards free movement. With the free movement or migration

of nurses' lack in preparation can challenge the adjustment process in a foreign or destination country (Mlambo & Adetiba 2017:62). In this study, the lack in preparation prior to migration is linked to South African expatriate nurse migration to the destination country (KSA).

There is a gap in literature pertaining to South African expatriate nurse migration, as well as support prior to migration. The assistance of a subject librarian was requested for a literature search (key words included South African expatriate nurse, migration AND adaptation, migration AND preparation, migration to KSA, migration AND support) with search engines used (Africa-Wide Information, Academic Search Premier, Health Source: Nursing/Academic Edition, EBSCOhost, MEDLINE, CINAHL, Scopus, Psychinfo, ProQuest Medicine, ERIC and PubMed) during the time frame 2015 and 2019 with limited success. In this study, the international recruitment agency gave the prospective expats a brief orientation (via PowerPoint presentation) on what to expect in the KSA, the question remains if it is sufficient to prepare them for the potential challenges they might face in working and living in the KSA.

International recruitment agencies recruit prospective expats but fail to provide an adequate preparation or orientation and support about the destination countries' expectancies and adaptation process (Garner, Conroy & Bader 2015:1879) resulting in gaps in preparation and support. According to Fokkema and De Haas (2015:8) orientation and preparation regarding the major cultural and political differences present in the destination country, language variations, expected work experience, host country habits and values are needed prior to migration as to ensure adjustment during migration.

Recruitment agencies give all prospective migrating nurses a brief orientation regarding the foreign destination, prepare work visas and arrange contractual agreements. Garner et al (2015:1888) state that emigrating nurses are often denied a proper orientation and are at risk for potential exploitation. These agencies receive financial gain for this service rendered by the destination country when successful expatriate nurse applicants are employed (Garner et al 2015:1880). The financial gain that agencies receive might play a role in fast tracking the orientation process. Inadequate preparation results in challenges in adaptation in a new or different context.

The second part of the research problem refers to the adaptation process of these South African expatriate nurses in the KSA and upon their return to SA. South African nurses who leave SA to work in the KSA face many challenges (including cultural and language differences) while adapting to the workplace and cultural environment in the KSA (Wang 2016:230).

Inadequate preparation and support by the recruitment agencies may result in adaptation challenges on an emotional and physical level in the unfamiliar environment (Wang 2016:231). Adaptation is influenced by cultural matching (the fit of the person or emigrant into the new environment), individual psychological characteristics (the need and drive to adapt) and the institution's climate (personalities of individuals already working at the institution) (Srivastava, Goldberg, Manian & Potts 2017:1351).

Cultural differences include differences in communication or language, customs and cuisine (Pretorius 2018:98). Violence (both physical and psychological) and sexual harassment infrequently occur to female nurse migrants, which will hamper their adaptation in the destination country (Ladum & Burkholder 2019:30).

When the South African expatriate nurse works in the KSA, the nurse will be exposed to different cultures and migrants from other countries. If these expatriate nurses do not have a cultural understanding and apply sensitivity when dealing with different cultures it might lead to misunderstandings, patient dissatisfaction and poor adjustment (Wang 2016:240). Nurse emigrants might face adaptation and adjustment problems, negative emotions and feelings, and possible culture shock in KSA, especially when they are inadequately prepared. Inadequate adaptation may negatively impact on the total wellbeing of the expatriate, affecting their work performance, personal life and health (physical health includes symptoms of stress which can result in emotional illness including isolation and depression) (Tu, Chen & Lam 2019:369).

The negative impact may result in personality changes, which may lead to isolation in the destination country (Tu et al 2019:369). Inability to adapt to the foreign culture may influence their work performance (Tu et al 2019:370). According to Thela, Tomita, Maharaj, Mhlongo and Burns (2017:717) migration causes major life-transformations accompanied by significant adjustment issues to new surroundings with return migration

and include anxiety, frustration and even feelings of hopelessness. The following section will discuss the facets of the problem statement.

There is a gap in literature pertaining to prospective and returning South African expatriate nurse migration preparation and adaptation support (the KSA and SA as settings). Poor adaptation can be reflected by lowered job satisfaction in the KSA, as well as when these expatriate nurses return to SA. Poor adjustment can lead to below standard patient care and job dissatisfaction. Reversed culture shock occurs when an expatriate returns home after residing in a foreign country for a period of time (Barakat et al 2015:785). Poor adjustment and adaptation result in poor work performance, overall dissatisfaction, and possible reversed culture shock upon return to SA. Nurses are expected to deliver high quality nursing care and to be responsible for their own health. When nurses deliver below standard nursing care due to their deteriorating physical and emotional health as a result of poor adjustment, patient care will ultimately suffer, resulting in prolonged hospitalisation due to complications or even death (Barakat et al 2015:785). Delivering below standard patient care and job dissatisfaction will influence the nurse's career growth (Barakat et al 2015:785).

The true extent of nurse migration cannot be ascertained from official statistical data as many countries do not keep records on expatriate migration (Li et al 2014:314). There is limited research available on migration and adaptation of South African expatriate nurses. There is no research data available on nurse migration and adaptation of South African healthcare workers working and living in the KSA or other countries and limited data and research available to guide migration and adaptation of nurses, especially upon their return to SA.

There is a gap in literature on migration preparation focussed on South African expatriate nurses, adaptation to the KSA, migration support when working and living in the KSA and adjustment support upon return to SA. According to Tahir and Egleston (2019:528) the effectiveness of expatriate assignments should also focus and include repatriation when expats return to their country of origin.

1.4 AIM OF THIS STUDY

The aim of this study is to gain an interpretation of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and who subsequently returned to SA to live and re-enter the workforce in SA. Understanding their lived experiences of migration and adaptation while working in the KSA and their adaptation upon return to SA may address the existing gap in literature by providing information for the development of guidelines to facilitate expatriate nurses' migration and adaptation in the KSA, adjustment when returning to SA (labour market and private living) and migration preparation and support to adaptation upon return to SA. These guidelines can be implemented by international recruitment agencies, nurse migration regulatory bodies, prospective and returning South African expatriate nurses to prepare and enhance migration and adaptation support to prospective expatriates in the KSA and upon return to SA.

The following section will describe the research objective and questions as applied to this study.

1.5 RESEARCH OBJECTIVES AND QUESTIONS

In order to address the aim of the study, the objectives were:

- To explore, describe, and interpret the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA.
- To explore and describe the lived experiences of adaptation of South African expatriate nurses when they return to SA.
- To develop and validate guidelines (based on the lived experiences) as to facilitate South African expatriate nurses' migration and adaptation to the KSA and adaptation upon their return to SA.

The following section will discuss the research questions applied to this study.

- *Research questions*

Research questions have a broad focus, are limited in number and include complex concepts (Alase 2017:13). The questions formulated to be answered by this research are:

- What are the experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA?

- What are the experiences of adaptation by South African expatriate nurses when they return to SA's living environment and workforce after working and living in the KSA?
- What guidelines could be developed to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?
- How can guidelines be validated to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?

The following section will address the significance of this study.

1.6 SIGNIFICANCE OF THIS STUDY

This study can be used to provide migration and adaptation guidelines that may be used by recruitment or governmental agencies (when nurses leave their country of origin as well as upon return) to assist in preparing prospective South African expatriate nurses to adjust to the KSA and to SA upon their return. The significance of South African expatriate nurse' adaptation support during migration include job satisfaction to the KSA and upon their return to SA, improvement in patient care standards and higher degree of adaptation when these expatriates know what is expected of them (both SA and KSA). It might also be possible to use the guidelines to facilitate migration and adaptation in other populations than the population identified for this study. This study can also aid to create awareness for prospective expats of migration and adaptation of expatriate nurses and awareness to assist with expatriate nurses' workplace preparation and satisfactory adaptation.

Significance of this study towards nursing management as to help facilitate the adaptation of expatriate nurses in certain facilities. It is also the responsibility of nursing managers and employee wellness programs to ensure successful adaptation of nurses.
Definitions on the key terms used in this study will be discussed in the following section.

1.7 DEFINITION OF KEY TERMS

The key terms defined in this section will be presented in alphabetical order. It will include the theoretical and operational definitions.

Adapt and Adaptation refers to both the physical and mental changes that will result due to adjustment to a different environment known (to the nurse) (Afifi, Milan, Etzold, Schraven, Rademacher-Schultz, Sakdapolrak, Reif, Van der Geest & Warner 2016:254). **Adapt** is the appropriate or beneficial behavioural responses to a changing situation (Afifi et al 2016:256). Changing environment refers to the diverse setting in the KSA when the South African expatriate nurse is facing diverse cultural behaviours, traditions and language variations, as well as adaptation upon their return to SA.

Adjustment refers to the process of adaptation into a new environment (Afifi et al 2016:257). In this study, the South African expatriate nurse will experience physical, mental and behavioural changes during the adaptation process in the KSA and upon their return to SA when exposed to diverse cultural behaviours and traditions. In this study, the researcher chose to use the term adaptation as it encompasses the progressive process of adjustment and not only the outcome, which is adjustment.

Coping mechanisms are the control processes inherent to the individual as part of the adaptive system, which could be genetically, inherited or learned and include behavioural and cognitive processes (Afifi et al 2016:258). In this study, coping mechanisms refers to the behavioural or cognitive changes the South African expatriate nurse intentionally or unintentionally applies during the *Adaptation Phase* into the KSA and their return to SA (include learned, behavioural and cognitive processes). The guidelines might enhance coping mechanisms through the preparation of the expatriate nurses with behavioural and cognitive processes on what to expect, assisting them with adjustment and adaptation in the KSA and upon their return to SA.

Culture is noticeable differences amongst groups, including group identities. Within a culture, there are noticeable similarities within members of the culture but also across different cultures. Culture defines certain properties amongst members of the group like language, gestures and ways of understanding identities (Yang, Zhang & Sheldon 2018:98). In this study, the culture in the KSA include traditional and religious practices (Islam), language (Arabic), treatment of other nationalities, gender separation, treatment of women and clothing or modesty practices whilst SA refers to modern views, diversity in the population, diversity in religion and culture and is marked by freedom.

Culture shock involves individual differences about culture, work and family situations in a specific context. Culture shock can be used as predictors of the intensity experienced when entering a diverse country or when returning to the country of origin (Yang et al 2018:98). In this study, culture shock will refer to the intensity of the experiences of South

African expatriate nurses when working and living in the KSA, as they are confronted by diverse cultures, traditions and languages.

Developing country refer to third world countries such as in Africa which is underdeveloped and have high levels of poverty and low political growth (Woolcock 2018:12). In this study, developing or third world country will refer to SA with high poverty levels and low political growth. SA is marked by diversity in animal, plant life, landscape, cultures as well as natural resources. Within this multi-ethnic nation:

79. 5% is African; Whites 9%; Asian/Indian 2.5%; and Coloured 9% (Statistics SA 2016:NP). SA in this study will refer to the country of origin.

Developed country refers to first world countries such as in Europe with stable political and economic growth (Woolcock 2018:12). In this study, the KSA refer to developed or first world countries in terms of stable political aspects and economic growth in the country. The KSA is regarded as one of the largest countries in the Middle East with a surface area of 14 million km² which covers about 80% of the Arabian Peninsula and has one of the largest oil reserves in the world (Woolcock 2018:14). The KSA in this study will refer to the destination country.

Environment (external surroundings) is the totality of all external conditions, surroundings and forces one is expected to interact to or partly interact to (Afifi et al 2016:257). In this study, environment refers to both the working and living environments of KSA and SA. External conditions and forces in the KSA refer to the extreme heat and geographical layout.

Expatriate refers to workers pursuing employment opportunities across international borders on their own initiative (Mlambo & Adetiba 2017:64). In this study, expatriate refers to South African professional nurses who left their country of origin (SA) to work as nurses in a destination country (KSA) and have returned to SA.

Guideline is supporting directions given to current or future policy compiling (Mahboob, Paltridge, Phakiti, Wagner, Starfield, Burns, Jones & De Costa 2016:44). In this study, guideline refers to the set of recommendations to facilitate migration and adaptation of South African expatriate nurses in the KSA as well upon their return to SA.

Immigration refers to a persons' legal action of entering a destination country and migration refers to the movement from one country or region to another (Alesina, Miano & Stantcheva 2018:2). In this study, the migrant nurse refers to the South African trained nurse who left SA (process of immigration) to work and live in the KSA.

Migration involves movement of expatriate nurses across borders (Mlambo & Adetiba 2017:64). In this study, migration refers to the movement of South African nurses from

their country of origin (SA) to a destination country (KSA), or from the destination country (KSA) back to the country of origin (SA).

Reversed culture shock refers to a state of confusion or uncertainty associated with anxiety that may affect expatriates when exposed to an alien culture or environment, or a culture, which they have been alienated from for a period of time, which they were not adequately prepared for (Yang et al 2018:98). Culture shock occurs when entering a foreign or destination culture and reversed culture shock when returning to country of origin.

Reintegration refers to the restoration of a unity, or to integrate into an entity (Yang et al 2018:96). In this study, reintegration refers to the South African nurses' adaptation when returning to SA after working and living in the KSA.

South African nurse is a registered professional nurse that is an individual authorised and capable of practicing nursing or midwifery in his or her own right by virtue of registration in terms of the South African Nursing Act, 2005 (Act 33 of 2005). In this study, the South African nurse refers to a professional nurse who is able to seek employment and registration with another international nurse regulatory body in the KSA (destination country), who can work independently under scope of practice, have certain skills and competencies that are sought in the global health market.

The following section will describe the theoretical foundation of this study.

1.8 THEORETICAL FOUNDATION OF THE RESEARCH

There is discourse in the literature (Horrigan-Kelly, Millar & Dowling 2016:2; Ojala, Häkkinen, Karppinen, Sipilä, Suutama & Piirainen 2015:365) about the use of a theoretical framework in phenomenological research. A theoretical framework can influence the researcher to categorise the findings according to the framework whereas phenomenology requires that the researcher do not control or influence the results (Horrigan-Kelly et al 2016:2). During phenomenology, the aim is to interpret and describe the phenomenon as accurately as possible whilst refraining from any pre-given frameworks (Ojala et al 2015:365). This study will follow a descriptive phenomenological approach.

As per Ojala et al (2015:365) the emphasis (during phenomenology) of self-understanding must be applied as world openness and a calling towards a true understanding of the worldview. Horrigan-Kelly et al (2016:2) stated that one of the

challenges during phenomenology is to accurately describe the lived experience without obstruction of pre-conceptions or theoretical notions. The researcher wanted to apply inductive reasoning and therefore the point of departure was from a specific point to a general conclusion (Horrigan-Kelly et al 2016:2). The specific point was the lived experiences of the expatriate nurses to the general conclusion of guidelines drafted from the findings, a literature review and a specific tool (AGREE 2017:NP). The researcher wanted to enter the field open to discover the specific point of departure.

For these reasons, there will be no reference to a theoretical framework in this Chapter. However, the research assumptions and paradigms will be discussed in general.

A detailed discussion about descriptive phenomenology will follow in Chapter 2. The following section will address the paradigmatic perspective.

1.9 PARADIGMATIC PERSPECTIVE

Paradigm refers to a set of beliefs or to a reference frame that aims to explain how individuals perceive the world and their place within it (Kelly, Dowling & Miller 2018:9). As per Shannon-Baker (2016:320) paradigm refers to distinct ideas, concepts and patterns used in research methodologies. In this study, the paradigmatic perspective was a constructivist paradigm (discussed later in this section).

Conducting research requires a systematic and rigorous approach (Rahi 2017:1). The application of a paradigm can create a marriage between the research aims and methods used to achieve these aims. Paradigms are constructed of ontology (one's beliefs about reality), epistemology (the connection between the researcher and the factors that can still be known and discovered) and methodology (how the research will be conducted relative to the stated questions and context) as indicated by Rahi (2017:1).

Thus, the worldview that one foster alters decisions one takes in life or practice. When deciding on a research approach, our worldview will influence these decisions and processes to address the research problem (Ndubisi & Anthony 2019:4). The following quote is internalised by the researcher when referring to worldview:

"…that we can have no certain knowledge of the real world, because, even if we could discover how our knowledge is derived from experience, there is no way of discovering

how our experience might be related to what there is before we experience it…" (Von Glasersfeld 1991:2).

From this cited quote it is expected that the research participants (in this study, South African expatriate nurses) had some positive and negative experiences whilst working and living in the KSA, as well when they returned to SA. These experiences were real, changed their own perspectives and worldviews; even when significant others or strangers could not understand the changes in the individual. These experiences in the KSA and SA changed the research participants on some level; either physical or psychological in ways that could never have been predicted. The paradigmatic perspective will be discussed in terms of phenomenology within a constructivist paradigm and a detailed historical overview of phenomenology will be provided.

In the following section, the phenomenological research paradigm will be discussed with the focus on the descriptive constructivist paradigm.

1.9.1 Research paradigm

- *Constructivism*

Constructivism according to Gasparyan (2015:231) refers to an approach that the researcher as observer follows as to not reflect on the 'world' but rather actively creates it through the process of thinking and perception. The researcher's observations are thus an active process and are created through interaction (communication, social and or cognitive). The research observer and observant interact within a creative circle; none more important than the other as to achieve co-evolution (Gasparyan 2015:231). The researcher chose this design for this study as the participants were people who personally lived the experience under investigation. Unstructured phenomenological interviews are a suitable data collection method to creatively explore these lived experiences without influence or bias from the researcher.

- *Constructivism ontology*

Constructivism ontology states that the truth factor is a narrative reality, which changes continuously. Reality requires the involvement of a person or subject and can only be personally and socially explained and constructed (Henriksen 2017:8). According to Kelly et al (2018:11) the participants are viewed as passive role players and data gathering is purely for the researchers' own purpose. According to Wolgemuth et al (2015:354)

interviews conducted by the constructionist or feminist orientations create a therapeutically beneficial orientation by the participants. During the interview, the researcher and participant will be involved in a collaborative meaning-creating situation revolving around the participant, similar to the therapeutic interview. In this study, participants could describe their lived experiences in the KSA without influence from the researcher. Social constructionism state that one will never really know and understand true or false, good, or bad meanings or be able to differentiate right from wrong (Amineh & Asl 2015:11). Constructionism according to Noss and Clayson (2015:285) symbolises the individual's way of thinking about learning and can be explained as a metaphor to explain how human beings come to learn in the most effective ways.

- *Methodological assumptions*

The methodological assumptions according to Kivunja and Kuyini (2017:33) derived from the constructivist paradigm include:

- The phenomenon should be studied in the field where it occurs. The researcher will become immersed in the culture under study through listening, observation and talking skills. Constructivists recognise the importance of cultural practices', understanding and the diverse meanings attached to it.
- Constructivists are similar to naturalistic enquiries, which favours qualitative methods when dealing with multiple realities.
- The research process is very interactive and the participant is inseparable from the researcher. The researcher aims to negotiate interpretations and meanings from the participants (in this study the South African expatriate nurses who lived and worked in the KSA and their adaptation upon returning to SA) as experienced within their reality framework as to reconstruct and describe meaning towards these experiences.

- *Social constructionism*

In this study, the participants described meaning towards their lived experiences by vivid description of events, re-constructing their thoughts and shared social interactions with colleagues and patients. Social constructionism according to Amin (2017:39) explains that most of human life exists due to interpersonal and social influences, whilst genetically and social factors are at work at the same moments. Speech as perceived from the social constructionism reality creates cultural consensus (Noss & Clayson 2015:285). Social constructionism views individuals as an integral part entwined within political, cultural and

historical evolutionary patterns (Amin 2017:40). In this study, social constructionism refers to language (different languages used in the context include Arabic in the KSA and English in SA) which is shared and understood to contribute to cultural understanding and expatriate adjustment. Specific language or terms used in phenomenology will be discussed later in this study. Radical constructionism refers to the individual's interaction with the world where he or she is required to construct, modify, or interpret information received and perceived.

- *Assumptions*

Assumptions can be described as general statements taken for granted but considered to be true even if not scientifically tested (Wolgemuth et al 2015:352). In this study, the research participant' voices were expressed during the unstructured phenomenological interview process and taken as true and accurate reflections of their lived experiences. Assumptions are often embedded and unrecognised during the thinking process but can be discovered through introspection (Wolgemuth et al 2015:352). The expressions, descriptions and findings of the research participants, as well as the essence connected to these descriptions will follow in Chapter 2. Research assumptions are imbedded in the design, framework, interpretation of findings and being able to recognise them is regarded as a strength (Wolgemuth et al 2015:352). This study followed a descriptive phenomenological design as to capture the true essence of findings – lived experiences of South African expatriate nurses working and living in the KSA and adaptation upon their return to SA.

Ontology refers to research about reality (aspects known or what can be known). Scientific methods are classified as positivist, objectivist, rationalist and the emerging worldview. Positivists advocate the existence of one reality, which is observable, the researcher has little or no impact on the observed object, the object has ontological status and can therefore be objectively studied from an outsider perspective (Kivunja & Kuyini 2017:27). Applied to this study, the reality which is referred to is a subjective experience as lived by the South African expatriate nurses who emigrated to the KSA, what they experienced during their day to day activities whilst working and living in the KSA and upon returning to SA. The next section will describe ontological assumptions and application to this study.

Ontology assumptions refer to the researchers' ideas about the characteristics and nature of the study concept (Pilarska 2015:65). Ontological assumptions include contemporary research mainstream approaches: positivist and anti-positivist approaches (Pilarska 2015:65). Positivists motivate quantitative methods whilst anti-positivists recognise ontological prospects and the possibility to know more about social realities (Pilarska 2015:65). During descriptive phenomenology, the research participants' lived experiences are reduced with a phenomenon and true descriptions of essence can be documented (Kivunja & Kuyini 2017:27). In this study, the lived world experiences of South African expatriate nurses working and living in the KSA and upon their return to SA, whether positive or negative as lived by the South African expatriate nurses who lived and worked in the KSA and adaptation on their return to SA has been explored by unstructured phenomenological interviews. Phenomenology aims to orients the researcher towards lived experiences, hermeneutics focus on the interpretation of lived experience whilst semiotics (study of signs and language) are used to convert linguistic into practical writing (Pilarska 2015:66). Participants voiced their experiences by communicating their meaning to the researcher.

Epistemology is a branch of philosophy and refers to the nature of knowledge gained (Bashir, Syed & Qureshi 2017:31), and refers to how things or truths can be known, facts or laws if existed be discovered and proven (Bashir et al 2017:31). There is an interaction between the researcher and the participants that might influence the participant (Bashir et al 2017:32). In this study, the South African expatriate nurses' lived experiences when migrating and adapting to the KSA culture and re-adjusting back to the environment is crucial in allocating understanding and complexity to the essence of this phenomenon. Participants explored what they know about this phenomenon and reflected on the meaning they ascribe to it.

Axiological assumptions refer to values as having a privileged position during research and researchers are openly passionate in pursuing research based on the value-laden purpose of it (Bashir et al 2017:33). In comparison, the rhetorical assumptions are written in the first person reflecting the involved and passionate researcher e.g. attempts to make a stance on the socially ill (Bashir et al 2017:34). During this study, the South African expatriate nurses who emigrated to the KSA explained their values and this was reflected as part of their lived experiences. In this study, the researcher applied bracketing to

capture her own values and experiences (as to limit bias) as to ensure a true reflection on the lived experiences of the participants was portrayed.

Methodological assumptions refer to the close interaction between the researcher and participants to discover meaning. The primary aim is working towards the construction of a social milieu, which the participants have experienced and can relate to. Some methods include in-depth interviews and prolonged observations (Bashir et al 2017:33). During Phase 1 of this study, unstructured phenomenological interviews were used by the researcher to create a bond between herself and the research participants, which allowed for true and accurate descriptions of constructs or lived experiences.

1.9.2 Phenomenology within a constructivist paradigm

- *Historical overview of phenomenology*

Phenomenological philosophy stemming from the 1900's influences psychological development. Prior to the 1900's harmonious styles of thinking and working applied to science and psychology. Both Goethe (as a famous poet) and Hering applied principles to the experience of light and the study of vision (Wilkinson & Hanna 2016:3).

Franz Brentano as a philosopher started writing from a psychological perspective. During 1874 Bretano published 'Psychologie vom empirischen Standpunktein' in which he explained the concept intentionality, which eventually became the cornerstone of phenomenology. Husserl adapted Bretano's views and descriptions of findings or givens without speculation (Wertz 2015:89).

Husserl's first publications on philosophy and descriptive psychology were done between 1884 and 1886 (Wertz 2015:87). During 1902-1903 Husserl started considering phenomenology as descriptive psychology, but again changed his opinion during 1905 due to doubts regarding the 'adequation of phenomenology in reference to descriptive psychology' (Wertz 2015:87). Husserl published his rejection on descriptive psychology when associated or characterised by phenomenology during 1905 in the 'Vorlesung E' (Castillo 2018:2). During 1905-1906, Husserl dissociated himself in totality from descriptive psychology as to avoid misunderstanding from phenomenologists (Castillo 2018:2). Publications during 1988 in the 'Vorlesungen Über Ethik und Wertelehre' marked a new era for Husserl's phenomenology (Laurukhin 2015:133).

Husserl's phenomenological publications suggested intentions and motives to support the revision of customary interpretations of phenomenology engaging only in the resolution of theoretical and epistemological issues (Laurukhin 2015:133). Husserl opposed consciousness in the world and questioned the 'true' existence of the world stretching beyond phenomenological research (Belousov 2016:20).

According to Husserl phenomenology is not only about bracketing (the existence or unaware existence of the world as known) but also about 'de-worlding' of consciousness in an attempt to reveal real existence (Belousov 2016:20). The following section will discuss phenomenology as a research approach, principles of phenomenology and the contrast between interpretive and descriptive phenomenology.

Husserl formulated some premises of phenomenological understanding with reference to consciousness and the relationship to the world. There is a differentiation between the world and consciousness, meaning that the world, which is an aggregate of all things are not connected and located in consciousness (Belousov 2016:21). The essence of consciousness can be found in relation to the world, but it cannot be identified in the parts of consciousness (Belousov 2016:22). Experience is gained only when attending and intending in the world, with the world an object to be intended (Belousov 2016:23).

- *Descriptive versus interpretive phenomenology*

Descriptive (eidetic) and interpretive (hermeneutic) phenomenology can be regarded as the two phenomenological approaches evident in nursing (Pilarska 2015:66). According to O'Hallora et al (2018:309) interpretive phenomenology is also referred to as hermeneutics which aim to interpret and describe the participant's experiences. The main focus of interpretive phenomenology is to explain lived experiences, to recognise different realities and how it is influenced, as well as how these experiences are linked to cultural, social and political factors.

Interpretive phenomenology challenged and built on the ideas of Husserl and focus on human experiences rather than conscious knowledge about concepts (Horrigan-Kelly et al 2016:4). Interpretive phenomenology explains situated freedom as not absolute and that individuals have a right to make choices and the results from the choices will not be clear. The expert knowledge of the researcher is seen as a valuable guide into the inquiry (Horrigan-Kelly et al 2016:4).

Descriptive phenomenology originated from the philosophy of Husserl that human consciousness is valuable and should be scientifically studied (Pilarska 2015:66). Human motivation can only be understood through the interpretation of subjective data because human actions are influenced by what they perceive as real. These experiences can be made relevant to a group of people who shared the same lived experiences. Husserl's descriptive phenomenological inquiry required the researcher to transcend the phenomenon under investigation and view the global essence of discovery as experienced or lived by the participant (O'Hallora et al 2018:308). This is in contrast with objectification of meaning and experiences as supported by Heidegger, which believed the researcher cannot remove himself or herself from any lived experiences and that the essence of a lived experience cannot be bracket off (O'Hallora et al 2018:308). The researcher must be aware of his or her own 'personal lens' as not to influence the research findings. The presented phenomena must be that of the participants; their own behaviour and reflections (O'Hallora et al 2018:308).

Descriptive phenomenology use bracketing as to limit any influences around the phenomenon under investigation as to reach full understanding of the essence (O'Hallora et al 2018:308). Bracketing as applied during interpretive phenomenology requires the researcher to be aware and acknowledge influences and understanding of the world and not be set aside (Gregory 2019:3). The descriptive inquiry focus on commonalities and differences in subjective experiences and an important concept is freedom (allowing the research participants to voice their lived experiences in their own views without manipulation and interference) (O'Hallora et al 2018:308). Descriptive studies' primary aim is to describe the phenomenon.

The difference between descriptive and interpretive phenomenology is that during interpretive phenomenology the researcher is aware of his or her own ideas and perceptions but are not required to set them aside, whilst during descriptive phenomenology all preconceived ideas, thoughts and opinions that could possibly interfere with the study must be shed to limit bias (Gregory 2019:3). During descriptive phenomenology, the emphasis is to describe universal essences, view the person as a representative of the world, belief that consciousness is shared between humans, self-reflection and discard of previous knowledge assist in the description of new phenomena

and bracketing ensures a bias free interpretation of the research findings (Sloan & Bowe 2014:1295).

Phenomenological research aims to describe the lived experiences of people with reference to specific phenomena, how these experiences were interpreted and what meaning the experiences held for them (Pilarska 2015:65). The researcher focuses on the individual's life, what was important and what changes needed to be made as explained by the individual (Wilkinson & Hanna 2016:3).

According to Wilkinson and Hanna (2016:3), the basic principle during phenomenological research is that a phenomenon as experienced by lived conditions itself should be investigated rather than trying to break it down into smaller parts. When using a phenomenological research method, the pure essence of individual lived experiences is explored (Wilkinson & Hanna 2016:3).

The purpose of this study will be evident in the phenomenological exploration and description of the perceived lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and adaptation on their return to SA.

Phenomenological research focuses on five aspects (Pilarska 2015:65). The first focus is on the 'eidos' (seeking being) which consists in three dimensions of a phenomenon namely objectivity, subjectivity and horisontal. Objectivity refers to the phenomenon of 'something' or the unknown. Subjectivity refers to the phenomenon for somebody or a person whilst Horisontal refers to the phenomenon, which remains in a relationship with other phenomena. The second focus is on epoché which is phenomenological reduction and include bracketing and exclusion of the researcher's attitudes and beliefs of the world and his or her knowledge about the world (Yüksel & Yildirim 2015:5).
The first and second focus can be linked to this study through the view that the research participants are actively involved in sharing their lived experiences as constructed into reality with no interference or manipulation on the researcher's side. The research participants shared their own positive and negative lived experiences in the KSA and SA (linked to subjectivity) which affected both their personal and work lives (horizontal effect).

Awareness as the third focus of phenomenology will be addressed in the following section.

- *Awareness*

The third focus of phenomenology is on intentionality of awareness. According to Yüksel and Yildirim (2015:5) object of experiences are constantly created by consciousness, thinking requires consciousness and requires objects or events. Intentionality of awareness refers to deliberate action (relationship between the object and consciousness). In this study, the phenomenon was the lived experiences of migration and adaptation of South African expatriate nurses (both in the KSA and upon their return to SA). The act of intentional experiences (both positive and negative experiences described by the research participants) is directly linked to the meaning of the phenomenon.

Phenomenon and meaning as the fourth focus of phenomenology to follow.

- *Phenomenon and meaning*

The fourth focus of phenomenology is on intentional activity and objective meanings that are inseparable, whilst the fifth focus refers to the participant's awareness of him or herself (Pilarska 2015:69). In this study, it fits with the personal and professional development of South African expatriate nurses working and living in the KSA. Meaning as a subjective reality is constructed when the South African expatriate nurses are internally challenged and remodelled on a professional, individual, spiritual or even personal level after migration and adaptation to the KSA and on their return to SA.

Explorative studies are done for investigations with relative unknown areas of research and cannot be generalised to large populations. This design allows for open, inductive and flexible approaches to discover new ideas that can immerge from a phenomenon. The fifth focus is on experience and refers to the assumption made by participants that the world is constructed of intentional existence (Pilarska 2015:69). Phenomenology thinking processes can be linked to a constructivism approach through observation and perception similarities. According to Annansingh and Howell (2016:40), constructivism refers to reality based on shared experiences.

(i) Consciousness

In order to explain a phenomenon, one must understand consciousness as a general principle of phenomenology. Phenomenological researchers believe that consciousness is always intentional (Pilarska 2015:66). Husserl referred to the lived experiences of thoughts, perceptions, memory, emotions and imagination as intentionality, which is direct awareness about an event (Yüksel & Yildirim 2015:7). Consciousness always has a connected meaning, has an object and is directed towards something. It is thus important for the researcher to view the participant in totality and to consider the complexity of his or her personality (Yüksel & Yildirim 2015:7). As applied in this study the researcher was constantly aware of the complexity of the different participants, not to influence their descriptions of events and to appreciate their uniqueness.

(ii) Transcendental phenomena

According to Yüksel and Yildirim (2015:7) transcendental phenomena consists of two dimensions ('Noema' and 'Noesis'). Common themes in phenomenology are called 'Noema' and the different modes of approaching awareness about common themes are called 'Noesis' (Pilarska 2015:66). 'Noema' refers to reflections and perceptions of feelings and thoughts, experience and actions regarding the object. 'Noesis' refers to acts such as feeling, judging, thinking, perceiving or remembering events related to the experience (Yüksel & Yildirim 2015:7). 'Noesis' (act of experience) is directly linked to the meaning of the phenomenon and Noema and Noesis cannot exist independently or studied separately (Yüksel & Yildirim 2015:7). These 'Noema' and 'Noesis' can be accessed through the process of reflection. In this study, the reflections and experiences of South African expatriate nurses who migrated to the KSA and ultimately returned to SA is the 'Noema', whilst their lived experiences (feelings, memories and description of the lived events in the KSA and SA) of migration and adaptation is the 'Noesis'.

(iii) Reality

Previous lived experiences cannot be classified as purely phenomenological: as purely phenomenological experiences are derived from the mental awareness (Pilarska 2015:66). Purely phenomenological events are always grounded within concrete space, time and occurrence. The process of imaginative variation allows the individual to think about infinite possible perspectives in which they can see an object. Descriptive phenomenology reaches the true meaning of the phenomenon through in-depth engagement into reality (Yüksel & Yildirim 2015:7).

(iv) Eidetic reduction

Eidetic reduction or determination of essence occurs during imaginative experiences when the individual looks at variations in concepts, invariant attributes and characteristics that are essential as for the idea to be perceived fully (Yüksel & Yildirim 2015:7). Eidetic reduction reduces experiences to essences. Horisontal understanding of an object implies that full understanding along with all possibilities is given to a single perspective (Pilarska 2015:67). Phenomenological research does not aim to develop theories, but rather provide insight into the phenomenon and bring people closer to the living world (Pilarska 2015:67).

(v) Phenomenology as philosophy

Phenomenology which aims to study lived experiences is thus both a philosophy and an approach. This study followed a phenomenological approach to examine the phenomenon of life-world experiences of migration and adaptation of South African nurses working and living in the KSA and when they returned to SA during Phase 1 of the study. As for a philosophy, Husserl's phenomenology explains the lived experiences as noema or noesis (discussed section 2.3.1 in this Chapter) (O'Hallora, Littlewood, Richardson, Tod & Nesti 2018:309). Phenomenological studies explain human experiences by those specific people involved (Brink, Van der Walt & Van Rensburg 2012:121; Pilarska 2015:66).

General principles related to phenomenology will be discussed in the following section.

General principles of phenomenology

Phenomenology which is rooted in philosophical traditions (developed by Husserl and Heidegger) is described as an approach to thinking about individual life experiences and the essence connected to these experiences (Pilarska 2015:66). Phenomenology studies pure mental phenomenon and consciousness (Pilarska 2015:66). There are many different approaches as to perform phenomenological research (Belousov 2016:24). There are certain positive and negative criteria associated with phenomenological studies.

The positive contributes during phenomenology includes:

- This research method can look at lived experiences at a specific point in time or over an extended time. During this study, the researcher described the lived

experiences of migration and adaptation (of the South African expatriate nurses working and living in the KSA and returning to SA) over an extended period. These expatriate nurses lived and worked in the KSA for a period (for a minimum of two years) and were exposed to different adjustment challenges before returning to SA, where they were exposed to another set of adjustments.

- It helps to understand the individuals' meaning connected to a lived experience. The research participants were asked to describe their lived experiences during unstructured phenomenological interviews whilst the researcher documented these events truthfully and accurately as to ascertain meaning towards it.
- It aids in adjustment during new trends or events. In this study, the researcher aimed to explore and describe the lived experiences of migration and adaptation of South African expatriate nurses working and living in the KSA and when they returned to SA during Phase 1 of the study.
- It assists in the development of new theories. The data gathered during this study will be used to develop and validate guidelines to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation upon their return to SA.
- All data gathered during the research is regarded as natural instead of artificial (Pilarska 2015:66). All data gathered during this study had a personal meaning to the participants as it was their lived experiences.

According to Pilarska (2015:65) the less positive contributes associated with phenomenological research includes:

- The data gathering process is very time and resource consuming. The researcher was the primary instrument in data collection and conducted all the interviews herself. In this study, the data gathering process was managed through planning and scheduling all unstructured phenomenological interviews according to the participant's availability. The researcher managed to schedule these interviews during lunch breaks or after hours over weekends.
- Data analysis and interpretation of the lived experience explanation can be challenging. The view and experience (of migration and adaptation) of the participants returning to SA after working and living in the KSA is all individual based. To translate these meanings as explained by the participants into words as to attach meaning towards it was managed by the researcher by active listening to the discussions whilst recording it and making notes (field notes) on which

statements needed clarification. Data analysis in this study was done according to Colaizzi (Ojala et al 2015:365) as explained later in Chapter 2. Both *Interpretivism* and *Objectivism* is in contrast with the constructivists (which view the research participant inseparable from the researcher and aiming to ascribe meaning towards feelings and experiences) and not purely studying objects from a subjective view (Pilarska 2015:65).

- Policy makers tend to give low credibility to phenomenological research. During this study, this view was managed by keeping an audit trail and to give an accurate and clear description of the participants' lived experiences.

The negative aspects included during this phenomenological study were the time spent during data collection and analysis. As mentioned earlier in this Chapter, the researcher was the primary source of data collection and totally dependent on the research participants' time schedules for interviews. The researcher had to remain neutral during data collection and analysis and had to interpret subjective data, which constructed the research participants' worldview into reality, which could be applicable to other individuals when exposed to similar conditions.

Critique against phenomenology to follow in the next section.

- *Critique against phenomenology*

According to Englander (2016:1), the phenomenological philosophy was once referred to as phenomenological psychology and the connection between philosophy and psychology is open to debate. Psychology could not fill the specifications required in fundamental concepts clarification. Englander (2016:320) also states "Through the phenomenological-psychological reduction, we abandon our common sense understanding of reality as consisting of objects and their causal underpinnings and adopt an appreciation of reality as consisting of the acts of experiencing itself". Other researchers might question the true and accurate reflections of the researcher, as they were not the ones living the experience.

As already discussed earlier in this Chapter, there are disagreement in the literature regarding the sample size (Teodoro, Rebouças, Thorne, Souza, Brito & Alencar 2018:5) and the use of a theoretical framework (discussed under section 2.2.1 in this Chapter) which deviates from 'standard' research practices. In this study, the researcher aimed to

perform enough unstructured phenomenological interviews until no new data emerged which indicated data saturation. The information gathered by the participants was used as foundation for this study and confirmed by a literature control as to keep the true and accurate essence of phenomenological studies.

The research methodology will be addressed in the section following.

1.10 RESEARCH METHODOLOGY

The research methodology pertains to the research design and methods. Research methodology, according to Bashir et al (2017:37), refers to systematic and theoretical methods applied in research, consists of principles associated with knowledge and underline concepts such as models, paradigms quantitative or qualitative techniques.

1.10.1 Qualitative design

Qualitative methods focus on the gathering of information through discoveries based on questions in natural conditions (Park & Park 2016:2). Table 1.1 below will provide an overview of the main differences between qualitative and quantitative studies. The aspects covered under qualitative methods (Table 1.1) substantiate the reason why the researcher chose the qualitative research approach.

Table 1.1: Differences between the main characteristics of the qualitative and quantitative research approach

Criteria	Quantitative methods	Qualitative methods
Focus	Objective	Subjective
Role of the researcher	Researcher is independent of research	Researcher interacts with research/essential tool or instrument

Adapted from (Park & Park 2016:4)

Qualitative research explores phenomena in a natural setting (Park & Park 2016:3). During unstructured phenomenological interviews phenomena experienced and the meaning that people attach to it, in their own words and understanding is interpreted (McCusker & Gunaydin 2015:537). In this study, the accurate and personal voices of the participants have been captured by means of verbatim quotes, using the participants' own words as to attach meaning and understanding to their lived experiences. The researcher

will attempt to make sense of these perceived lived experiences through a phenomenological approach.

There are certain distinctive features associated with qualitative research as explained by Park and Park (2016:3):

- Qualitative research focuses and emphasises a phenomenon in own right rather than applying outsider perspectives to it. There is no single reality, but rather an absence of truth. In this study, the researcher focussed on the description of the essence of the phenomenon of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and returned to SA.
- **Importance of context:** the use of open exploratory questions allows for in-depth investigation and description of the phenomenon. Reality is based on research participant' perceptions. In this study, the researcher applied unstructured phenomenological interviews to collect data as to receive true and accurate versions on lived experiences (in reference to nurse migration and adaptation to and from the KSA and upon returning to SA) from the participants themselves.
- **Importance of meaning:** words and meanings as provided by the research participants' forms the unit for analysis with an in-depth and holistic approach to describe the phenomenon. Descriptions of lived experiences (referring to migration and adaptation) as voiced by the research participants (South African expatriate nurses) during the unstructured phenomenological interviews formed the basis of this study.
- **Researcher-participant-relationship:** in contrast with quantitative research or prescribed rating scales, this research method allows for unlimited description options. The researcher builds rapport with the research participants as to receive a true and accurate description of their lived experiences with migration and adaptation to the KSA and upon their return to SA.
- **Researcher as instrument:** the focus is on discovery rather than proof. The researcher seeks to gain comprehensive understanding of activities related to behaviour. In this study, the researcher aimed to stray away from bias, to actively listen to the participants and to transcribe their voices and opinions as accurately as possible. The focus during Phase 1, with the unstructured phenomenological interviews, was to explore and describe the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA

and upon their return to SA. The researcher ensured that open-ended questions were asked during probing to provide data with depth.

- **Researcher skill set:** special strategies are applied to enhance the credibility of the research design and analysis. The researcher needs good communication and listening skills as to establish rapport with the research participants (gain trust as to allow for open description of lived experiences).
- **Analysis and inductive approach:** in this study, analytical approach of data following inductive approach and reasoning as to give order, structure and meaning to the content (data gathered during the unstructured phenomenological interviews). The data from Phase 1 was analysed (following Colaizzi's approach discussed later in this Chapter, section 2.2.5) by reading and re-reading the content and identifying emerging themes and sub-themes.
- **Flexibility of emergent research design:** in this study a descriptive phenomenological design was followed, data collection and analysis were used as basis for the validation of data (during guideline validation process and discussed in Chapter 4 of this study).
- The research methodology will include the setting, research design, sampling methods and data collection process. In this Chapter, the research design and settings will be addressed. The sampling methods (convenient combined with purposive sampling techniques) and data collection process for Phase 2 (development of guidelines) and Phase 3 (3A and 3B) (validation of guidelines) of this study will be discussed in Chapters 3 and 5. This study followed a qualitative approach with a descriptive phenomenological design.

1.10.2 Contextual design

Contextual design as per Löffler, Wallmann-Sperlich, Wan, Knött, Vogel and Hurtienne (2015:31) involves collecting real-world data (through interviews) and observations. In this study (Phase 1), the researcher collected primary data by means of unstructured phenomenological interviews and kept field notes (observation) during these interviews.

In this study, the researcher had close and direct interaction through unstructured phenomenological interviews with all the participants in a natural, safe and free of interruptions setting as to explore and describe the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA before returning to SA. From this data collected through unstructured phenomenological

interviews, the essence of the study was captured and explained in detail in Chapter 2. The findings of this study as performed during a phenomenological analysis provided insight into the South African expatriate nurses experiences when adapting to the KSA environment, as well as re-adjustment back to the SA environment.

- *Descriptive phenomenological design*

According to Padilla-Díaz (2015:102) qualitative studies have a phenomenological aspect to it, but a phenomenological approach does not apply to all qualitative research. The assumptions of the descriptive phenomenological approach will be discussed next:

- During descriptive phenomenology, the researcher must shed all previous personal knowledge about the lived experience being studied to grasp the true essence of those participants in the study (Belousov 2016:23). The exclusion of the world perceived is a prerequisite during logical investigations in phenomenology but will have no effect on consciousness (Belousov 2016:24). Husserl referred to the term 'natural world', which include a world in existence and doesn't require any theoretical position; thus, is the world not a mere object or the totality of all existence, but the world in which one live in (Belousov 2016:24). According to Belousov (2016:14) Husserl did not identify the natural world with any outside world as quoted from his work (1913): *"…for I perceive myself in the natural experience of life in the world, along with my consciousness as a person who belongs to this world and is, in a certain way, localised within it"*.
- According to Parvan, Shahbazi, Ebrahimi, Valizadeh, Rahmani, Tabrizi and Esmaili (2018:42), Spielberg (2009) advocates a direct investigation of phenomena as experienced by the person and without preconceptions and presuppositions, the true essence of the world can be discovered. Parvan et al (2018:42) stated that Spielberg's focus remained on subjective processes of thinking, not facts but rather phenomena, describing things as how they appear in one's perception.
- Spielberg's phenomenological method describes some steps or operations to be followed. These steps (bracketing, intuiting, analysing and communication of findings) serve as inspiration and only give direction towards the themes or lived experiences of phenomenology (Belousov 2016:24).

According to Pilarska (2015:71) research on social reality is based on a phenomenological approach when the following aspects apply:

- Examination of the everyday life and the horisons of how individuals understand the world they live in.
- Experience the process of being shaped through linguistic expressions.
- Differentiation and examination between phenomena for similarities or contradictions.
- Comparison of phenomena with similar occurrence.
- Relating phenomena to local, cultural, or psychological conditions.
- Applying distinctive features to phenomenological descriptions.
- Consideration of the phenomenon and the descriptions with reference to the cause, interactions and findings.

In this study, research participants could share their personal lived experiences (by means of unstructured phenomenological interviews) without influence by the researcher through the application of bracketing (reflective journal was kept by the researcher, see Annexure K).

Descriptive phenomenology refers to the study of personal experience, describing it as to allow for meaning of experiences by participants (Padilla-Díaz 2015:103). In this study, a descriptive phenomenological approach was used to allow for true, accurate and personal descriptions of lived experiences from participants, which allowed for extraction of essence of meaning connected to these lived experiences. During each Phase of this study, a different research design and method were used which will be discussed in separate Chapters to follow.

- *Epoché*

Epoché involves shedding all pre-existing knowledge, shedding ideas or experiences, shared information, getting rid of judgment and ideas about the research topic through e.g. bracketing (Yüksel & Yildirim 2015:5). Discovering of new emerging themes and data occurs rather than confirming already known hypothesis (Yüksel & Yildirim 2015:7). The first Phase of epoché (suspension of all pre-conceived ideas applied during qualitative studies; and more specific phenomenology) creates a shift between the theoretical world and the everyday life in which one function within a natural setting (Pilarska 2015:70). The second Phase refers to phenomenological reduction where there is a shift from the natural setting towards a phenomenological approach. During this Phase there is no reference to the theoretical world or the daily life world and all seems to be suspended.

The researcher is an active research instrument on the search for new and emerging meanings derived from lived experiences. During this Phase (or approach), the researcher is allowed to gain insight into a phenomenon as well as its horisons with time and perspectives which can allow eidetic reduction (Pilarska 2015:70). The third Phase of epoché allows for the essence of the phenomenon to be disclosed. The fourth Phase of epoché is born from phenomenological reduction (Pilarska 2015:70). During phenomenological reduction individual experiences are described through textual language (Yüksel & Yildirim 2015:7).

The researcher must hold back or bracket all basic ideas about the nature of the concepts for the emerging of the essence. The focus should be on the fundamental belief in existence and how the individual experienced a phenomenon in their consciousness (Doyon 2015:123). Epoché consists of four dimensions and include reduction of the known theoretical world, the world one live in daily, the phenomenological attitude as well as inspection between transcendent subjectivity and the essence of existence (Pilarska 2015:69).

- *Bracketing*

Bracketing is a process where the researcher needs to be free of any bias or trying to control the results (Yüksel & Yildirim 2015:3). A literature review can give the researcher more ideas to bracket any pre-conceived ideas about the research topic. In this study, the researcher applied bracketing by keeping a reflective journal and reflective notes to limit bias. Descriptions of beliefs about the research topic can be written down and explored separately. According to Yüksel and Yildirim (2015:14) Husserl' phenomenology bracketing gives validity to the person's lived and real experiences. The application of bracketing as applied during Phase 1 of this study will be addressed in Chapter 2.

According to Yüksel and Yildirim (2015:10) there are certain qualities present in the researcher who applies bracketing and these include:

- The researcher to be *reflective and self-aware* of his or her values and how these could impact on the study. During this study, the researcher had to apply bracketing as to prevent bias and personal influences to interfere with the data. This was done by the researcher constantly being aware of her possible bias and influence on the research, keeping to the planned methodology and ethics of the

research, she kept field notes (included in the data or findings) and a reflective journal (not included in the data or findings).

- For the researcher to fully understand the participant's explanations he or she must remain *curious* about the phenomenon. During this study, the researcher was curious to discover the lived experiences (both positive and negative) from South African expatriate nurses who lived and worked in the KSA and their adaptation and re-adjustment (work and personal life) upon their return to SA.
- *Precise explanations* of events must be used. During this study, the researcher used and applied the explanations given by the participants without editing or changes made.
- Findings must be re-checked by the supervisor has to *remain insightful.* All the research findings were submitted to the supervisor for confirmation.
- The researcher must be *willing to accept wrong or unclear entries* and to refer back to the participants. The researcher maintained an open and honest relationship with all the participants as there were shared commonalities – to understand and give meaning to their lived experiences both in the KSA and SA.
- The researcher must *remain open* to alternative ideas which aid in insightfulness during the data collection process. In this study, the researcher kept field notes on observations made during Phase 1 of this study, or non-verbal communication observed. Data from the field notes has been incorporated in the data analysis process – discussion later in this Chapter. Inductive reasoning was applied during the development of the guidelines.
- The researcher must *organise data collection and data analysis to ensure a well-structured study.* During this study, the researcher kept to the unstructured phenomenological interview schedules, worked diligently on all data collection and analysis as to deliver an organised and structured study.
- The trustworthiness criteria *honesty and transparency* must always be adhered to. The researcher kept all documents and recordings for an audit trail (see section 2.12 for detailed descriptions).

- *Transcendental subjectivity*

Some researchers advocate not performing a comprehensive literature review prior to initiation of the study to achieve transcendental subjectivity (Padilla-Díaz 2015:102). Transcendental subjectivity is explained by Husserl (2001) as a conscious condition where the researcher can successfully abandon his or her own lived reality or experiences

and describe the phenomenon: *"...in its pure, universal sense"* (Padilla-Díaz 2015:102). In this study transcendental subjectivity has been achieved by the researcher not performing a literature review prior to commencement of the research as to achieve the true and accurate essence of findings as voiced by the research participants during Phase 1.

This method is used to understand the complex uniqueness of human beings, describe and investigate all phenomena in the way that it appeared. There are four aspects of lived experiences of interest to the phenomenologist and include: spatiality, lived body, lived time and lived human relations (Padilla-Díaz 2015:103).

Phenomenology assumes that the essence of human experiences can be understood as it is lived and the truth about reality is grounded within these experiences (Padilla-Díaz 2015:103). It focuses on the meaning attached to the lived experience of the phenomenon (Padilla-Díaz 2015:103). In this study, phenomenology was used during Phase 1 to explore and describe the participants' lived experiences of migration and adaptation when working and living in the KSA and adaptation upon returning to SA.

This information will be used to reach the first two objectives of this study to:

- Explore and describe the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA.
- Explore and describe the lived experiences of adaptation of South African expatriate nurses when they returned to SA.

According to Padilla-Díaz (2015:103), the researcher can only explore the deeper experiences of people through a phenomenological approach. The researcher will aim to gain a better understanding of an issue from the participants' perspective of their social realities in order to understand their lived experiences. Once a truly deeper meaning and understanding is reached, the researcher can attempt to describe the phenomenon (Padilla-Díaz 2015:103).

Phenomenology which is rooted in philosophical traditions (developed by Husserl and Heidegger) is described as an approach to thinking about individual life experiences and the essence connected to these experiences (Doyon 2015:124). All data gathered during phenomenological research are not limited to objective empirical data or observable facts,

but rather factual reflections from participants. One concern of phenomenological research is the ability of the researcher to understand the cognitive subjective views of the individual who has lived the experiences as well as the effect of the lived experiences on the behaviour of the individual (Doyon 2015:124).

- *Intuiting*

Intuiting occur where the researcher becomes absorbed into the phenomenon. According to Padilla-Díaz (2015:107) intuiting involves viewing different horisons, which are unlimited: *"...we can never exhaust completely our experience of things no matter how many times we reconsider them or view them"*. More descriptions applicable to Phase 1 will follow in Chapter 2.

- *Analysing*

Analysing occurs when the researcher contrasts the descriptions of the phenomenon (Padilla-Díaz 2015:106). Identification of recurrent themes as well as their inter-relationship must be analysed. An overview of the data analysis process for Phase 1, according to a phenomenological approach will follow in Chapter 2.

- *Communication of findings*

Communication of findings can also refer to dissemination of findings through publications and conference presentations. In this study, communication of findings will involve publications of findings in accredited national and international journals and presentation of findings at national and international conferences.

Table 1.2: Overview of methodological design and methods used during Phases

	Research questions	Objectives	Design	Method	Population	Sampling	Data collection	Data analysis
Phase 1	What are the experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA? What are the experiences of adaptation by South African expatriate nurses when they return to the SA living and workforce after working and living in the KSA?	To explore, describe and interpret the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA. To explore, describe and interpret the lived experiences of adaptation and adjustment of South African expatriate nurses when they returned to SA.	Qualitative approach	Descriptive phenomenology	The target population of Phase 1 was the South African expatriate nurses who migrated to work and live in the KSA, completed their contracts in the KSA and returned to SA. The accessible population were those South African expatriate nurses who lived and worked in the KSA and returned to SA to reside in the Western Cape region as it is accessible to the researcher.	Non-probability, convenient; purposive and snowball sampling techniques.	Unstructured phenomenological interviews and field notes.	Colaizzi method

Phase 2 (consisted of 6 Steps): **Step 1:** Inductive and deductive reasoning **Step 2:** Extraction of essence and constituents **Step 3:** Vote, rank and prioritise draft guidelines **Step 4:** Draft guideline development with AGREE II instrument domains **Step 5:** Refinement of guidelines through validation with an e-Delphi technique **Step 6:** Modification and finalising of guidelines in response to expert	What guidelines could be developed to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?	To develop guidelines to facilitate South African expatriate nurses' migration and adaptation to the KSA and adaptation upon their return to SA.		Descriptive phenomenology with AGREE II instrument and NGT	NGT – consists of seven experts sampled from education institutions in SA, who had vast knowledge or personal experience with South African nurse migration and adaptation.	Non-probability: convenient and purposive sampling techniques.	Researcher used data collected during Phase 1 and a literature control to draft guidelines. NGT – to prioritise draft guidelines, to reach consensus on draft guidelines.	NGT used to rank, vote and prioritise draft guidelines.

feedback from the e-Delphi rounds								
Phase 3 **Phase 3A:** Population included nurse managers or educators **Phase 3B:** Stakeholder discussion with SANC and recruitment agency representatives for consensus	How can guidelines be validated to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?	**Phase 3A:** To validate guidelines to facilitate South African expatriate nurses' migration and adaptation to the KSA and adaptation upon their return to South Africa **Phase 3B:** Stakeholder discussion/ consensus		Descriptive phenomenology with AGREE II instrument and e-Delphi technique (Phase 3A and 3B).	Modified e-Delphi consists of 10 participants. Accessible population: expert South African nurse educators and managers either residing in SA or the KSA. Stakeholder involvement included SANC: (1) and international recruitment agency representatives; (2) Target population: returning and prospective South African expatriate nurses, recruitment agencies, SANC.	Non-probability: convenient and purposive sampling techniques (Step 3A and 3B).	e-Delphi technique used with the AGREE tool as validation instrument. Data on refinement of the guidelines. Phase 3A validation of guidelines and Phase 3B stakeholder discussion/consensus.	Two-rounds of e-Delphi used to refine and validate guidelines – (Phase 3A and 3B link to Step 5 of the guideline development process).

Research design is a detailed outline and description of how the research will take place and include how data will be collected, instruments that will be used and the data analysis process (Bashir et al 2017:37). Research approaches are determinants, which give direction towards a study, guide the design to be followed and the data analysis methods (Bashir et al 2017:34). According to Park and Park (2016:2), the debate regarding the correct social research methodology with reference to quantitative or qualitative designs (or approaches) continues to cause controversy. The two main ways of data collection and analysis is either by quantitative or qualitative methods (Park & Park 2016:2).

This study followed a qualitative approach with a descriptive phenomenological design as it was appropriate to explore and describe the lived experiences of South African expatriate nurses who migrated to the KSA and ultimately returned to SA. A qualitative approach was chosen as the researcher strived to have an in-depth understanding into the phenomenon (lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and returned to SA).

1.10.3 Research Phases

The different Phases in which this study has been conducted will be addressed in the sections following.

1.10.4 Phase 1: Empirical Phase for exploration and description of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the Kingdom of Saudi Arabia (KSA) and adaptation upon their return to South Africa (SA) (Chapter 2)

A qualitative, descriptive, phenomenological and contextual design was applied in Phase 1 to address objective 1 and 2 of this study. Prior to commencement of this study's data collection, ethical approval was granted by the Research Ethics Committee of the Department of Health Studies, UNISA (HSHDC/268/2013) which can be viewed as Annexure A; as well as informed consent (Annexure C) from all participants during each Phase of this study. Refer to Table 1.1 for more detail applied during Phase 1.

(i) Population

According to Harriss and Atkinson (2016:1), population refers to all the participants involved in the research and target population all the participants meeting the criteria to be included in the research. This will be addressed in detail in Chapter 2 (heading 2.1).

(ii) Sample and sampling

The names of South African expatriate nurses who lived and worked in the KSA, who completed their contracts in the KSA and returned to SA were identified from a list provided from the recruitment agency after the permission from potential participants were obtained. A full description of this process is discussed Chapter 2, heading 2.1 (sample and sampling).

As per Etikan, Alkassim and Abubakar (2016:55) probability sampling calculates the probability of participant selection and every participant having equal opportunities of being selected in a study. Non-probability sampling techniques allow the researcher to subjectively select participants representative of the population and applicable to the study (Etikan et al 2016:55). In this study, the researcher used non-probability sampling as the participants were selected based on their previous lived experiences on migration to the KSA and adaptation upon their return to SA.

Convenience sampling as per Etikan et al (2016:56) refers to non-probability sampling where participants from the target population meets the inclusion criteria, are easily accessible within a geographical proximity, shows availability and willingness to partake in the study. Purposive, convenience and snowball sampling were applied. Most often during phenomenological research purposive sampling is used (Yüksel & Yıldırım 2015:9). Purposive sampling does not only depend on participants' availability or willingness to participate in the research, but they are typical cases of the population selected (Yüksel & Yıldırım 2015:9).

(iii) Sampling criteria

Sampling criteria (inclusion criteria) included South African expatriate nurses who lived and worked in the KSA for a period equal or longer than two years (completion of at least one contract) before returning to SA, and nurses aged above 30 years with no constrictions on time spent back in SA. More descriptions will follow in Chapter 2, heading 2.1 (sampling criteria). The time frame for data collection in this study was during the period April 2016 to August 2017. Data collection was done by means of nine

unstructured phenomenological interviews, which continued until data saturation occurred. More detail is discussed in Chapter 2. All central questions were asked during these interviews (view Annexure G for the interview guide).

(iv) Research setting

In this study, there has been two research settings namely the KSA and SA. An overview of KSA to follow below:

- *Overview of the Kingdom of Saudi Arabia (KSA)*

The KSA is regarded as one of the largest countries in the Middle East with a surface area of 2.24 million km² which covers about 80% of the Arabian Peninsula and has one of the largest oil reserves in the world (Azeem & Altalhi 2015:191). The KSA had a population of 24 573 000 during 2010 (Alrashidi & Phan 2015:32) and 29 994 272 during 2014 (with 9 723 214 expatriates) (Alrashidi & Phan 2015:33).

The KSA can be regarded as the home of Islam (Alrashidi & Phan 2015:33). The Holy Quran and "Sunna" (life ways of the prophet Mohammed) are the ethos in the Kingdom (Alrashidi & Phan 2015:33). There are approximately 1.3 billion Muslims around the world with approaches varying from very extreme to quite liberal and it is estimated that 85% resides in the KSA. The population of the KSA comprises mostly of urban Muslims, smaller nomadic groups known as Bedouin tribes and host 5.6 million foreign residents (Alrashidi & Phan 2015:33).

Within the KSA, there are very diverse opinions about the supremacy of Islam as religion, traditional practices based on religion and the view of women, which is in contrast with the Western views most of the emigrating South African nurses have. The role of women in the KSA is seen as modest, subservient to the man, have limited rights of freedom, are not allowed to drive their own vehicle or travel unaccompanied by a husband or family member, have limited or no speech, voting and opinion rights (Azeem & Altalhi 2015:191). The KSA is divided into 18 health regions and is accountable to the Minister of Health (Alrashidi & Phan 2015:33). Hospitals are managed under strict Islamic codes (Saudi Arabia.com:ND).

Female Saudi trained nurses can work in certain healthcare institutions, both public and private settings. According to strict Sharia laws, females are not allowed to work with men and therefore the larger number of trained male nurses in the KSA (Azeem & Altalhi 2015:191). It can also be argued that there is constant family-work-life interference when employed in a full-time position. Family roles, social expectations, work culture and policies play a direct role on the work performance of nurses in the KSA (Azeem & Altalhi 2015:193). When a young female Saudi nurse decides to get married, the husband will give permission for her to either continue working or to become a housewife.

When comparing the KSA with SA, some factors that are vast in differences include: the geographical layout; climate variants and travel opportunities; language and communication; healthcare systems; border security; defence, housing accommodation and currency, laws and political control, religious practices; traditions, image of women; and education and training. A comparison between the mentioned criteria can be viewed as Annexure B. Proper orientation (including cultural differences, religious traditions and language) is needed for all prospective South African expatriate nurses to adapt to the KSA environment, as well as upon their return to SA.

The research setting refers to the cultural, physical or social site in which the research is being conducted (SAGE 2018:NP). The research setting (where data collection took place, Phase 1 of this study) was SA as discussed earlier in this Chapter. The next section will provide an overview of SA.

- *Overview of South Africa (SA)*

South Africa is marked by diversity and is known as the rainbow nation (Ferguson & Adams 2015:1). This diversity includes eleven official languages, animal and plant life, landscape as well as natural resources. Within this multi-ethnic nation 79.5% is from African decent, Whites 9%, Asian/Indian 2.5%, and Coloured 9% (Statistics South Africa 2016:NP). Within SA there are 80% Christians, 2% Hindu, less than 2% Muslims and the remaining adhere to "traditional indigenous beliefs" (Statistics South Africa 2016:NP). Despite the end of Apartheid, half of the population still lives below the poverty line and one quarter of all inhabitants are unemployed (Koot, Hitchcock & Gressier 2019:346).

It is important to contrast the difference between SA (Western paradigm) and the KSA (Eastern paradigm) to understand the different cultural environments in which the

expatriate nurses will be functioning when they choose to leave their country of origin for employment in the KSA. The Eastern paradigm as indicated by Mark (2016:NP) focus on general holistic knowledge of the being whilst the Western paradigm is concerned with specific fragmented knowledge on human conditions.

Immigration to SA has always been an important component of its demographics. During the period 1965 to 1975 a total of 300 000 immigrants arrived from Europe, with 70 000 Whites from other African countries. During 1975 to 1985 immigration continued with 4% of the annual population growth. After 1990 immigration has declined but there was a rise in emigration due to political changes, worsening employment situations and national economy and security changes (Labonté et al 2015:2). According to De Haas et al (2019:886), more than 13% of SA's total population immigrated over the past 10 years.

Providing healthcare to the rural populations remains a challenge (Labonté et al 2015:5). Resource imbalance, human resource distribution inequities, the burden of infectious and non-communicable diseases and the migration of healthcare workers limit the achievement of Primary Healthcare (PHC) services in SA (WHO 2018:NP). Although the country is faced with several healthcare problems, it has internationally renowned health professionals (WHO 2018:NP). South Africa could be an attractive destination for skilled labour as well as a constant source of skilled workers for the world health care market (Labonté et al 2015:2).

South Africa is plagued by various infectious and non-communicable diseases including Tuberculosis (TB) (119 901 new TB cases documented 2012/13), Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (Abraham & Nosa 2018:33; WHO 2018:NP). Challenges in the South African healthcare systems include addressing social disparities, to empower and strengthen the current systems and to establish access and coverage for all inhabitants (Abraham & Nosa 2018:33). Health in SA is affected by the lack of basic needs including: adequate nutrition, clean water and sanitation facilities, poor housing conditions, schooling and unemployment (Abraham & Nosa 2018:33).

The national public health sector remains to be provider for healthcare for more than 40 million people, which constitute to 84% of the national population. State hospitals are in a crisis with infrastructures that are run down, dysfunctional and mismanaged (Labonté

et al 2015:5). Although the nurse population has grown, shortage of nurse educators and a decline in training opportunities resulted due to increase emigration patterns. The available nurses are still not adequate to provide for the health needs of the growing population (Labonté et al 2015:5). Community health worker programs have been implemented to improve the access to health care especially in the rural areas (Caporale & Gil-Alana 2018:80).

Nurses are expected to work additional hours, with limited stock or equipment and care for patients with a variety of diseases at a low salary (Caporale & Gil-Alana 2018:80). Unfavourable working conditions leads to stress, which can affect the nurses' physical, emotional and psychological wellbeing, which can ultimately influence patient care. Returning South African expatriate nurses (due to poor migration preparation and support) find it difficult to adapt back into the South African environment after working and living in KSA.

- *South African healthcare systems and disease profile*

South Africa has an estimated population of 58.5 million people, the age, gender and density structure varies dramatically across the different provinces (Ferguson & Adams 2015:3). Only 16.9% of inhabitants belong to a medical aid scheme (Labonté et al 2015:2). There has been a shift in approach from centralisation towards a district approach with the focus on primary health care. The number of general practitioners has increased since post-Apartheid when the focus moved to primary health care, at the cost of specialists (Labonté et al 2015:2).

District health expenditure has increased over the last eight years from R659 to R1327 per capita in 2012/13 (WHO 2018:NP). Primary health care expenditure also increased from R324 to R780 (per capita) over the same period. The delivery rates in women younger than 18 years have decreased from 9.2% to 7.7% during 2013, but acute malnutrition in children below five years is still 4.3 cases per 1000 children (WHO 2018:NP). Due to SA's vast geographical outlay, the government still struggles to control diseases such as HIV/AIDS, TB, high maternal and infant mortality rates, a series of communicable diseases and violence (NHI SA 2014:8; Ladum & Burkholder 2019:30). Although the government has increased the amount of condom distribution during 2013 to 387 million, there is an increase of 33% in individuals on ART (2 161 170 during

2012/13) (Smith, Sharma, Levin, Baeten, Van Rooyen, Celum, Hallett & Barnabas 2015:e160).

The WHO (2018) made recommendations (during 2014/15) regarding the minimum standards of 228 healthcare workers (physicians and nurses) for every 100 000 people (or 438 people per healthcare worker) (WHO 2018:NP). SA is just above the minimum recommendations made by the WHO with 468 healthcare workers for 100 000 people (WHO 2018:NP). The recommended nurse-patient ratio is 200:100 000 (500 people per healthcare worker).

It is unfortunate that the number of nurses and physicians are growing slower than the increasing population. Human resources are distributed unevenly between the private and public sectors, as well as urban and rural areas with 81% of nurses working in urban regions (which is populated by 54.5% of the population) (Labonté et al 2015:10). The burden of nurse shortages in SA will increase when nurses who are working in rural areas (unsatisfactory working conditions - push factors towards migration) decide to migrate to other countries like KSA, which will offer them better benefits (pull factors towards migration). SA's inhabitants' unhealthy lifestyle and increase in non-communicable diseases place a burden on the healthcare system and could be a push factor that motivates nurses to leave their country of origin and push them to work in the KSA.

(v) Data analysis

Data analysis was done by a phenomenological design (as explained by Colaizzi, 1978), by reading and re-reading the content of the interviews (discussed in detail in Chapter 2, heading 2.1).

1.10.5 Phase 2: The development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses working and living in the Kingdom of Saudi Arabia (KSA) and adaptation when they returned to South Africa (KSA) (Chapters 3 and 4).

Data from Phase 1 was used in Phase 2 to address objective 3 of this study, to develop draft guidelines to facilitate migration and adaptation of South African expatriate nurses who lived and worked in the KSA and adaptation upon their return to SA. Draft guidelines were developed by the researcher based on findings from Phase 1, a literature control

and the AGREE (Appraisal of Guidelines for Research and Evaluation) (2017:NP) tool that described how the draft guidelines were developed from the empirical findings and literature review on concepts and existing guidelines as guided by the AGREE (2017:NP) tool. The Nominal Group Technique (NGT) (including population, sampling, data collection and analysis) during this Phase was used to refine, prioritise and reach consensus on the content of the draft guidelines (discussion Chapter 3). Prior to commencement of the NGT informed, consent was obtained by all participants.

The draft guidelines can be viewed in Chapter 4 (Table 4.1).

The Steps followed during the guideline development process are described in Chapter 3 and included:

- Step 1: The researcher applied inductive and deductive reasoning to create a conceptual map portraying the research findings (Chapter 2, Figure 2.1).
- Step 2: The essence and the constituents (Chapter 3, Table 3.2) were extracted from the conceptual map (Chapter 2, Figure 2.1).
- Step 3: The NGT – vote, rank and prioritise draft guidelines.
- Step 4: Application of the AGREE ll tool to develop draft guidelines (second draft).
- Step 5: Refinement of guidelines through validation with an e-Delphi technique.
- Step 6: Modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds.

A detailed description of the guideline development process with the drafted guidelines will follow in Chapters 3 and 4.

1.10.6 Phase 3 (3A and 3B): Refinement and validation of guidelines

Phase 3 of this study was divided into Phase 3A (e-Delphi technique) and Step 3B (Stakeholder discussion/consensus). The draft guidelines generated during Phase 2 of the study resulted in five guidelines that was refined and validated during Phase 3A (discussed in Chapter 5) with an e-Delphi technique (with the AGREE tool). Phase 3 was divided into Phase 3A (validation of guidelines using the e-Delphi technique) and Phase 3B (Stakeholder discussion/consensus). During Phase 3A the AGREE ll tool was used with the e-Delphi technique as validation method. Non-probability sampling, purposive

and convenient sampling were applied to identify experts in the field of nursing with the focus on migration and adaptation to the KSA and all seven participants sampled agreed to partake in this study. During Phase 3B stakeholders were involved through a discussion to reach consensus on the guidelines and consisted of SANC and international recruitment agency representatives. The same e-Delphi process used during Phase 3A was followed. A description of the accessible population will be addressed in Chapter 5. The inclusion criteria will also be discussed in Chapter 5. All potential participants were contacted by email and the research aim and objective explained.

Prior to commencement of Phase 3 (3A and 3B), informed consent was obtained from all participants. A return email was received from the participants indicating their willingness to participate in this study and an informed consent form was forward for completion and return to the researcher (Annexure H). An e-Delphi technique was used (during Phase 3A) and two rounds of the AGREE tool was distributed via email. A questionnaire was used based on the AGREE tool to collect data (Annexure I) during the validation process. The AGREE ll was used during the e-Delphi process as validation tool. During Phase 2 of this study the NGT was used as consensus method and during Phase 3A the e-Delphi as validation method. The researcher measured the validation of the e-Delphi similar to the NGT consensus calculation as described in Chapter 4. During Phase 3B (Stakeholder involvement) consensus was reached as all three participants agreed with the validated guidelines (based on Phase 3A) with expert participation, using the e-Delphi technique. Consensus was reached (81% as discussed in Chapter 5) after the second round of the e-Delphi and the guidelines were finalised, refined and validated. More details on the process of data collection and analysis will follow in Chapter 5.

The following section will give an overview on the scope and limitations of this study and a detailed description will be addressed in Chapter 6.

1.11 SCOPE AND LIMITATIONS

The scope of this study (micro level) was to gather data using unstructured phenomenological interviews from participants (South African expatriate nurses) who worked and lived in the KSA and ultimately returned to SA; to use this data to draft and validate guidelines to support the migration and adaptation process. These guidelines can be used by returning or prospective expats and international recruitment agencies to

facilitate South African expatriate nurse migration to the KSA and adaptation support upon their return to SA (macro level).

This study only focused on South African nurses' challenges and experiences when migrating to work and live in the KSA as well as their adaptation upon their return to SA and did not include other foreign countries for comparison.

During this study, although in line with phenomenology, the sample size was small and is open to critique. The research participants all resided in the Western Cape region of SA and other provinces were not included for comparison. The rationale for this is that the Western Cape was accessible to the researcher.

The following section will give a brief overview of the ethical considerations as applied in this study and full descriptions will be provided in Chapter 2.

1.12 ETHICAL CONSIDERATIONS

The ethical considerations in this study are based on an extraction from the Bill of Rights (South Africa) as described in Chapter 2 of the Constitution and include the following topics: bodily and psychological protection, dignity, environment, freedom and security, freedom of belief and opinion, freedom of expression, privacy, protection, promotion and fulfilment (ANC African National Congress 2018:NP). Table 1.3 will provide an overview of the ethical considerations adhered to in this study and a full description will follow in Chapter 2. The ethical principles to be adhered to while conducting research includes: autonomy; justice; beneficence; and non-maleficence as to increase research validity and limit bias (Harriss & Atkinson 2015:2).

Ethical approval has been obtained from the Higher Degrees Committee, Department of Health Studies at UNISA (HSHDC/268/2013) (Annexure A). Site permission and informed consent from all participants were obtained (Annexure C), as well as informed consent for both Nominal group and e-Delphi technique (Annexures E, F and H).

Table 1.3: Ethical considerations and principles as applied in this study

Ethical principle	Theme extraction from Bill of Rights Charter (ANC Congress 2018)	Application in this study
Autonomy: Refers to informed consent, protection of personal information and confidentiality (Sellars & Wassif 2019:178).	Bodily and psychological protection; Freedom of belief; and opinion Freedom of expression Privacy	In this study, all participants had freedom of expression when they voiced their lived experiences in both the KSA and SA. All participants had a choice to decide to either partake in this study or to withdraw at any time. The participants were at ease and during the data collection Phase a period of debriefing was followed to ensure emotional support. All of the participant's information was kept confidential and secured after informed consent was obtained by the researcher keeping this information in a secure file on her computer (with password protection), access control for only herself and the researcher supervisor. This security and confidentiality measures applied during all 3 Phases of this study.
Justice: Refers to fair and equal treatment of all participants (Sellars & Wassif 2019:178).	Dignity protection	In this study, all participants were handled in a dignified manner and ensured that their information would only be managed by the researcher and the supervisor. All participants had equal opportunity for inclusion in this study by allowing freedom of choice to partake in the study, having accessible sites for interviewing and time limits set (applied during all three Phases of this study).

Beneficence: Refers to the efforts to maximise the benefits for participants (Sellars & Wassif 2019:178).	Environment promotion and fulfilment	In this study, the areas or environment where the unstructured phenomenological interviews were conducted were safe and non-threatening. All participants were informed that they themselves might not benefit from this research, but future migrants might receive migration and adaptation support.
Non-maleficence: Refers to no direct or indirect harm intended to participants (Sellars & Wassif 2019:178).	Freedom and security	In this study, there were no harm intended on research participants and the research setting was designed to make the participants feel secure as they were sharing experiences similar to other participants. As the participants experienced some emotional discomfort the services of a counsellor were offered free of charge but none of them made use of it.

- *Trustworthiness to validate rigour*

Trustworthiness refers to the way in which data are collected, sorted and classified, especially if they are verbal and textual (Ojala et al 2015:368). Trustworthiness consists of four standards: truth value; consistency; applicability; and neutrality (Rodham, Fox & Doran 2015:69). According to Rodham et al (2015:68) the phenomenological researcher explores trustworthiness during the process of reaching study consensus.

Four main steps to enhance trustworthiness are identified during Husserl's phenomenological approach during the description of experiences as perceived by the individual. These steps include bracketing, intuition, analysis of data and description of the research findings (Rodham et al 2015:68). Description of findings (description Chapter 2) were categorised according to themes and sub-themes as it relates to the South African expatriate nurse' lived experiences on migration and adaptation in the KSA and SA. In this study, the researcher kept reflective notes and a journal to limit bias. These steps will be addressed in detail in Chapter 2 (heading 2.3 and Table 2.2).

The following section will provide detail on the structure of this dissertation.

1.13 STRUCTURE OF THIS DISSERTATION

- Chapter 1 provides the overview and orientation of this study.
- Chapter 2 presents Phase 1 of this study: exploration and description of lived experiences of migration and adaptation of South African expatriate nurses: research methodology, data analysis, interpretation and literature control.
- Chapter 3 describes the literature review on guideline development (principles and process according to literature).
- Chapter 4 presents a discussion on Phase 2: the development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses: research methodology, data analysis and interpretation with a literature control.
- Chapter 5 describes Phase 3 (Step 3A and Step 3B) of this study: refinement, validation of guidelines; methodology and final guidelines.
- Chapter 6 contains the conclusions of findings, limitations and recommendations.

1.14 SUMMARY

Chapter 1 provided an overview of the research process followed to address the research aim and objectives of this study. An overview was provided on the research problem and the different context, namely the KSA in comparison with SA and the different Phases of the research method was indicated. The research methodology including the 3 Phases followed, scope and limitations, ethical considerations, the structure of this dissertation as well as trustworthiness (to validate rigour) has been addressed.

Chapter 2 will follow with a discussion on Phase 1 of this study: exploration and description of lived experiences of migration and adaptation of South African nurses, research methodology, data analysis, interpretation and literature control.

CHAPTER 2

PHASE 1:

EMPIRICAL PHASE FOR EXPLORATION AND DESCRIPTION OF LIVED EXPERIENCES OF MIGRATION AND ADAPTATION OF SOUTH AFRICAN EXPATRIATE NURSES WHO WORKED AND LIVED IN THE KINGDOM OF SAUDI ARABIA (KSA) AND ADAPTATION UPON THEIR RETURN TO SOUTH AFRICA (SA): RESEARCH METHODOLOGY, DATA ANALYSIS, INTERPRETATION AND LITERATURE CONTROL

2.1 INTRODUCTION

Chapter 1 provided an overview of the research process, addressed the research aim and objectives, provided an overview on the research problem and the different context, namely the KSA in comparison with SA and the different Phases of the research method was indicated, data collection and analysis as well as aspects relating to ethical and trustworthiness issues.

Chapter 2 will focus on Phase 1 of this study: exploration and description of lived experiences of migration and adaptation of South African expatriate nurses who worked and lived in the KSA and adaptation on their return to SA: research methodology; data analysis; interpretation; and literature control. The research methodology, data analysis, interpretation of data and literature control will be discussed according to the Phases (refer to Table 1.1) of the study.

This study was conducted in 3 Phases:

- **Phase 1:** Empirical Phase for exploration and description of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and adaptation upon their return to SA.
- **Phase 2:** Development of guidelines to facilitate migration and adaptation of South African expatriate nurses working and living in the KSA and adaptation when they returned to SA. Full descriptions to follow in Chapter 4.
- **Phase 3:** Validation of guidelines, presentation of final guidelines - full description in Chapter 5. Phase 3 consisted of 2 Steps, namely 3A (Validation of

guidelines) and Step 3B (Stakeholder discussion or consensus) (SANC and the recruitment agency).

The focus of this Chapter will be on Phase 1 of the study.

2.2 PHASE 1: EMPIRICAL PHASE FOR EXPLORATION AND DESCRIPTION OF THE LIVED EXPERIENCES OF MIGRATION AND ADAPTATION OF SOUTH AFRICAN EXPATRIATE NURSES WHO WORKED AND LIVED IN THE KINGDOM OF SAUDI ARABIA (KSA) AND ADAPTATION UPON THEIR RETURN TO SOUTH AFRICA (SA)

In the first section of this Chapter, the research methodology for Phase 1of this study will be discussed.

2.2.1 Research Methodology

The term methodology refers to what practical processes researchers will follow to study what they belief should be known (Park & Park 2016:2). Research methodology allows one to study, explore and explain phenomena which either has been subjected to research before; that either needs to be explored more or to explain previously misunderstood phenomena (Park & Park 2016:2).

The aim of this study was to gain an understanding of the lived experiences of migration and adaptation of South African expatriate nurses who worked and lived in the KSA and who subsequently returned to SA to live and re-enter the workforce in this country. Phase 1 focused on attaining an understanding of these lived experiences through exploration and description by applying unstructured phenomenological interviews. The research methodology will include: the research setting; design; population; sample and sampling; data collection; and analysis of Phase 1.

(i) Research setting

The research setting refers to the area where these lived experiences took place (Rahi 2017:3). In this study, there were two research settings namely the KSA and SA (see Annexure B for a detailed comparison between the two diverse research settings). The

research participants had to migrate and adjust while working and living in the KSA (see Chapter 1 section 1.4.2). The participants had to adjust upon their return to SA (Western Cape Province). The participants worked in different areas of the KSA, inclusive of Jeddah, Riyad, Tabouk and Taif. The research setting where data collection took place was areas around Western Cape region, at venues convenient to both the researcher and participants and varied from quiet offices at work or coffee shops. The research design and method of Phase 1 will be discussed in the following section.

(ii) Research design

This section will include the research approach and design. A qualitative phenomenological approach with a descriptive and contextual design was followed in Phase 1 of this study to address objective 1 and 2. Full descriptions on the phenomenological approach have been provided in Chapter 1. Qualitative research can be defined as an interactive, systematic approach used by researchers to explore and describe lived experiences and to attach meaning to these experiences (Bashir, Syed & Qureshi 2017:33). Sampling, data gathering methods and analysis are not tightly controlled during qualitative research (Saunders, Sim, Kingstone, Baker, Waterfield, Bartlam, Burroughs & Jinks 2017:4). The researcher decided to use the phenomenological approach (qualitative design) as it allowed for accurate and true reflections of lived experiences, as voiced by the participants. The following section will describe the population, sample and sampling, data collection and analysis.

(iii) Population

The term population refers to the entire group of participants that will be involved in the research and meeting the criteria to be included in the research (target population) (Rahi 2017:3). In this study, the target population was the South African expatriate nurses who worked and lived in KSA and returned to SA after completion of their contract (at least two years work experience during contract in the KSA). The accessible population is defined as the selection of the target population to which the researcher has reasonable access (Pilarska 2015:67). The researcher made use of participants who reside in the Western Cape region of SA as they were easily accessible to the researcher. The accessible population was South African nurses listed on the International recruitment agency list residing in the Western Cape region (as the International recruitment agency is based in this region and the researcher resides there), who complied with the sampling criteria.

(iv) Sample and sampling

Sample according to Rahi (2017:3) refers to a part or sub-section of a larger population that is selected for a study. Sampling is the process of selecting the participants to partake in a study and include sampling criteria (Rahi 2017:3). The two sampling techniques are *probability* and *non-probability* sampling.

Probability sampling refers to a sampling approach where participants have equal opportunity to be selected and non-probability sampling occurs when participant selection is not known. Probability sampling include stratified, random, simple random and cluster sampling techniques commonly used during quantitative research methods (Rahi 2017:3).

According to Rahi (2017:3) *non-probability sampling* includes a sampling approach where samples are selected based on the subjective view of the researcher to ensure that relevant participants are chosen based on their subject knowledge (nurse migration and adaptation) rather than random selection methods and include purposive or convenient, snowball, quota and judgmental sampling techniques. In this study, the researcher applied a non-probability sampling approach to ensure that participants were knowledgeable about migration to the KSA and returning to SA and used convenient, purposive and snowball sampling techniques.

Convenient sampling refers to selection of a population that is easily accessible to researcher (Pilarska 2015:67). In this study convenient sampling was applied by the researcher selecting participants residing in the Western Cape region as it was conveniently accessible to the researcher. According to Pilarska (2015:67) purposive sampling includes the selection of participants who have in-depth knowledge about the research topic and meet the inclusion criteria. In this study purposive sampling has been applied as participants who worked and lived in the KSA and ultimately returned to SA has been selected. Snowball sampling according to Pilarska (2015:67) refers to the accumulation of relevant participants by means of reference or contacts. In this study, the researcher made use of snowball sampling to recruit additional participants during Phase 1 to ensure data saturation. Participants who has already been interviewed made personal reference to person(s) they were aware of that might fit the inclusion criteria of this study. The researcher obtained their contact details from the participants who took part in the interviews who acted as gatekeepers and informed prospective participants

about the research aim and process. Prospective participants gave permission to be contacted by the researcher. The contact details of those participants who were interested and willing to partake in this study were provided to the researcher who contacted them and all three of them agreed to partake in this study.

During Phase 1 of this study convenient and snowball sampling was combined with purposive sampling. Ethical approval was obtained from the Research Ethics Committee, Department of Health Studies, UNISA (Ref: HSHDC/268/2013 view Annexure A) before sampling commenced. The Western Cape region was conveniently and purposively sampled. Convenient sampling as it is the residing province of the researcher and eased logistical management of participants and purposive as the International recruitment agency is in Cape Town. The recruitment agency was conveniently and purposively selected from 23 recruitment agencies as it was accessible to the researcher (convenient) and recruited and placed South African nurses in the KSA (purposive). The recruitment agency keeps a detailed electronic database of all nurses' qualifications, physical, social, medical and previous work history as reference. Before any of the personal information was made available to the researcher, the agency first obtained permission from the potential participants in accordance with the Protection of Personal Information (POPI) Act of SA, Act 4 of 2013.

Potential participants were contacted by a gatekeeper at the recruitment agency who informed them about the aim and objectives of the study as well as data collection methods and only the information of those who were willing to be interviewed and gave their permission that their contact details can be shared was provided to the researcher to be contacted. Name lists stemming from 2006 until 2013 (750 nurses) that left SA for the KSA and returned to SA was made available to the researcher by the agency. The researcher considered the inclusion criteria for this study and only names of possible participants who met the inclusion criteria were identified by the agency. A total of 14 potential participants were taken from the list. All 14 participants who met the eligibility criteria for the study and who were part of the accessible population were contacted by the researcher. From the 14 potential participants contacted, some returned to the KSA and others were not reachable. Initially, only seven participants agreed to partake in this study and only six participants were available to be interviewed as explained later in this Chapter. By means of snowball sampling another three participants were selected to

ensure data saturation (see section 2.7), which makes a total of nine participants in this section (Phase 1) of the study.

The following section will describe sampling criteria as applied to this study.

- *Sampling criteria*

Sampling criteria refers to a prescribed list of characteristics which are essential for inclusion from the larger population in a study and include both exclusion and inclusion criteria (Rahi 2017:3). The sampling (inclusion) criteria during this study was:

- South African expatriate nurses who worked and lived in the KSA for a period equal or longer than two years (one contract) before returning to SA. Nurses who completed one contract acquired sufficient experience to immerse themselves into the culture and grow use to the changes in the culture and lifestyle.
- Nurses aged above 30 years as these participants will have possible stable relationships with or without children in SA. They had returned to SA after completing their contract. The following section will discuss sample size.

- *Sample size*

Sample size according to Sim, Saunders, Waterfield and Kingstone (2018:621) refers to the number of participants to be included in the sample. Phenomenological studies involve a small number of participants, usually as small as ten or less because the researcher wants to learn, study and experience the lived experiences of the participants in-depth (O'Halloran et al 2018:309) until data saturation is reached. Data saturation implies that all collected data and analysis has reached consensus and further data collection, or analysis is not needed (Saunders et al 2017:1).

The researcher did not know in advance exactly how many participants will be needed as she continued with data collection until data saturation occurred (Sim et al 2018:621). In this study, seven participants initially agreed to be interviewed, but only six were interviewed using unstructured phenomenological interviews. The seventh participant was unavailable to be interviewed. Snowball sampling was applied to ensure data saturation and enhance the validity and depth of the data gathered and three more participants were recruited. A detailed description of the research participants' demographical data as well as data presentation of Phase 1 will follow later in this Chapter.

(v) Data collection

Ethical approval was granted by the Research Ethics Committee of Department of Health studies, UNISA with certificate number HSHDC/268/2013 as reference (see Annexure A) before data collection commenced. Informed participant consent (form available as Annexure C) was obtained prior to data collection. The international recruitment agency was requested by the researcher to act as gatekeeper and contact prospective research participants to inform them about this study and request permission to provide their contact details to the researcher.

The following section will describe data collection methods.

- *Data collection methods*

Qualitative research data collection techniques can include simple or non-participant observations, participant observations, modified participant observations, interviews (non-scheduled structured interviews, self-administered questionnaires, mailed questionnaires), semi-structured interviews, structured interviews, self-report and focus groups (Jorm 2015:888). Data collection during hermeneutical phenomenology can include narratives and focus groups to gain an understanding of experiences or practices (Rahi 2017:3). During phenomenological studies, the main method used by the researcher is unstructured phenomenological interviews (Rahi 2017:3).

Data collection during Phase 1 of this study was done by means of unstructured phenomenological interviews and field notes. This allowed for participants to reflect on personal experiences with maximal flexibility without underpinned assumptions (Rahi 2017:3). The first part of the unstructured phenomenological interview focused on the lived experiences when migrating and adapting to the KSA environment. During these interviews, the participants were asked to reflect on everyday occurrences relating to migration and adaptation (see unstructured phenomenological interview guide as Annexure C). All interviews were voice-recorded with the permission of the participants and managed through a digital voice recording system. According to Sim et al (2018:621) interview duration should last between 45 to 70 minutes. In this study the average length of the unstructured phenomenological interviews was 45.7 minutes. Data entry included detailed raw ‘emic’ data from the participants, field notes as well as the reflective journal of the researcher’s own feeling and contextual data for a full account.

Although there were only six research participants initially, the data collection period consisted of three months (April 2016 to August 2017). This was due to the geographical placement of the interviewees, as well as their availability to be interviewed. The additional three interviews were conducted between June and August 2018. Data collected during this study was transcribed verbatim and presented in a raw form to enhance authenticity. The venue where data collection took place was a private and quiet setting, with no distractions and comfortable for the participants. In this study, the researcher performed all the unstructured phenomenological interviews and took field notes by herself.

Data is classified according to the way or techniques used to collect data or the intrinsic properties (Sim et al 2018:621). Primary data refers to the data the researcher collected him or herself for the study (Pilarska 2015:66). Data collection refers to the accurate, systematic approach to gathering of information relevant to the research purpose or specific objectives, hypothesis or questions of a study (Pilarska 2015:66). In this study, the researcher obtained primary data, which assisted in the answering of the research questions by means of a qualitative design. Participants were encouraged to give full, detailed explanations of events, emotions, thoughts, or memories, which provided the researcher with the necessary information or data to reach objective 1 of this study.

During the data coding and as means to reach data saturation additional participants were sampled through snowball sampling (see section 2.5.2.1). Data saturation was reached with an additional three more participants, thus accounting for a total of nine research participants.

Information on unstructured phenomenological interviews presented in the following section.

- *Unstructured phenomenological interviews*

Unstructured phenomenological interviews are a way of collecting data about beliefs without predetermined questioning (Sim et al 2018:625). The researcher decided on this technique as the aim of this study was for the participants to share their lived experiences without being guided. There are certain positive and negative aspects associated with unstructured phenomenological interviews.

Two strengths of the unstructured phenomenological interviews are the gaining and revelation of rich, specific and unfiltered personal experiences (Pilarska 2015:67). The unstructured phenomenological interview was done in two parts: during each part, a grand tour question was addressed (Annexure D). The first part of the interview focused on the lived experiences when migrating and adapting to the KSA environment, both working and living circumstances. The second part of the interview focused on the adaptation and lived experiences when returning to SA and included both working and living experiences. The benefit of using unstructured phenomenological interviews as to gain rich, personal and intimate raw data (Pilarska 2015:67), and it was for this reason the researcher chose this technique. One disadvantage of this technique is possible bias (Pilarska 2015:67).

During the unstructured phenomenological interviews, there are no pre-determined set of questions. The questions asked during the interview process are open-ended as to encourage the participant to volunteer information (Pilarska 2015:67). The grand tour questions (Annexure D) in this study included:

- Please describe your lived experiences when adapting to the KSA environment (both private living and working).
- Please describe your lived experiences when you returned to the SA workforce after living and working in the KSA.

Probing questions asked during the unstructured phenomenological interviews was non-directive or leading. The interview schedule can be viewed as Annexure E.

The researcher listened actively to all the events and stories explained by the participant during the interviews, kept field notes on the discussions but did not interfere with the participants' thoughts and opinions in any way. Documenting and reflecting on observations as they occur allowed the researcher to become immerged and socialised into the norms and worldview of the participants without prejudging how it will relate to the study (Fujii 2015:536).

Data collected during a phenomenological approach is presented in a raw form to enhance authenticity (O'Halloran et al 2018:308). During the unstructured phenomenological interviews, participants were encouraged to speak freely and probing questions were only used to clarify ambiguities (Sim et al 2018:625). In this study, the researcher used field notes to triangulate the data collection method.

The following section will discuss field notes as a data collection method.

- *Field notes as data collection method in Phase 1*

According to Thomas, Nelson and Silverman (2015:NP) there are four types of observational notes, namely: anecdotal (critical incidents), specimen records which are done over a place or person: field notes: and ecological descriptions regarding the environment. During qualitative research, personal and reflective notes reflect the researchers' thoughts and ideas (Stuckey 2015:7). Field notes such as theoretical or observational notes are less structured and encoded with the researchers' understanding and interpretations (Thomas et al 2015:NP). In this study, the researcher kept observational field notes after every unstructured phenomenological interview. The researcher is not merely an observer but plan which incidents to record, conversations to note or copy verbatim and how to relate relevant themes and ideas to the study (Thomas et al 2015:NP).

The researcher kept field notes to document any non-verbal communication observed by the participant, and reflected on own lived experiences associated with an interview. Even with the application of bracketing whenever a participant mentioned a certain occurrence the researcher ensured that she composed herself to withhold comments or to get distracted from the interviews.

The following section will discuss bracketing, intuiting and communication of findings as applicable to Phase1.

- *Bracketing and reflexivity*

Definitions, application and benefits of bracketing during phenomenological studies have been addressed in Chapter 1, section 1.10.2. Reflexivity as per MacIntosh, Beech, Bartunek, Mason, Cooke and Denyer (2017:7) refers to the process of self-questioning of the researcher and how impactful views and opinions on the research might be. Reflexivity was applied by the researcher when documenting her own thoughts in a reflective journal (Annexure K). Care was taken by the researcher not to influence the participants' own experiences during data collection by providing them the opportunity to share their experiences in their own words. The researcher kept handwritten field notes on the participants' descriptions and expressions during the unstructured

phenomenological interviews (Annexure D) and reflection on the researchers' own experiences was written in the form of a reflective journal prior as well as during the interview process as to capture thoughts (Annexure K). The researcher strived for a true reflection of the essence as described by the participants by bracketing her own experiences during Phase 1.

During this study, bracketing was applied by the researcher's ability to shred all previous knowledge and experiences about her working and living experience in the KSA. Through the process of bracketing the researcher could adopt a phenomenological curiosity about the research topic. As part of phenomenological guidelines, a literature review should not be done before data collection. In this study, a literature control was done after data collection and analysis to interpret and contextualise the findings in context with existing research.

The following section will describe intuiting as applied to this study.

- *Intuiting*

Intuiting definitions and application have been provided Chapter 1, section 1.10.2. In this study, intuiting was applied during Phase 1 when the researcher became immerged into the data and understood the different views, meanings and opinions attached to the data (in this study the researcher did all the interviews, analysis and coding herself).

- *Communication of findings*

In this study, when the data collection was completed by means of unstructured phenomenological interviews, an email was circulated between all participants as to confirm the results (member checking), or to suggest amendments or changes. All participants concurred with the results. These findings were confirmed with an independent coder and forwarded to the study supervisor for review.

The following section will describe transcendental subjectivity applied to Phase 1 (full descriptions provided in Chapter 1).

- *Transcendental subjectivity*

Transcendental subjectivity definitions and application to phenomenological studies have been provided in Chapter 1, section 1.9.2. Transcendental subjectivity in this study was achieved through a process where the researcher applied bracketing with a reflective

journal (Annexure K) to abandon her own lived experiences and to listen attentively to the participants without influencing their own views and expressions. The researcher achieved this by suppressing all emotions connected to described events mentioned by the participants, not showing any facial expressions as to enhance descriptions given by the participants or not influencing or interfering with the true and accurate descriptions of lived events explained by the participants.

The following section will discuss the application of a reflective journal in this study.

- *Reflective journal as applied in this study (as bracketing method)*

The reflective journal was not used as part of the data collection process but as a bracketing method. The researcher kept a reflective journal (Annexure K) to limit bias as she spent seven years working in the KSA. Although the reflective journal was not incorporated in the data it could not be kept separate during the data collection process. During this study, the researcher constantly documented her own experiences in the reflective journal and had to be aware as not to influence participant's experiences and descriptions of lived experiences.

The following section will describe communication techniques as applied during data collection (Phase 1) of this study.

- *Communication techniques*

Communication techniques used during this study include clarification of statements and debriefing of described events whilst still capsuling the true essence of the lived experience. Communication skills (clarification, paraphrasing and debriefing applied in this study) are important to understand, clarify and accurately describe the verbal context expressed by participants (Mallinson, Sennrich & Lapata 2017:881). The researcher acts as instrument to gather data from participants in the most truthful and accurate way, as intended by the participants and not mere creations by the researcher. Before the commencement of the unstructured phenomenological interview rapport and trust has been established with the participants.

The following section will describe paraphrasing as applied to this study.

- *Paraphrasing*

Paraphrasing refers to using and applying different citations or wording to express the written or spoken words of another person (Mallinson et al 2017:881). According to Mallinson et al (2017:881) the goal of paraphrasing is to aid in relation extraction and question answering. Paraphrasing should be done efficiently to simplify content. Paraphrasing is done through the transfer of content from reading to writing (Napoles, Callison-Burch & Post 2016:62). According to Mallinson et al (2017:881) paraphrasing of material appears simple but the procedure is complex and often elusive for researchers.

During paraphrasing the researcher captures the participants' original ideas and words. During summaries, the researcher captures the key information in his or her own words in individual sentences. During paraphrasing the researcher creates a combination of structures from the source text with a new grammatical structure (Napoles et al 2016:62). In this study, open-ended-questions were used during the unstructured phenomenological interviews as to not lead the participants in any way of thinking or responding; their descriptions of lived experiences were paraphrased to express the real feelings or realities. The following section will discuss debriefing during, and post unstructured phenomenological interviews as applied in this study.

- *Debriefing*

Debriefing refers to the act of processing information after completed actions (Wang 2016:232). During Phase 1 most of the participants became overwhelmed with emotion and started crying when they recalled some of the events that took place while working in the KSA. Participants were given time to gather themselves and asked if they were willing to continue with the session. The researcher provided the needed support and referred them for counselling, offered free of charge. However, none of the participants felt the need for additional support through counselling.

Information on data analysis as applied in this study will be presented in the following section.

(vi) Data analysis

Data analysis implies the analysis of significant statements made by the research participants, allocation of meanings to the identified units and ultimately the development of essence descriptions (Yüksel & Yildirim 2015:9). Techniques used during qualitative data analysis (phenomenological design) include: codes and coding; reflective remarks;

marginal remarks; memoing; and the development of propositions (Ngulube 2015:133). Data were analysed according to the phenomenological method as described by Colaizzi (Morrow, Rodriguez & King 2015:643). The process of data analysis is conducted to reduce and organise received data and give meaning to it (Ngulube 2015:133). Several authors like Colaizzi (1978) and Giorgi (1970) have suggested the Steps to be followed during phenomenological data analysis (Morrow et al 2015:643).

Data analysis per Colaizzi's (1978) strategies includes the following Steps (Morrow et al 2015:643):

- **Step 1:** The researcher to *read and re-read* all the participants' *descriptions of the phenomenon* for the researcher to acquire a feeling for the lived experiences and trying to make sense of the data. Field notes and reflective notes, which were kept after the unstructured phenomenological interviews, were read by the researcher in conjunction with the data to make sense of the true essence portrayed by the participants.
- **Step 2:** Formulates *meaning* for the significant statements – during this Step any hidden meanings should be illuminated or discovered. In this study, the researcher attempted to connect links between the participant's data as to identify similarities or differences in their lived experiences. Any meaningful patterns identified by the participants meant that *shared experiences* occurred and contributed to validity of data.
- **Step 3:** Categorise *meanings into clusters of themes* known to the participants. In this study these clusters were referred to the original transcriptions for confirming and validation of the researcher's findings and the participants' lived experiences. During this Step the researcher aimed to identify sub-themes from the main themes identified through the collected data. It required the researcher to re-read all data sheets to confirm or delete emerging themes supporting the phenomenon. The sub-themes identified in Phase 1 of this study will be discussed in detail later in this Chapter.
- **Step 4:** Findings are integrated into dense descriptions of the research phenomenon. Description includes code segments and comparing of topics for consistency. During this Step there was either inclusion or deletion of sub-themes derived from the unstructured phenomenological interviews. All the codes, categories and sub-categories were cross-referenced against all unstructured phenomenological interviews for inclusion in this study.

The process of data analysis is conducted to reduce and organise received data, manage and give meaning to it (Yüksel & Yildirim 2015:9). In this study field data was kept, coded, analysed and described. Data management in this study refers to the storing of all data (voice recordings and printed documents) in electronic format on a computer. Data storing methods included: hard copy interview sheets; the transcribed or typed documents; digital voice recorders; and relevant field notes. All data was stored in a secure place and will be kept under lock and key in the researcher's private study (office) for five years after the study ended where only the researcher have access to and can be made available upon request. Data analysis in qualitative research is non-numerical and in the form of audiotapes and written notes (Yüksel & Yildirim 2015:9). Audio files kept in electronic format on a computer. Data analysis during qualitative research happens concurrently with the data collection process (Yüksel & Yildirim 2015:9).

The researcher analysed the data from Phase 1 and thereafter it was submitted to an external coder to reach consensus on the findings. The supervisor also assisted with the data analysis during this Phase.

The following section will describe rigour and trustworthiness as applied to methodological descriptions in this Chapter (data collection, data analysis and design quality).

2.2.2 Rigour and trustworthiness (data and design quality)

- *Rigour*

Rigour refers to an open, relevance, methodological congruence, accuracy in data collection and analysis, as well as the researcher's self-understanding of the essence of findings (Noble & Smith 2015:34). Relevance related to methodological congruence with phenomenology, data collection and analysis has been described in Chapter 1.

- *Trustworthiness*

Trustworthiness refers to the way in which data are collected, sorted and classified, especially if they are verbal and textual (Noble & Smith 2015:34). Husserl's phenomenological approach to enhance trustworthiness includes bracketing, intuiting, analysis and description of finding which has been discussed earlier in this Chapter.

Criteria to establish trustworthiness included researcher reflexivity, adequacy of data and adequacy of interpretation (Lefdahl-Davis & Perrone-McGovern 2015:7).

Researcher reflexivity was applied to prevent bias by using bracketing and a reflective journal. When performing a phenomenological research study, it is expected of the process to adopt a curious stance about reflexivity, to explore similarities and differences when approaching and responding to data (Rodham et al 2015:65). Adequacy of data occurred during the unstructured phenomenological interviews, which allowed for rich, detailed data to emerge. Data interpretation, immersion into the data, re-reading of the transcripts and member-checking of findings (adequacy of interpretation) resulted into the researcher' ability to draft guidelines (Lefdahl-Davis & Perrone-McGovern 2015:70).

Trustworthiness consists of four standards: truth value; consistency; applicability; and neutrality (Noble & Smith 2015:34). In this study, the researcher provided truth and accurate descriptions of the research findings. As to enhance the truth-value and as part of the audit trial, data can be retrieved as the researcher saved the information on the internal memory of the digital voice recorder as well as digital format on the computer that is available for auditing on request. More application of trustworthiness during phenomenological studies will be illustrated in Table 2.1.

There are specific strategies to enhance trustworthiness in phenomenological studies and include: a balanced integration between the philosophical principles and the research; openness; actualisation; concreteness; recognition; readability; resonance; reasonableness; raised consciousness; relevance; revelations; responsibility; representativeness; and the phenomenological nodding (Koopman 2015:7).

In this phenomenological study, the researcher aimed to stay true to the philosophical principles of openness, relevance, representativeness and raised conscious by allowing the participants' voices to be heard through description of lived experiences in the KSA and SA. Specific criteria related to rigour or trustworthiness applied during phenomenological studies will be presented in Table 2.1.

Table 2.1: Strategies used to ensure rigour or trustworthiness during phenomenological studies

Criterion	Description	Application in this study
Balanced integration between philosophical principles and the research (topic, method and participants)	According to Willgens, Cooper, Jadotte, Lilyea, Langtiw and Obenchain-Leeson (2016:2383) a balanced integration of the research' philosophical principles (data collection and analysis process) add to the validity of research. Lived experiences explained by research participants can be examined independently (questioning its real existence, objective or physical nature).	In this study, the research topic (including problem statement) and methodology has been described according to phenomenological principles discussed earlier in this Chapter. During data collection, the researcher reflected on her own subjectivity through reflective notes and a reflective journal.
Openness	As to address openness during phenomenological studies the researcher discovers meanings connected to lived experiences from the person self, remaining open to different meanings whilst focusing on the phenomenon (Willgens et al 2016:2383).	In this study, the researcher used the data obtained from the research participants of Phase 1 during data analysis to reflect on the meaning of their lived experiences. The lived experiences of participants formed the essence of this study.
Actualisation	Future effects of the research findings (applicability to other or similar research settings) (Willgens et al 2016:2383).	In this study, the data and findings could be used and applied in similar research settings to enhance migration and adaptation support of South African expatriate nurses working and living in the KSA and adaptation upon their return to SA. Nurses can be

		adequately prepared by international recruitment agencies for migration based on these findings.
Concreteness	According to Lynn (2016:73) internal rigor includes the study design, whilst external rigor refers to the theoretical approach. Concreteness in phenomenology refers to abstractness as consciousness is not known until phenomenological reduction is complete (Schmidt 2017:60).	In this study, data collection was done by means of unstructured phenomenological interviews during Phase 1. Prior to data collection, no literature review was done and the researcher refrained from using a theoretical framework as discussed earlier in this Chapter. The data collected during the interview process was used to derive abstract themes, which formed the essence of this study.
Recognition	According to Heath, Greenfield and Redwood (2015:23) a conscious decision can be made not to engage deeply with other research (about the phenomenon being studied) as to recognise unexpected discoveries.	In this study, the researcher prevented bias through bracketing by keeping a reflective journal and field notes to enhance objectivity. Furthermore, member-checking was done to confirm the data collected during Phase 1 which allowed for confirmation of accuracy and to allow for new or emerging ideas to develop.
Readability	Readability according to Heath et al (2015:23) refers to the reinforcement of prolongation into research.	In this study, prolongation was done during all Phases. Phase 1 included prolonged time spent during the unstructured phenomenological interviews with the participants. The researcher emerged herself into the analysis process to derive the essence of this study.
Resonance	Resonance refers to deep, full similarities transpiring when analysing experiences as to discover truth value into shared experiences (Lynn 2016:73).	Although lived experiences are personal and real it could be made into a shared experience when participants (South African expatriate nurses migrating to the KSA and upon their return) are exposed to diverse conditions (adjustment to the KSA and SA. Similar shared experiences contributed to validity of findings and formulation of the essence during analysis.

Reasonableness	According to Lynn (2016:73) reasonableness refers to similarity in data's accuracy.	Data presentation in this study represented a true and accurate description of the essence (without bias or data contamination). Accuracy of the data in this study was achieved by member-checking.
Raised consciousness	The focus of phenomenology is to describe and explore lived experiences raised into awareness (Lynn 2016:73).	In this study, the research participants all aimed to understand and make sense of their lived experiences of migration and adaptation in the KSA as well as when they returned to SA during Phase 1. The lived experiences were shared with the researcher during the unstructured phenomenological interviews, where after the researcher proceeded with data coding and analysis.
Relevance	Spaulding (2015:1075) describe relevance in phenomenology as the non-consciousness manifesting in explicit and conscious explanations.	In this study, the research participants during Phase1 shared their lived experiences. The relevance was enhanced (as a collective whole during data analysis) when the essence was extracted and gave true meaning to this study.
Revelations	According to Willgens et al (2016:2383) there should be an active examination of phenomenon for any revelations (as all lived experiences are unique and fulfilled and not always completed).	In this study, the research participants could describe their lived experiences (both in the KSA and SA) freely. The research found revelation of data when experiences were examined for appearance, repetition and clarification.
Responsibility	According to Coeckelbergh (2016:749) responsibility in phenomenology refers to Aristotelian conditions and differentiates between responsibility towards others and responsibility for what one does.	In this study, the researcher handled all data responsibly (access control, confidential and accurate representation of lived events as voiced by participants).
Representativeness	Representativeness according to Wertzberger (2016:56) include:	In this study, the level of accuracy (coding schemes derived from inductive and deductive reasoning, which resulted in Step 1 of the guideline

	• Coding schemes must be derived from the data collected. • Inductive and deductive reasoning should be applied. • Data coding include evaluation of raw transcribed data – as to bring it to conceptual levels. • Data collected and ascribed meaning should correlate. • The meaning should be similar when research repeated in similar conditions.	development process) that presents the participants' described lived experiences can be traced by an audit trail.
The phenomenological nodding	As per Willgens et al (2016:2383) refers to clarity of meaning and experience when the data are presented and one could hear both the researcher' and participants' voices.	In this study, the researcher aimed to describe all lived experience in detail as to enhance clarity and meaning towards it. When reading the data findings, the voices of the participants will be audible through verbatim quotes. The voice of the researcher will be captured in the form of a reflective journal.

According to (Koopman 2015:7)

Table 2.1 discussed the strategies used to ensure rigour or trustworthiness during phenomenological studies. The following section will discuss truth value or credibility, neutrality or confirmability, triangulation and authenticity as applied to Phase 1 of this study.

- *Truth value or credibility*

According to Willgens et al (2016:2383), methodological congruence in phenomenological studies include the capturing of the essence of the phenomenon, application of bracketing, data collection based on unstructured phenomenological interviews, self-report (reflective journal, field notes and triangulation), data analysis done according to emerging themes and not any pre-conceived ideas.

In this study, balanced integration between philosophical principles and the research (topic, method and participants) can be verified as the researcher kept an audit trail and can be made available upon request. Data obtained during this study reflect true and accurate reflections as voiced by the participants themselves *(openness).* The researcher is the holder of a Masters' degree in health studies (UNISA) and had experience in qualitative research.

Truth value or credibility refers to the significance of the research findings, the credibility found by the participants and research when reading the results (Noble & Smith 2015:34) and actualisation or future effects of the research. Member checks for *reasonableness* of data was done after data collection and analysis performed during the unstructured phenomenological interviews.

The following section will discuss neutrality or confirmability.

- *Neutrality or Confirmability*

Neutrality or Confirmability refers to objectivity and absence of errors during the research and the research is confirmable when the findings display the data from the participants rather than the subjective influences from the researcher (Noble & Smith 2015:34). When performing a phenomenological research study, it is expected of the process to adopt a curious stance about reflexivity, to explore similarities and differences when approaching and responding to data (Rodham et al 2015:65) (relevance and raised consciousness). Reflexivity took place during Phase 1 with field notes and a reflective journal (Annexure K) to ensure objectivity and prevent bias. The following section will describe triangulation.

- *Triangulation*

The process of triangulation occurs when the researcher aims to increase validity during data collection by increasing validation sources and establishing reliability (Annansingh & Howell 2016:45). Triangulation requires different sources of information, methods, theories and data recordings (Annansingh & Howell 2016:45). According to Noble and Heale (2019:67) triangulation is a method used to enhance credibility and validity in research. There are four types of triangulation which include data triangulation, investigator triangulation, theory triangulation and methodological triangulation (Noble & Heale 2019:67).

In this study, data triangulation has been achieved by the researcher keeping an audit trail of the time spent on the research, time frames and participant information. Investigator triangulation refers to researcher involvement. In this study, only the researcher and the supervisor had access to the research data and no other researchers have been involved (although data can be made available upon request). Theory triangulation was not supported as the researcher refrained from using a theoretical framework and only followed a descriptive phenomenological approach. Methodological triangulation has been achieved by using different methodological approaches during each Phase of this study, as explained in Chapters 2, 4 and 5. In this study the researcher collected data during Phase 1 by means of unstructured phenomenological interviews and kept field notes which aided in triangulation of data.

The following section will describe authenticity.

- *Authenticity*

Authenticity according to Messner, Moll and Strömsten (2017:25) refers to the credible communication by the researcher, which reflects the integrity of research findings. In this study, the researcher aimed to see the world as explained from the participants' point of view and aimed to interpret and describe the information provided by the participant as accurately as possible *(phenomenological nodding)* without any bias or personal influences. The feelings and emotions of the participants were captured in accurate and reliable verbatim quotes and descriptions.

The following section will discuss the ethical considerations as applied to this study.

2.3 ETHICAL CONSIDERATIONS

The purpose of research ethics is for the protection of research participants, prevention of plagiarism and identification of scientific misconduct (Waycott, Morgans, Pedell, Ozanne, Vetere, Kulik & Davis 2015:1521). As per the South African Health Act (Act 61 of 2003), all research involving human participants should be approved by an Ethics committee (De Vries, Abayomi, Littler, Madden, McCurdy, Oukem-Boyer, Seeley, Staunton, Tangwa, Tindana & Troyer 2015:1). Ethical approval has been obtained from the Department of Health Studies, Higher Degrees Committee at UNISA (HSHDC/268/2013) (Annexure A). Site permission as well as informed consent from all participants was obtained before data collection commenced (Annexure A). A brief overview of the ethical considerations as applied to this study was addressed in Chapter 1 (see Table 1.2).

The following section will discuss the *Belmont Report*.

- *Belmont Report*

According to Friesen, Kearns, Redman and Caplan (2017:15) the *Belmont Report* was created in 1978 and published during 1979 to prescribe research ethics during publications and include autonomy or respect for person, beneficence and justice for research participants.

According to Friesen et al (2017:15) the *Belmont Report* ('National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1979') had an impact on ethics in research. The *Belmont Report* originated to identify boundaries between research and practice, determine risk-benefit analyses, guidelines for subject selection and informed consent (Friesen et al 2017:15). The ethical principles included in this Report are respect for the person, beneficence and justice (Friesen et al 2017:15). In this study, there were no direct benefits for the participants, no direct or indirect harm and all participants (during all Phases of this study) signed informed consent prior to commencement of data collection.

The ethical philosophical principles to be adhered to while conducting research include autonomy, justice, beneficence and non-maleficence and application of this approach is known as principalism (Friesen et al 2017:15). The application of the principles described in the *Belmont Report* as applied to this study will be discussed in the section to follow.

- *Autonomy and respect for the person*

Autonomy is linked to the importance of informed consent in research (Pullman 2018:37). According to Wolf, Clayton and Lawrenz (2018:7) informed consent refers to Latin source "consentire", meaning consent done by one's own choice and to fully agree or comply with the choice. The goal of informed consent is to sustain autonomy of the participant (Wolf et al 2018:7).

Informed consent was obtained prior to data collection commencement during Phase 1 of this study. In this study, informed consent (written document explaining the aim, purpose and objectives of the study) was handed to all potential participants explaining their participation required in the study, timelines, as well as freedom or option to withdrawn at any time (Annexure C). As the identity of the participants were only known to the researcher, numbers were used as to keep the participant information anonymous and confidential. All data gathered, including the signed consent forms, were kept in electronic format which only the researcher had access to (as discussed earlier in this Chapter). Participants were informed that Ethical approval was granted from the Research Ethics Committee, Department of Health Studies, UNISA (Ref: HSHDC/268/2013 view Annexure A). In this study, autonomy was achieved by gaining informed consent from all participants during all Phases of the study. The next section will discuss justice as applied during this study.

- *Justice*

Justice is the general principle that requires participants to receive what is fair and due to them (Pullman 2018:36). Justice as a research principle requires that participants are being treated fairly during all stages of the research and all potential participants have equal opportunity for inclusion (Pullman 2018:36). In this study, all participants who met the sampling criteria had equal opportunity to partake and confirmed through informed consent. In this study, justice was achieved by the researcher treating all participants fairly with dignity and respect.

- *Right to privacy*

The participant's right to privacy during research doesn't constitute control over data but reasonable measures to control private information (Pullman 2018:36). Confidentiality and anonymity were achieved by keeping personal information secured with access control (only the researcher had access to information gathered) and anonymity was maintained by linking participants with numbers instead of personal information so they couldn't be traced.

- *Beneficence and non-maleficence*

Beneficence requires that the researcher must ensure that the maximal benefits are afforded to the participants with minimum harm (Friesen et al 2017:15). In this study, beneficence was achieved by the common goal of all participants to attach meaning to their lived experiences (on migration and adaptation) in both the KSA and SA. None of the participants in this study would benefit from the research directly but future South African expatriate nurses working and living in the KSA and returning to SA might benefit in terms of migration and adaptation guidelines set by international recruitment agencies or local government (benefits might include contribution towards adjustment and improved preparation before migration).

In this study, the possible risks included uncomfortable situations when the participant was not willing to share her lived experiences and willingness to offer their time to voluntarily partake in the unstructured phenomenological interview. All participants were motivated and made comfortable in the interview setting as to allow for open descriptions of lived experiences. Emotional discomfort experienced by participants was managed by providing a counselling service offered free of charge, but none chose to utilise this service.

Non-maleficence supports autonomy principle and requires that the researcher ensure that no direct or indirect harm are caused to the participants (Friesen et al 2017:15). In this study, no direct or indirect harm was caused to any of the participants.

The following section will provide a presentation of findings obtained during Phase 1.

2.4 PRESENTATION OF FINDINGS

The following section (Table 2.2) will describe the demographical data from participants used during Phase 1.

Table 2.2 Demographic information participants Phase 1

No	Age	Gender	Religion	Experience
1	36	Female	Christian	10 years KSA, Dubai. Unit manager NICU private hospital.
2	44	Female	Christian	7 years KSA. Medical unit manager private hospital.
3	59	Female	Muslim	8 years KSA. ICU Sister private hospital.
4	56	Female	Christian	4 years KSA. Nursing manager retirement village.
5	63	Female	Muslim	10 years KSA. Nursing service manager private hospital.
6	40	Female	Christian	2 years KSA. Theatre Sister private hospital.
7	58	Female	Christian	15 years KSA. Unit manager ICU private hospital.
8	41	Female	Christian	10 years KSA and Dubai. Nursing service manager private hospital.
9	53	Female	Christian	14 years KSA and Oman. Nursing service manager private hospital.

All nine participants resided in the Western Cape region during the unstructured phenomenological interview timeframe as discussed in Chapter 1. The years' experience in the KSA varied from two up to 15 years (average nine years). Only two participants had exposure to the Arabic language prior to migration as they were born Muslims, the remaining seven participants were devoted Christians. Interviews lasted between 29-55 minutes (average time of 45.7 minutes). In this study, the term Participant (P) will refer to South African expatriate nurses who worked and lived in the KSA and returned to SA and took part in the interviews of Phase 1. The main findings as obtained through unstructured phenomenological interviews, field notes and the reflective journal was integrated to present data to support the essence in this study (discussed later in this Chapter). Interpretation of findings was done by support of a literature control. The following section will describe the essence of findings.

- *Essence of findings*

Intentionality connected to consciousness is regarded as the 'Essence of the Psyche' (Belousov 2016:22). During this study the main essence or true meaning of the lived experiences of migration and adaptation of South African expatriate nurses working and living in the KSA was discovered and described, and adaptation upon their return to SA by means of a phenomenological approach. Bracketing was used to mitigate the

potentially deleterious effects and or any preconceptions the researcher may have on this research process.

During Phase 1 of this study, the researcher observed and described the lived experiences of migration and adaptation of South African expatriate nurses who worked and lived in the KSA and adaptation on their return to SA. All lived experience descriptions gathered through unstructured phenomenological interviews and field notes were analysed into meaningful units for presentation.

It was quite challenging to transcribe lived experiences during the data analysis process as the participants explained everyday lived experiences with emotion and in detail, as it would be impossible to reflect their true and raw emotions reflected (facial expressions and body composure was observed by the researcher). Paper could not credit full observations observed from participants towards time and space reflections. During Phase 1 of this study, the researcher kept field notes that were analysed with the data collected from the unstructured phenomenological interviews and incorporated into the findings of Phase 1. The same difficulty as already referred to was applicable during the second part of the unstructured phenomenological interview when the researcher asked the participants to explain and describe their lived experiences on adjusting when returning to SA after working and living in the KSA. There was a presence of tangible emotions from the participants, which would never reach full justification if trying to write it down on paper, which has been captured in field notes.

The **essence** of this study was *'Nomads seeking greener pastures'* that started off as '*Strangers in a strange land (KSA)'* and became '*Strangers in their own land (SA)'*. In an effort to find themselves, they lost a part of themselves and experienced losses in different dimensions of their lives. They moved from a stage of shock and discomfort to accepting the 'new reality' as well as unexpected surprises or disillusionment. The exposure facilitated personal and professional growth. They lost their sense of belonging and felt disconnected and isolated.

The three main themes derived from the data collected through the unstructured phenomenological interviews and field notes include: *(i) Nomads seeking greener pastures; (ii) Strangers in a strange land (KSA);* and *(iii) Strangers in own land (SA)*. Emerging themes were broken down into categories and sub-categories. The essence of

the findings as well as a description of themes and sub-themes can be viewed in Table 2.3. Interpretation of findings will be addressed after each main theme.

Table 2.3 Findings of the study

Themes	Categories	Sub-categories
1. Nomads seeking greener pastures	1.1 Motivators	1.1.1 Financial gain and career development as external motivator. 1.1.2 The need for independence as internal motivator.
2. Strangers in a strange land (KSA)	2.1 Culture shock	2.1.1 Exposure to different cultures (Saudi's and colleagues from Europe). 2.1.2 Exposure to different religious practices. 2.1.3 Language barriers limiting Communication. 2.1.4 Dress code. 2.1.5 Gender segregation.
	2.2 Unexpected disillusionment	2.2.1 Not being paid. 2.2.2. No translator. 2.2.3 Own health affected. 2.2.4 Climate differences, extreme heat. 2.2.5 Safety issues.
	2.3 Finding your feet	2.3.1 Making friends. 2.3.2 Professional adjustment – different terminologies and different procedures.
	2.4 Lifestyle or Living standards	2.4.1 Paid accommodation and transport.
	2.5Reality kicks in	2.5.1 Different world views.

		2.5.2 Negative treatment by Saudi's (disrespect; talked down to). 2.5.3 Mistrust amongst colleagues.
	2.6 Social networks	2.6.1 Socialising with fellow South Africans. 2.6.2 Making new friends from Saudi or diverse cultures.
	2.7 Personal growth	2.7.1 Travel opportunities. 2.7.2 Survival skills – 'It shaped us'.
	2.8 Professional growth	2.8.1 Training and learning. 2.8.2 Gained global exposure and experience. 2.8.3 Enhancing clinical competence.
3 Strangers in their own land (SA)	3.1 Losses in different dimensions	3.1.1 Relationship loss. 3.1.2 Feeling like an outsider or not fitting in and or disconnected. 3.1.3 Loneliness. 3.1.4 Losing a part of yourself. 3.1.5 Loss of sense of belonging.
	3.2 Re-adjustment	3.2.1 Struggling to fit in. 3.2.2 Struggling to find a job. 3.2.3 Disorientation. 3.2.4 The need to return to KSA.
	3.3 Differences between first and third world countries	3.3.1 Limited human resources and Equipment. 3.3.2 Lack of remuneration. 3.3.3 Decrease in quality of patient care. 3.3.4 Patient ratios. 3.3.5 Nurses' poor caring attitudes. 3.3.6 Safety issues.

2.4.1 Essence of the experiences of migration and adaptation of South African expatriate nurses who worked and lived in the Kingdom of Saudi Arabia (KSA) and adaptation upon their return to South Africa (SA).

The **essence** of the experiences when migrating and adapting to the KSA environment was that participants became '*Nomads seeking greener pastures'*.

Most of them were motivated for financial gain and career development to work in the KSA. Some were driven by an internal motivation for independence. In an effort to find themselves they also lost a part of themselves in the process as they experienced losses in different dimensions of their lives. Their exposure to the KSA changed them. Initially they started as '*Strangers in a strange land (KSA)'*. They were able to adjust and 'find their feet' in the KSA. They moved from a stage of shock and discomfort to accepting the 'new reality' as well as unexpected disillusionments. The exposure facilitated personal and professional growth. They were faced with losses on different dimensions (both in the KSA and SA), leaving them disconnected and lonely.

Upon return to SA, they were '*Strangers in their own land (SA)'*. Some of them were still struggling to adjust in their own land (SA), even after seven years. They had to face the differences between a first and third world that left a gap that they found difficult to bridge. Some tried to share their gained knowledge and expertise in an effort to fill this gap. Most of their efforts were met with resistance, leaving them isolated as they struggled to fit in. Some felt they wanted to return to the KSA while others did return, some more than twice. They seemed to be weary travellers commuting between their land of origin and a strange and distant land they found hard to explain but longed to return to.

2.4.1.1 Themes, categories and sub-categories

The following section will give descriptions on the themes, categories and sub-categories identified in this study.

Theme 1: Nomads seeking greener pastures

The participants of this study were like nomads searching for greener pastures. They felt the urge to move away from what was familiar and known to them in an effort to better

their lives. They were motivated by external (push and pull factors towards migration) and internal motivators.

According to Wickramasinghe and Wimalaratana (2016:22) Lee's push-pull theory of migration was developed during 1966 and indicate that migrant between different countries may not develop if the pull factors towards migration is not attractive. A concept of Lee's push-pull theory of migration include that both countries involved in migration have certain push and pull factors. Push factors as per Lee's push-pull theory towards migration include: poor renumeration; job satisfaction; workload; and safety issues (Wickramasinghe & Wimalaratana 2016:22). Pull factors include: career; training or development opportunities; and better renumeration (Wickramasinghe & Wimalaratana (2016:22). In this study, both the KSA and SA have push and pull factors which might either attract South African expatriate nurses or not.

The following section will describe the first category for this theme and refer to the internal and external motivators towards migration.

Category 1.1: Motivators

In this study, participants described motivators as the drive force behind migration and adaptation. Participants identified money (Table 2.3, sub-heading 1.1.1) as an external motivator and the need for independence as in internal motivator.

South African trained nurses often feel that they are not being remunerated for the service they deliver. *"…I had this measly salary…there is constant poverty in SA*…" (P5); *"…SA don't pay you…I left for financial reasons"* (P6). Motivational factors for nurses' to migrate include financial constraints, continuous training and education which are limited in the country of origin but which can be achieved in another foreign country like the KSA (P1): *"…I learned such a lot – socially, education and to further my studies, …you work a lot but can still do a lot…"* (P3); *"…I learned so much about the American systems and that motivated me to immigrate to the USA"* (P6). *"I was young, single and free and was looking forward towards ways to make money…which was not possible in SA"* (P9). [Field note – can recall the luxuries, not having to stress about money.]

Participants in this study indicated that motivators were pull factors that played a crucial role in their decision to emigrate to the KSA. Pull factors according to Pretorius (2018:27) include: the first world or developed countries' working and living conditions in the KSA (in this study linked to financial gain, sub-category 1.1.1).

When nurses choose to migrate, they will identify places with better political and cultural control (Wickramasinghe & Wimalaratana 2016:15). According to Pretorius (2018:27) the major pull factors include the efforts made by the international recruitment agencies to sell the first world countries' financial gain and better working conditions to the nurse migrants. The findings from Phase 1 of this study fits with research findings that that the need to improve career opportunities and development is an external motivator towards migration.

According to Walton-Roberts (2015:375), migration traditionally has been discussed by push and pull factors which in this study are linked to internal or external motivators. This traditional view is coherent with a dualist version of migration where two countries are compared in terms of opportunities and connected by migration in a unidirectional flow. Push factors towards migration include job availability and opportunities for professional development and growth (in this study linked to 'need for independence as internal motivator', sub-heading 1.1.2), recognition of skills and qualifications, personal development opportunities, the socio-political conditions in the country, quality of living, attractive salaries with retirement benefits as well as diversity sensitive employment policies (Wickramasinghe & Wimalaratana 2016:15).

It can be argued that the migration trends (due to motivators or pull factors towards first world countries) of nurses between the global South to North left inequalities between (both host and country of origin) countries and therefore cannot reach recovering equilibrium (Walton-Roberts 2015:375). In this study, participants were drawn to the KSA for financial gain, which left SA with a shortage of nurses.

The following section will discuss financial gain as external motivator towards migration.

Sub-category 1.1.1 Financial gain and career development as external motivator

Participants indicated financial gain and career development as external motivators to seek employment in the KSA to improve their career and lifestyle. Financial strain limits training and education of participants in their country of origin (SA).

One of the biggest attractions according to participants to work in the KSA is financial gain: *"…the biggest thing for these girls is seeing their children going through school financially and they just cannot adjust to the mere South African salary…" (*P2); and *"…I could never afford to live in a house like this here in SA, it had a full-on gym and laundry services"* (P3). Participant 7 mentioned that she had financial strains and no social life after the death of her husband which was a motivator for her to seek employment in the KSA*… "I was 45 years old when my husband died. I had (three) children: 21, 22 and 14 years old. I had financial strain and no social life…."* (P7).

The data gathered from the participants was confirmed with literature control that financial gain is an external motivator for nurse migration (Pretorius 2018:27).

Pull factors including opportunities for improved wages, working conditions, employment or attractive amenities are aspects that would attract nurse migrants to destination countries (Pretorius 2018:27). In this study, the participants were drawn to the KSA because of the low salaries and poor working conditions in SA. Push factors according to Wickramasinghe and Wimalaratana **(**2016:15) include sub-standard working conditions or living circumstances in the country, lower salaries in the country, poor career opportunities, limited educational opportunities, lack or resources which hamper execution of daily work tasks, unstable working conditions, poor or no social retirement opportunities and the prevalence of HIV or AIDS that will motivate the nurse to emigrate to another country.

According to Wickramasinghe and Wimalaratana (2016:15), push and pull factors towards migration include: improved working conditions; better renumeration; career development and opportunities; and support this study' findings that there are unstable working environments in SA compared to the KSA (limited human resources, nurse shortages).

Push factors creates discomfort in a country while pull factors attract the nurses to these countries (Pretorius 2018:19). Economic factors (financial gain as pull factor towards migration) encourage persons to migrate to developed countries (Wickramasinghe & Wimalaratana 2016:15). According to Madanoglu, Alon and Shoham (2017:31), favourable economic gain is a major pull factor towards migration. Van Hear, Bakewell and Long (2018:931) state that financial gain is a key pull factor towards migration and support this study's findings: participants were drawn to the KSA as external motivator or pull factor towards migration. Participants in this study mentioned that they experienced a need for independence as an internal motivator or a change in lifestyle.

Sub-category 1.1.2 The need for independence as internal motivator

An internal motivator identified by participants was the need for independence. The need for independence was experienced as a need to change or improve their lives: *"…I can never afford the lifestyle or luxuries in SA…"* (P3). Unfortunately, in this study, the participants did not achieve the level of independence they were desperately seeking, but it was rather taken away from them: *"…I just couldn't get used to that…a huge amount of your independence is taken away" (P2).* One participant (P3) mentioned that she married young and had children and was so occupied with housework that she never had time for find herself: *"…I will say enjoyable in the sense of being alone for the first time and finding myself, to do things I wanted to do, having friends and doing things that I would never be able to do or afford when I lived in SA"* (P3). South African nurses might be on the search for 'something' or something changed in their lives, changing their circumstances by forcing independence. Two participants have lost their spouses during their stay in the KSA: *"…my husband died during that period…"* (P1; P7).

According to Alhassan, Beyere, Nketiah-Amponsah and Mwini-Nyaledzigbor (2017:10), internal motivator factors include: love for the work; willingness to work; job security; low cost of living; career upgrading; respectful; and disciplined colleagues, teamwork and unity. Some of the traditional South African people raise their children in a very protective manner and these individuals might often wonder what it would be like in the 'real world' and experience 'things' that was off limits before: *"…being the 'laatlammetjie' [meaning – youngest child born years after parents felt their family was complete] I grew up very protective and here I was going into this foreign environment, into a very extreme culture…I was excited…"* (P3); *"I went purely for the experience and I was interested to*

know what life is like on the other side" (P6). Most often, these protective families wouldn't allow their children, especially young females to travel alone: (P6): *"…travelling on my own was probably one of the scariest experiences of my life at that stage"*. It might be that these individuals decided to emigrate to the KSA purely for adventure and curiosity reasons: *"…during that time I felt adventurous…it was really fantastic", "… first time away from my family…it was about finding myself as a person…wanted to do things for me…"* (P2).

As per Madanoglu et al (2017:22) internal motivators towards migration is highly taken with family consultation and approval to migrate (family supportive and approve of migration). In this study, participants during Phase 1 mentioned that the decision to migrate was taken independently and not in consultation or based on approval from family members. The findings of Phase 1 are contradictory to the findings by Madanoglu et al (2017:22) that stated the decision to migrate was taken in consultation with family members.

There is a gap in literature on 'need for independence' as internal motivator towards migration.

The following section will discuss theme 2, '*Strangers in a strange land (KSA)*'.

Theme 2: Strangers in a strange land (KSA)

In this study, participants mentioned that they felt like strangers in a strange land (the KSA) after migration and exposure to diversity that required adjustment. The categories for this theme included: culture shock; unexpected disillusionment; finding your feet; lifestyle or living standards; reality kicks in; social networks; personal and professional growth; and each section will be discussed as categories.

When the South African expatriate nurses migrated to the KSA, they initially felt like strangers as they were unfamiliar with the context and culture of the strange land. It was strange on many levels: *"...it was so strange I wanted to make a video…"* (P5); *"…men all on their knees it was so strange…"* (P7); and *"…transferring money at the bank…a long line with females but the male line is open…they were so strange…"* (P2).

According to Walton-Roberts (2015:376) migration might have some diverse effects on the migrating nurse, which varies from extremely negative feelings to feelings of euphoria. The negative effects of migration include factors like missing family and friends, changes in dietary customs, transition into a new culture, language differences, different value expectations, challenging technology or terminology and unfavourable working conditions (Walton-Roberts 2015:376). The KSA was experienced as a strange land where they knew no one and felt like strangers.

The following section will discuss how the participants struggled to fit in with the KSA environment and traditions like public display of prayer, gender segregation and traditions.

The South African expatriate nurse might experience feelings of loneliness and vulnerability when entering a new culture (Walton-Roberts 2015:376). In this study, the participants were exposed to diverse traditions and behaviours not known in SA which made them feel vulnerable in a strange land while missing home. When the expatriate nurse migrates to a foreign country like the KSA, children can be separated from their mother or father who is emigrating and this could lead to feelings of insecurity. Normal family structures and daily routines can become disrupted and inherent value conflicts could occur (Walton-Roberts 2015:375). The expatriate nurse could also develop an eating disorder whilst working in a destination country (Almajwal 2016:191) like the KSA. The possible reasons for developing eating disorders in the KSA might be due to the unfamiliarity of the food, the availability or non-availability of certain food products such as pork, stress related stop-eating or overindulging because of emotional changes as a coping mechanism in the strange environment. In this study, none of the participants mentioned that they developed any eating disorders and adjusted their eating patterns.

Those initial feelings of euphoria and excitement of being exposed to a new culture might be short lived. When the South African expatriate nurse realises she is missing family responsibilities and gatherings in SA, reality hits home (Almajwal 2016:191). The findings from Almajwal (2016:191) correlate with this study's findings as participants mentioned that they initially felt overly excited to migrate to the KSA but then became overwhelmed with the diversity in the destination country (KSA). After time spent in the KSA these expatriates just wanted to return to SA. Once these South African expatriate nurses realised that the time spent away from home will only be temporary, she might be able to

make the best of the new adjustment and settle into the culture, only to re-adjust back to SA environment upon return.

The South African expatriate nurses' exposure to a new cultural during migration to KSA left them feeling like 'strangers in a strange land' that resulted in challenges in adjustment for participants that included culture shock. This fits in with the problem statement of this study that nurses are not adequately prepared by the recruitment agencies and the outcome of the study (to develop guidelines) to assist these South African expatriate nurses with migration and adaptation between the KSA and SA.

The following section will describe the second theme identified in the study namely culture shock.

Category 2.1 Culture shock

In this study, culture shock as experienced and described by participants' included feelings of being overwhelmed when exposed to the traditions and behaviours in the KSA. Feelings and emotions included stress, loneliness, isolation, depression and even physical illness. Participants experienced feeling overwhelmed and a stage of shock linked to their exposure to a different culture. Culture shock is defined by Wang (2016:231) as when there is exposure to different cultures and different religion resulting in discomfort (language barriers, which limits communication, dress code and gender separation). Participants mentioned that they were moving: *"…into a very extreme culture…"* (P6), that they need to adapt into a foreign culture *"…the adaptation in the KSA initially wasn't easy because you get like culture shock…"* (P2) and the experiences were a shock to them *"…so it was all a bit of a shock for me…"* (P7). The expatriate adjustment stages are depicted in U-curve (Oberg model 1960), where culture shock is at the lowest point of the curve (Brown 2016:4).

According to Davies et al (2015:172) expatriates immersed into a culture different to their own during migration. Changes in culture and location might result in adjustment issues and culture shock. Cross-cultural adjustment happens when the individual adjusted to the new cultural, work and social environment. Poor adjustment has negative consequences on the individual, causing disengagement and culture shock.
In this study, all the participants felt that they experienced culture shock to some degree

whilst working and living in the KSA. There is a lack of literature/research on the preparation of South African expatriate nurses' migration and adaptation in the KSA. International recruitment agencies do not offer adequate preparation to prospective expatriate nurses on culture shock, the symptom identification and the management thereof. In this study, participants did not receive adequate orientation and preparation on the diversity in the KSA resulting in culture shock being eminent.

According to Oh, Guay, Kim, Harold, Lee, Heo and Shin (2014:135) culture shock could be minimised through the following:

- The type of service and culture should be considered when designing resource management systems. Recruitment, selection and socialisation should be specifically planned, taking into consideration the country of origin as well as the host culture.
- The destination country should provide realistic job information and previews early during the recruitment process.
- Organisational orientation programs should include aspects such as expected behavioural norms, specific expectations, policies, job roles and responsibilities. This process should include cooperation between supervisors and colleagues, with involvement through affective events and social activities.

The significance of this study (culture shock experienced in South African expatriate nurses living and working in the KSA) as mentioned by Oh et al (2014:135) correlate that culture shock is a reality and recruitment or placement of expatriates including proper preparation and orientation prior and during migration should be considered to limit these effects.

Immigration initially might also lead to increased levels of stress, depression, aggression, work absenteeism or even drug and alcohol abuse to cope with the adjustment (Donoghue 2016:4). Stress from emigration derives from the initial optimistic and enthusiastic mode within the first weeks of departure, but with the increased cultural adjustment stress, the emigrant will enter a 'crisis adjustment Phase'. Cultural stress according to Donoghue (2016:4) is the stress that happens to emigrants who need to integrate more than one culture into their lives and minds, which leads to confusion in values, behaviours and identity. In this study, participants experienced cultural stress when exposed to the diversity exhibited in the KSA and cultural adjustment occurred

when these expatriates accepted their new environment.

Absence of familiar signs like food, cuisine and communication could result in frustration and anxiety (Shannon-Baker 2015:48; Slonim-Nevo & Regev 2015:123). Individual differences, culture, work and family situations are determents of the intensity of culture shock experienced (Shannon-Baker 2015:48; Slonim-Nevo & Regev 2015:123). Mastering of the new culture contributes to expatriate adjustment (Walton-Roberts 2015:374). To add fuel to diverse exposure and adaptation issues in the KSA factors like language barriers, treatment by Saudis, extreme heat and limited social networks or losses in relationships will contribute to culture shock (Li et al 2014:314).

Cultural stress is also exaggerated by religion, language barriers, building of social networks, medical emergencies and poor health caused by stress and adjustment to unfamiliar geographical environment. Social media plays an important role where emigrants can share concerns or discuss their lack of understanding (Donoghue 2016:4). In this study, the participants all mentioned that the language barrier between colleagues and patients was exuberated by the lack in social support or friendships whilst working and living in the KSA.

Health care workers experience culture shock when they relocate to different environments (Slonim-Nevo & Regev 2015:118). There are different methods (including separation, marginalisation, assimilation or integration) of coping with culture shock cross-culturally, but they form their own cultural identity by the way they endure culture shock (Slonim-Nevo & Regev 2015:117). Resilience to adjust to culture diversity might hamper the expat' ability to adapt and might cause culture shock. Culture shock might appear common between Western and Eastern country migration (Slonim-Nevo & Regev 2015:118). In this study, South African expatriate nurses migrated from a Western country (SA) to Eastern country (KSA).

According to Oberg (1960) as quoted by Brown (2016:4) there are three stages involved in culture shock. The first stage is the honeymoon stage, the second stage is the negotiation or disintegration stage and the third stage is the recovery phase. The honeymoon stage is characterised by fascination until the novelty wears off and takes place during the first weeks in a foreign country. When the South African expatriate nurse enters the KSA, prepared or unprepared, he or she looks forward to the new cultural

exposure. Initially, he or she might find the stringent dress code fascinating, but after a while, the black custom dress called “Abaya” becomes a sign of female oppression when she realises that one cannot wear casual clothes as accustomed to in SA.

In this study, the participants mentioned that the “Abaya” became both a sign of modesty and oppression in the KSA, although when returning to SA they couldn't get used to not wearing it and felt almost naked without it: *“...when I returned to SA I had like 10 Abayas and wanted to wear it when leaving the house – without it I felt naked and if everybody was staring at me…”* (P1). The negotiation or disintegration is the second stage and is characterised by aggression and hostile attitudes towards locals and starts with the identification of difficulties in language and functional displacement (Brown 2016:4). The female South African nurses working in the KSA are expected to cover their hair with a black veil and if not adhered to it can lead to verbal abuse from the religious police called “Mattawa”. Females are also not allowed to look males in the eye when talking to them and are expected to look down. This can cause some aggression due to the interpretation of humiliation.

In this study, the participants mentioned that they were always cautious of the “Mattawas” and found it extremely difficult to communicate with male physicians who didn't recognise them as healthcare professionals. One participant mentioned: *“...you should not be sitting here, it is for males only…if you see the Mattawas you need to run…”* (P3). [Context – P3 explaining that the South African expatriate nurse need to be cautious of the religious rules in the KSA, “Mattaw” or religious police advising participants that they should not be sitting in an area which is designated for males only.]

The third stage is characterised by recovery, cultural relativism and acceptance of the new cultural environment (Brown 2016:4). Once the South African expatriate nurse accepted that they cannot change the fixated and rigid Islamic traditions, they settled down into the new culture exhibited in the KSA. Acceptance of the diverse culture and behaviour in KSA resulted in adjustment of the South African expatriate nurse in this study. Once the South African expatriate nurse returns home a fourth stage namely reverse culture shock can occur. This stage occurs once the South African nurse becomes overwhelmed or underwhelmed by the day to day routines that he or she had taken for granted in the country of origin (Brown 2016:4).

Culture shock, which has been experienced by the South African expatriate nurses in the KSA were aggravated by religious factors, customs, language and traditions might result in reversed culture shock when these nurses return home to SA. All participants in this study, whether born Muslim or Christian mentioned that they experienced issues with the religious practices and traditions in the KSA. The South African expatriate nurses were unable to communicate with patients and colleagues due to language barriers and found it very difficult to associate with the foreign cultural traditions, which ultimately lead to signs and symptoms of culture shock.

Symptoms of culture shock might include social symptoms like feelings of loneliness, over identification with the native culture and social withdrawal. Physical symptoms might include oversleeping or insomnia and frequent physical sickness. Psychological or emotional symptoms might include mood swings, irritability, lack of confidence, fighting with others or constant crying (Brown 2016:4). In this study, the participant' descriptions fit with research publication of Brown (2016:4) as all of them experienced either physical sickness, mood lability, irritations or emotional distress with social withdrawal from loved ones whilst in the KSA.

Whilst the South African expatriate nurses were working and living in the KSA they experienced exposures to different cultures. The sub-categories for this category included: exposure to different cultures; religious practices; language barriers limiting communication; dress code and gender segregation.

The following section will discuss sub-category 2.1.1, exposure to different cultures.

Sub-category 2.1.1 Exposure to different cultures (Saudi's and colleagues from Europe)

The participants experienced culture shock when they were exposed to a culture different from their own. One participant tried to familiarise herself with the culture and religion of the KSA. Some experienced negative feelings, including irritation and unhappiness related to the extreme cultural differences. This was illustrated by the following excerpts from the data: *"…I tried to find out more about the culture, tried to immerse myself into the nitty gritty of Islam, tried to figure out why things are the way they are and why people are the way they are"* (P1); *"…I can honestly say there are things about the culture that irritated me"* (P4) and *"…I moved into a very extreme culture and I wasn't happy"* (P6).

The time period to adjust and integrate into a foreign culture is not predictable and differs from one individual to another: "…*in the beginning it wasn't easy, and the first 6 weeks I wasn't comfortable with them"* (P1); *"…it was so scary sitting in a room filled with different cultures"* (P3); and *"…I made no friends and the culture shock was immense"* (P6). Some participants indicated that adaptation of the new culture occurred when they accepted the new cultural behaviours and traditions: *"…you know you are in another country, and you know you have to adjust yourself otherwise you will go crazy"* (P4); and *"…you actually adjust to their way of living by accepting their ways and not trying to change them"* (P5).

In this study, there has been discourse between the participants' experiences by either trying to emerge themselves into the new culture or denying any cultural curiosity and interaction with the experienced diversity. One can gain knowledge about the emerging culture by interaction or observation (NHI 2015:NP). According to Brown (2016:4) culture shock symptoms include: psychological strain when exposed to different cultures; anxiety; and feelings of not coping with the new environment.

The adaptation into the new culture and strange environment was a shock and difficult for the participants to absorb as they tried to make sense of their surroundings. The participants were exposed to the culture from the KSA but also other diverse cultures, including American, Australian, Canadian and Filipinos who were their colleagues in the work context. These experiences of the participants are similar to Slonim-Nevoand Regev (2015:123) who indicate adjustment and adaptation in a foreign culture is influenced by diverse cultural exposures in a foreign environment which can result in culture shock.

The findings of this study correlate with research findings that language, religious practices, dress code and gender segregation distinguish cultures from each other (these differences can either attract curiosity in the expatriate nurse or cause more distance and isolation) (Brown 2016:3). The following section will describe the exposure to different religious practices from the participant' experiences whilst working and living in the KSA.

Sub-category 2.1.2 Exposure to different religious practices

Participants, even those who were born Muslim were not used to the extreme display of religion and the strict adherence to the Islamic principles, which include dress code and

gender segregation. The South African expatriate nurse (Western paradigm) was exposed to diverse working and living conditions regulated by religious principles in the KSA that was unknown to them. Participants mentioned that they experienced extreme religious practices in KSA and observed race, gender and cultural discrimination. One participant mentioned *"…it was during Ramadan…Pakistanian workers has been working in the blazing sun…they never had money as they were poorly paid…"* (P9). [Context – due to the racial or gender discrimination observed by participants, they noticed how i.e. Pakistanian workers were not allowed to rest during Ramadan and were expected to work during the fasting periods of Ramadan even though they were poorly paid.]

Religion could be regarded as a major factor that will influence adjustment in a foreign country when expatriates are confronted with a religion different to what they have known and practised: *"…seeing men on their knees in the Ballad, all praying, I wanted to make a video, but they said it was not allowed…*" (P5). This foreign religious exposure (which is also associated with culture) could contribute to culture shock. The Islamic religion in the KSA is based on inhabitant's worldview and all daily practices is based on religion (including prayer schedules, Quran reciting and call for prayer). Islam means peace, submission and obedience (Rehan, Block & Fisch 2019:8). The holy book is the Qur'an, which guides conduct in daily life, worshipping and praying.

Within the KSA there is a strict adherence to Islamic practices (including prayer times and methods, lifestyle based on religion and basing all decisions and actions on the Islamic religion). Adjustment issues according to participants included traditional, religious and cultural practices. These practices were different from those of the participants and required adaptation: *"…I adapted, I knew I was in their country and I knew I had to keep myself as a Christian with my beliefs on my side – private in my own room"* (P3); and *"…not to openly talk about Christianity was a little difficult in the beginning"* (P1). The religious practices of the KSA included prayer times: *"…they had their prayer times and disappeared for hours"* (P5).

Participants also mentioned that the views expressed by the Saudis were based on religion such as "Insha-Allah" meaning 'God willing'. The South African expatriate nurses who were Christians, found it difficult to associate everyday activities and thoughts with the specified religious references. Religious police known as "Mattawas" patrol the roads and will punish people who deviate from religious guidelines. Participant 9 mentioned:

"…the Mattawas was controlling the areas and there were strict separations…I remember one time we went out and when we saw them we had to run away and in different directions not to get caught…" (P9). Participants agreed on their exposure and experiences of diverse religious practices.

Within the Islamic folds there are no separation of law, traditions and religion (Rehan et al 2019:8). In other religions like Buddhism, Christianity and Hinduism, laws are separate from religion (Rehan et al 2019:8). In Islam there are no hierarchy of mosques. The mosque is seen as a place of worship and it is recommended that all Muslims pray together in these mosques. The "Imam" (priest) will lead the Muslims in prayer. During the Friday congregation, political messages are preached by imams (priests) (Hasanović, Pajević & Sinanović 2017:25). According to Hasanović et al (2017:25) Islam isn't only a religion, but rather a holistic life system.

During prayer times all shops were closed, and people would go to the nearest mosque to attend the prayers. Participants couldn't understand why the shops would close and cause inconvenience to them: *"…I found that a massive mind shift – in the beginning going to purchase an item and you could hear the call for prayer – and the guy was like – put down everything and I would see you back in 20 minutes"* (P1); and *"…I have already been standing in a queue for 20 minutes, but that didn't matter, it is prayer time now…other times you got locked inside a store doing your shopping while everybody left for prayer"* (P6).

When Muslims pray (scheduled five times per day at specific intervals) they face towards Mecca ("Qibla") and the Ka'ba, which is considered a symbol of unity amongst all Muslims worldwide (Hasanović et al 2017:25). All of the participants mentioned that the call of prayer became part of their daily routine and activities: *"…it was waking up to the call for prayer, it gets into your blood, it gets into your water as they say"* (P1). These participants said that it was easy to get used to the religious practices in the KSA, whilst some of the participants said that they could not understand the religion and struggled to understand these practices which could contribute to culture shock: *"…being a Christian… the praying, the mosque was an adjustment for me…" (*P3). Fasting (not eating from sunrise to sunset) during the month of Ramadan was also noted: *"…during Ramadan the Saudis fast, but other fasting nationalities must work in the beating sun without food while the Royals sleep comfortably…"* (P8).

There is a gap in literature on expatriate nurse adjustment, migration, religious exposure in reference to specific geographical areas with specified religious practices. These expatriate nurses need to live and work in a strange environment which will leave them lonely and disorientated when confronted with unfamiliar cultural and religious aspects (traditional Muslim or Islamic practices including prayer times, fasting, treatment of women and gender segregation) (Hasanovićet al 2017:25).

The following section will discuss language barriers limiting communication as experienced by participants whilst working and living in the KSA.

Sub-category 2.1.3 Language barriers limiting communication

Language is important within every cultural context. It gives meaning to everyday life and a social sense of belonging. Participants in this study mentioned that they struggled to communicate with patients and colleagues, which were Arabic speaking, as they themselves couldn't speak or understand Arabic and this ultimately influenced their adjustment in the KSA. Prayers, preaching and daily communication in the KSA is done in Arabic, which might be challenging for non-Arabic speaking individuals.

Participants' experiences of the culture shock were exaggerated by language barriers. Most of the participants mentioned that the language barrier caused difficulties in explaining basic procedures to a patient, getting directions or even obtaining transport i.e. a taxi to and from a destination. Participants became aware that they were *'Strangers in a strange land (KSA)'* when they realised, they were not able to communicate as they did not know the language. This resulted in isolation. Participants experienced difficulty when communicating with some of the patients and physicians. One participant was promised a translator that did not realise which caused major frustration when trying to explain basic procedures to Saudi nurses who was unable to communicate in English: *"...I was promised a translator…trying to explain what to do was impossible…"* (P2).

The non-Arabic speaking participants were unable to explain terminology or procedures to their patients: *"…she could not speak English and I could not speak Arabic or French, therefore we could not communicate, and it wasn't nice at all"* (P3); *"…it was also the language thing"* (P2); *"when the porter arrived we couldn't understand one another…there*

were computers to add everything of the patient, but they could not understand English – so you could not ask them anything" (P6). In nursing it is essential to communicate clear messages that are understood by every member of the healthcare team in order to improve standards of care.

The global need or high demand for nursing services and nurse migration empowerment will have both positive and negative influences on the person and the host countries. Certain obstacles like barriers and multi-cultural population interactions might influence the nurse migration experiences (Brown 2016:3). The Arabic language might be challenging to learn and the extreme temperatures in the KSA difficult to adjust to (Azeem & Altalhi 2015:191). In this, study participants agreed that language caused an obstacle in communication and adjustment in the KSA. According to Kelman (2018:185) language is a powerful instrument to unify diverse populations or drive them apart. Nurse-patient communication is a dynamic and complex phenomenon, which will ensure patient satisfaction (Norouzinia, Aghabarari, Shiri, Karimi & Samami 2016:66). The official languages in SA include: Ndebele; Northern Sotho; Sotho; SiSwati; Tsonga; Tswana; Venda; Xhosa; Zulu; Afrikaans; and South African English (Gloppen 2019:NP).

Even with the 11-official languages in South African nurses don't speak or understand all the native languages. When the South African expatriate nurses work in the KSA they are expected to speak only English and Arabic in the workplace. Participants mentioned that the dress code in the KSA resulted in culture shock and reminded them that they are *'Strangers in a strange land (KSA)'*. The following section will describe dress code differences between the KSA and SA.

Sub-category 2.1.4 Dress code

Traditional clothing in the KSA is a black throbe called the "Abaya" and hair must be covered by a black veil (Hodges 2017:41). Participants were not used to cover their bodies with this dress, enhancing their experiences of culture shock. All of the participants mentioned that the modest dress style of women was initially disturbing, but they grew used to it up to the point where they felt exposed or naked when not wearing it.

The male, but more specifically the female dress code in the KSA is according to Islamic principles and guidelines. One born Muslim participant commented on the traditional clothing which is contradictory to Islamic practices in SA (P5): *"…you have to cover, that*

was not a problem for me because I always cover my hair, but they take this a little bit further and say this is the religion, but it is not … this is a cultural thing" (P4). This dress code worn in the KSA was also extremely difficult for the participants to accept: *"…the day was hot as hell, and we were expected to wear an Abaya – the black dress"* (P6). [Field note – researcher mental flashback - I can recall the severe perspiration even when not wearing any clothing under Abaya.]

Some of them even discovered that it will be cooler not to have any clothes except underwear under the Abaya as a coping mechanism against the heat. All the participants mentioned that their initial disgust in the Abayas changed as they realised they missed it whenever they didn't wear the Abaya: *"…I felt exposed, naked…"* (P1); *"… the Abaya can hide a multitude of skin…"* (P3). Participant 9 mentioned that her initial shock was when: *"…you saw black Abayas and men dressed in white throbes everywhere…"* (P9).

This appearance is very different from the modern Western clothing seen all around SA. The dress code in the KSA has already been discussed earlier in this Chapter. There is a gap in literature on different dress code affecting adjustment of expatriate nurses in a foreign culture. Search engines used Ebscohost, MEDLINE and Google Scholar with search words dress code in foreign culture AND adaptation; expatriate nurse dress code AND adjustment did not deliver literature on this topic. Within the KSA there are strict separation rules between males and females. These will be addressed in the next section.

Sub-category 2.1.5 Gender segregation

Participants were used to wearing clothes of their choice, mixing with men according to their own preference without segregation laws. This was not the case in the KSA when participants mentioned: *"…women must not mix with men, it is not allowed…"* (P1); *"…you have to cover your whole body and hair…"* (P2); *"…I couldn't get used to that"* (P6). The participants found it very difficult to understand the strict male and female segregation: *"…we had a section upstairs and downstairs for male and female segregation and separate waiting areas"* (P5).

If a female transgresses these strict segregation laws, they will be addressed or even punished by the religious police: *"…it was so frustrating going into a restaurant and [being] instructed to be seated in a specific area"* (P6). The role of females and especially the view of Western females were very difficult for participants to accept: "…*standing in a*

bank with 10 males and one female queue – the female row is already outside the door, but they will refuse to assist you...they don't have any regard for females…" (P3). The strict adherence to male and female segregation is an Islamic principle, which cannot be breached until marriage, although under aged marriages are not discouraged.

Within the Arabian community there are visible discrimination between genders, limited implementation of law to protect women and a gender pay gap (Alghamdi, Topp & AlYami 2018:120). The role of the women in the KSA is seen as subservient and salaries are therefore less than men who are regarded superior irrespective of training and educational levels. According to Hodges (2017:41) it is culturally expected of men and women to be segregated, even in the workplace (and the sharing of toilets is totally prohibited). Male individuals prefer to work in an environment which is male orientated (no female managers) because of fear of stereotyping (Alghamdi et al 2018:120).

There is a gap in literature on how gender segregation can influence adjustment in expatriate nurses in a foreign culture. The traditional or religious based gender segregation in the KSA has already been discussed earlier in this Chapter. Whilst the participants still adjusted to the different traditions and practices, including traditional clothing and gender segregation, they were unaware of the pending disillusionment waiting on them.

The following section will describe unexpected disillusionment experienced by South African expatriate nurses in the KSA.

Category 2.2 Unexpected disillusionment

The participants were disillusioned with unexpected and unwanted surprises when entering the KSA, which influenced their adaptation to the KSA diverse working and living environment. This included not being paid, no translators, own health affected, climate differences (extreme heat) and safety issues.

Challenges associated with migration include drought, extreme religious practices, political intolerance, famine or conflict, poor economic status, lack of job opportunities and race or cultural discrimination (Pretorius 2018:23). In this study, participants mentioned that the idea of working and living in the KSA was initially very exciting, but as

time went on, they experienced disillusionment. The following section will describe sub-category 2.2.1, not being paid.

Sub-category 2.2.1 Not being paid

One of the external motivators for the South African expatriate nurses to work in the KSA was financial gain. Disillusionment occurred when the hospitals could not afford to pay them their monthly salaries. In this study, two participants mentioned that they were not paid and this was added as a sub-category as it is in contrast with financial gain as motivator which was a pull factor to migrate and work in the KSA.

Participant 8 (P8) mentioned that workers did not receive their salaries regularly and some of the nationalities (including Bangladesh) had to borrow money from colleagues to send back to their own families. This participant also said that the nurses from a very prestigious private hospital were called in to say that the hospital cannot pay salaries as there is no money available. This situation was rescued when a Prince gave a cash injection of ten million Saudi Riyals. Participants reflected on not being paid as follows: *"…nursing staff from other nationalities had to borrow money for survival. For us [South Africans] it was not the same, we were happy to wait. We got everything for free – accommodation, travel and medical…"* (P8); "… *some [P]rince from somewhere came and gave them a cash injection so they can pay their staff…" (*P9); and *"…the workers did not get their pay regularly…" (*P8).

Participants' adjustment into the KSA environment has been influenced by the lack of remuneration that caused disillusionment. There is a gap in literature, which links expatriate adjustment with non-payment for services and how this will influence job satisfaction.

According to Wickramasinghe and Wimalaratana (2016:15), international migration is linked to improved remuneration and lack thereof can result in poor job satisfaction. Recognition of performance through adequate remuneration is important to the person and lower recognition will result in lower performance (Calvin 2017:1). The participants found it difficult to understand the Arabic language with no translators, especially when a translator was promised and therefore expected by the participants. The following section will describe sub-category 2.2.2, no translator.

Sub-category 2.2.2 No translator

As communication is an integral part of relaying messages, translators are needed to interpret words and contexts between people from diverse backgrounds. Translators were promised as part of the employment contract and therefore expected by participants. However, participants were disillusioned when translators were not available. This language barrier made optimal and holistic patient care even more difficult and was a constant reminder to the participants that they were *'Strangers in a strange land (KSA)'*. *"…I was promised a translator when I got there – no translator…" (*P2); *"…I could not understand Arabic…" (*P5); and "…*no translators available…"* (P9).

There is a gap in literature on the role of the translator in foreign countries and how it will influence adjustment of expatriate nurses. According to Salloum, AlHamad, Al-Emran and Shaalan (2018:418) Arabic amounts second highest of the world's most popular languages, more than 280 million people speak it as a first language and 250 million individuals use this as second language. The Arabic language is more difficult to study compared to the English language (Barhoumi, Estève, Aloulou & Belguith 2017:NP). Due to the difficulty level of the Arabic language, it was difficult for the participants to study this language prior or during migration. The stress when adjusting to the foreign culture and traditions in the KSA caused health issues for participants. The following section will describe sub-category 2.2.3, own health being affected.

Sub-category 2.2.3 Own health affected

In this study, participants mentioned that their own health was affected by stress during adjustment and they experienced physical signs of illness, including loss of voice, raised blood pressure and skin rashes related to below standard hygienic practices.

Participant 1 said that the stress affected her health so much: *"…I could not even talk, I lost my voice…"* (P1), whilst Participant 6 said *"…in the first week I was there I got terribly sick, I had germs my body wasn't used to. I was worried what would happen to me if I died there…"* (P6). It also affected their ability to work as one participant felt sick at work: *"…[stress] raised my blood pressure. I felt sick. Even at work…"* (P5).

Increased stress, migration and adaptation experiences and culture shock can influence the expatriate nurses' personal health status negatively which will be reflected in their job performance and patient care (Walton-Roberts 2015:375).

Hygienic standards and principles are not always adhered to in the KSA and could contribute to participants' fearing their own health would be affected: *"…Taif was very rural, so with the camel farms and the early morning smell of camel dung it wasn't so nice…when we arrived I was shocked to see the state of the clinic…my worst experience was seeing a poor housekeeper standing in the passage eating a sandwich – he took me to this bathrooms with lockers inside – in the middle of the room there was a drain that was blocked and the faeces was pouring down the passage"* (P5); and *"…the other thing that was really upsetting was the water that we used to wash with started to give us skin rashes"* (P6).

According to Bader and Schuster (2015:63) expatriates that deal with diverse culture values, strange behavioural rules and language barriers will experience uncertainty and stress. This stress of being a 'stranger in a strange land' will have severe consequences for expatriates' psychological well-being and physical health.

As per FilipicSterle, Verhofstadt, Bell and De Mol (2018:336) cultural and psychological changes lead to a culture of conflict and stress. Poor adjustment to a strange environment result in stress and deterioration of mental health for expatriates, leading to anxiety, sleep disorders, depression, alienation and feeling of homesickness.

In this study, the participants' experiences (including anxiety, depression and feelings of loneliness and homesickness) correlate with FilipicSterle's et al (2018:336) description of migration and adaptation causing health-related issues and one's own health being affected. The climate the participants were exposed to in the KSA was much more extreme than what they were used to in SA enhancing their unexpected disillusionment. The following section will describe sub-category 2.2.4, climate differences (extreme heat) in KSA.

Sub-category 2.2.4 Climate differences (extreme heat)

Although all of the participants mentioned that they read online about the climate in the KSA they were not fully prepared for the extreme temperatures experienced: *"…it was hot as hell, I will never forget how hot it was"* (P6); *"… there is a different kind of heat"* (P8)*; "...it was terrible, we were told that we would acclimatise the next day"* (P3); *"…but I wanted to take the first flight out…when you went shopping all of the aircon were blasting"* (P1); and *"…my second shock was the heat wave I experienced when the aeroplane landed on Jeddah, which was in fact a daily occurrence. Temperatures can reach up to 60º with a humidity of 100%"* (P9).

The vast area of the KSA, 80% of the Arabian Peninsula has large climate variations (Almazroui, Dambul, Nazrul Islam & Jones 2015:2556). Possibilities of rainfall is greater in the North and Southern regions. Northern regions like Arar, Rafha and Tabuk can have rainfall of 5-20mm per month (Almazroui et al 2015:2558). Temperatures as can be expected from a desert land can reach up to 50ºC in the shade with a 100% humidity (Almazroui et al 2015:2558). There is a gap in literature on how climate and heat influence expatriate nurse adjustment. Participants agreed that the extreme temperatures in the KSA was intolerable but they got used to it the longer they stayed in the country.

Safety was a pull factor towards the KSA; however, they were disillusioned when they realised that there are also safety issues in the KSA. Participants had mixed opinions regarding the safety aspect in the KSA when compared to SA.

The following section will describe sub-category 2.2.5, Safety issues.

Sub-category 2.2.5 Safety issues

In this section, participants voiced mixed opinions about the safety issues in the KSA, as they assumed the KSA might be safer than SA.

According to Ahmad, Rehan, Balkhyour, Abbas, Basahi, Almeelbi and Ismail (2016:1), the growth in population and urbanisation in KSA led to serious environmental pollution (safety risk for expatriates). Safety issues in the KSA focus on substance abuse, sexual exploitation and violence amongst inhabitants (AlBuhairan, Al Eissa, Alkufeidy & Almuneef 2015:45). Psychopathic attacks and victimisation are high amongst scholars in the KSA (Beaver, Al-Ghamdi, Kobeisy, Alqurashi, Connolly & Schwartz: 2015:NP). Saudi

Arabia has the lowest crime rate in the world (Rehan et al 2016:1). Although the crime rate in KSA is lower than compared to SA, there are still safety issues as experienced by participants in this study.

Participant 2 mentioned that she wanted to go to the KSA because of the conflict and crime in SA. However, she was faced with safety issues in the KSA as well. Participant 2 was very concerned about the safety in SA: *"…it was the safety, it was the crime…"* (P2); whilst Participant 4 said *"…it is so dangerous to go out at night [in the KSA and SA] because of the dangers, you don't go anywhere, you don't trust anybody…"* (P4).

Participant 6 said that: *"…there were military at the airport with guns which I have never seen – I travelled a lot but never seen soldiers with guns at the airport…that was a big shock and I wasn't sure if I read up enough…if there was a war going on somewhere…"*. [Field note – researcher mental flashback – she could remember first encounter with soldiers on airport and upon arrival at compound – pointing guns at you, could notice the fear in participant' eyes.] Participant 8 left for the KSA only to be sent home after four months when there were bombings. She returned to the KSA only after the violence was settled. Participant 1 mentioned the 9/11 attack: *"…which was a big culture shock, there was a lot of Western people that felt unsafe…but the truth is that was most probably the safest place on earth at the time…"*

The participants agreed that the South African expatriate nurses were treated better than other nationalities. When entering or exiting from the KSA, a visa is required and strict control is maintained not to allow any person into the country without a valid visa. When an emergency occurred: *"…after [three] months my mom died. I was surprised at the speed at which I was allowed to exit the country to attend the funeral. They really have expertise in dealing with expats…"* (P8).

Furthermore, safety and security have been discussed in Annexure B (comparison between the KSA and South Africa). Safety issues experienced in the KSA left the South African expatriate nurses working and living in the KSA with feelings of insecurity; and these expats could be seen as *'Strangers in a strange land (KSA)'* that struggled to find their feet as reflected in the next category (category 2.3, finding your feet).

Category 2.3 Finding your feet

The participants, who were ‘strangers in a strange land’, struggled to find their feet. The adjustment period in the KSA might have some challenges, which include the sub-categories of making friends as well as professional adjustments. The following section will describe sub-category 2.3.1, making friends.

Sub-category 2.3.1 Making friends

Participants felt lonely and isolated as they were ‘strangers in a strange land’ and not able to speak the language. Some had no friends while others were able to make new friends. [Context – participants 2, 5 and 7 felt that the ability to make new friends would assist in fitting in and the newly founded friends might help them to adjust and find their feet.] Participant 3 mentioned: *“…nobody knew my name…I made no friends”* (P3); *“…I was entering the unknown, I was all alone”* (P2). One participant said: *“…I obviously made new friends”* (P7)…Another participant said that the KSA taught her: *“…a lot of things – how to establish lasting and true friendships…”* (P5).

International nurse recruitment agencies send nurses’ abroad with confidence in the applicant’s skills, enterprise and expertise to face organisational challenges in a foreign country. Immigrant nurses therefore will constantly be challenged with global talent. Single immigrant nurses might experience feelings of loneliness, isolation and separation from close family members. Even if the immigrant nurse initially finds it difficult to make new friends, it might be even more difficult to sustain that friendships or even keeping in touch with old ones (Donoghue 2016:4).

According to Ciobanu and Fokkema (2017:203), loneliness and isolation refers to unpleasant feelings experienced by the migrants as result of discrepancy between actual and desired social interactions and loneliness result in social vulnerability. Mental or psychosocial illness including social isolation is prevalent in vulnerable migrants (Pavli & Maltezou 2017:1). Ciobanu and Fokkema (2017:203) state that desired social interactions and loneliness result in migrant vulnerability which could result in the expat not finding their feet. Pavli and Maltezou (2017:203) also indicate that social isolation is prevalent in migrants. Both publications support this study’s findings that the participants experience loneliness or isolation, depression, social isolation when struggling to make new friends whilst working and living in the KSA. The South African expatriate nurses working in the

KSA struggled to find their feet in the workplace, which made professional adjustment difficult. The following section (sub-category 2.4.2) will discuss professional adjustment issues experienced by the South African expatriate nurse whilst living working and living in the KSA.

Sub-category 2.3.2 Professional adjustment

All participants mentioned that there were different terminologies, procedures and working conditions in the KSA which challenged their professional adjustment. Participant 1 mentioned: *"…there [KSA] a charge nurse is much different to a shift leader in SA…things there [KSA] was so unnecessary and they complicated everything…"* (P6); and *"I learned a lot from them in terms of tricks and short cuts…the manager said to pass a cannula, and I did not know what she was talking about"* (P1). Participant 9 said that: *"…you need to perform above and beyond…working longer hours was actually terrible"* (P7).

Due to the global shortage of nurses' countries with developed healthcare systems are forced to recruit trained nurses from foreign countries (Lagardé & Blaauw 2016:NP). Nurses' primary intent is to enhance a patient's health (WHO 2018:NP). South African nurses who migrate to the KSA might find it very difficult to communicate with colleagues who use different medical terminologies which can influence their professional growth and adjustment.

According to Calvin (2017:35) work adjustment refers to work achievement after exerted effort. As per Baruch, Altman and Tung (2016:NP) willingness to change into a new work environment will result in optimal adjustment into the new environment. In this study, participants were willing to learn and accommodate to the new work setting in the KSA. According to Alghamdi et al (2018:119), job satisfaction is changeable, emotional feelings influenced by socio-cultural influences including adjustment into the workplace. Alghamdi et al (2018:119) state that job satisfaction is changeable and that socio-cultural influences impact work adjustment correlate with this study findings that participants mentioned that they struggled to adjust to the cultural behaviours in the KSA which was also reflected in the workplace i.e. the treatment by Saudi physicians.

Performance is connected to behaviour and individuals who are adjusted during migration will be beneficial to the organisation (Calvin 2017:35). Baruch et al (2016:NP) mention that adjustment in a foreign context (during migration) refers to acceptance of diversity (including gender, sexual orientation and forces driving decisions to migrate). The research publication by Calvin (2017:35) which stated that well-adjusted expats will be beneficial to the organisation hasn't been evaluated or supported in this study, but the publication Baruch et al (2016:NP) which stated adjustment during migration refers to acceptance of diversity support with this study's findings, participants experienced adjustment into the new workforce in the KSA once they accepted the diverse traditions and behaviours.

Working in another country for a period of time might enable participants to explore new cultures and broaden life experiences through foreign cultural exposures. All of the participants mentioned that although it took time to initially adjust to the KSA healthcare environment, after adjustment they referred to the 'strange' or new environment in the KSA as 'home' which indicate that professional adjustment took place. The participants agreed that there was obvious difference in living and lifestyle standards in the KSA when compared to SA. The following section will describe category 2.4, lifestyle or living standards in the KSA.

Category 2.4 Lifestyle or living standards

Participants mentioned that they were not used to the different lifestyle (lavish standards) and living standards in the KSA (items could be afforded as the participants received higher remuneration, paid accommodation and transport as pull factors towards migration) as compared to SA (participants couldn't afford luxuries on salaries, have to pay own accommodation and transport as push factors towards migration). A sub-category included paid accommodation and transport (Sub-category 2.4.1, paid accommodation and transport discussed below).

Sub-category 2.4.1 Paid accommodation and transport

Participants received free accommodation: *"…the compound' apartments were given to us, free of charge and everything was available…from washing machines, dryers and furniture…"* (P1). Participant 2 said: *"…in the whole it was the lifestyle, everything was*

available. In terms of quality, everything was of the best quality, I had the best experience I had in my whole life. Those are the memories I will carry with me forever and ever…". Also, *"...we were waiting on the bus to take us to and from work…initially it was nice not driving yourself to work every day…transport was provided free of charge…"* (P4); and *"everything was handed to use, free transport to and from work, medical care – we didn't pay anything…"* (P7).

Accommodation and transport in the KSA have been discussed as Annexure B. Apart from the contractual agreements handed to South African expats, there are no existing literature on the type of accommodation (standard or free) made available to expats in the KSA. When the South African expatriate nurses got used to the lifestyle and traditions in the KSA, they were facing a new reality with negative experiences at times when reality kicked in as discussed as category 2.5 below.

Category 2.5 Reality kicks in

Participants were confronted by the reality of the 'strange land' as they were faced with different worldviews, negative treatment by Saudis and mistrust among colleagues.

Sub-category 2.5.1 Different worldviews

According to participants, there were vast differences between the worldviews, including culture and traditions in the KSA compared to SA. As discussed previously in this Chapter, the participants noticed the suppressive role of females in the KSA; their independency was taken away by not being allowed to drive their own vehicles. The dress code which initially was seen as an irritation by the participants became a source of comfort for them when they could not leave their homes without it and felt naked when not dressed in the black Abaya.

The recruitment agencies prepared all the participants with regard to the dress code and strict conservatism and even gave advice on how to go through customs: *"...when you go through customs they are going to search your luggage, so when you pack your suitcase you must go and buy tampons and revealing lingerie and place it on top of your suitcase – so when I eventually got through customs the guys' eyes got really big and he stopped his search"* (P1).

All the participants mentioned that they picked up on some Arabic words, but most of the phrases uses were difficult to comprehend: *"...words irritated me like the term Insha-Allah, meaning God willing"* (P2); *"…You will not sit back and wait for God to send it to you – if God wanted you to do something, you will do it"* (P1); and *"God is not always putting things off…everything gets put off and it almost becomes an excuse"* (P6).

Women are not allowed to drive their own vehicles in the KSA and are dependent on a taxi or bus to transport them to work, shopping or travelling. Participant 6 said: *"...all the things I couldn't do stressed me out – not driving, waiting for a bus or taxi to take you out…the fact that I could drive, I just couldn't understand that…"* (P6). One participant mentioned that she was told women are not allowed to travel on their own because of safety issues. All participants mentioned that they felt that their freedom and independence was taken away from them: *"...the fact that you were not exposed to travelling to work, the pleasure of driving to work and taken to and from work in a bus"* (P2); *"…it was difficult finding a reliable taxi to pick you up any time and drop you off safely was an issue"* (P4); which is in contrast with *"…I had never seen so much traffic in my life, they have no regard for traffic lights or stop streets"* (P6).

As per Hardy (2018:3), worldview refers to the inclusion of the person's perspective on the world that exists (ontology), how this person came to understand the existence of the world (epistemology) and whether this person accepted this world and changes in it. In this study, there has been disagreement between the participants as to accept or reject the worldviews in the KSA. Some of the participants were curious about the diversity whilst others just could not accept the strange behaviours.

According to Brown (2016:4) culture shock symptoms include feelings of rejection and confusion experienced when confronted with different worldviews. This study's findings that participants experienced disorientation and culture shock when confronted with different worldviews in the KSA, and reversed culture shock upon their return to SA, is similar to that of Brown (2016:4).

According to Al-Harbi, Thursfield and Bright (2017:2795), the KSA is not known for democracy and performance evaluated is based on group-outputs rather than focus on the individual. Certain employees or cultural groups will be favoured above others based

on “Wasta” (what you own and who you know) and refers to who the individual is connected to and his or her relationship and contribution to the institution (Al-Harbi et al 2017:2795). Al-Harbi et al (2017:2795) state that certain employees or cultural groups will be favoured during migration is similar to this study’s findings – participants observed the negative treatment by Saudi’s towards certain culture groups i.e. Pakistanian and these ‘minority’ cultures were expected to work during fasting hours and extreme heat.

According to Lefdahl-Davis and Perrone-McGovern (2015:418) differences in the KSA culture (compared to the Western paradigm) include gender segregation, family ties and reputation, religious morality, respect for elders, generosity, gender roles, dress code and courtship. Research findings from Phase 1 of this study is supported by Lefdahl-Davis and Perrone-McGovern (2015:418) that indicate that different worldviews will influence or hamper adjustment in a strange land and can ultimately lead to culture shock, poor adjustment and dissatisfaction. Research participants mentioned that they observed a distinctive behaviour from the Saudis when dealing with other foreign nationals.

The following section will discuss sub-category 2.5.2, Negative treatment by Saudis.

Sub-category 2.5.2 Negative treatment by Saudis

Participants observed the attitudes of the Saudis as disrespectful by talking down and acting as superiors towards other nationalities. Two participants mentioned that it was especially observed by Saudi men when dealing with women as they have very little regard for females in the KSA. The participants had different methods of coping with the negative treatment (communication, management and general attitudes) handed down by the Saudis: *“...going back after the (seventh) month’s holiday was a whole lot different, the adventure was over and the reality was that I was there to stay”* (P1); *“…working with Arab men was probably the most intimidating in the beginning because they are not used to be questioned by females”* (P3); *“…this was an adjustment and a major challenge”* (P2); and *“…one lady (nurse) was crying profusely, it was just too much for all of us, I couldn’t get used to that”* [The treatment of women by Saudi men]*”* (P6).

All of the participants mentioned that the female treatment in the KSA is totally different than what they are used to in SA: *“…and we just freaked, being true South Africans, we had our boundaries and when it came to certain things we were kind of a horror to the*

Saudis, *we couldn't bow our heads and look the other way"* (P6). In KSA, it is expected of women to be subservient. When the SA nurses went out: "…*you cannot say to someone you need to serve me now"* (P1); and *"…you just have to bite your tongue"* (P2). All participants mentioned that it was not easy for a woman alone in the KSA due to the restrictions.

The superior status of men against women could lead to a limited ability to deal with workplace situations that might require cultural and gender sensitivity: *"…it was a challenge, but what is good about South African nurses who lived through the Apartheid era, we are taught certain skills, we constantly had to prove ourselves and we were constantly disadvantaged…"* (P5). There is a gap in literature to support the link between the perception of nurses during Apartheid and certain coping skills learned in nursing during Apartheid.

The research participants mentioned that although they had to constantly prove their worth, they still experienced mistrust amongst some of their colleagues (discussed sub-category 2.5.2 below).

Sub-category 2.5.2 Mistrust amongst colleagues

When participants had to adjust to the working and living conditions in the KSA they felt like 'strangers in a strange land', surrounded by strange and foreign cultures, including Americans, Canadians, Egyptians, Indians and Filipinos. All participants pointed out that the Filipinos were perceived to be devious and back-stabbing (perceived by participants in KSA) and always agreeing and acting together (simulating a mafia). Working and living with diverse cultures might pose a whole new set of challenges when you cannot trust the people you are expected to work with. Participant 1 referred to the Filipino colleagues as: *"...nasty bunch of people…"* (P1); *"brain washed"* (P7); *"mafia…"* (P8); and *"...and not good people…"* (P9). The feelings of 'unreliability' experienced by the participants created emotions of mistrust amongst colleagues.

The Philippines is regarded as a leading labour exporter of nurses to foreign countries in need of nurses and contribute to approximately 19% of the global nurse market (Vartiainen, Pitkänen, Maruja, Raunio & Koskela 2016:31). The exact number and severity of Philippine and Jamaican nurse emigrants is impossible to indicate due to

incomplete registration and recording data (Vartiainen et al 2016:32).

According to Bautista, Ducanes and David (2019:259) there are 10.5 million Filipinos working overseas (mainly in China, Hong Kong, Qatar, Saudi Arabia, Singapore and the United Arab Emirates). Most of the 17 000 to 22 000 health professionals that leave their country of origin (in this instance the Philippines) to work abroad are nurses. Between 1993 and 2010 most nurses went to Saudi Arabia (90 382) (Bautista et al 2019:259). A gap in research findings could not produce recent numbers on the expatriate nurses who emigrated to other countries. There is also no evidence of studies based on the participants' findings related to mistrust amongst colleagues in foreign countries.

Although the participants said that they were working with different nationalities and they were not able to trust some of them, they had opportunities to build social networks (discussed category 2.6 below).

Category 2.6 Social networks

The sub-categories included socialising with fellow South Africans and making new friends from diverse cultures. In this study, participants felt it was difficult to make friends from diverse cultures as they felt like 'strangers in a strange land' and their social networks with friends or families in SA has been damaged or lost. The absence of social networks in the KSA resulted in loneliness, feelings of isolation and depression in the South African expat. The following section will describe sub-category 2.6.1, socialising with fellow South Africans.

Sub-category 2.6.1 Socialising with fellow South Africans

The social networking in the KSA included socialisation with fellow South Africans and making new friends from diverse cultures. Participants had different opinions about their social networks in the KSA. Some felt isolated while other socialised with fellow South Africans or made new friends. Some of the participants felt that they had no fellow South African colleagues: *"…I felt so isolated…"* (P1); *"…I made no friends and the culture shock was totally different from SA – you are there, you are polite, you go home and you are alone…"* (P2); and *"…I was so lonely, all alone…"* (P7). Other participants socialised with fellow South Africans but felt that these fellow South Africans behaved very strange in the

KSA: *"…I was told by the South African girls that I had to get an Arab boyfriend, they can get you all you need, even alcohol. Most of them had Arab boyfriends…" (*P6). [Field note – the researcher could recall one incident where a fellow South African colleague made a 'good wine'. Unfortunately, the plastic container which was used to make the wine was kept in a cupboard and the heat caused the container to explode which left the whole apartment smelling for a few months; P6 frowning when mentioning Arab boyfriends.]

According to O'Reilly and Benson (2016:14) migrants will seek out similar individuals after the euphoric phase of migration. In this study participants mentioned that they felt lonely and isolated even when surrounded with colleagues from SA, which is contradictory to the study done by O'Reilly and Benson (2016:14).

Expatriate nurses working and living in the KSA suffered losses in friendships and working relationships and experienced feelings of isolation and loneliness (Chen & Chang 2016:2). Although the participants initially felt very alone and isolated some of them managed to establish friendships whilst working and living in the KSA. The following section will describe sub-category 2.6.2, making new friends from Saudi or diverse cultures.

Sub-category 2.6.2 Making new friends from Saudi or diverse cultures

The following section will address the perceptions of some participants who made new friends from different diverse cultures. Some of the participants established lasting friendships: *"…establish new relationships…lasting and true. I…still [have contact with] one girl I met there…my Saudi friends during my second return was different, they had different lifestyles…"* (P7). Most of the participants mentioned that as a way of survival it was encouraged to get a Saudi 'boyfriend' who can support and provide socially and financially in needs whilst in the KSA. This is in contrast with Participant 1: *"…I had relationships that I never thought of, doing things I am not so proud of – but that was all part of the coping mechanisms out there…"* (P1). Participant 9 said: *"…it was house parties hosted in other compounds; there I met my first husband which was Kenyan…"* (P9). This marriage did not last when returning to the SA.

Whilst the participants were 'finding their feet' in a 'strange land', they struggled to establish and maintain social networks. Despite this, all participants indicated that they

have experienced personal growth whilst in the KSA. The following section will describe category 2.7, personal growth.

Category 2.7 Personal growth

The participants had access to travel opportunities that was not available while working and living in SA. With these travel opportunities, participants could learn survival skills and obtain independence when travelling to foreign countries alone. Sub-categories included travel opportunities and attaining survival skills that resulted in personal growth. Participants mentioned: *"…I travelled a lot, experienced different countries and cultures..."* (P1); *"…I learned how to cope in stressful situations…"* (P6); and *"…I went to London and Dubai…"* (P5).

According to Mesidor and Sly (2016:263) adjustment is influenced by academic and personal growth structures. In this study, all participants experienced some level of personal growth during the migration and adaptation process between the KSA and SA. Furthermore, Hoppe and Fujishiro (2016:18) state that enhancing self-efficacy and growth is a motivation towards migration. Migrants master new norms and ideas that can improve their stance in the country of origin (Wahba 2015:NP). Wahba (2015:NP) state that migrants can master new norms and ideas during migration which support this study's findings: South African expatriate nurses mastered new norms during migration to the KSA (personal growth and learnt additional life skills which assisted them during the adaptation process upon their return to SA).

The following section will discuss the travel opportunities (sub-category 2.7.1) available to South African expatriate nurses whilst working and living in the KSA.

Sub-category 2.7.1 Travel opportunities

Although all of the participants mentioned that the extreme temperatures hampered their adjustment, they were given numerous opportunities to travel because of the affordability: *"…you can travel when you are there because it is so affordable…"* (P1); *"… it is easy and everything is available"* (P2); *"…it is easy to go around – I went to Bahrain and London…"* (P4); *"…I had this global experience and I travelled extensively, saw things*

some people can only see on National Geographic" (P1); and *"…I have been to Egypt, Oman and Dubai…"* (P3).

Travelling for entertainment in the KSA is limited to scuba diving, desert excursions and family orientated amusement parks. Movie theatres are prohibited but DVD's are available for purchase (Almazroui et al 2015:2558). Playing loud music in the streets, taking photographs of public buildings and people and the selling of religious artefacts other than Islam is strictly prohibited (Lefdahl-Davis &Perrone-McGovern 2015:418). In this study, participants were very curious about the public display of prayer and wanted to take pictures of it but were discouraged by colleagues as it is deemed illegal in Islam. None of the research participants in this study referred to loud music in streets and the absence of movie theatres.

According to Battour, Ismail, Battor and Awais (2017:54) travel is a push-pull motivator and people are pushed by an internal desire to travel and pulled towards a new adventurous destination. The findings from this study were supported by Battour et al (2017:54) that highlighted internal (need for independence) and external (financial gain and career development) motivators towards migration. In this study, the participants agreed that they were exposed to travelling opportunities in the KSA due to the geographical accessibility of the country as well as affordability (these expatriates received better remuneration in the KSA and could afford to travel). Research participants mentioned that although they had exposure to travel opportunities (during the migration process) their survival skills were put to the test (both the KSA and SA). The following section will describe sub-category 2.7.2, survival skills.

Sub-category 2.7.2 Survival skills

In this study, participants mentioned that working and living in the KSA taught them certain survival skills as they were expected to survive in a 'strange land', most often alone. Participant 2 said that: *"…I needed to stay; I needed to (keep) going…"* (P2), whilst Participant 7 mentioned that: *"…it showed us how to cope in difficult situations"* (P7); and *"…we were taught how to survive, we are from SA…"* (P5). [Coping skills included both resilience and perseverance whilst working and living in KSA.]

Bobowik, Basabe and Páez (2015:201) state that expatriate adjustment and high levels of self-actualisation is influenced by personal growth, friendships, support and self-acceptance. As per Bobowik et al (2015:201), the whole migratory process is a process of personal growth. The study by Bobowik et al (2015:201) that mentioned survival skills is linked to personal growth (how to adjust to ever-changing environments during migration) supported by friendships support this study's findings: study participants mentioned that they developed personal growth during the migration experience. There is a gap in literature regarding South African expatriate nurses' adjustment and coping skills during migration (KSA).

Apart from the personal growth and numerous travel opportunities and survival skills learned, all participants felt that they experienced professional growth whilst working and living in the KSA. The following section will describe category 2.8, professional growth.

Category 2.8 Professional growth

All participants indicated that they experienced professional growth as the training and learning experienced in the KSA provided global exposure and experience as well as enhancing their clinical competence. Participants mentioned: *"…I learned such a lot…"* (P1); *"…I learned things that I never thought existed in SA…"* (P5); and *"…I thought SA taught me about haematology, but they can never begin to understand what I have learned there…"* (P7).

The sub-categories were training and learning and gained global exposure and experience and enhancing clinical competence. Globalisation and ultimately migration of nurses brought changes in the healthcare setting with a demand for culturally appropriate and competent care. The global migration of nurses created culturally diverse skills and culturally competent knowledge (NHI 2015:NP). Cultural competence as explained from a nursing perspective is the ability to understand cultural differences, to be culturally sensitive to issues like race and gender and to provide holistic quality care to all diverse patients (NHI 2015:NP). The goal of professional grow is to achieve optimal and effective work relations with patients and colleagues from diverse cultural backgrounds (NHI 2015:NP). Research documents published by the National Health Insurance Institute (NHI) (2015:NP) state that positive working relationships with colleagues from other countries and the ability to learn from them will aid in effective, high standard holistic

nursing care. The NHI (2015:NP) states that positive working relationships in nursing will encourage the ability to learn from each are similar to this study's findings – participants mentioned that they had to be understanding of the diversity exhibited in the KSA and had to foster understanding and acceptance of colleagues from diverse backgrounds as to deliver optimal patient care.

According to Hoppe and Fujishiro (2015:18) motivation towards migration include job benefits and career development. International migrants returning home acquired skills that will enable these migrants to earn higher salaries. Hoppe and Fujishiro (2015:18) state that job benefits and career developments are motivators towards migration which are similar to this study's findings – all participants agreed that the decision to migrate included career development opportunities and participants achieved professional development whilst working and living in the KSA. Unfortunately, when participants returned to SA their professional development (global exposure and experience gained in the KSA) has not been recognised as they were not offered higher salaries based on their international exposure. Training and learning opportunities in the KSA contributed to South African expatriate nurses' professional growth. The following section will discuss sub-category 2.8.1, training and learning opportunities in the KSA.

Sub-category 2.8.1 Training and learning

All participants in this study agreed that they received superior training (procedures, techniques and technology) and exposure to learning opportunities whilst in the KSA: *"…the education you were exposed to…"* (P4); *"…the systems you were exposed to…"* (P1); *"…I learned such a lot, education and to further my studies…"* (P4); *"…everything is high level and standardised…"* (P9); and *"…we were allowed to make decisions, dealt with doctors, do physical assessments and order prescriptions…"* (P9). Participant 8 mentioned: *"…they [KSA] have technology, they were advanced unlike SA can ever imagine…"* (P8); and *"…in KSA you were bombarded with everything – skills and knowledge"* (P9). [Field note – researcher flashback - I could not stop shaking my head as if it were a revelation from P8, remembering the freedom of access to the best equipment and services; P1 was smiling while thinking back on these excellent exposure and opportunities.]

As per Chen and Chang (2016:1), positive and comprehensive training processes related to self-assessment and cultural awareness enhances cross-cultural exposures and experiences. According to Abdullah and Jin (2015: 550) migration and expatriate assignments include training and development of expatriates on environmental factors and culture differences and the benefits of this training is an investment for the company.

In this study participants agreed that they received a higher level of training and development in the KSA (pull factor and external motivator towards migration) compared to SA. All participants mentioned that they gained global experience, which improved their professional skills and knowledge as discussed as sub-category 2.8.2 below.

Sub-category 2.8.2 Gained global exposure and experience

Participants gained global exposure and experience but felt it was not appreciated or acknowledged when they returned to SA. All participants mentioned that although they grew professionally while working in the KSA, they did not get any recognition for their global experience gained when they returned to SA. They also could not share their newly obtained skills and knowledge with their fellow colleagues: *"…I just felt I had so much energy, we were exposed to state of the art equipment, our hospitals were accredited for the third time, we set standards"* (P5); *" our people in SA could benefit if I could share some of that information"* (P4); *"…the people stay in the same 'rat', you try to implement the things you have learned there, but you realise you are never going to win here"* (P6); and *"…the South Africans have different thoughts"* (P4).

In this study, participants claimed that they gained international experience, skills and knowledge. According to Van den Broek and Groutsis (2017:852) international migrants have global trends and experience which does not always interlink with local behavioural trends. As per Van den Broek and Groutis (2017:852) South African expatriate nurses gain international experience whilst working and living in the KSA, gain exposure on cultural diversity which is not as focused when compared to SA which is similar to this study's findings where participants agreed that they gained global, cultural exposure. International migration involves processing of 'what was' and 'what is now' as the migrant was exposed to international exposure and experiences (Roberts 2019:105). Roberts (2019:105) indicates that participants had to shed all previous knowledge and behaviours regarded as 'normal' in SA (what was) and learn new behaviour and skills in the KSA

(what now) as to adjust to the new environment.

Participants in this study gained global experience (pull factor towards migration) and their clinical competence improved as a result. The following section will describe sub-category 2.8.3, enhancing clinical competence.

Sub-category 2.8.3 Enhancing clinical competence

Most of the participants mentioned that they had gained clinical competency that they had to constantly proof: *"…it taught us different skills…we constantly had to prove ourselves…how to cope in difficult situations…"* (P5). Participant 1 said: *"…so you make adaptions and I think that is most probably the key to survival and competence…I had this massive international experience with golden standards…"* (P1). Participant 9 mentioned: "…*in the KSA you are bombarded with everything – skills and knowledge…advancement unlike SA can ever imagine…"* (P9).

The international experience gained whilst working in the KSA lead to all of the participants returning to SA with a feeling of almost superiority compared to those nurses who never left SA: *"…it is almost in a certain way, and you can deny it all you want – one feel superior when you come back, you have been empowered"* (P2); *"…now you have different thoughts than them"* (P6); and *"…you approach things totally different now"* (P5).

Participants also mentioned that South African nurse training teach nurses to act without reason and thinking *"…unfortunately in SA we do things blindly. I worked in transplant but gave no thought to what we were doing there…"* (P9). When the participants returned to SA and worked with individuals who did not gain international experience it leads to conflict.

In this study, participants felt that they gained more skills and knowledge in the KSA, which they wanted to implement in SA. Unfortunately, the reception of South African nurses towards these expatriate nurses' transfer of gained knowledge was not appreciated or valued and caused resistance and conflict. Conflict in nursing creates negative feelings and avoidance is used as a coping mechanism (Leon-Perez, Medina, Arenas & Munduate 2015:251). Managing conflict in the workplace is time consuming but a necessary component for nurses to perform their duties well (Leon-Perez et al

2015:251). Conflict in the workplace can cause adverse effects like low morale, decreased productivity, low standards in patient care and continued dissatisfaction can lead to rapid employee turnovers (Leon-Perez et al 2015:251).

According to Einarsen, Skogstad, Rørvik and Nielsen (2018:549) conflict or bullying in the workplace result in health issues, poor outcomes, low performance, low productivity and higher turnover rates. The findings from this research supports the findings from Einarsen et al (2018:549) that showed health issues and low performance can result during the adjustment Phase of expatriate migration. This study did not focus on bullying or conflict in the workplace but did address mistrust amongst colleagues. Although argued that some level of conflict may be beneficial, it is usually harmful which causes dysfunction in employees and negatively impact adjustment (Zhou, Xi, Zhang & Zhao 2017:3).

After periods of working and living in the KSA, gaining personal and professional growth the participants took personal decisions to return to SA, only to feel like *'Strangers in their own land (SA)'* (theme 3 discussion below).

Theme 3: Strangers in their own land [South Africa (SA)]

The research participants initially felt like 'strangers in a strange land', but eventually became used to the lifestyle and traditions in the KSA. When adaptation took place the KSA became 'home' to them. When participants returned to SA, they felt like 'strangers in their own land'. The lifestyle and traditions that they were previously part of now become strange and difficult to understand. They experienced losses in different dimensions including relationship loss, not fitting in, feeling disconnected and lonely. They experienced losing part of themselves and lost their sense of belonging. In this study, the participant's experiences when they returned to SA was very similar as when they emigrated to the KSA. The initial adjustment experiences in the KSA exposed the participants to culture shock, however the re-adjustment in SA caused reversed culture shock.

The following section will describe category 3.1, losses in different dimensions.

Category 3.1 Losses in different dimensions

The following section will address the participant' responses regarding losses in different dimensions with the sub-categories relationship loss, '*feeling like an outsider/not fitting in/disconnected',* loneliness, '*losing part of yourself'* and loss of sense of belonging. Discussions on each sub-category to be discussed in separate sections to follow.

Participant 5 mentioned that when she returned to SA, it was difficult to understand and connect with friends and colleagues. She had gained knowledge and experience, while those left behind became stagnant: *"…people were on the same level where we left them…things were totally different…"* (P5). Participant 6 felt her friends, colleagues and loved ones have moved on with their lives without her: *"…they have moved on with their personal and work lives without me…"*; and *"…you come here with all your fancy things, we don't know you anymore…"* (P3) and *"…they did not understand I had my own life now…"* (P6).

In this study, participants felt disconnected and lost in another dimension from family and friends, they have changed and grown but those left behind in SA stayed the same. There is a gap in literature regarding losses in different dimensions experienced by South African expatriate nurses when returning from the KSA. When the participants could no longer associate with their friends, colleagues and families as they had developed different worldviews, it led to relationship loss (discussion sub-category 3.1.1 below).

Sub-category 3.1.1 Relationship loss

Two participants mentioned that they had issues re-adjusting to connect with their families in SA after living alone in the KSA. When they returned to SA they felt alone and isolated from their friends and families: *"…I have been living alone for (two) years in the KSA, it had its' challenges but now I am back in this house…"* (P1); and *"…I actually got divorced during that time – it was so awkward for me to live with a man [when returning to SA during holidays] who doesn't love me anymore…but I stayed for my children…"* (P3). During the time participants spent in the KSA, their families, friends and loved ones did not necessarily wait for their return; and moved on with their lives without them. Friends and family filled the gaps left by participants by forming new friendships and getting involved with other activities that did not involve the participants.
When participants eventually returned to SA, friends and family members they have been

close to might have moved on as time spent apart might have caused a loss in the relationships: *"…my friends made new friends, I felt isolated…"* (P3); and *"…in terms of socially, people I have been very close to I have lost, lives have changed, they moved on…"* (P2). [Field note – P2 mumbled… the loneliness was overwhelming, or maybe I wanted to be 'left alone'.]

According to Bader and Schuster (2015:68) social relationships are built on information, emotional, instrumental and appraisal support. In this study, the participants lost relationships (which could be emotional in origin) as they were alone in the KSA without emotional support. There is a gap in literature related to relationship loss of South African expatriate nurses whilst working and living in the KSA. These participants might have tried to mend these broken relationships, but they felt disconnect or like outsiders. The following section will describe sub-category 3.1.2, '*feeling like an outsider/not fitting in/disconnected'*.

Sub-category 3.1.2 Feeling like an outsider/Not fitting in/Disconnected

When the participants returned to SA after working and living in the KSA, they felt like outsiders (in both the working and living environments). Things known to them before has changed, leaving them feeling disconnected. Participant 3 mentioned that she felt disconnected from her children: *"…you actually miss out on your children growing up…it is a lot of negative things…"* (P3). All participants mentioned that they have lost their friendships whilst in the KSA because: *"…get worse…first time everybody was excited…this time nobody really bothered, they were not interested in my experiences…"* (P2). Participant 9 mentioned that she is still feeling disconnected from her family and colleagues: *"…It has been 7 years and I don't think I will ever settle here…"*. [Field note – P9 appears to be very strong, but this statement reflects her weakness in SA. She cannot accept her 'new' environment and will do basically anything to be back in the KSA.]

In this study, participants felt disconnected, '*like an outsider and not fitting in'* to the environment, which has been previously known to them (all of them worked and lived in SA before emigrating to the KSA, had some form of family or friend support systems). There is a gap in literature on disconnect and alienation in South African expatriate nurses when returning from the KSA. When the participants felt disconnected from their loved ones it contributed towards feelings of loneliness (discussion sub-category 3.1.3 below).

Sub-category 3.1.3 Loneliness

Participants indicated that lost relationships lead to feelings of loneliness and or depression [upon their return to SA]: *"…I was lonely for the first year and even longer"* (P1); *"…it took me a good 12-18 months to feel that I was back home and settling in"* (P2); *"…my adjustment back to SA was very difficult for me…"* (P3); and *"…I was so lonely…"* (P4). Participant 7 mentioned that: *"…this is a lonely world…"* (P7), while another participant referred to being "*surrounded by family and children but still feeling very alone…"* (P5). [Field note – P7 mumbling…I wanted to go home and see my kids but did not want to go – so confusing.]

According to Bader and Schuster (2015:71) closeness in expatriate' social relationships refer to the intensity of social connection between the expatriate and his or her social network. In this study, the participants mentioned that even when surrounded by their families or friends they still felt lonely. There is a gap in literature regarding loneliness experienced by South African expatriate nurses whilst working and living in the KSA. When the participants lost previously valuable friendship and experienced loneliness, they also lost part of themselves (discussion sub-category 3.1.4 below).

Sub-category 3.1.4 Losing part of yourself

Participants in this study mentioned that they lost a part of themselves in both the KSA and upon return to SA. Participants became part of the KSA culture, emerged within traditions and practices which was previously unknown to them (they felt at home in a strange land when adjusted to the extravagant lifestyle and cultural behavior in the KSA). Participant 3 referred to the fact that when she went to Saudi, she was changed: *"…when you go over, you lose some of yourself…"* (P3). [Field note – researcher recall - I understand this exactly – have been the same for me. Sometimes the picture reflected in the mirror seems unfamiliar.]

Upon return to SA, participant 7 stated: *"…something inside me changed. I am not status quo anymore…"* (P7); whilst participant 9 mentioned *"…they changed me. How can I even try to explain to people what change and at what level we were changed as I myself don't even understand it…"* (P9). In this study, participants all experienced similar feelings as

described by ‘losing a part of themselves’ and their sense of belonging. As if the participant’s whole sense of being has been changed and tampered with by a force not known, to a level that they themselves didn’t even understand anymore. There is a gap in literature regarding the changes of South African expatriate nurses when emigrating to the KSA and upon their return to SA. The findings from this study aims to address this gap.

When the participants felt like they lost a part of themselves and lost previous friendships and relationships, they felt a loss of sense of belonging (discussion sub-category 3.1.5 below).

Sub-category 3.1.5 Loss of sense of belonging

All participants said that when they returned to SA after working and living in the KSA, they experienced a loss in their sense of belonging as they had difficulty to connect with people they once knew and befriended: *“…you just don’t connect to people on that level anymore”* (P2); and *“you have changed and they have changed – or they have stayed in the same place and you have become this totally different person on a strange level”* (P4). [Field notes – researcher recall - I can associate with everything said – how do I recognise the person I became; P2 appears sad.]

Participants spent an average of 10.6 years in the KSA. The time spent is individual dependent, but all of them agreed that when they decided to leave the KSA there was no stopping them: *“…the reason why I left when I did at that stage – everybody else was already gone, 12 years of my life was gone”* (P5). Participant 9 mentioned *“…I became an immensely different person…in a different dimension…maybe misplaced…things were totally different…”* (P9). Participant 7 said that she *“…like(s) to be alone…”* (P7).
In this study, participants agreed that they lost their sense of belonging on various levels (they did not fit in and had no more connections with friends, family and or colleagues anymore). Firstly, when they adjusted to the KSA and their support structures or friends left they had the desire to leave as well. Then, upon their return to SA, the people around her have changed and they did not feel that they belonged back home in SA anymore.

According to Grzymala-Kazlowska and Phillimore (2018:1), increased inter-connectiveness between communities and migrant diversification influence adaptation

into new environments. Gabdrafikov, Khusnutdinova, Karabulatova and Vildanov (2015:221) mention that cultural composition (level of assumed power by the migrant) influence adaptation patterns as migrants from 'lower income communities' might feel afraid to voice their concerns which will make it difficult to fit into the new environment.

Also identified and explained by Grzymala-Kazlowska and Phillimore (2018:1), inter-connectiveness between cultures influence adaptation correlate with this study's findings – interaction with the KSA culture (language, tradition, religion) influenced South African expatriate nurse adjustment. Gabdrafikov et al (2015:221) state lower income migrants might not feel comfortable voicing their opinions in a strange environment fits into this study findings - although all participants were born and raised in SA, they still didn't have the freedom to voice their opinions in the KSA which is male dominated.

Adaptation is a multi-dimensional process and individual as well as diverse characteristics of migrants shape adaptation opportunities and create challenges in the new environment (Grzymala-Kazlowska & Phillimore 2018:1). Employees with high perceived levels of authority might not be at fear to lose fellow colleagues' trust during disagreements and find it easier to adjust to new environments (Gabdrafikov et al 2015:221). There is a gap in literature regarding loss of sense of belonging during migration and adaptation in South African expatriate nurses. When behavioural changes occurred in the participant or the person(s) they were once close to, common ground of re-connection was difficult. After a period where the participants felt a loss of sense of belonging, an adjustment Phase was entered. The following section will describe category 3.2, re-adjustment.

Category 3.2 Re-adjustment

When the participants returned to SA, they struggled to fit in, struggled to find a job, experienced disorientation and identified the need to return to the KSA. The participants all mentioned that they struggled with adjustment in the KSA, but even more with re-adjustment upon their return to SA.

All participants mentioned that although they felt like 'strangers in a strange land' in KSA, it was even more difficult to adjust back into the South African context (both working and living conditions). The difficulty with adjustment resulted in them feeling like 'strangers in their own land'. The re-adjustment back to SA took between one and seven years,

depending on the duration the participant stayed in the KSA. Participants in this study who only stayed in the KSA for a two-year period took between 18 months to two years to re-adjust when returning to SA. The participant who stayed in the KSA for 14 years mentioned they took three years to adjust; whilst the participant who stayed in the KSA for 10 years mentioned that she is still struggling to adjust to the South African context after seven years. With the re-adjustment into the destination country (SA) reversed culture shock was identified by the participants. Re-adjustment in this study was an individual process and the possibility of linking re-adjustment to time spent in the KSA has not been evaluated in this study.

Adaptation is the process of change and adjustment, including the process of culture shock, which has its own effects on the migrating nurse (Gabdrafikov et al 2015:221). Gabdrafikov et al (2015:221) state that the process of migration includes change and adaptation which can lead to culture shock support this study's findings – the South African expatriate nurse underwent a process of change and adjustment whilst living and working in the KSA which ultimately resulted in culture shock.

There are two aspects of intercultural adaptation (Einarsen et al 2018:549). Socio-cultural adaptation is based on the nurses' previous cultural learning and approach, which are reflected in her ability to engage in interaction with a foreign culture (Einarsen et al 2018:549). Psychological adaptation involves the nurse's sense of wellbeing, enhanced by the positive appraisal of situations and general feelings of satisfaction (Einarsen et al 2018:549). Poor adaptation patterns among nurses relate to higher levels of depression, low self-esteem, anxiety and other psychological disturbances (Gabdrafikov et al 2015:221).

In order to be fully functional in the new environment the expatriate nurse must become culturally competent (NHI 2015:NP). This process of becoming culturally competent has no time limit connected to it. Cultural competence can be explained as a process of becoming rather than accomplishment and is a never-ending process (NHI 2015:NP). Cultures are constantly changing and reforming as a response to environmental, physical and social realities and nurses are expected to deliver culturally competent care. In this study, the South African expatriate nurse worked and lived in two contexts namely the KSA and SA (see Annexure B for detailed comparison). Upon return to SA, these expats

struggled with re-adjustment to the SA working and living conditions which was influenced by factors such as struggling to fit in, struggling to find a job and disorientation. If this process of cultural adaptation is not successful, the expatriate nurse can experience culture or reversed culture shock (Walton-Roberts 2015:2).

Explanations on expatriate adjustment and the influence of migration on the person will follow in the following sections. The following section will describe sub-category 3.2.1, struggling to fit in.

Sub-category 3.2.1 Struggling to fit in

All participants mentioned that it was easier to adjust to the KSA than to re-adjust or fit in with the SA ways of working and living: *"…it is hard, very hard…"* (P4); *"…I have family here but nothing is the same"* (P1); *"…struggling to find my own feet…"* (P9); and *"…I found out how far behind our hospitals in SA still are, by the time we left, we thought they would improve but my expectations were not met"* (P5).

Expatriate adjustment has already been defined in the introduction and identified as a key concept in this study. Expatriate adjustment is explained by Labonté, Sanders, Mathole, Crush, Chikanda, Dambisya, Runnels, Packer, MacKenzie, Tomblin Murphy and Bourgeault (2015:6) as the measured degree of psychological comfort experienced by the expatriate during a new situation. Adjustment is a state where changes occur in the individual. Expatriate adjustment could be regarded as a predictor of an expatriate's performance and fitting in (Walton-Roberts 2015:2). South African nurses who emigrated to the KSA might experience individual changes in personalities, or struggle to fit in to their new working environment which can affect their physical, emotional and psychological wellbeing (Walton-Roberts 2015:2). Expatriate nurses who experience favourable working conditions will fit in better with the environment (Labonté et al 2015:6).

When these nurses return to the healthcare workforce they are faced with lack of resources, shortage of nurses and equipment, lower remuneration and challenges in nursing standards and care (Labonté et al 2015:6). Returning South African expatriate nurses all concur that they were faced with limited human resources, nurse shortages, nurses' poor caring attitudes and low salaries upon their return from the KSA. Labonté et

al (2015:6) which state that returning expats face lack in resources, equipment, lower renumeration and poor standard care supports this study's findings.

Grzymala-Kazlowska and Phillimore (2018:1) who state that adaptation during migration influence the person on physical, mental and spiritual levels are similar to this study's findings – adaptation during migration into a foreign environment like the KSA and upon return to SA influenced the participants on various levels.

The following section will discuss the returning South African expatriate nurses' struggle to find a job (sub-category 3.2.2) upon return from the KSA.

Sub-category 3.2.2 Struggling to find a job

Participants mentioned that it was difficult to find a job in SA upon return from the KSA. Some of the participants found themselves unemployed when they returned to SA. Others expected higher wages but was offered remuneration packages below their expectation. Their expectations of remuneration was not realistic within a South African context: *"…I swallowed my pride and joined the agency...the (D)epartment became very quiet and I had no shifts…"* (P1); and *"…coming back to that kind of unstable job market…"* (P4). [Field notes – P4 was clearly very upset or angry about being back in SA. She cannot accept the changes from the KSA, very negative.]

Participants in this study mentioned that they were initially drawn to the KSA for financial gain (pull factor towards migration with financial gain as external motivator), but were disappointed when they returned to SA and eventually found a low paying job, which influenced their adjustment. As per Abraham and Nosa (2018:33), SA had a population growth of 6.36% with an unemployment rate of 15.87% during 2017 which means that high unemployment rates contribute to population growth in the country. SA shows very low economic and financial development compared to international market growth and unemployment has permanent negative effects on the country (Caporale & Gil-Alana 2018:80). South Africa offer lower nurses' salaries as compared to international markets due to a decrease in economic growth, therefore nurse migration will continue.

The following section will discuss disorientation (sub-category 3.2.3) as experienced by returning South African expatriate nurses when returning from the KSA.

Sub-category 3.2.3 Disorientation

Participants experienced a feeling of disorientation upon their return to SA [both in work and personal life] as they were not familiar with the context: *"…it was total disorientation…"* (P4); *"…I have never experience that tangible emotion anywhere, never…"* (P1); *"…I found myself withdrawing and I was intolerant of my family and friends…"* (P4); *"it was total chaos, disorientation, still until today…"* (P9); and *"…you wonder what is going on – globally – here, I treated people around me differently"* (P3); and *"…it really wasn't easy trying to get people to buy into what I was telling them, I was running on my own here, everything was challenged…they saw me as a threat, they have no principles, there is no humanity in SA"* (P5). [Field notes – after interview with P1 she asked me about my experiences and if she in some way was 'abnormal' for feeling the way she did.]

All participants said that upon their return to SA they experienced their fellow colleagues as being resistant to changes they were close-minded; and would encourage all nurses to gain international experience: *"…they will not allow you to apply what you have learned"* (P5); *"the South Africans will put you back into your box because they are not open to learning and this is the sad part…standards went down the drain…the infection rate goes up, there are no privacy and confidentiality here…registered nurses make so many mistakes…"* (P4); *"…the doctors asked why we cannot try certain products and that was because of the red tape and strict control involved…"* (P5); and *"…I just have to swallow my pride…the attitude of the nurses in SA killed me – the ethics is bad and that is difficult to come to grips with…"* (P4).

In this study, participants agreed that they experienced some levels of disorientation when returning to SA – both working and living dimensions. As indicated by Ardington, Bärnighausen, Case and Menendez (2016:458) unemployment and inactivity rates are high in SA. A comparative overview of the KSA and SA is discussed in Annexure B. There is a gap in literature regarding disorientation experienced by South African expatriate nurses when returning from the KSA.

Participants mentioned that due to this feeling of disorientation upon their return to South African personal and healthcare environments, they wanted to return to the KSA. The

following section will describe sub-category 3.2.4, the need to return to the KSA.

Sub-category 3.2.4 The need to return to the Kingdom of Saudi Arabia (KSA)

Eight out of nine participants said that they would go back to the KSA in a heartbeat. The lifestyle adjustments and the monetary value, working with international expertise and the opportunities for travel and training opportunities were motivators to emigrate to the KSA. All participants indicated that the peaceful lifestyle and lowered stress levels [in the KSA] contributed to them considering leaving SA again to work in the KSA. Most of the participants said that they would go back to the KSA if given the opportunity: *"…for 1 year I dreamt I was still in Saudi"* (P2); *"… I wanted to be in Saudi…"* (P5); *"…you are going to struggle when you come back…"* (P6); and *"…I will go back tomorrow if given the opportunity"* (P9). [Field notes – P9 appears upset about being back in SA, straightening arms next to body - possibly angry about the circumstances now in SA.]

One participant mentioned that she experienced euphoric feelings connected to the KSA (P1): *"…there is a peace there that I did not feel anywhere else…people speak of Lawrence of Arabia, of Aladdin and the flying carpet…that to me is Saudi…the mythic Arabian nights is kind of legend - I have been to Egypt and Oman and it is not the same…Saudi is special"* (P1). [Field notes – P1 seemed to be 'transported' back in time, told me not to document this whilst giggling, but she is still in love with her Arabic prince – although she knows they will never be together again.]
All participants agreed that they had the need or urge to return to the KSA upon returning to SA. These feelings continued in some participants for numerous years after returning from the KSA. There is no evidence of return emigration statistics of South African expatriate nurses between the KSA and SA. Most of the participants in this study returned to the KSA for another contract.

Through this adjustment Phases the participants became aware of the differences between the first and third world countries (discussion category 3.3 below).

Category 3.3 Differences between first and third world countries

All participants mentioned that the differences between the two countries were vast and included limited human resources, lack of equipment, poor remuneration, decreased

quality in patient care, increased patient ratios, nurses' poor caring attitudes and safety issues. The following section will describe sub-category 3.3.1, limited human resources and equipment.

Sub-category 3.3.1 Limited human resources and equipment

All participants mentioned that Saudi is much more advanced than SA in terms of human resource availability and technology. Participant 9 said: *"…they have technology, they are advanced unlike SA can imagine…, the staffing was excellent, not here…"* (P9). Participant 7 mentioned: *"…it took me some time to realise what was happening here [in SA]…in this small environment. Your back is against the wall…"* (P7); and *"…they [KSA] are much more advanced than us here [SA]"* (P8).

Apart from the limited human resources in SA, participants also had to deal with a lack of equipment in healthcare settings. All participants mentioned that Saudi had 'everything' in terms of equipment and other resources *"…we were used to state of the art equipment…"* (P1) compared to SA where nurses have to improvise with whatever stock they have on hand. Participant 8 mentioned: *"…carers were not wearing gloves [in SA] when working with exudate and I was told 'sister ons weet hoe om dit te doen'…[sister we know how to do this work] [improvising of South African healthcare staff when no or limited stock is available]"* (P8). Participant 7 mentioned: *"…we were used to state of the art equipment…here we still trying to implement technological advances…" (*P7).

As per Walls, Vearey, Modisenyane, Chetty-Makkan, Charalambous, Smith and Hanefeld (2016:17), SA is the largest recipient of migrants, have high levels of communicable diseases and a struggling public healthcare system (limited resources and equipment). Participants agreed that the limited resources available in the South African healthcare systems did hamper re-adjustment to SA. Apart from struggling to adjust upon their return to SA, limited resources and equipment, participants mentioned that they had to be satisfied with the limited monetary compensation offered in SA.

Healthcare in the KSA is free and available to all Saudis (Bcheraoui, Tuffaha, Daoud, Kravitz, Mazroa, Saeedi, Memish, Basulaiman, Rabeeah & Mokdad 2015:1). A challenge in the South African healthcare system is bringing healthcare to the rural populations (specialised hospitals is not always accessible due to the geographical layout of the

country and the district hospitals are often overloaded and understaffed (NHI SA 2015:7). Research participants agreed that they observed the high burden on South African healthcare systems, including lack in human resources and high nurse: patient ratios upon return to SA, which is supported by a publication NHI SA (2015:7) that state that South African hospitals are overloaded and understaffed.

The following section will discuss the lack of remuneration (sub-category 3.3.2) experienced by South African expatriate nurses upon return from the KSA.

Sub-category 3.3.2 Lack of remuneration

All participants said that they were given no monetary recognition for their experience and clinical skills obtained whilst employed in the KSA: *"…even still today when I apply for jobs it isn't easy because you are told that this is what we can afford to pay you…"* (P4); *"…don't bring your fancy Saudi Arabian things here…"* (P2); *"…we all came back with so much experience – much more than SA would give us…"* (P5); and *"…now we would be earning such little money after having this lovely lifestyle – it is not a beautiful experience in SA…"* (P1).

Thapa and Shrestha (2017:7) explain pull factors and external motivators as better working and living conditions, job satisfaction and improved quality of management in the destination country while limited career growth opportunities, poor salaries, lack in training and education is push factors from the country of origin. Pull factors also include better career opportunities with family security, higher salaries and job security.

Push factors from the country of origin according to Garner, Conroy and Bader (2015:1880) include limited professional career growth opportunities and unsafe working conditions. Pull factors include incentives such as better salaries and better working conditions. In this study participants agreed that they received better remuneration in the KSA (pull factor towards migration) compared to SA and the prospect of earning more money in the KSA was an external motivator towards migration. There is a gap in literature comparing nurse' remuneration between the KSA and SA as each region or hospital might have their own financial structures. The economy of SA has been addressed earlier in this Chapter.

According to Abraham and Nosa (2018:33) SA is part of the Sub-Saharan-Africa economy (SSA) and include: Botswana; Guinea; Gabon; Mauritius; Namibia; and SA. SA has a population of 55.9 million, an unemployment rate of 23.61% and inflation rate of 6.3% during 2018. During 2011-2016, approximately 241 758 individuals moved from the Eastern Cape (rural areas) to urban areas. This could be due to better work opportunities in the more developed areas like Johannesburg and Cape Town (urban developments) (Statistics South Africa 2016:NP). This study only focussed on participants residing in the Western Cape region of SA. The higher level of urban development in Johannesburg and Cape Town result in these two provinces being a favourable destination for employment. Participants were faced with a lack in remuneration and an increase in workload resulting in a decline in the quality of patient care in SA compared to the KSA. The following section will describe sub-category 3.3.3, decrease in quality of patient care.

Sub-category 3.3.3 Decrease in quality of patient care

The participants identified the difference in quality patient care between SA and the KSA. Participant 8 referred to the hospital in: *"Saudi is good and was expected to perform sterling work…"* (P8). Participant 4 said that she wished she could stay in Saudi until she turned 70 because: *"…the nursing care is of much higher quality than RSA…[where] they don't care, they want to do the least…"* (P4); and *"… the standard [in SA] went down the drain and it is not the same anymore…"* (P5).

In this study, participants agreed the quality of patient care was higher in the KSA when compared to SA. This might be due that there was more nursing staff available in the KSA to care for patients. There is no evidence of publications in reference to comparison studies between the KSA and South African nursing standards.

According to Armstrong, Rispel and Penn-Kekana (2015:1), the South African government established an independent quality care regulator known as the Office of Health Standard Compliance (OHSC) as part of the overall health reform to monitor and achieve universal health access, protection of healthcare users, management of patient complaints and monitoring of compliance to standards. As to improve the quality of nursing care in SA the Continuous Professional Development (CPD) system has been implemented by the Minister of Health (Viljoen, Coetzee & Heyns 2017:75).

According to WHO, up to 80% of medical equipment in developing countries (like SA) is not functional and this can be the reason for dishonest nursing practices and poor patient care (Moyimane, Matlala & Kekana 2017:2). Although participants in this study didn't make specific mention to poor quality patient care linked to poor nursing standards, they did notice the shortage of stock and equipment.

The following section will discuss the patient ratios (sub-category 3.3.4) in SA as experienced by the South African expatriate nurse upon their return from the KSA.

Sub-category 3.3.4 Patient ratios

Participants in this study stated that there was a noticeable difference between SA (third world or developing country) and the KSA (first world or developed country). According to Armstrong et al (2015:3), the poor-quality patient care in SA can be linked to the shortage of nurses and the high nurse per patient ratios. As per Charalambous, Grant, Churchyard, Mukora, Schneider and Fielding (2016:1109), there is one nurse for every 500 patients which support the publication of Armstrong et al (2015:3) which states that there is a shortage of nurses in SA. According to Bakhru, McWilliams, Wiebe, Spuhler and Schweickert (2016:1536) an international nurse per patient ratios is 1:3 or 1:4.

According to Ditlopo et al (2017:3) the high nurse shortages in SA expose the healthcare system to risks (incidents, poor standards of care, non-adherence to policies and procedures). According to Khamisa, Peltzer, Ilic and Oldenburg (2017:253), nursing is a stressful profession due to patient demands, working hours, emotional demands and conflicts. Budget cuts with less staff and more patients to care for increase work stress and impact on performance and productivity (Khamisa et al 2017:253). As per Khamisa et al (2017:256), the government and SANC received negative publications regarding the nurse shortage and training implementation in SA.

This study's findings support the research publication by Khamisa et al (2017:253) in that nursing is very demanding and is characterised by high stress when working in healthcare settings with limited human resources; nurse shortages and higher nurse: patient ratios will influence job performance and productivity (linked to returning expatriate nurse re-adjustment upon return from the KSA).

Participant 9 mentioned that the: *"…staffing issue in the KSA was excellent, everything ran smoothly…"* (P9); whilst participant 7 said *"…the nurse patient ratios were wonderful, 1:3 during day duty and 1:4 during night duty…"* (P7). This is not the case in SA where: *"…here one staff nurse to take care of patients and there is one registered nurse for 30 patients. In (the) KSA it is much different…here [SA] they don't have proper nurse: patient ratios…"* (P4). This below-acceptable patient ratios applied in South African healthcare system could lead to nurses developing poor caring attitudes (sub-category 3.3.5 discussion below).

Sub-category 3.3.5 Nurses' poor caring attitudes

In this study, participants felt that South African trained nurses had poor caring attitudes which meant that these nurses either didn't care about the quality of nursing and or did not have adequate competencies in terms of knowledge and skills to execute certain procedures. All participants said that they have outgrown their fellow colleagues on an intellectual level and that they could not understand why their fellow colleagues had such bad caring attitudes: *"…here in ICU the infection levels, the MRSA…they just don't care…"* (P6); and *"things are so bad here…"* (P7).

In this study, participants agreed on nurses' poor caring attitudes in SA. Although statistics indicate that during the period 2002 until 2011 there has been an increase in the total number of registered nurses in SA from 172 869 to 238 196 (SANC 2011:NP), 27 9037 during 2016 (SANC 2016:NP); 15% of these nurses will migrate from SA (White, Phakoe & Rispel 2015:2) which will leave the country with 383 nurses per 100 000 population (WHO 2016:NP). The high number in nurse vacancies and nursing shortages link to poor performance and low caring attitudes of healthcare workers in SA (Khamisa et al 2017:257). The 37.8% growth in the nursing population is in line with the general population growth but the demand for more nurses due to illness profiles like HIV/AIDS and Tuberculosis never decrease (WHO 2018:NP).

As per White et al (2015:2), the South African government called for the restoration of ethics, respect in nursing and fostering of good caring attitudes. According to Khamisa et al (2017:256), the relationship between burnout, stress and job satisfaction lead to nurses' poor caring attitudes. Nursing shortage lead to burnout and personal health issues, which result in 'non-caring' and poor attitudes of healthcare workers (Khamisa et al 2017:256).

According to Ditlopo et al (2017:3), SA nurses make up the largest group of healthcare providers, but face challenges like international migration, ageing workforce and sub-optimal performance.

According to Khamisa et al (2017:256), higher stress levels, nurses' poor caring attitude and nurse shortages result in delivery of below standard patient care is similar to this study's findings that participants observed nurses' poor caring attitudes and the shortage of nurses which influenced the expat adjustment back to the South African environment. Most of the participants mentioned that they had issues with the safety aspects prevalent in SA. The following section will describe sub-category 3.3.6, safety issues.

Sub-category 3.3.6 Safety issues

Most participants mentioned that crime, safety, bribery and rape risk in SA was of real concern when returning from the KSA. The safety factors that were push factors towards migration that motivated the participants to leave SA for the KSA was concerns experienced upon their return to SA. Safety issues refer to both personal and working conditions.

The crime in SA seems to be a push factor that motivates nurses to migrate to the KSA: *"…when I think of Saudi I think of safety"* (P1); *"…I only experienced safety in the KSA"* (P2); and *"…a lot of concerns in SA is the safety"* (P5). Although SA is known as the rainbow nation and host a variety of nationalities similar to the KSA, the crime and bribery rate is evident: *"…we have different nationalities like Zimbabweans, Sudanese, Indians, Bangladesh and Chinese, yet there is negativity attached to these nationalities and cultures"* (P2); *"…in Saudi you can travel without the fear of being mugged"* (P4); and *"…the Saudis are humble and peace-loving people"* (P5).

After the death of King Abdulaziz (age 90) during 2015, there has been a rise of the Islamic State of Iraq and al-Sham (ISIS) which attack and terrorise any non-Islamic states or countries under the control of newly appointed King Salman bin Abdulaziz which doesn't necessarily have the same belief to foster peaceful relationships with non-Islamic countries (Cummins 2015:121). SA is known for its porous borders which encourage trans-national crime like Rhino poaching (Meth 2017:410). In addition to the rhino poaching there is also a lot of drugs, diamond and ivory smuggling since 1980 (Meth

2017:410). More comparative data relevant to safety and security is presented in Annexure B.

Alhassan et al (2017:10) mention that a push factor for South African nurses toward migration includes safety issues (both living and workplace related). Participants in this study agreed that a motivator towards migration was the safety issues in SA which is supported by a publication by Alhassan et al (2017:10): that safety concerns and issues in SA is a push factor towards migration.

All participants mentioned that they found it difficult to understand their fellow South Africans' mentality and ways of working and felt unsafe in their work environments as there was a nursing shortage that resulted in unsafe patient care: *"…I worked in this hospital, there was only one registered nurse with one enrolled nurse or auxiliary on duty and I felt unsafe… [untrained staff, inadequate number of staff, unsafe practices]"* (P1).

Although participants initially found it difficult to adjust to wearing the black Abaya whilst working and living in the KSA, but again found it difficult not wearing it when returning SA: *"…in the KSA I had ten Abaya's and I learned to love it…I felt naked without it…"* (P1). In this study the black Abaya could be a safety net, blending in with others, not standing out or not being noticed.

South Africa is a very diverse country and to determine acceptable and taboo socially acceptable behaviour is very demanding. South Africans reported violence and crimes as a source of everyday anxiety, inhibiting their daily activities, decreasing their quality of life and want the death penalty to be re-instated for convicted criminals (Meth 2017:408). Although there is an increasing objection against brutality by the police against innocent victims, inhabitants welcome brutal force used against suspected criminals. Cooperation between the South African Police Service (SAPS), the South African National Defence Force (SANDF), the Special Task Force (STF) units and the Tactical Response Teams (TRT) have a principal *modus operandi* as to protect the locals and provide law and order (Meth 2017:408).

This study's participants indicated that although the South African expatriate nurses experienced safety issues in SA, they also felt unsafe in the KSA is supported through a publication by Meth (2017:408) that safety issues is a global phenomenon. In the KSA

there is religious police and the army – which both are focussed on the Islamic belief system of modesty, religious practices and gender segregation.

All participants said that it was a positive experience to be driving their own cars when they returned to SA and experiencing a sense of freedom, but they were concerned about their safety: *"…I even got to know the rural roads again, and it was so bad"* (P4); *"…it is so dangerous to go out at night because of the dangers"* (P2); *"I miss being able to travel…I struggled with the safety aspect in SA"* (P5); and *"I was so afraid of the crime stories I have heard"* (P3). Crime and safety issues in SA is a real concern for all inhabitants, especially for participants who were single women. [Field notes - When participants described these experiences, they showed mixed sadness and anger emotions. Anger emotions observed (P4) included pupils dilating, pulse increasing. P5 was sad, almost tearful.]

According to Meth (2017:408) murder rates in SA declined since 1994 but remain 4.5% higher than international data. Actual crime statistics is unreliable due to no real data available. There is a gap in literature on crime rates in KSA as official data of crimes are not kept (Algahtany, Kumar & Barclay 2019:306). The following section will provide a conceptual map of this study's findings. This conceptual map formed part of Step 1 of the guideline development process (full discussion Chapters 3 and 4).

2.4.2 Conceptual map of findings

The findings presented in the conceptual map (Figure 2.1) have been discussed throughout Chapter 2. Push factors which will motivate South African trained nurses to migrate include safety issues, job dissatisfaction, lack of remuneration as well as lack of training opportunities. Pull factors for South African expatriate nurse migration to the KSA include both internal and external motivators. Internal motivator towards migration includes the need for independence and external motivators include financial gain and career development.

Adjustment issues in the destination country will result in expatriate nurses feeling like 'strangers in a strange land'. This will hamper adaptation, resulting in culture shock that influences adaptation in the destination country and the South African expatriate nurse

will return to SA. Preparation (done by the recruitment agency) of the prospective migrant will aid in adaptation during migration to the KSA and upon return to SA and limit culture shock.

The migration process will result in losses in different dimensions and require adaptation skills upon arrival to the KSA and re-adjustment upon return to SA. Recruitment of prospective migrants needs to include migration preparation, orientation and support on what to expect in the KSA and upon their return to SA. Retention of staff is aimed to retain skilled and trained nurses in SA.

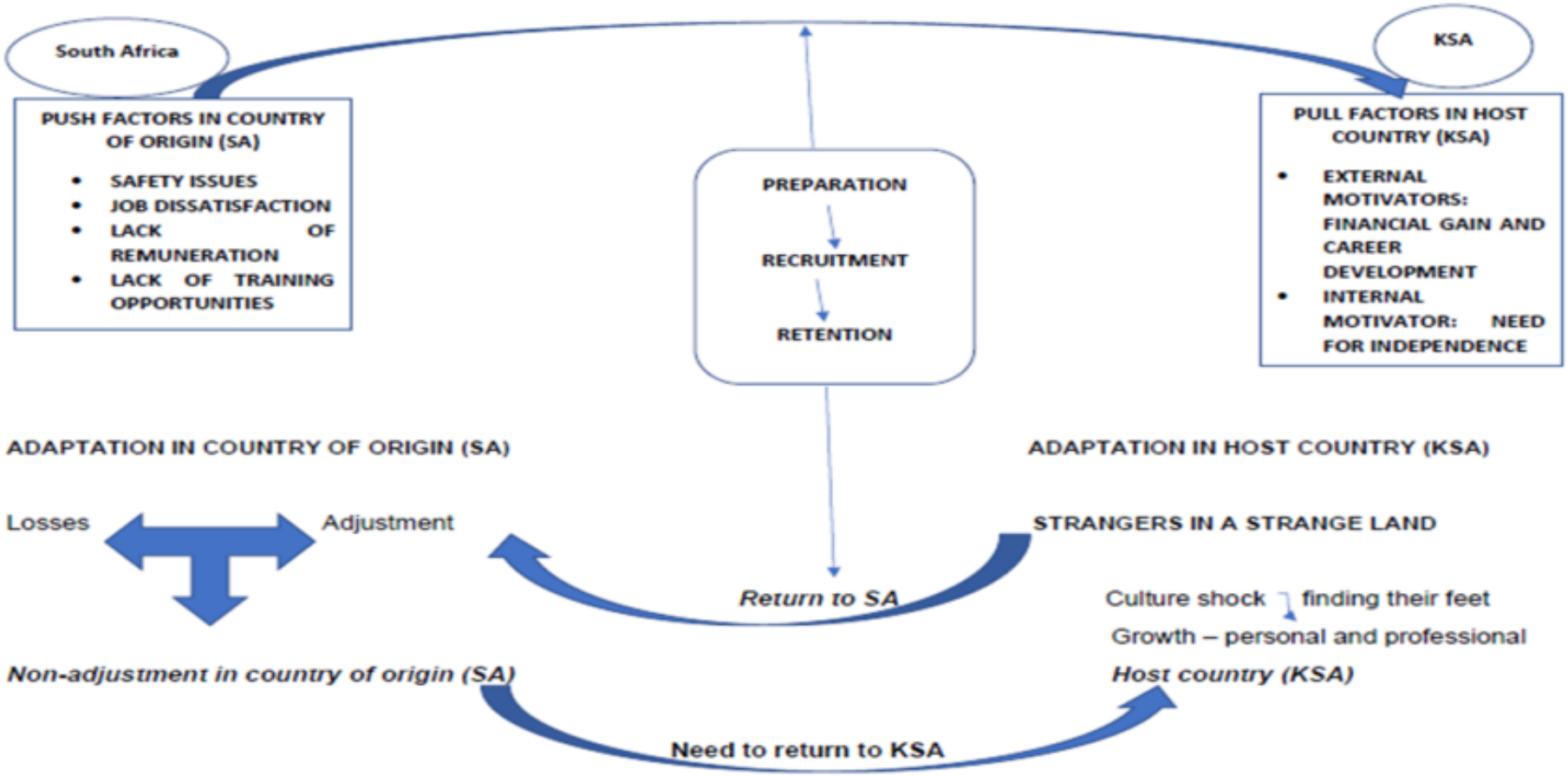

Figure 2.1: Conceptual map reflecting the essence of the lived experiences of South African expatriate nurse migration and adaptation of working and living in the KSA and upon their return to SA

Data presented in the conceptual map should be read from left to right to interpret migration adaptation to KSA, and from right to left to interpret findings upon return to SA.

2.5 SUMMARY

The **essence** of this study as described by the research participants, we were *'Nomads seeking greener pastures', 'Nomads in no man's land'* that started off as '*Strangers in a strange land (KSA)'* and became '*Strangers in their own* land (SA)'. In an effort to find themselves, they lost a part of themselves and experienced losses in different dimensions of their lives (both the KSA and SA). They moved from a stage of shock and discomfort to accepting the 'new reality' as well as unexpected surprises or disillusionment. The exposure facilitated personal and professional growth. They lost their sense of belonging and felt disconnected and isolated upon their return to SA.

Chapter 2 discussed Phase 1 of this study: exploration and description of lived experiences of migration and adaptation of SA expatriate nurses: research methodology, data analysis, interpretation and literature control. The lived experiences of the South African expatriate nurses were either similar between adjustment in the KSA and re-adjustment to SA. Similar experiences in participants included culture shock when exposed to different religious practices, language barriers, dress code and gender segregation; own health being affected; the improved living standards and lifestyle in the KSA; mistrust amongst colleagues, negative treatment by Saudis; improved personal and professional growth; lost social networks, losses in different dimensions and the differences between first (the KSA) and third world (SA) countries. The participants disagreed regarding unexpected disillusionment and not getting paid in the KSA. The initial adjustment issues in the KSA ['*Strangers in strange land (KSA)'*] caused culture shock and the re-adjustment issues ['*Strangers in their own land (SA)'*] reversed culture shock when returning to SA. In this study, a conceptual map of findings (Figure 2.1) developed during Phase 1 was used during the guideline development process (Phase 2 of this study, Step 1: the researcher applied inductive and deductive reasoning to create a conceptual map portraying the research findings) and Step 2 (essence and the constituents were extracted from the conceptual map, Chapter 3).

Chapter 3 will describe the literature review on guideline development (principles and process according to literature).

CHAPTER 3

LITERATURE REVIEW ON GUIDELINE DEVELOPMENT (PRINCIPLES AND PROCESS ACCORDING TO LITERATURE)

3.1 INTRODUCTION

Chapter 2 provided discussions related to Phase 1 of this study which included the exploration and description of lived experiences of migration and adaptation of South African expatriate nurses. The focus was on the research methodology, data analysis, interpretation, literature review and a conceptual map of the findings. Chapter 3 will focus on Phase 2 of this study, which include literature review on guideline development (principles and process according to literature). The following section will provide background information to the guideline development process.

3.2 BACKGROUND TO THE GUIDELINE DEVELOPMENT PROCESS

According to Efendi, Mackey, Huang and Chen (2017:314) global shortage of nurses in developed countries lead to active recruitment of nurses from low-to-middle income countries. Recruitment of nurses is a simple strategy to increase healthcare services and ensuring acceptable staffing levels. Nurses migrate for a variety of reasons (including educational, economic, social, personal, professional or political) (see Chapter 1 for detailed descriptions). The ever-growing global nursing shortage and international recruitment of foreign nurses remain to be controversial (Li et al 2014:315).

There are certain ethical and legal components that influence migration. The individual need of the expatriate nurse to improve her skills, knowledge and competencies through international exposure versus the ethical aspects of the nursing shortage in her country of origin is controversial (Van Liempt & Bilger 2018:NP).

Migration is a human right and migrants have a right to access healthcare (Willen, Knipper, Abadía-Barrero & Davidovitch 2017:969). As per Dhavan, Dias, Creswell and Weil (2017:610) migrants are critical development drivers in their country of origin, during transit and destination. According to Willen et al (2017:969), expatriates are exposed to health risks, human rights violations and the lack in legal status leave these expats

vulnerable to violation of rights. In this study, participants mentioned that nurses should be given the choice to migrate as it can enhance their professional and personal development through international exposure. However, the preparation of these prospective migrants is lacking at times resulting in adaptation issues that can affect their work performance and health (as discussed in Chapter 2). Participants experienced culture shock when working and living in the KSA and reversed culture shock upon their return to SA.

In this study's findings, cultural and reversed culture shock could be due to poor preparation of the migrant prior to migration and limited support during the migration process, which resulted in poor adaptation with an increased risk for physical and emotional illness. These ongoing emigration patterns of nurses should be agreed upon between both the recipient and source countries and every possible effort should be made to support these expatriate nurses during the migration and adaptation process. Guidelines are needed to standardise the preparation procedures undertaken by prospective expatriate nurses as well as preparations done by recruitment agencies to create awareness and expectation on South African expatriate nurse' migration and adaptation when arriving and working in the KSA and upon their return to SA.

According to Van Liempt and Bilger (2018:NP) the ethical guidelines available for migration only include: aspects of privacy; confidentiality; benefit versus harm assessments; duality of roles; and informed consent. In this study, the South African expatriate nurse departs for the KSA due to the proposed or believed benefits and signs an agreement via the international recruitment agency regarding the position applied to and accepted and remuneration offered. There is a gap in literature on existing guidelines supporting South African expatriate nurses during migration to the KSA (both working and living) and adaptation upon return to SA. This study aims to provide guidelines to support expats (prospective or returning expatriates) during the migration process to the KSA, adjustment into the KSA culture and adaptation support upon their return to SA.

The role of the guidelines in this study includes, but is not limited to the following components in the sections to follow. There are certain push and pull factors (discussed in Chapter 1, section 1.2.2.2) which can be linked to the mission statements of the ICN that indicates that nurses can migrate to enhance their professional development by developing their skills and competencies through training opportunities in other countries

(ICN 2019:NP).

Contrary to the belief of the ICN, the WHO monitors the flow and movement of nurses and is concerned about the global nurse shortages (WHO 2018:NP). As per Efendi et al (2017:317), the WHO endorsed a code to protect nations involved in migration. The WHO *"Code of Migration"* was based on the right of humans to achieve the highest standards of health and healthcare, and healthcare workers have the right to migrate between countries to seek suitable employment (Efendi et al 2017:317). Certain aspects in the WHO *"Code of Migration"* include: objectives; scopes; principles; responsibilities; recruitment practices; healthcare sustainability; research methods; information sharing; implementation of the Code; monitoring of arrangements; partnerships; and financial support (Efendi et al 2017:314).

Due to the global shortage of nurses as recognised by the ICN and WHO, migration of nurses will continue to fill the gaps or shortages in global countries. The problem arises when these migrant nurses migrate to a country without proper preparation and inadequate migration support which will result in adaptation issues or cultural shock. The development of guidelines to address the issues of migration preparation prior and during migration, as well as upon return to the country of origin is needed to support the expatriate in adaptation and re-adjustment during and post migration. In this study, the focus will be on South African expatriate nurses migrating to the KSA and ultimately return to SA.

According to Bach (2017:391) the international migration of healthcare professionals has been divided into 3 Phases from 1997. Phase 1 was active recruitment between 1998-2005; Phase 2 was involved in migration policies and the use of international healthcare professionals between 2006-2008; and Phase 3 focused on repositioning of immigration policies since 2009 where source countries agreed to closure of migration limited to exceptional cases. Closure of migration refers to the stopping or limiting of migration of nurses (Back 2017:391).

In this study, all participants were recruited by the international recruitment agency over different periods in time. During a WHO meeting held during September 2018 (WHO 2018:NP) to discuss the international platform on health worker mobility, it was decided to document strategies to mitigate adverse effects of migration which included policies

implemented for effective retention of health personnel, allow for governmental agreements for healthcare personnel exchange instead of migration and supporting countries to strengthen their own healthcare systems. In addition to these discussions, the WHO (2018:NP) proposed the protection of migrants' human rights: reduction in labour migration costs; elimination of exploitation; initiatives to assist when stranded; improvement of the public perceptions; integration and development of the migrant's skills and adaptation support; research and data collection of the migrant (age, gender, adaptation issues i.e. language barriers); and improvement of the partnerships between source and destination countries.

The Commonwealth Code according to Labonté et al (2015:98) was the forerunner to the WHO Code. The Commonwealth Code included agreements amongst Commonwealth countries (including South Africa) on ethical recruitment which was proven ineffective as migration is viewed as voluntary (Labonté et al 2015:98). The Commonwealth safeguards the right of nurses who are emigrating and supports the development of guidelines. Both WHO and Commonwealth Code support the development of guidelines pertaining to nurse migrants.

The problem arises when South African expatriate nurses is attracted to other countries like the KSA (pull factors towards migration, including financial gain), but have inadequate migration preparation and support (done by the international recruitment agencies) which result in poor adaptation in the KSA and re-adjustment issues upon their return to SA. South African expatriate nurses in this study leave SA (developed country) for the KSA (developing country). These expatriate nurses have certain skills and knowledge, which contribute to the development of healthcare in the KSA but leave SA with a shortage of skills.

In this study, it was evident that there is a gap in literature pertaining to South African expatriate nurse migration to the KSA and adaptation upon return to SA. Guidelines are needed to prepare the prospective expatriate nurses on what to expect in the KSA; support during the migration process whilst working and living in the KSA, and these South African expatriate nurses should be supported and assisted with adaptation upon their return to SA through guidelines. The South African expatriate nurses migrate to improve their professional skills and competence through training and developmental opportunities. These expats might want to invest these advances in their knowledge and

skills in their country of origin (SA) from where they migrated. However, there is a gap in terms of how the process of re-emerging into the country of origin and specifically the workplace and the transference of skills and knowledge should be facilitated. This gap will not be addressed in the developed guidelines but will be a recommendation that covers skills and knowledge transfer by South African expatriate nurses post migration.

The need for the development of guidelines supporting nurse migration and adaptation between the KSA and SA has already been discussed in Chapter 1 (section 1.6).

- *Guidelines defined*

According to Gagliardi, Brouwers and Bhattacharyya (2015:E127) guidelines are the foundation of recommendations and effective management proposals to ensure improved performance and outcomes. As per Gagliardi, Marshall, Huckson, James and Moore (2015:10), guidelines are documents that synthesise evidence on how to organise and deliver solutions to a given condition or issue. Guidelines serve as basis for planning, evaluation and quality improvement systems.

In this study, the developed guidelines will be the foundation of nurse migration (focus on South African expatriate nurse migration) which will support the planning and supportive measures of migration processes and guides quality improvement systems during migration. These guidelines will support South African expatriate nurse migration and adaptation to the KSA (preparation procedures provided by recruitment agencies and to create awareness on expectation and adaptation when arriving and working in the KSA) and re-adjustment of these South African expatriate nurses upon return to SA.

The following section will address the purpose of the guideline development process.

- *Guidelines' purpose*

As per Gagliardi and Alhabib (2015:12), the purpose of guidelines is to enhance policy making, planning, delivery and evaluation of quality improvement initiatives. Guidelines translate to complex research findings and recommendations (Gagliardi & Alhabib 2015:12). Despite the crucial function of guidelines, it is not always translated into practice, leading to sub-optimal outcomes or experiences (Gagliardi & Alhabib 2015:12). The researcher's plan on translating these guidelines into practice is through awareness creation (article publications and symposiums) which place focus on this issue of South

African expatriate nurses' lack of preparation pertaining to migration and adaptation. Stakeholder involvement during the guideline development process included South African expatriate nurses.

The researcher performed a literature search and identified limited studies and guidelines related to South African expatriate nurse preparation relevant to migration and adaptation.

The guidelines developed in this study might be of use to international recruitment agencies to prepare prospective expatriate nurses for migration and adaptation and returning expats to aid preparation support for expatriate nurse migration and adaptation.

According to Hannes, Heyvaert, Slegers, Vandenbrande and Van Nulands (2015:2), guidelines are developed from experimental, longitudinal and non-randomised research. As per Hannes et al (2015:2), transparency in reporting guidelines will judge the accuracy of the research. Due to the variety in qualitative research approaches, there is no formal consensus for guideline reporting and therefore potential agreement and disagreement amongst qualitative researchers should be considered (Hannes et al 2015:2). Common studies reporting guidelines include: case studies; ethnographic designs; narrative approaches; and phenomenological approaches (Hannes et al 2015:2). This study will focus on a descriptive phenomenological approach to develop and validate guidelines.

The following section will discuss guideline attributes, with the focus on feasibility, reliability and validity.

- *Guidelines' attributes*

Attributes according to Farrell, Pottie, Rojas-Fernandez, Bjerre, Thompson and Welch (2016:NP) refer to the characteristics or character of something and is used to ascribe quality. Guideline attributes should include feasibility, reliability and validity (Farrell et al 2016:NP). In this section of this study, feasibility refers to the ease of guideline usage and application, reliability refers to how trustworthy and reliable the guidelines will be and validity refers to the factual soundness of the guidelines. The application of the guideline attributes will be addressed in Table 3.1.

Valid guidelines should include relevant literature and scientific evidence to support recommendations. Reliable guidelines would allow for conclusions similar with another

peer review. Feasible guidelines are clearly stated, user friendly and suitable for use in the intended setting (Gagliardi & Alhabib 2015:12).

The key terms or attributes described in Table 3.1 was used during the guideline development process (develop draft guidelines), whereby the researcher had to re-think if the guidelines were effective, feasible, appropriate and meaningful as linked with to the aim of this study. Table 3.1 below will provide an overview of the attributes applied during the guideline development process in this study.

Table 3.1 An overview of attributes used during guideline development

No	Term	Explanation	Application in this study
1	**Effectiveness**	The positive or negative relationship between the outcomes.	During the guideline development process, the researcher had to evaluate if the guidelines would be effective. The guidelines proposed in this study is effective in preparation for prospective and returning South African expatriate nurses on migration and adaptation to the KSA and adaptation upon their return to SA, as there are no known existing guidelines pertaining to this topic.
2	**Feasibility**	The practicability of the guidelines and if it is effective within the qualitative research context.	During the guidelines' development process, the feasibility of the guidelines had to be considered. The proposed guidelines are feasible and practical within a qualitative design, stemming from a descriptive phenomenological approach (Phase 1, Chapter 2) and reflect true and accurate research descriptions. The applicability of context in this study is the KSA and SA.
3	**Appropriateness**	The extent of the guidelines adherence to ethical, epistemological and methodological debates.	During the guidelines' development process, appropriateness as part of ethical considerations had to be considered. The ethical foundations of the proposed guidelines reflect truth, accuracy, validity, non-maleficence and trustworthiness. Epistemological and methodological debates have been discussed in Chapter 1, section 1.8.1.

4	**Benefits**	Will the guidelines be helpful and advantageous to someone?	During the guidelines' development process, the researcher considered the benefits of the draft guidelines. The proposed guidelines hold benefits for the (prospective or returning) South African expatriate nurses on preparing them for migration and adaptation to the KSA and re-adjustment upon their return to SA.
5	**Meaningfulness**	Refers to both positive and negative experiences (in reference to beliefs, interpretations, opinions, thoughts and values).	During the guidelines' development process, the meaningfulness of the draft guidelines was kept in mind. The proposed guidelines are meaningful (for prospective or returning South African expatriate nurses) as there is an existing gap in literature on nurse migration and adaptation in the KSA context as well as on their return to SA. Meaningfulness will be achieved by returning South African expatriate nurses if they understand the adaptation process and give meaning to their lived experiences. Meaningfulness can be linked to '*a sense of belonging'* when South African expatriate nurses can provide migration and adaptation support to returning or prospective South African migrant nurses.

According to (Hannes et al 2015:2)

The purpose of guidelines can be explained as the reason for the guidelines or recommendations while the advantages as discussed below could be seen as the building-blocks or characteristics of the guidelines.

The following section will discuss the advantages of guidelines.

- *Advantages of guidelines*

As already stated earlier in this Chapter, a guideline can be viewed as a rule or advise on how to perform in a certain situation (Hannes et al 2015:11). Strategies develop long-term action plans to achieve overall aims and goals (Hannes et al 2015:11). For this reason, the researcher decided on guidelines rather than strategies in this study, as she wanted to provide guidance on migration and adaptation related to South African expatriate nurses working and living in the KSA and adjustment support upon return to SA. Some advantages of guideline development and reporting during qualitative studies are that a common understanding regarding credibility, rigor and quality statements are addressed (Hannes et al 2015:11).

The advantages of the guidelines formulated in this study will be advisory to prospective and returning expatriates, as well as international recruitment agencies on how to aid these expats in preparing them for migration and adaptation. These guidelines might be of use to international recruitment agencies, nurse migration regulatory bodies and potential migrants themselves to aid in South African expatriate nurse migration and adaptation to the KSA and adaptation upon their return to SA. These guidelines can also create awareness during migration preparation for prospective expatriate nurses and support during adaptation. Participants in this study all mentioned that they experienced culture shock when working or living in the KSA and reversed culture shock upon return to SA [discussed Chapter 2, Theme 2: *'Strangers in a strange land (KSA)'*].

The following section will address the factors to consider when formulating guidelines.

According to the WHO (2018:14), certain factors should be considered when formulating guideline recommendations which include:

- *Available evidence from quality studies.*

  There is a lack of evidence due to the gap in literature on guidelines supporting nurse migration and adaption. In this study, guidelines were developed (based on

a literature review on aspects relating to migration and adaptation) to address this gap.

- *Any balance between harm and benefits.*

  In this study, the aim is to enhance benefits of migration and adaptation (to prospective or returning South African expatriate nurses migrating to the KSA and upon their return to SA) through guidelines, which will limit any risks and harm associated with migration and adaptation.

- *Values and preference of research participants.*

  In this study, the preferences of the research participants, e.g. to stay anonymous, freedom of choice to voluntary partake in the study or to communicate in English has been considered. The values of the participants were to make sense of their experiences and to assist other South African expatriate nurses with migration and adaptation issues between the KSA and SA (values included desirability, benefit, helpfulness, assistance and significance).

- *Implications for research.*

  As mentioned earlier in this Chapter, there is a gap in literature regarding support for South African expatriate nurses' migration and adaptation in the KSA and re-adjustment upon their return to SA. There is no evidence on published guidelines supporting either international nurse migration or adaptation. The guidelines developed from this study's findings will address this identified gap in literature by supporting nurse migration and adaptation; and suggest the preparation procedures provided by recruitment agencies as to create awareness on expectation and adaptation for nurses when arriving and working in the KSA. Recommendations for future research include the impact on South African expatriate nurse migration (both on the individual and the countries involved); South African expatriate nurse migration to other countries, excluding the KSA and the impact of migration on children and significant others left behind in the country of origin.

- *Priority of the problem should be addressed.*

  Nurse migration is a reality and preparation prior to migration as to aid in adaptation is a priority. This study is needed to address gaps in literature on nurse migration and adaptation. The problem is that these expatriate nurses depart to a foreign country like the KSA without the much needed mental, physical, emotional or psychological preparation, which leads to issues in adaptation resulting in cultural and upon their return, reversed culture shock. Culture shock experienced

during migration and adaptation can be seen as a priority concern as the participants in this study all experienced it and might have been prevented or limited with proper preparation and orientation prior to migration. Other problems caused or experienced with migration and adaptation in the KSA has already been discussed in Chapter 2 (Theme 2, culture shock).

- *Human rights and equity issues should be considered by the researcher.*
  This study's findings show that nurse migration is a human right and cannot be taken away through policy makers and regulators. The ethical and legal Codes pertaining to migration have been discussed earlier in this Chapter. The problem or gap arise in preparation and support measures for these South African expatriate nurses during this migration and adaptation process.
- *Acceptability of the guidelines should be clear.*
  The guidelines in this study has been validated and accepted by an expert panel during Phase 3, however it was not implemented, but will be shared at national and international conferences and published in national and international accredited journals.
- *Feasibility of interventions should be stated.*
  In this study, feasibility has been measured with the AGREE ll as the guidelines' development and validation tool.

The following section will address the guideline development process followed in this study.

3.3 GUIDELINE DEVELOPMENT PROCESS: STEPS FOLLOWED

In this study, the researcher used inductive and deductive reasoning to develop a conceptual map portraying the research findings (Phase 1, Step 1, displayed Chapter 2, Figure 2.1). After the conceptual map has been developed, the essence and constituents were extracted from the map. Step 2 involved that the essence and the constituents (Chapter 3, Table 3.2) were extracted from the conceptual map (Chapter 2, Figure 2.1). During Step 3, the NGT was used to rank, vote and prioritise draft guidelines as part of Phase 2 (Chapter 4, Figure 4.3). The fourth Step included the researcher applying the AGREE ll tool (AGREE 2017:NP) and the domains connected to the AGREE ll tool to develop the draft guidelines. Step 5 included refinement of guidelines through validation with an e-Delphi technique (discussion Chapter 5, Phase 3, Step 3A) and Step 6

concluded the guidelines' development process with modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds. Phase 3 of this study was divided into Phase 3A (e-Delphi) and Phase 3B (Stakeholder discussion or consensus).

The following section will discuss the Steps in detail.

- **Step 1: Inductive and deductive reasoning (to draw a conceptual map of findings (Phase 1)**

According to Armat, Assarroudi, Rad, Sharifi and Heydari (2018:219), a dualistic approach to content analysis include inductive (conventional) and deductive approaches to reasoning. Content analysis during Step 1 meaning that the raw data collected from participants during Phase 1 had to be synthesised by means of inductive and deductive reasoning. According to Bhat (2016:79) reasoning ability is important to solve everyday problems. Reasoning abilities include six components which include: inductive and deductive reasoning; linear reasoning; analogical reasoning; cause-effect reasoning; and building generalisations (Bhat 2016:79). For the purpose of this study, the focus will be on inductive and deductive reasoning.

Inductive reasoning starts with the review of concrete examples (Sudria, Redhana, Kirna & Aini 2018:93). Inductive reasoning allows for the researcher to generalise findings based on previous evidence (Bhat 2016:82). *Deductive* reasoning is the process of creating inferences based on facts and logic (Bhat 2016:82). Deductive reasoning starts with abstraction or review of concepts (Sudria et al 2018:93). Deductive reasoning as per Fahsing and Ask (2018:23) is a downwards process which starts by the identification of a general rule and result in a specific conclusion. Inductive reasoning is used in the absence of theories or research findings and the researcher use the research questions, aim and research findings to analyse content inductively (Armat et al 2018:220). Inductive reasoning is an inwards process, which moves from specific to general criteria (Fahsing & Ask 2018:23).

Building generalisations during research starts with inductive reasoning and reflects on observations and findings and abstracting conceptualisations (Sudria et al 2018:92). Through the process of induction, new themes will emerge deductively (Armat et al 2018:220). Inductive reasoning is less dominant than deductive reasoning (as the researcher can create new or emerging themes during inductive reasoning) (Armat et al

2018:220).

Principles to follow during guidelines' development according to Farrell et al (2016:NP) include subject area needs to be identified and refined. In this study, the themes to be included in the guidelines was deducted from findings and interpretation of Phase 1 through inductive reasoning (data from unstructured phenomenological interviews) and refined through a literature review. The subject areas in this study were migration, preparation and adaptation support for prospective South African expatriate nurses migrating to the KSA and re-adaptation upon return to SA. The researcher linked the main themes derived from Phase 1 with push or pull factors towards migration and ascribed constituents and attributes toward each theme. This process formed the foundation of the guideline development process (pertaining to migration preparation, migration support and adaptation processes in SA and the KSA), as the developed guidelines needs to focus on addressing the issues covered in the main themes. More details will be identified and discussed in Chapter 4.

The following section will provide an overview of the conceptual map on the research findings of this study.

- *Conceptual map of research findings*

The following section will describe the essence and constituents of Phase 2 of this study. Application of the conceptual map of research findings will follow in Chapter 4.

- **Step 2: Extraction of the essence and the constituents (Chapter 3, Table 3.2) from the conceptual map (Chapter 2, Figure 2.1)**

Essence of findings refers to the meaning connected to lived experiences and provides insight into a social phenomenon (Katsirikou & Lin 2017:469). The essence of findings has been discussed in Chapter 2, Table 2.3.

During the guidelines' development process, the researcher identified the essence of the experience and then through inductive and deductive reasoning synthesised the data collected during Phase 1 of this study - to fit into each essence identified. The following section will discuss the constituents and how it related to each essence of experience.

Constituents refer to the structure of the shared lived experiences (Katsirikou & Lin 2017: 470). In this study all participants during Phase 1 of this study was South African expatriate nurses who migrated to the KSA and ultimately returned to SA. Shared lived experiences in both settings (the KSA and SA) were similar and included aspects like culture shock, reversed culture shock, poor preparation and support during migration and adaptation and poor adjustment upon return to SA. Full descriptions have been provided in Chapter 2.

Table 3.2 below will provide an overview of the essence and constituents of this study (Phase 2, guideline development process).

Table 3.2: Essence and constituents of lived experiences of migration and adaptation of participants (in the KSA and upon their return to SA)

No	Essence	Constituents
1	Essence of South African expatriate nurses' experiences of migration to the KSA.	**Push factors from country of origin (SA)** Push factors included poor remuneration, lack of training and career development opportunities, job dissatisfaction and safety issues. Poor or a lack of preparation (regarding push factors) will result in poor adaptation processes including culture shock. **Pull factors from destination country (KSA)** Pull factors include external and internal motivators: External motivators (pull factors) include financial gain and career development. Internal motivator (pull factor) includes the need for independence.
2	Essence of South African expatriate nurses' experiences of adaptation whilst working and living in the KSA.	Adaptation in the KSA has been influenced by exposure to different cultures; religious practices; language barriers limiting communication; dress code and gender segregation, which caused culture shock in the South African expatriate nurse.

3	Essence of South African expatriate nurses' experiences of adaptation upon returning to SA.	Exposure to personal losses influenced adaptation negatively as the South African expatriate felt lonely and isolated from their friends and families. Awareness of differences between country of origin and destination country (first and third world countries) influenced adaptation whereby the South African expatriate nurses struggled to understand these differences and different worldviews, which contributed to poor re-adjustment and reversed culture shock upon return to SA. Adaptation issues resulted in reversed culture shock.

As portrayed in Table 3.2, the essence was reflected in three main essential meanings derived in this study (essence of migration to the KSA, essence of adaptation in the KSA and essence of adaptation upon return to SA).

The following section will describe Step 3 of the guidelines' development process.

- **Step 3: NGT – Vote, rank and prioritise draft guidelines**

Step 3 of the guidelines' development process involved voting, ranking and prioritising of draft guidelines using NGT. According to McMillan, King and Tully (2016:655), the NGT employs face-to-face meetings in small groups and fit into qualitative designs. According to McMillan et al (2016:655) the NGT is a consensus method used in research which is aimed at idea-generation, problem-solving or setting priorities.

The two main consensus methods predominate in research is the e-Delphi technique and the NGT which share similar techniques but also have separate distinctive features (Humphrey-Murto, Varpio, Gonsalves & Wood 2017:15). According to Wallace, Worrall, Rose, Le Dorze, Cruice, Isaksen, Kong, Simmons-Mackie, Scarinci and Gauvreau (2017:1372), the NGT consists of participants who are grouped together and then respond to questions posed by a facilitator, including certain steps where participants take turns in responding until data saturation occurs. The final step in the NGT is where participants rank, vote and prioritise their responses (Wallace et al 2017:1372).

The role of the NGT during the guideline development process was refinement of draft guidelines developed by the researcher through ranking, voting and condensing processes.

- *Nominal Group Technique (NGT) origin and application*

According to McMillan et al (2014:95), the NGT was developed during 1971 by Delbecq and Van de Ven to identify problems and develop programs to solve them. The NGT can be useful to generate ideas surrounding a problem, possible solutions and the ranking of these solutions in order of priority. As per Kremer, Evers, Jongen, Van der Weijden, Van de Kolk and Hiligsmann (2016:NP), the structure of the NGT allows for various participant perspectives to be included into research topics. In Phase 2 of the study, all participants of the NGT were given equal opportunities to voice their opinions as to refine the draft guidelines.

According to McMillan et al (2016:657) the NGT consists of four stages which include silent generation of ideas and opinions, round robin, clarification of ideas and opinions and lastly, ranking or voting on ideas and opinions as to prioritise them. Silent generation of ideas (participants given some time to silently reflect on their own ideas relevant to the refinement of drafted guidelines) were followed by *Round Robin*: where each participant

had the opportunity to share a single idea with the other participants (McMillan et al 2016:657). In this study, as the researcher emailed the draft guidelines to all participants of the NGT in advance, the facilitator allowed some time to reflect on ideas and opinions (description Chapter 4). During the *Round Robin*, each participant could share an idea pertaining to the draft guidelines. This was not used to generate new ideas but rather to share opinions on the knowledge relevant to the draft guidelines. During clarification of ideas, the facilitator allowed the participants to group the guidelines as to vote, rank and prioritise these guidelines (condensing them from a total of 15 guidelines to only five). The process of guideline condensing in this study was necessary as some of the guidelines shared common ideas and could be merged into one overall guideline with separate recommendations. The following section will discuss the application of the NGT to this study.

- *Application of the Nominal Group Technique (NGT) in this study*

The rationale for applying the NGT in this study was to involve external experts to provide inputs on the draft guidelines to rank, vote and prioritise them and to reach consensus on the draft guidelines through a face-to-face, structured meeting. During the NGT, it is crucial to reach consensus within the guidelines' development process as it will be presented for final inputs and validation during the e-Delphi technique in Phase 3 of this study. Presented as a % in this study, consensus reached 75% during the NGT. Application of this technique was cost effective as the researcher was in close geographically area to the participants and facilitator.

Full descriptions on the application of the NGT (population, sample, sampling, sampling criteria) will follow in Chapter 4 section 4.3. The following section will provide an overview of Step 4 where the AGREE ll tool was applied during the guidelines' development process. The following section will discuss the advantages and disadvantages of the nominal group technique.

- *Advantages and disadvantages of the Nominal Group Technique (NGT)*

Advantages of the NGT according to Humphrey-Murto et al (2017:15) include the generation of a large volume of ideas and allowance for debate and discussions between experts. In this study, the advantages of the NGT allowed for experts to share knowledge pertaining to migration and adaptation with other participants within the same space.

Disadvantages occur when a small group of experts meet and participants who are more dominant influence the group (Humphrey-Murto et al 2017:15).

In this study, all participants were classified as experts as discussed earlier in this Chapter, based on their training and experience based on migration and adaptation. The role of the participants was to refine and condense the draft guidelines during the NGT. Other disadvantages occur when participants who are new to each other meet face-to-face (breach of anonymity) which can create controversial or heated interactions (Taibi, Lenarduzzi, Pahl & Janes 2017:22). The possible disadvantages of the NGT in this study was managed by the facilitator who controlled the processes and flow of the NGT, as she gave clear instructions and timelines for each Step to be followed in the NGT. More details on the facilitator used during the NGT to follow in Chapter 4, section 4.3.

The following section will address Step 4 of the guideline development process.

- **Step 4: Application of the AGREE ll tool to develop draft guidelines**

During Phase 2 of this study, the AGREE ll tool was used by the researcher (item or criteria reduction and generation of structure and focus during the guideline development process). The role of the AGREE ll tool application during this section of this study was to finalise the draft guidelines in preparation for validation during Phase 3, Chapter 5.

As per Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Ververs, Graham, Grimshaw, Hanna, Littlejohns, Makarski and Zitzelsberger (2014:1), the AGREE ll tool is widely used to assess the methodological quality of guidelines and is the preferred tool to use during guideline development. This tool originated from item reduction and generation, focus on the quality and standards during guideline development, has underwent significant testing and validation procedures as discussed earlier in this section; and it is for this reason this instrument was used in this study. The criteria of the AGREE ll instrument was scope and purpose, stakeholder involvement, rigour of development, clarity and applicability and editorial independence.

During Phase 1 of this study (data collection by means of unstructured phenomenological interviews and a literature control), the researcher used inductive reasoning to extract the essence of findings. The AGREE ll tool was used by the researcher after the NGT as to

prepare the final draft guidelines for validation and the tool's domains was used as basis for this process. The following section will discuss the AGREE ll tool and domains.

- *Appraisal of Guidelines for Research and Evaluation (AGREE) ll tool and domains*

According to Brouwers, Kerkvliet and Spinhoff (2016:1) the AGREE research development team developed this tool to assess the methodological qualities in practice guidelines. The original AGREE l tool was released during 2003 and revised during 2009 (AGREE ll). The AGREE ll tool also aim to develop and report requirements for practice guidelines (Brouwers et al 2016:1). The AGREE checklist' items originated through generation and reduction stages involving 82 key items relevant to quality in practice guidelines (Brouwers et al 2016:1). During the review of the AGREE ll tool more than 200 participants were involved where the key items were reduced to 23 key items (Brouwers et al 2016:1).

According to the AGREE Trust (AGREE 2017:NP) the purpose of the AGREE ll tool is to assess quality of guidelines, provide methodological strategies for guideline development and provide instructions on what information to be included in guidelines. The AGREE ll instrument consists of 23 key items (AGREE 2017:NP). Theoretical explanations will follow with the application hereof in Chapter 4. Each of the 23 key items or domains will be discussed in detail below. The application of these domains and key aspects will follow in Chapter 4.

- *Scope and practice (Domain 1)*

The first domain (scope and practice) have three key items which include: the overall objectives of the guideline are specifically described; the research questions are specifically described; and the target population to which the guidelines are applicable is specifically described.

(i) Overall objectives of the guidelines are specifically described.

In this study, the aim and objectives of the draft guidelines' development process was to develop guidelines as to facilitate South African expatriate nurses' migration (preparation of migration as well for prospective expatriates) and adaptation to the KSA and adaptation upon their return to SA.

(ii) The research questions are specifically described.

The research questions developed during Phase 1 formed the basis of Phase 2 of this study included (see Table 1.1, Chapter 1.):

- What are the experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA?
- What are the experiences of adaptation by South African expatriate nurses when they return to SA's 'living' environment and workforce after working and living in the KSA?
- What guidelines could be developed to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?
- How can guidelines be validated to facilitate expatriate nurses' migration and adaptation to the KSA and their adaptation to SA when they return?

In this domain the third and fourth research questions are applicable during the guidelines' development process.

(iii)Target population is specifically described.

The target population for Phase 2 of this study (guideline development process) is focussed on prospective and returning South African expatriate nurses.

The following section will describe stakeholder involvement, domain 2.

- *Stakeholder involvement (Domain 2)*

The second domain namely stakeholder involvement has four key items.

(i) The guideline development group include participants from the profession.

In this study, during Phase 2, participants from relevant nursing professional (nurse managers and educational) groups were included. During Phase 3 participants from nurse professional (managerial and educational) and SANC was included and non-professional stakeholders included members from the international recruitment agency.

(ii) Participants' views were sought.

During each Phase of this study, participants' views were sought and described: data collection Phase 1 by means of unstructured phenomenological interviews, during Phase 2 expert involvement during the NGT and expert participants during Phase 3 using the e-

Delphi.

(iii) Target population is clearly defined.

The target users in this study will be prospective and returning South African expatriate nurses.

(iv) The guidelines have been piloted.

This is not applicable to this study as the guidelines were not piloted but validated only.

The following section will discuss the third domain: rigour of development.

- *Rigour of development (Domain 3)*

The third domain (as discussed earlier in this Chapter) consists of seven key items which include: systematic methods used during the development process; criteria for evidence selection is described; methods used during guideline formulation is clearly described; benefits and risks have been identified (no identified risks during this Phase of this study); link between evidence and recommendations (Description Table 1.1, Chapter 1); external reviewed by a panel (NGT experts to rate the guidelines according to the AGREE II tool) and procedures for updating of guidelines are available (not applicable to this study).

The following section will discuss the fourth domain – clarity of presentation.

- *Clarity of presentation (Domain 4)*

The fourth domain (clarity of presentation) consists of four key items.

(i) Recommendations are specific.

In this study, the validated guidelines (Phase 3, Chapter 5) used e-Delphi experts to ensure clarity of guidelines. Recommendations derived from this study were made for approval as presented in Chapter 6.

(ii) Management options are clear.

The guidelines developed in this study management' options are clearly written and specific to the end-users.

(iii) Easy identifiable recommendations.

The developed and validated guidelines have identifiable recommendations applicable to the end-users which are prospective or returning South African expatriate nurses and international recruitment agencies.

(iv) Guidelines have tools that support application.

The guidelines developed in this study specify the target population and actions needed for application.

The following section will discuss applicability as the fifth domain.

- *Applicability (Domain 5)*

The fifth domain (applicability) consists of three key items.

(i) Potential barriers are identified.

The experts during the e-Delphi technique evaluated applicability of the validated guidelines (Chapter 5, Phase 3). In this study, there were no barriers of availability (regarding participants during the NGT or e-Delphi).

(ii) Cost for application has been considered.

The cost of guideline application has not been determined in this study.

(iii)The guidelines have criteria for monitoring and audit purposes.

In this study, an audit trail was kept which can be made available upon request.

The following section will discuss the sixth domain namely editorial independence.

- *Editorial independence (Domain 6)*

This domain consists of two key items.

(i) Guidelines are editorially independent.

This aspect is not applicable to this study as the researcher developed and validated guidelines.

(ii) Conflict of interest has been recorded.

There was no conflict of interest between the researcher or any stakeholders involved in

this study. Application of the domains as applied to this study will follow in Chapter 4. Figure 3.1 below will provide a comparison between the AGREE I and AGREE II instrument. As discussed earlier in this Chapter, the AGREE tool has been revised during 2009, which resulted in the AGREE II tool (latest version in use) (AGREE 2017:NP).

AGREE I			AGREE II			Change from AGREE I to AGREE II
Domain	**No**	**Item**	**Item**	**No**	**Domain**	
1. Scope and purpose	1	The overall objective(s) of the guideline is (are) specifically described	The overall objective(s) of the guideline is (are) specifically described	1	1. Scope and purpose	No change
	2	The clinical question(s) covered by the guideline is (are) specifically described	The health question(s) covered by the guideline is (are) specifically described	2		Change in underline part
	3	The patients to whom the guideline is meant to apply are specifically described	The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described	3		Change in underline part
2. Stakeholder involvement	4	The guideline development group includes individuals from all the relevant professional groups	The guideline development group includes individuals from all the relevant professional groups	4	2. Stakeholder involvement	No change
	5	The patients' views and preferences have been sought	The views and preferences of the target population (patients, public, etc.) have been sought	5		Change in underline part
	6	The target users of the guideline are clearly defined. No	The target users of the guideline are clearly defined. No	6		No change
	7	The guideline has been piloted among end users				Delete item. Incorporated into user guide description of item 19
3. Rigour of development	8	Systematic methods were used to search for evidence	Systematic methods were used to search for evidence	7	3. Rigour of development	No change, renumber to 7
	9	The criteria for selecting the evidence are clearly described	The criteria for selecting the evidence are clearly described	8		No change, renumber to 8
			The strengths and limitations of the body of evidence are clearly described	9		New item
	10	The methods for formulating the recommendations are clearly described	The methods for formulating the recommendations are clearly described	10		No change
	11	The health benefits, side effects, and risks have been considered in formulating the recommendations	The health benefits, side effects, and risks have been considered in formulating the recommendations	11		No change
	12	There is an explicit link between the recommendations and the supporting evidence	There is an explicit link between the recommendations and the supporting evidence	12		No change
	13	The guideline has been externally reviewed by experts prior to its publication	The guideline has been externally reviewed by experts prior to its publication	13		No change
	14	A procedure for updating the guideline is provided	A procedure for updating the guideline is provided	14		No change

AGREE I			AGREE II			Change from AGREE I to AGREE II
Domain	No	Item	Item	No	Domain	
4. Clarity of presentation	15	The recommendations are specific and unambiguous	The recommendations are specific and unambiguous	15	4. Clarity of presentation	No change
	16	The different options for management of the condition are clearly presented	The different options for management of the condition or health issue are clearly presented	16		Change in underline part
	17	Key recommendations are easily identifiable	Key recommendations are easily identifiable	17		No change
	18	The guideline is supported with tools for application	The guideline describes facilitators and barriers to its application	19	5. Applicability	Change in underline part, renumber to 19, change in domain from #4 clarity of presentation to #5 applicability
5. Applicability	19	The potential organizational barriers in applying the recommendations have been discussed	The guideline provides advice and/or tools on how the recommendations can be put into practice	18		Change in underline part, renumber to 18.
	20	The potential cost implications of applying the recommendations have been considered	The potential resource implications of applying the recommendations have been considered	20		Change in underline part
	21	The guideline presents key review criteria for monitoring and/ or audit purposes	The guideline presents monitoring and/ or auditing criteria	21		Change in underline part
6. Editorial independence	22	The guideline is editorially independent from the funding body	The views of the funding body have not influenced the content of the guideline	22	6. Editorial independence	Change in underline part
	23	Conflicts of interest of guideline development members have been recorded	Competing interests of guideline development group members have been recorded and addressed	23		Change in underline part
Overall guideline assessment			Rate the overall quality of this guideline	1	Overall guideline assessment	New item
	1	I would recommend this guideline for use	I would recommend this guideline for use	2		Renumber to 2

Figure 3.1: Comparison between the AGREE I and AGREE II instrument [Seto et al. BMC Res Notes (2017) 10:716]

According to (Seto, Matsumoto, Kitazawa, Fujita, Hanaoka & Hasegawa 2017:3)

- *Discussion on Figure 3.1*

The six domains covered in the AGREE ll tool includes: scope and purpose; stakeholder involvement; rigour and development; clarity of presentation; applicability and editorial independence (AGREE 2017:NP) as discussed earlier in this Chapter. Further application of these domains during the guideline development process will follow in Chapter 4.

A comparison between the AGREE l and AGREE ll in this study indicate the changes made to the original version of the AGREE instrument. The reason for presenting a comparison between the AGREE l and AGREE ll instrument in this study is to portray the detailed changes made to the AGREE ll which include: scope; purpose; and clarity of presentation. These changes or updates include: the purpose of the AGREE ll instrument is more explicitly stated; the quality of practice guidelines; the development of these guidelines; and specific information required in the guidelines is specified (AGREE 2017:NP). The original scoring points on the AGREE l was changed from a four to a seven-point scoring response on the AGREE ll instrument which aid in methodological principals of instrument testing (AGREE 2017:NP). The AGREE ll instrument focus on methodological principles and issues related to the guidelines' development process and reporting of guidelines (AGREE 2017:NP). The views of the target population, strengths and limitations of the research evidence, facilitators used during the guideline development process and barriers to guideline application have been included in the AGREE ll instrument (AGREE 2017:NP).

After the researcher developed the draft guidelines, experts selected to partake in the e-Delphi were used to rank, vote and prioritise these guidelines during the NGT. The following section will address the application of the e-Delphi (Phase 3 - Validation of guidelines, Steps 5 and 6) during the guideline development process.

- **Step 5: Refinement of guidelines through validation with an e-Delphi technique**

According to Mukherjee, Huge, Sutherland, McNeil, Van Opstal, Dahdouh-Guebas and Koedam (2015:1098), the e-Delphi technique is an iterative, anonymous and structured technique used to generate consensus on issues, explore assumptions on judgments, fills data gaps or validation of data, address complex issues through collective inputs of panel experts and to evaluate or formulate policies.

According to Humphrey-Murto et al (2017:16) it is vital to consider the experience of the participants when applying the e-Delphi technique as it contributes to the validity and reliability of the results. The group size used during the e-Delphi technique is related to the purpose of the study but samples ranging from seven to 30 are recommended (Humphrey-Murto et al 2017:16). The difference between the Delphi [which requires collective inputs of panel experts as per Mukherjee et al (2015:1098)] and the e-Delphi, which consider experience of individual participants and can be done electronically (online) was the reason for the researcher opting for the e-Delphi in this study.

In this study, during the last Phase (Phase 3A and 3B, Chapter 5), the draft guidelines developed during Phase 2, (reflected in Chapter 4) were submitted to participants selected for the NGT for refinement and validation using the e-Delphi technique. The Steps followed during the e-Delphi included:

- **Step 1:** Issue formulation and how will it be phrased.
- **Step 2:** Requires exposing different options available to the problem.
- **Step 3:** Discussing agreeable issues, identifying those who are important and which can be discarded.
- **Step 4:** Aim to obtain reasons for disagreement, explore underlying assumptions and the panel's respective positions.
- **Step 5:** Evaluate of the individual arguments and reasons for separate arguments. Full descriptions to follow in Chapter 5.

According to Jorm (2015:889) the following processes are linked with the Delphi technique:

- One facilitator who organise the Delphi process. In this study, the researcher took the role of the facilitator.
- The group of individuals must have some expertise on the topic of discussion. In this study, all nurse participants used during the e-Delphi technique had numerous years of experience in nursing administration and education, SANC representative and representation from the international recruitment agencies who had first-hand experience on nurse migration and adaptation (See Annexure P).

- Validation of the instruments used. During the validation process the AGREE ll instrument was used (instrument already discussed Chapter 3, Figure 3.1).
- The facilitator gathers all responses from the participants and anonymous feedback from other participants are provided. During this process the researcher compiled a summary of all participants' responses and circulated it to participants during e-Delphi round 2 for comments.
- All members can revise their responses before and after receiving feedback. During e-Delphi round 2, all participants' feedback and comments were synthesised and circulated for final comment to participants.
- Responses converge around different rounds of questionnaires as to define consensus. In this study, only 2 rounds of the e-Delphi were used as to reach consensus on the final guidelines. Consensus in this study was defined as the agreement rate amongst all participants using a grading score and conversion into an overall percentage and presented as a %. In this study the agreed upon % for consensus was 75%.

The following section will describe Step 6 of the guideline development process.

- **Step 6: Modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds**

In this study, 2 rounds of e-Delphi were used to finalise and validate the developed guidelines. The same expert panel selected for the e-Delphi was used during both rounds. Further in-depth descriptions will be addressed in Chapter 5.

The following section will conclude this Chapter with a summary.

3.4 SUMMARY

Chapter 3 focused on the literature review on guidelines' development (principles and process according to literature). The background to the guidelines' development process, the Steps followed during the guidelines' development process, key items during the guidelines' development process, the essence and constituents of lived experiences of migration and adaptation of South African expatriate nurses has been addressed, the AGREE ll instrument has been explained as well as the application to this study. Chapter 4 will follow on Phase 2 of this study: the development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses: methodology, data analysis, interpretation and literature control.

CHAPTER 4

PHASE 2:
THE DEVELOPMENT OF DRAFT GUIDELINES TO FACILITATE MIGRATION AND ADAPTATION OF SOUTH AFRICAN EXPATRIATE NURSES; METHODOLOGY; DATA ANALYSIS; INTERPRETATION AND LITERATURE CONTROL

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4.1 INTRODUCTION

Chapter 3 discussed the literature review on guideline development (principles and process according to literature). Chapter 4 will focus on Phase 2 of this study: the development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses working and living in the KSA and adaptation when they returned to SA.

In this study, as explained in Chapter 3, the researcher applied *inductive* and *deductive* reasoning (extraction of essential meanings from the empirical findings from Phase 1 to constituents as reflected in Table 3.2) for the formulation of draft guidelines (first draft) during Phase 2 together with the AGREE II instrument (AGREE 2017:NP). The AGREE ll instrument has been used after draft guidelines was ranked, voted and prioritised as applied after the NGT (second draft), as to present these guidelines for validation during Phase 3. These guidelines address the second objective of this study as reflected in Chapter 1, to develop and validate guidelines to facilitate South African expatriate nurses' migration and adaptation to the KSA and adaptation upon their return to SA. This chapter will focus on the development process of these guidelines.

These guidelines might be of use to both international recruitment agencies, prospective and returning expats to aid preparation for expatriate nurse migration and adaptation. During the unstructured phenomenological interviews (Phase 1, Chapter 2) data was gathered on each participant's lived experiences relating to migration and adaptation in the KSA as well as adaptation and adjustment when they returned to SA. This data was used to draw a conceptual map (Chapter 2, Figure 2.1) that assisted in identifying constituents for the development of draft guidelines. After the researcher compiled the draft guidelines, the NGT was used to vote, rank and prioritise these guidelines as discussed later in this Chapter (Phase 2, Chapter 4). This Chapter will focus on the

development of the draft guidelines (process through application), methodology, data analysis and interpretation with a literature control.

The following section will discuss the guideline development process.

4.2 GUIDELINE DEVELOPMENT PROCESS: APPLICATION

The Steps followed during the guideline development process (explained in Chapter 3, section 3.3) will be discussed to address the aim and objectives of the draft guideline development process.

- *Aim and objectives of draft guidelines*

The aim and objectives of the draft guideline development process was to develop guidelines to facilitate South African expatriate nurses' migration (preparation of migration) and adaptation to the KSA and adaptation upon their return to SA.

The Steps followed during the guideline development process (Chapter 3, section 3.3) will be addressed in the following section.

The Steps followed included:

- **Step 1:** The researcher applied inductive and deductive reasoning to create a conceptual map portraying the research findings from Phase 1 (Chapter 2, Figure 2.1).
- **Step 2:** The essence and the constituents (Chapter 3, Table 3.2) were extracted from the conceptual map (Chapter 2, Figure 2.1).
- **Step 3:** NGT: vote, rank and prioritise draft guidelines as part of Phase 2 (see Figure 4.2 later in this Chapter).
- **Step 4:** Application of the AGREE ll tool and the domains connected to the AGREE II tool (AGREE 2017:NP) to develop draft guidelines (Phase 2).
- **Step 5:** Refinement of guidelines through validation with an e-Delphi technique (Phase 3A as discussed in Chapter 5, Figure 5.1).
- **Step 6:** Modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds and stakeholder discussion. Phase 3 of this study was divided into Phase 3A (e-Delphi) and Phase 3B (Stakeholder discussion or consensus).

The following section will describe the Steps that guided the guideline development process in more detail.

4.2.1 Step 1: Inductive and deductive reasoning

During inductive and deductive reasoning, the researcher uses intuition at a high cognitive level and processing of information can either be analytical or intuitive (Anderson, Mueller & Schneider 2017:70). Inductive reasoning as per Anderson et al (2017:70) is *an implicit and natural process* where general conclusions are *derived from multiple observations*, which are considered true or consistently found true. In this study, the emerging themes, ideas and concepts (gathered during Phase 1) were grouped together by the researcher and supervisor and substantiated with a literature control. Inductive reasoning was applied by the researcher reading and re-reading all the data and forming general conclusions from the multiple observations presented to her. By re-reading all data and comparing it with current literature (literature control), emerging themes were identified by the researcher which were supported by literature.

- *Conceptual map of findings*

A conceptual map indicating the essence of findings can be viewed in Chapter 2 (Figure 2.1). The researcher used the conceptual map, applied inductive and deductive reasoning to ascribe guidelines to the lived experiences (pertaining to migration preparation, migration support and adaptation processes in SA and the KSA).

The 3 main themes derived from Phase 1 are: (i) *'Nomads seeking greener pastures';* (ii) *'Strangers in a strange land (KSA)'*; and (iii) *'Strangers in own land (SA)'.*
The *essence* of the experiences when migrating and adapting to the KSA environment was that participants became '*Nomads seeking greener pastures'*. Their exposure to the KSA changed them. Initially they started as '*Strangers in a strange land (KSA)'*. They were able to adjust and *'find their feet'* in the KSA. They moved from a stage of shock and discomfort to accepting the *'new reality'* as well as unexpected disillusionments. The exposure facilitated personal and professional growth. They were faced with losses on different dimensions (both in the KSA and SA), leaving them disconnected and lonely. Upon return to SA, these expats were '*strangers in their own land'*. From this essence of findings (Phase 1 of this study), the following three essential extracts were formulated: (i)

essence of South African expatriate nurses' experiences of migration to the KSA; (ii) essence of South African expatriate nurses' experiences of adaptation whilst working and living in the KSA; and (iii) essence of South African expatriate nurses' experiences of adaptation upon returning to SA.

The role of the conceptual map in this study was to portray a visual presentation of the essence of findings. The developed conceptual map can be viewed in Chapter 2, Figure 2.1. The application of the conceptual map during the guideline development process can be viewed in Table 4.1. The following section will describe the push and pull factors linked to the main themes linked to the conceptual map as derived from Phase 1.

There are certain push factors in the country of origin (SA) which will motivate South African trained nurses to migrate to the destination country (KSA).

The process between push and pull factors towards migration (as identified by this study) is influenced by preparation of the prospective migrant, recruitment of migrants and retention of staff. In this study, participants mentioned that they struggled with adaptation in the destination country (due to lack in preparation), felt like '*strangers in a strange land'* and experienced '*culture shock'* whilst trying to '*find their feet'*. During this process of adaptation, the participants did gain *'personal and professional growth' (*benefits of international recruitment). South African expatriate nurses experienced adaptation in the KSA, however they had to return to SA when their contract expired. When these South African expatriate nurses returned to SA, they were faced with '*losses in different dimensions'* back in SA and again struggled with *adaptation* which ultimately was a predictor for *'reversed culture shock'*. When participants experienced *non-adjustment* in SA, they felt like '*strangers in their own land'* and wanted to return to the KSA (destination country).

In this study, the researcher extracted the essence (meaning connected to specific lived experiences by South African expatriate nurses working and living in the KSA and upon their return to SA) inductively from the findings of Phase 1 and then connected the constituents (structure or 'building blocks') resulting in these lived experiences. The researcher aimed to connect the essence of findings to specific guidelines to support migration preparations, adaptation and retention (see conceptual map of findings, Chapter 2, Figure 2.1). The process of inductive and deductive reasoning linked with the

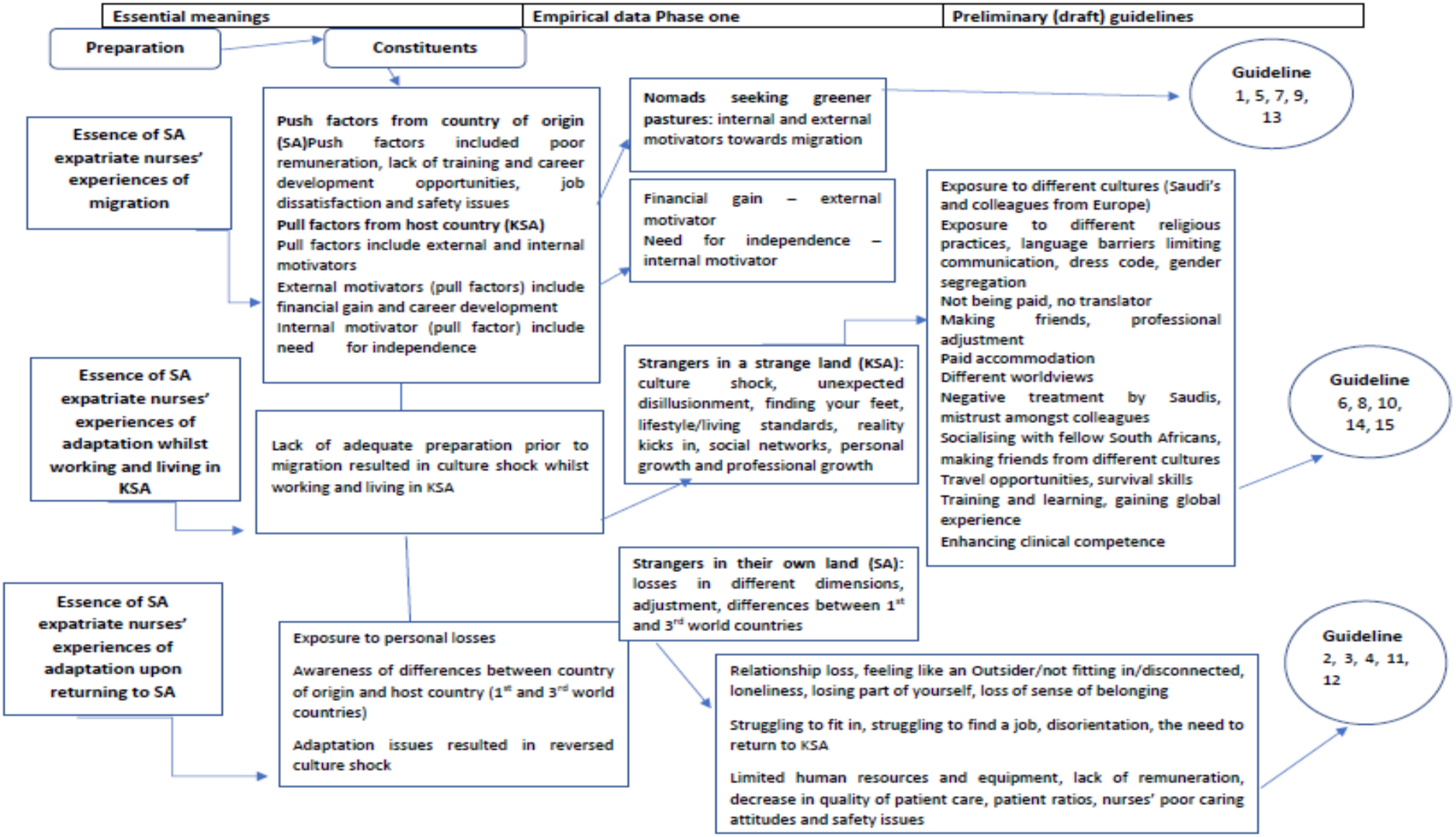
AGREE ll instrument as the researcher integrated the scope and purpose, specific aims, objectives and the research participants' views from Phase 1 during the guideline development process. The following section will describe the extraction of the essence and the constituents during the guideline development process.

4.2.2 Step 2: Extraction of essence and constituents

After the researcher applied inductive and deductive reasoning to synthesise data, she extracted the essence of the findings from Phase 1 to draft a conceptual map (see Chapter 2, Figure 2.1). The lived experiences as voiced by the participants were deduced into attributes and constituents to form a conceptual map (Phase 1 of this study, Table 3.2 which indicates the essence and constituents). The constituents used in this study included: push factors from country of origin (SA); pull factors from destination country (KSA); culture shock caused by adaptation issues in the KSA and reversed culture shock in SA.

Figure 4.1 below will provide a framework of the integration of empirical findings that guided the development of the draft guidelines. Figure 4.2 illustrates a framework of the integration of empirical findings from Phase 1 that guided the development of 15 (first draft) guidelines during Phase 2.

Figure 4.1 Framework of the integration of empirical findings that guided the development of the first draft guidelines



Full descriptions of the guidelines numbered on the Figure can be viewed in Table 4.1.

- *Discussion of Figure 4.1*

The essential meaning in this study, as derived during Phase 1 of this study, the participants mentioned that they were like *'nomads seeking greener pastures'* for financial gain (external motivator) and a need for independence as internal motivator. When the South African expatriate nurses entered the KSA, they felt like *'strangers in a strange land'.* Reality kicked in and the participants started experiencing the different worldviews on another level (religious and traditional practices, which upon their arrival in the KSA were tolerable, but later caused irritation and frustration). Unexpected disillusionment was experienced when the participants' own health was being affected. These differences in culture and traditions caused adjustment issues in the KSA, which ultimately caused culture shock. Participants felt lonely and isolated even when surrounded by people, started missing their family and loved ones in SA.

In this study, participants struggled with finding their feet and making friends in the KSA. The terminology used in the KSA was different to those known to them and that hampered their professional adaptation. Upon return to SA, the participants struggled to fit in, struggled to find a job, experienced disorientation and wanted to return to the KSA. Participants indicate they were strangers in their own land when they returned to SA. They were faced with adjustment issues, which again relates to the interaction between the person and the environment. The South African expatriate nurses experienced different dimensions (worldviews including lifestyle, cultural traditions and behaviours, dress code and religious practices) between first world (KSA) and third world countries (SA).

From the essential meaning, the essence of findings were extracted and linked to the lived experiences of South African expatriate nurses working and living in KSA: essence of South African expatriate nurses' experiences of migration, adaptation whilst working and living in the KSA and adaptation upon returning to SA. The essence of findings or lived experiences was linked to constituents representing the factors causing the lived experiences (discussion to follow later in this Chapter).

As reflected in Figure 4.1, the researcher utilised the findings of Phase 1 of this study (as described in Chapter 2 Table 2.6), performed a literature control, compiled a conceptual map of findings and incorporated it with the AGREE ll instrument.

Table 4.1 Framework of the integration of empirical findings from Phase 1 that guided the development of draft guidelines in Phase 2

Empirical findings from Phase 1 (Essential meanings)	Integrated findings/themes with literature control	Draft guideline link	Draft guidelines with actions	Literature control indicating any existing guidelines or findings from studies that support first draft guidelines (also see Annexure M)
Essence of South African expatriate nurses' experiences of migration	**Push factors** from country of origin (SA) Included: poor remuneration; lack of training and career development opportunities; job dissatisfaction; and safety issues. **Pull factors** from destination country (KSA) Includes: external and internal motivators. External motivators (pull factors) include financial gain and career development. Internal motivator (pull factor) include the need for independence.	**Guideline 1** **Guideline 5** **Guideline 7** **Guideline 9** **Guideline 13**	**Guideline 1: international recruitment agencies to offer migration support (in the form of workshops) to all prospective South African expatriate nurses with the focus on awareness creation on push and pull factors towards migration (nurses who is migrating to KSA).** **Target population: International recruitment agencies, prospective South African expatriate nurses.** **Recommendations:** • The international recruitment agency to facilitate South African expatriate nurse' migration and adaptation to the KSA through assessing the level of awareness of push factors from the country of origin and pull factors from the destination country by means of a questionnaire. The purpose of this questionnaire is to explore the level of understanding of the push and pull factors which motivate South African prospective expatriate migration and to identify any gaps in awareness. • Facilitation of South African expatriate nurse migration and adaptation support to be done by the international recruitment agencies together with returning or potential expatriate nurses through workshops. The international recruitment	There is a gap in literature pertaining to migration support offered to South African expatriate nurses migrating to the KSA. As per Hoffmann, Konerding, Nautiyal and Buerkert (2019:2) employment opportunities, education and income improvement is both push and pull factors towards migration. Push factors towards migration include inequitable land distribution, poverty and violent conflicts (Hoffmann et al 2019:2). Pull factors towards migration include: education and employment opportunities; improved income; less discrimination; and violent conflicts (Hoffmann et al 2019:2).

			agency is responsible for recruitment and preparation of prospective expats on what to expect in the KSA (e.g. traditions, cultural diversity, language, religious practices) which can be discussed by means of workshops. International recruitment agencies can arrange for orientation sessions and workshops to include lived experiences of returning South African expatriate nurses (experiences relating to migration experiences, issues with adaptation and re-adjustment upon their return to SA). **Guideline 5: South African trained nurses to be motivated by healthcare employers and regulatory systems to migrate to another foreign country (like the KSA) as to gain global experience, experience cultural diversity and interaction with international nurse' market which can improve the healthcare quality in SA upon return.** **Target population: Prospective South African expatriate nurses, South African healthcare providers (general).** **Recommendations:** • Leaders in healthcare facilities can motivate nurses to leave the country (migrate and explore other countries and cultures) when having enough experience in their speciality, to gain more experience on culturally diverse patients, opportunities, experiencing new cultures, working with diverse cultures and patients and travel opportunities to foreign countries like the KSA. Although this might not be a	There is a gap in literature pertaining to motivation from healthcare providers to motivate nurses to gain global experience through migration.

			feasible action due to the nurse shortage and brain drain in SA, other international nurses could be motivated to come and work and live in SA. • Returning expats can apply the knowledge and skills obtained whilst working and living in the KSA upon their return by implementing it into the South African healthcare systems, which can improve patient care and contribute of the body of nurse knowledge and understanding. It can be argued that healthcare facilities might not want to let go of their skilled staff, but these nurses will return to the healthcare facility with international exposure, which can be applied in the local healthcare setting in SA to improve health care. • Health care facilities in SA could link up with health care facilities in other countries. This could allow for SA nurses to have exchange programs with Saudi nurses. This would allow for sharing of knowledge and skills and will also add in retainment of staff. **Guideline 7: South African healthcare regulatory bodies to reconsider financial compensation of South African trained nurses (upon completion of training) equivalent to the international nurse remuneration standards, as poor compensation will result in migration (to the KSA as financial gain is a pull factor towards migration).** **Target population: South African healthcare regulatory bodies, South African trained nurses, healthcare facilities.** **Recommendations:** • South African healthcare regulatory bodies	Expatriate nurses are attracted to foreign countries by higher salaries, better working conditions, hard currency, career development and opportunities for family members to work and study (Lagardé & Blaauw 2016:2).

			should oversee that trained nurses receive basic needs benefits like housing support from employers (nursing homes or accommodation facilities provided by government or private healthcare institutions), medical aid and pension funding to retain these nurses in South African healthcare facilities. • South African regulatory bodies should impose offering of retainment benefits by healthcare employers to prospective expatriate nurses, which might limit migration and brain drain from SA. • Remuneration offered by healthcare facilities should be benchmarked according to international standards, equivalent to training and years of experience. **Guideline 9: South African healthcare regulatory bodies to oversee that annual training and career development opportunities are available to all South African trained nurses, as a lack of training and career development in nurses will result in migration (as pull factor towards migration to the KSA).** **Target population: South African healthcare regulatory bodies, both private and government healthcare facilities.** **Recommendations:** • Healthcare regulatory bodies should encourage skilled and trained nurses to stay in SA through offer of improved benefits like career promotion opportunities, setting realistic career advancement and achievements, training and development opportunities should be free and ongoing. • National healthcare regulatory bodies	There is a gap in literature on set standards or minimum nurse training to be provided by healthcare providers.

			should set standards for nurse' promotion opportunities, reviewed annually and statistics kept on promotions as to motivate nurses to stay in SA (retention). • Private and government healthcare institutions should set realistic career advancement opportunities for South African trained nurses as to promote job satisfaction. If not available in the facility other possibilities (e.g. internal transfer and promotional opportunities or new post creations) should be made available to deserving nurses (based on years' experience, overall performance and appraisals) (professional development as gathered during Phase 1 of the study). **Guideline 13: South African expatriate nurses to receive migration support (psychological and emotional support prior to migration) offered and facilitated by the international recruitment agency which include the description and exploration of motivators towards migration (both internal and external motivators to be analysed and discussed by the prospective expat and the international recruitment agency as to determine possible negative migration experiences).** **Target population: International recruitment agencies, prospective South African expatriate nurses.** **Recommendations:** • International recruitment agencies should arrange, coordinate and implement migration support sessions between representatives from the agency and prospective expats to determine the	There is a gap in literature relevant to South African expat migration preparation and support. According to the US Department of State (2016:NP) can reversed culture shock degree levels experienced be influenced by the following:

			motivators (by means of counselling sessions) towards migration to the KSA – if it is reasonable and achievable in the KSA or can changes in South African context be done to achieve same desirable outcomes. Should the agency offer emotional and psychological support through counselling sessions to the prospective expat prior to migration possible solutions to 'forced migration' can be identified and the negative experiences possibly experienced by migration limited.	• If returning to the home country was voluntary or involuntary. • If the return was planned and expected or unexpected. • Age of the expatriate. It is assumed that older people will re-adjust easier. • Previous expatriate experiences which required re-adjustment to the home country as it is assumed that the first time would be worse. • Length of international exposure. It is believed that the longer the international exposure the harder it would be to leave the destination country and re-adjust home. • The degree of cultural interaction with the destination country – the more interaction and involvement with the destination country will make it harder to adjust back home. • A supportive and familiar environment will lessen the degree of reversed culture shock experienced. • The level of differences between the host and home country – if there are vast differences between the two countries it would

				increase the chances of reversed culture shock.
INDUCTIVE AND DEDUCTIVE REASONING TO DEVELOP DRAFT GUIDELINES				
Essence of South African expatriate nurses' experiences of adaptation whilst working and living in the KSA	Lack of adequate preparation prior to migration resulted in culture shock whilst working and living in the KSA	**Guideline 6** **Guideline 8** **Guideline 10** **Guideline 14** **Guideline 15**	**Guideline 6**: **International recruitment agencies to facilitate adaptation of South African expatriate nurses migrating to the KSA by offering adaptation preparation and support sessions (through workshops or information sharing sessions) to all prospective expats prior to migration.** **Target population: International recruitment agencies, prospective South African expatriate nurses.** **Recommendations:** • International recruitment agencies can enhance adaptation preparation of prospective South African expats through optimal and well-structured information sessions and orientation offered by the recruitment agency at least three to six months prior to departure (trained and experienced staff members who either worked and lived in the KSA, or have in-depth experience and understanding of the KSA about the working and living conditions in the KSA (vast difference as compared to SA), including the culture (traditions, behaviours) and government control (Islamic law and religion). **Guideline 8: South African healthcare regulatory bodies should include trans-cultural nursing as a compulsory component of nurse**	There is a gap in literature that focuses on expatriate nurse adaptation during migration. According to De Jonckheere, Vaughn and Jacquez (2017:403) resilience during emigration is successful adaptation in the presence of adversity and include physical and psychological factors. Risk factors in resilience during migration include: discrimination; educational stress; resource access; and poor adjustment (De Jonckheere et al 2017:403). Cultural training does not include social representations but rather

			training programs. International recruitment agencies should evaluate trans-cultural nurse exposure and training of all prospective South African expats prior to migration to the KSA. **Target population: South African healthcare government; private and government nurse education institutions, international recruitment agencies, prospective South African expats.** **Recommendations:** • South African healthcare regulatory bodies (including SANC) to oversee that trans-cultural nursing programs (including diverse cultures, traditions and religious practices) form part of all nursing training programs as offered by private and public nurse education institutions. Trans-cultural nurse competency checklists (completed by nurse education institutions) could be used as part of nurse-training completion assessments. • South African healthcare government to make cultural diversity and sensitivity program training compulsory to all skilled and trained nurses to improve cultural interactions, patient care and satisfaction. This training can either be included in basic nurse training programs or a state-regulated qualification after nurses have qualified. **Guideline 10: International recruitment agencies to provide migration preparation to all prospective South African expatriate nurses (preparation packages) which include diverse cultural behaviours and social isolation experienced in the KSA.**	an intense way in which one is disposed into the world (Baerveldt 2016:539). To participate in cultural activities, or to have a shared worldview, does not mean shared or generalised systems but rather *"be historically attuned to other such concrete beings in an embodied way"* (Baerveldt 2016:539). There is a gap in literature which focuses on South African expatriate nurse migration preparation.

			Target population: Prospective South African expatriate nurses; international recruitment agencies. **Recommendations:** • International recruitment agencies can encourage prospective expatriate nurses to do research about the KSA (diversity, traditions, behaviours, geographical layout, temperatures) and social aspects (communication, interaction with other expats and Saudis) in the KSA at least six months prior to departure to allow for mental and emotional understanding and preparation of diversity in the KSA. • International recruitment agencies to facilitate contact sessions or workshops between returning and prospective expats where prospective expatriate nurses will have the opportunity to talk or interview returning expatriates as to gain first-hand feedback about the social or isolation challenges in the KSA. These sessions can be arranged by the recruitment agency and prepared at least six months prior to departure to the KSA as to allow for clarification of concerns. • International recruitment agencies to have migration orientation and preparation packages available which can be in the form of research websites free of charge for all prospective migrants where they can either have direct contact with returning expats or the recruitment agency representatives. Technological applications like Skype or Zoom can be used to facilitate meetings between the prospective expat and the international recruitment agency.	According to Belhadi and Ayad (2017:NP) pre-departure preparations can limit culture shock by reading about the culture, sharing foreigner experiences, be ready for changes and learn how to manage them.

			Guideline 14: International recruitment to facilitate migration preparation with the focus on culture shock training (including symptom recognition, identification and management of culture shock) to all prospective South African expats prior to migration to the KSA. **Target population: Prospective South African expatriate nurses; international recruitment agencies.** **Recommendations:** • International recruitment agencies to prepare all prospective expats on culture shock (including causes, signs and symptoms, management of culture shock), proper preparation and induction (regarding aspects related to culture shock) prior to the expatriate departure (at least three months prior) to the KSA (as to limit the degree or level of culture shock). This preparation can be facilitated through workshops or information sharing sessions including formal lectures done by the international recruitment agency. • International recruitment agencies to facilitate work- shops or one-on-one session between prospective and returning expatriate nurses who experienced culture shock as to prepare the prospective expat on what to expect in the KSA and how other expats dealt with this condition. **Guideline 15**: **International recruitment agencies to facilitate and coordinate coping skills and resilience workshops to all prospective South African expatriate nurses prior to migration to the KSA.**	Culture and reversed culture shock occur when an expatriate departs to a foreign country and returns home after residing in a foreign country for a period (Barakat et al 2016:785). The place that was previously known as 'home' has changed. Outbound shock is eminent, unanticipated and unexpected and known as reversed culture shock. When staying, living or working in a foreign country one start to act and think like the local population which can vary in degrees. It is therefore believed that once the expatriate returns to his or her home country and they realise how much they have changed and need to repatriate shock will occur (US Department of State (2016:NP). Feelings that can be experienced during reversed culture shock include compartmentalisation of experiences, changed relationships, homesickness reversed to the destination country, boredom, alienation or even the ability to apply basic skills and knowledge (US Department of State 2016:NP).

			Target population: International recruitment agencies, prospective South African expatriate nurses. **Recommendations:** • International recruitment agencies to arrange coping skills and resilience workshops between returning and prospective expats prior to prospective migrant' departure (at least weekly intervals for a period of three months) as to prepare them for possible challenges faced (cultural conflicts in the KSA) and how to handle these challenges which will influence adaptation.	
INDUCTIVE AND DEDUCTIVE REASONING TO DEVELOP DRAFT GUIDELINES				
Essence of South African expatriate nurses' experiences of adaptation upon returning to SA	Exposure to personal losses. Awareness of differences between country of origin and destination country (first and third world countries). Adaptation issues resulted in reversed culture shock.	**Guideline 2** **Guideline 3** **Guideline 4** **Guideline 11** **Guideline 12**	**Guideline 2: South African healthcare regulatory bodies to create favourable nurse' working conditions and aim to increase healthcare standards in the country of origin to those of first world countries (KSA). Human resource availability should be standardised to international standards and levels set in first world countries.** **Target population: South African healthcare governing bodies.** **Recommendations:** • The South African healthcare governing bodies to create favourable healthcare working conditions for nurses by ensuring there is adequately trained staff and equipment to deliver a high standard of care to address patient needs. • The South African government to set standards for availability of healthcare	According to Khamisa, Oldenburg, Peltzer and Ilic (2015:653), South African nurses suffer from burnout and emotional depletion caused by working in stressful healthcare environments. This mismatch between the job and the working environment causes high levels of job dissatisfaction. High workload is associated with poor mental and physical outcomes of nurses (Khamisa et al 2015:653).

			workers (nurse-patient ratios) per facility (both private and public), make resources available (financial and human resources) to train additional nursing staff if needed. • The South African government to provide adequate resources in terms of human resource availability, adequate number of professional nurses for patient ratios and fiscal resources in terms of equipment that is fully functional and maintained, in all healthcare facilities. **Guideline 3**: **International recruitment agencies and South African healthcare providers to facilitate re-adjustment of returning expats to the country of origin by facilitation of support groups between returning expatriates.** **Target population: International recruitment agencies, returning expats, South African healthcare providers.** **Recommendations:** • International recruitment agencies and healthcare employers can facilitate support groups for returning expats as to establish a sense of belonging and create meaning for South African expatriate nurses' in the country. Support groups can be facilitated between returning expats, at venues and times convenient for all involved and continued until re-adjustment support has been satisfactory. • South African expatriate nurses can facilitate support groups amongst themselves as to create meaning between expats by mentoring prospective expatriates before they leave for the KSA, to prepare them in terms of expectations and adaptation as well as mentoring those	There is a gap in literature pertaining to re-adjustment support offered to South African expatriate nurses upon return to SA.

			that return and seek employment upon their return to SA. **Guideline 4: South African healthcare government to enforce safety and protection of nurses travelling to work, ensure safety of nurses in the workplace, and oversee that healthcare providers apply all reasonable measures to protect nurses in the workplace context to minimise safety issues as push factors towards migration** **Target population: Returning expats, prospective expats, South African healthcare government.** **Recommendations:** • South African healthcare government and healthcare employers in healthcare settings can oversee that expatriate nurses returning from the KSA and resident nurses are protected in the workplace. Safety of nurses can be ensured through healthcare facilities appointment of adequately skilled safety and security guards and to have processes in place for nurses to report security or safety threats. As safety concerns and violence in the workplace is not only relevant to nurses but nationally, the government is responsible to provide enough (daily coverage) and adequately trained safety officers or police for protection of citizens (crime identification, prevention and control). As mentioned by participants the KSA offer free and safe transportation to and from work. • The South African healthcare government to provide for enough public transport (especially for essential service delivery	Madzhadzhi, Akinsola, Mabunda and Oni (2017:29) stated that violence against healthcare workers is a growing problem in SA.

			such as healthcare workers) as well as safety and security officers to protect the travellers (nurses on or from their way to work). **Guideline 11: South African healthcare government and healthcare regulatory bodies to oversee that the working conditions in the country is improved which include resources and staffing ratios as to improve nurse' job satisfaction (as poor working conditions are a pull factor towards migration).** **Target population: South African national healthcare government, healthcare regulatory bodies.** **Recommendations:** • The national healthcare government to make provision for more trained and skilled nurses in SA as to improve the working conditions and job satisfaction with the South African healthcare environment. External, independent nurses can be appointed to monitor and evaluate nurse satisfaction levels on national levels and to make recommendations to the government as how to improve on job satisfaction levels. • The healthcare regulatory bodies and healthcare employers to ensure that nursing is viewed as a favourable career option through provision of favourable healthcare environments (adequate nurse-patient-staffing ratios, financial compensation and benefits when other career options are considered). • The South African government to consider recruiting trained and qualified nurses from abroad to assist in healthcare settings to	Globalisation encouraged international migration of nurses to places with favourable working conditions (WHO 2016:NP). Due to the global shortage of nurses developing healthcare systems are forced to recruit trained nurses from foreign countries with less favourable working conditions (Donoghue 2016:4).

			address nursing shortages (provision of patient care, decrease burnout and improve patient outcomes), evaluate the shortage and replacements annually. **Guideline 12: South African healthcare regulatory bodies and healthcare providers to appoint adequate nurse staffing levels (as to provide for optimal patient care), limit overtime hours worked by nurses which will cause burnout and poor job-satisfaction.** **Target population: South African healthcare providers.** **Recommendations:** • Healthcare employers both private and public to appoint enough skilled and trained nurses, limit the number of overtime hours (state regulated) as to prevent burnout and stress of nurses who are forced to work additional hours to deliver patient care. Retention of staff and reduction of migration to be controlled by skilled human resource management.	As per Wickramasinghe and Wimalaratana (2016:15) nurses are dissatisfied with their working conditions which include high workloads, high nurse-patient ratios which cause low job satisfaction.
INDUCTIVE AND DEDUCTIVE REASONING TO DEVELOP DRAFT GUIDELINES				

Annexure M will provide the draft guidelines, combined with the data from Phase 1 as well as a literature control.

4.3 METHODOLOGY OF GUIDELINE DEVELOPMENT

The aim of this study (Chapter 1, heading 1.3) was to gain an understanding of the lived experiences (migration and adaptation) of South African expatriate nurses who worked and lived in the KSA and who subsequently returned to SA to live and re-enter the workforce in SA. Understanding their lived experiences of migration and adaptation while working in the KSA and their adjustment upon return to SA will provide information for the development of guidelines to facilitate expatriate nurses' migration preparation and adaptation, as well as reintegration and adjustment in the South African labour and private living contexts. These guidelines might be used by the recruitment agencies to prepare prospective expatriate nurses on issues pertaining to migration and adaptation.

The methodology includes: the process; population; sample and sampling; planning of the NGT; and Steps followed during the NGT.

The following section will describe Step 3 of the guideline development process, which included the NGT: voting, ranking and prioritising of draft guidelines.

4.3.1 Step 3: Vote, rank and prioritise draft guidelines

During Phase 2 of this study (guideline development process) all prospective participants for the (NGT) were contacted via email by the researcher. The appointed facilitator acted as gatekeeper for this section as she contacted the potential participants to partake in the NGT and was the only other person besides the researcher who was aware of the research findings and the participant' credentials and expertise. Informed consent was obtained by emailing the consent form, explaining the purpose for their participation in Phase 2 of this study to all participants and returned to the researcher via email (see Annexure C). An external facilitator was requested by the researcher to limit bias.

During Step 2 of the guideline development process (extraction of essence and the constituents) draft guidelines were formulated. During Step 3 these guidelines were submitted for refinement through the NGT to vote, rank and prioritise them. The following section will discuss population as applicable to the NGT.

- *Population*

According to McMillan et al (2016:656), the NGT can include between two and 14 participants, but an average of seven is recommended. The ideal NGT size ranges from 6-12 experts (Harvey & Holmes 2012:191; Humphrey-Murto et al 2017:15) The duration of this process varies between 1.5 and 6 hours, and the literature control is not always completed during this stage (Humphrey-Murto et al 2017:15).

In this study, the 15 draft guidelines developed by the researcher (Phase 2) was voted, ranked and prioritised during the NGT using seven expert stakeholders to reach consensus. The stakeholders include the researcher, the facilitator and experts representing the target population (seven in total) who had in-depth knowledge or experience in nurse migration and adaption. Participants were classified as experts (by the researcher) due to their vast knowledge and experience pertaining to nursing, nurse education and managerial skills, which included exposure to South African expatriate nurse migration and adaptation. The accessible population was experts residing in the Western Cape region.

The following section will describe sample and sampling.

- *Sample and sampling*

Sample according to Etikan et al (2016:1) refers to a selected portion of a population. For this phase of the study, convenient sampling was combined with purposive sampling (description Chapter 1, section 1.9.3) and the participants were selected based on their knowledge about the research topic (purposive sampling) as well as their residing region Western Cape (convenient sampling as this was accessible to the researcher). The sample of the NGT consisted of seven participants (see Table 4.2 for descriptive information of the sample). The researcher had access to a list of nurse managers and educators residing in the Western Cape region. The researcher emailed the seven names on the list available to her and all seven participants who were invited by the researcher agreed to partake in the NGT.

The inclusion criteria were nurse educators or managers with vast knowledge on nurse migration and adaptation and who resided in the Western Cape region. Expert vast knowledge was linked to the participants' competencies as they had experience in teaching (more than 10 years) multi-cultural aspects in nursing **or** had exposure to the KSA migration. The only exclusion criteria were the inability to speak and understand

English and participants who were not willing to take part in this study. The inclusion criteria are reflected in Table 4.2.

Table 4.2: Descriptive information of the nominal group participants

No	Professional qualifications	Age	Gender	Employer	Experience in the field of nursing, migration and adaptation
1	D.Ed. Ideal and Reality in Nurse Training in SA: An Action Research Approach to the Improvement of Nursing Practices. M.Cur. Cum Laude. "Verpleegopleiding binne die Andragogieseopset" 1987, UWC. Hons B.A. Cur. Cum Laude, 1984 UNISA - Major Advanced Nursing Education. B.A. Cur. Cum Laude, 1982 - UNISA Majoring in Nursing Education and Community Nursing Science.	71	F	Head of College, Private NEI, Cape Town	50 years nurse training and education experience. Worked at two higher education institutions as head of department, facilitating nursing, sociology and community nursing.
2	MCur, BCur Clinical Psychology	54	F	Private NEI, Cape Town	More than 25 years nurse training and education experience with specialisation in Sociology and Psychology. Actively involved with international recruitment agency as recruiter or selection of expats.
3	D Lit (Nursing Education and Administration)	64	F	Private Higher Education Institution, Cape Town	More than 30 years' experience in nurse training and management. Personal

					experience with migration and adaptation.
4	MCur (Nursing Admin and Education), MCur Public Relations	56	F	Private NEI, Western Cape	More than 18 years' experience in nurse training and management, close liaison with the SANC.
5	D Lit (Nursing Education and Administration)	69	F	Private Higher Education Institution, Cape Town	More than 40 years' experience in nurse training and management, head of college. Personal experience with friends and family members who migrated.
6	BCur Cum Laude, MCur, in process of D Lit	39	F	Private Higher Education Institution, Cape Town	More than 10 years' experience in nurse training, clinical nursing, sociology and research majors.
7	MCur, final year D Lit	52	F	Private Higher Education Institution, Cape Town	More than 12 years' experience in clinical nursing. Head of clinical unit. Worked with expatriate nurses.

The demographics of the nominal group' participants were 100% females, a mean age of 57.8 years and average of 26.7 years of experience in nursing and nurse education or exposure to the KSA migration and adaptation.

The following section will describe the planning process involved in the NGT.

- *Planning and introduction of the NGT*

As discussed earlier in this Chapter, the NGT was used in this study to vote or rank and prioritise the draft guidelines as to reach consensus on the guidelines. The draft guidelines in this study were classified into three categories (by the researcher prior to the NGT) namely: preparation (addressing push factors); migration support (facilitation the pull factors); and adaptation (balancing the push and pull factors).

Informed consent was emailed by the researcher and returned by participants before the commencement of the NGT, a specific date and time were set and agreed upon by the researcher and participants for this session. The facilitator gave a brief introduction and explained that the draft guidelines were derived from data collected during Phase 1 (inductive and deductive reasoning which resulted in a conceptual map) and a literature control. The 15 draft guidelines were presented during the NGT process to be voted, ranked and prioritised (as to condense these guidelines). There was no known conflict of interest and this technique was at no cost to the researcher.

The following section will discuss the process followed during the NGT.

- *Process followed*

Figure 4.2 will provide an overview of the process of the NGT (McMillan et al 2016:657). The NGT in this study did not include survey and forum event, but rather re-ranking, voting and prioritising of guidelines until consensus was reached on the draft guidelines. The facilitator had access to a flip chart with a marker pen and all participants were issued with index cards and pens.

Prior to commencement of the nominal group, the facilitator shared the ethical clearance obtained by the researcher to conduct this study (Annexure A). The facilitator explained the stages and the role of the NGT for the development of guidelines to the participants. The venue was a private office, which was made available by a training institution and was free from any disturbance. The space could accommodate up to 15 persons seated. Seating was done in a U-shape. The following section will discuss the application of the NGT in this study.

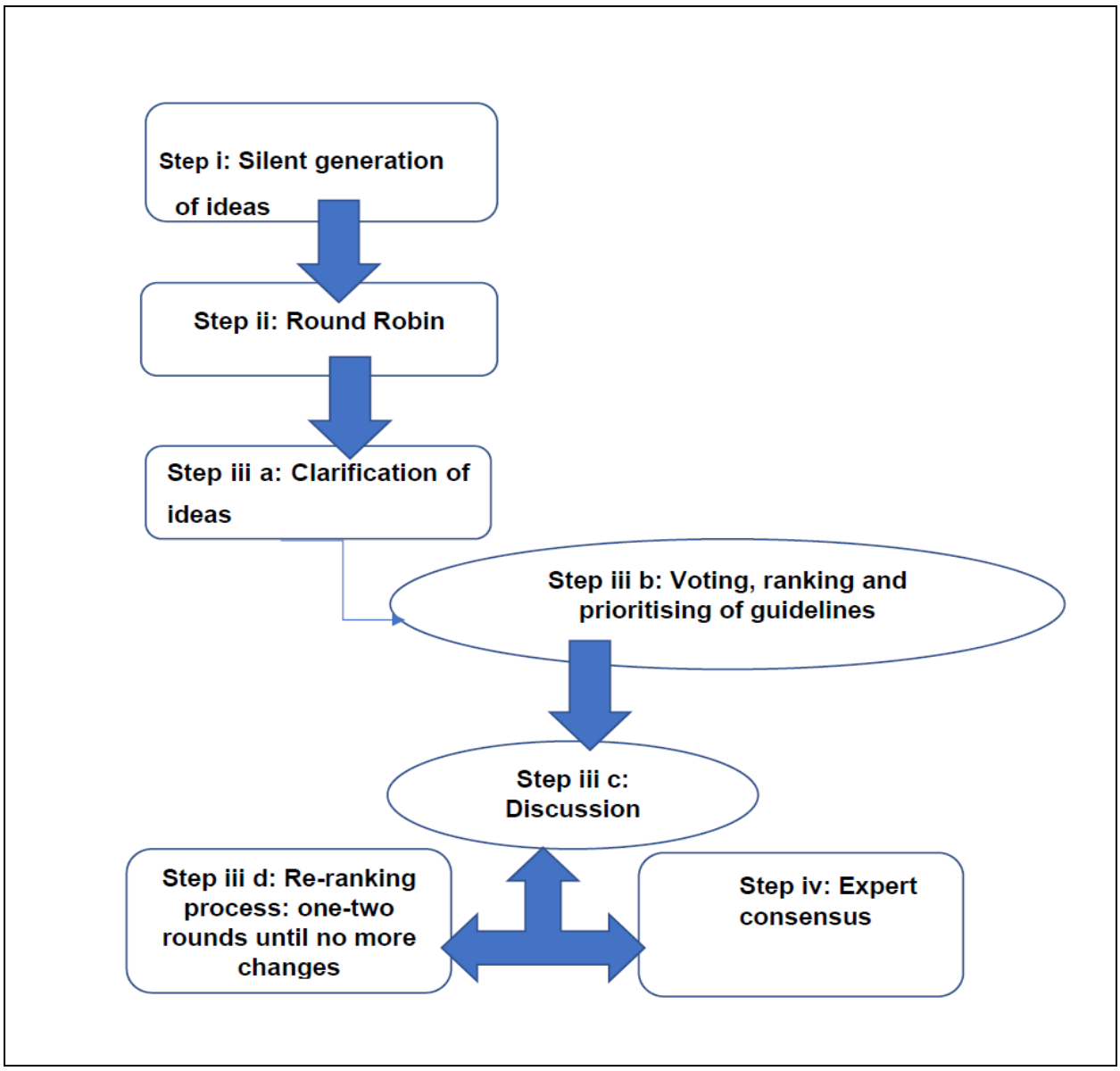


Figure 4.2 Overview of the process of the NGT adapted from (McMillan et al 2016:657)

The following section will provide an overview of the steps (as indicated in Figure 4.2) followed during the NGT and how it aided in guideline development process: ranking, voting, prioritising and consensus reaching.

Step (i): Silent generation of ideas

The facilitator allowed the participants to silently reflect on their own ideas and opinions regarding the draft guidelines (instrument used Annexure D). During this Step of the NGT, the researcher provided a brief overview of the findings from Phase 1 of this study and how the draft guidelines were formulated (inductive and deductive reasoning to draw conceptual map as to derive essence of findings). The role of the facilitator and the purpose of the NGT was explained to all participants. The facilitator allowed for 15 minutes of silent reflection. As the participants already received a copy of the draft guidelines via email after they have signed informed consent and had time to reflect on these guidelines, the additional 15 minutes allocated was deemed adequate. All participants silently reflected on the presented draft guidelines and the summary of findings from Phase 1 (described in Chapter 2) and made notes to present to the facilitator.

Silent generation of ideas was followed by Step ii, the *Round Robin*.

Step (ii): Round Robin

The *Round Robin* provided the opportunity to share a single idea with the other participants (McMillan et al 2016:657). The facilitator explained that this process is not to generate new ideas but rather to reflect on the draft guidelines and to provide inputs on voting, ranking and prioritise the guidelines (aim to condense and reach consensus). The facilitator allowed each participant to communicate their ideas before moving to the next one and not allowing any interruptions for other participants, but rather letting them wait until it was their turn again to express an idea. This process continued until no new comments or suggestions were generated by the participants. Time spent on this was 25 minutes. The facilitator wrote all the shared ideas on a flip chart for all participants to view. The facilitator allowed some time to clarify the shared ideas and group similar ideas. This process flowed into Step (iii)(a) which was clarification of ideas.

The shared ideas generated through the *Round Robin* moved from draft guidelines to the third Step for the clarification of ideas.

Step (iii)(a): Clarification of ideas

According to McMillan et al (2016:656), clarification of ideas during the NGT refers to the stage where participants are given the opportunity to group ideas and all participants agree with the shared ideas or themes' meanings. During the third Step (clarification of ideas) similar ideas and opinions were grouped together, some excluded or even included. During this Step, the participants were reminded by the facilitator that the draft guidelines (discussed earlier in this Chapter) was categorised (by the researcher prior to the NGT during Phase 1) according to preparation, migration and adaptation or adjustment. During the NGT, no new ideas were generated, but opinions and ideas linked to the draft guidelines were clarified by means of explanation and agreement between participants.

The following section will discuss the voting, ranking and prioritising of guidelines during the NGT.

Step (iii)(b): Voting, ranking and prioritising of guidelines

Guidelines are condensed during the NGT through a process of voting, ranking and prioritising (McMillan et al 2016:657). This process was managed by the facilitator as she listed themes in order or priority on the flip chart and identical items were removed and similar items were grouped together. If there would be disagreement or uncertainty about an idea, it would have either been explained in detail or excluded from the list. During this process, the facilitator wrote the 15 guidelines (first draft) on a flipchart. The meanings attached to each guideline (from Step 11b) were documented next to each guideline. Each participant had to vote for each guideline out of a score of 5 and had to decide for themselves if it was a priority guideline according to their own ranking. Some of the guidelines were condensed as they shared the same meaning to the participants as reflected in Table 4.2. Some shared ideas included push and pull factors towards migration, internal or external motivators towards migration, adaptation or re-adjustment issues related to migration. The following section will describe guideline (second draft) formulation and discussions. The explanation of guideline (second draft) has been addressed earlier in this Chapter.

The following section will describe Step (iii)(c), guideline (second draft) formulation and discussion.

Step (iii)(c): Guidelines' second draft formulation and discussion

The NGT is a useful process to allow for discussion around and formulation of guidelines (McMillan et al 2016:657). In this study, the facilitator coordinated the process around the (draft 1) guidelines' discussions done by the researcher. The aim of this Step was to condense the draft guidelines (final draft). Participants were requested to refine the second drafted guidelines. From the second draft guidelines, only five guidelines remained after the participants reached consensus. The condensed guidelines to focus on the essence of findings derived from Phase 1 of this study. The 15 draft guidelines developed and condensed will be discussed in Table 4.3 below.

Table 4.3: Draft guidelines condensed discussion

No	Guideline	Condense discussion
1	International recruitment agencies should offer migration support (in the form of workshops) to all prospective South African expatriate nurses with the focus on awareness creation on push and pull factors towards migration (nurses who is migrating to theKSA).	Condense into a push and pull guideline – motivators towards migration.
2	South African healthcare regulatory bodies to create favourable nurses' working conditions and aim to increase healthcare standards in the country of origin to those of first world countries (KSA). Human resource availability should be standardised to international standards and levels set in first world countries.	Condense into a push and pull guideline – motivators towards migration.
3	International recruitment agencies and South African healthcare providers are responsible to facilitate re-adjustment of returning expats in the country (by facilitation of support groups between returning expatriates).	Focus on re-adjustment upon return from the KSA.
4	South African healthcare government must enforce safety and protection of nurses travelling to work, ensure safety of nurses in the workplace and oversee that healthcare providers apply all reasonable measures to protect nurses in the workplace context.	Condense into a push and pull guideline – motivators towards migration.
5	South African trained nurses should be motivated by healthcare employers and regulatory systems to migrate to another foreign country (like the KSA) as to gain global experience, experience cultural diversity and interaction with international nurses' market which can improve the healthcare quality in South African upon return.	Focus on migration preparation and support.
6	International recruitment agencies to facilitate adaptation of South African expatriate nurses migrating to the KSA by offering adaptation preparation and support sessions (through workshops or information sharing sessions) to all prospective expats prior to migration.	Focus on migration preparation and support.
7	South African healthcare regulatory bodies should reconsider financial compensation of South African trained nurses (upon completion of training) equivalent to the international nurse remuneration standards, as poor compensation will result in migration (to the KSA as financial gain is a pull factor towards migration).	Condense into a push and pull guideline – motivators towards migration.
8	South African healthcare regulatory bodies should include trans-cultural nursing as a compulsory component of nurse training programs. International recruitment agencies should evaluate trans-cultural nurse exposure and training of all prospective South African expats prior to migration to the KSA.	Focus on migration preparation and support – even link with culture shock.
9	South African healthcare regulatory bodies should oversee that annual training and career development opportunities are available to all South African trained nurses, as a lack of training and career development in nurses will result in migration (as pull factor towards migration to the KSA).	Condense into a push and pull guideline – motivators towards migration.
10	International recruitment agencies are responsible to provide migration preparation to all prospective South African expatriate nurses (preparation packages) which include: diverse cultural behaviours; and social isolation experienced in the KSA.	Focus on migration preparation and support – specifically adaptation.

11	South African healthcare government and healthcare regulatory bodies should oversee that the working conditions in the country is improved which include resources and staffing ratios as to improve nurses' job satisfaction (as poor working conditions will be a pull factor towards migration).	Condense into a push and pull guideline – motivators towards migration.
12	South African healthcare regulatory bodies and healthcare providers should appoint adequate nurse staffing levels (as to provide for optimal patient care), limit overtime hours worked by nurses which will cause burnout and poor job-satisfaction.	Condense into a push and pull guideline – motivators towards migration.
13	South African expatriate nurses to receive migration support (psychological and emotional support prior to migration) offered and facilitated by the international recruitment agency which include the description and exploration of motivators towards migration (both internal and external motivators to be analysed and discussed by the prospective expat and the international recruitment agency as to determine possible negative migration experiences).	Focus on migration preparation and support.
14	International recruitment to facilitate migration preparation with the focus on culture shock training (including: symptom recognition; identification; and management of culture shock) to all prospective South African expats prior to migration to the KSA.	Culture shock.
15	International recruitment agencies are responsible to facilitate and coordinate coping skills and resilience workshops to all prospective South African expatriate nurses prior to migration to the KSA.	Coping skills – adaptation in the KSA.

As displayed in Table 4.3, the 15 guidelines were ranked and prioritised in three categories which focussed on: migration preparation (inclusive of retainment); migration support; and adaptation.

The facilitator coordinated the process of condensing the 15 guidelines into only five guidelines discussed below.

Guideline 1 (condense draft guidelines 1, 24, 7 and 9): International recruitment agencies must facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.

Guideline 2 (condense guideline 5 and 6): International recruitment agencies must facilitate workshops relevant to migration preparation and focussed on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.

Guideline 3 (condense guideline 8, 10 and 14): South African healthcare regulatory bodies and nurse education institutions to enforce trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs) are responsible to prepare South African trained nurses for the global health market with diverse cultural context and cultural competent nurse' skills will enhance adaptation into a foreign setting like the KSA.

Guideline 4 (condense draft guideline 3 and 11): South African healthcare regulatory bodies, including private and public healthcare providers to facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats.

Guideline 5 (condense guideline 5 and 12): International recruitment agencies to collaborate with South African healthcare regulatory bodies to advocate for retainment of skilled and trained staff in SA. Retainment of staff can be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

The following section will discuss Step 3(d) which included the re-ranking process of the NGT.

Step (iii)(d): Re-ranking process

According to McMillan et al (2016:657), voting and ranking during the NGT occurs when the facilitator requests the participants to vote anonymously on the guidelines using a ranking sheet (a score of 5 is the highest and indicating highest consensus).

During the final Step of the NGT, the facilitator asked the participants to rank the draft guidelines in order of importance. This Step involved participants awarding a score linked to the most important guideline, where a score of 5 was the highest (*Likert Scale*). Each participant was requested by the facilitator to vote for the guideline rank on importance

using a score of 1 to 5. Guideline 1 achieved a score of 4.14; guideline 2 scored 4.57; guideline cored 3 scored 3.14; guideline 4 scored 3.57; and guideline 5 scored 3.14. Guidelines 1 and 2 scored the highest during the voting and ranking process. Guideline 4 was scored third place with both guideline 3 and 5 in fourth place of importance.

The following section will discuss the last Step during the NGT – expert consensus.

Step (iv): Expert consensus

According to McMillan et al (2016:657), the NGT is a useful process to obtain expert consensus during the guidelines' development process. The aim of this Step was to reach consensus from all participants on the final draft guidelines. The facilitator encouraged the participants to limit the repetitions that have been noted in their previous discussions and to keep to the three categories of the guidelines that will be presented for validation (preparation, migration and adaptation or adjustment). This scoring was done with a *Likert Scale*, done individually and confidential as not to influence the other participants' views.

Participants were asked to rank each guideline on clarity, validity, accuracy, scope and practice (McMillan et al 2016:657). Each category or recommendation of the guideline could receive a maximum score of 5 which has been converted into a %. No half marks i.e. 3.5 have been accepted. Each guideline was allocated a scoring percentage (consensus percentage), which included: guideline 1 scored 91%; guideline 2 scored 83%; guideline 3 scored 54%; guideline 4 scored 90%; and guideline 5 scored 78% (see Annexure N). An consensus (overall) score for all 5 draft guidelines was 75%. As presented, guideline 3 only scored 54% and there was disagreement amongst participants as to remove it, however in totality (as indicated by participants) as it was still significant and applicable to this study. Participants argued that trans-cultural nursing knowledge and skills will not only influence the choice to migrate but will aid in adaptation and re-adjustment when migrating. It was agreed amongst participants to keep this guideline and to be submitted for validation. This percentage was calculated by adding individual scores of experts without a consensus measuring tool, adding the individual scores (seven each) and then dividing the individual scores into a single score out of 5 per guideline. Specific recommendations on the guidelines have been added into the final draft guidelines, discussion 4.4. The voting step only took 15 minutes and consensus (75%) was reached regarding the importance of the strategies to be included in the proposed guidelines.

The following section will discuss the final draft guidelines (referred to as second draft) as done during the NGT.

4.4 FINAL DRAFT GUIDELINES

The five draft guidelines (third and final draft) were documented as facilitated by the facilitator and experts during the final Step of the NGT. These guidelines that were submitted for ranking, voting and prioritising included:

Guideline 1

International recruitment agencies to facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.

Target population: International recruitment agencies, prospective expats.

Purpose of guideline: To create awareness of the push and pull factors towards migration.

Rationale:

According to Wickramasinghe and Wimalaratana **(**2016:22), the reasons towards migration (pull factors) can be classified into economical, demographical, socio-cultural, political and miscellaneous factors. Economic factors are regarded as the primary motivator for people to migrate from developing countries where the income is low to countries, which can provide for better economic opportunities (Wickramasinghe & Wimalaratana 2016:15).

Migration will only occur when the pull factors at the destination country outweighs the plus or positive factors in the country of origin (Wickramasinghe & Wimalaratana 2016:15). In this study, the pull factors are linked to participants seeking greener pastures. Individual decisions to migrate (between countries) are based on push-pull effects and where the positive aspects of the destination country outweigh the negative aspects in the country of origin; migration trends will continue (Ruedin & Nesturi 2018:240).

The greener pastures included financial gain and the need for independence as reflected in Table 2.2, Chapter 2. Socio-cultural factors include: history of family conflict; communication facilities (including no access to internet or telephone services); discrimination based on education; job opportunities; access to medical services; and the

need for independence (Wickramasinghe & Wimalaratana 2016:15). In this study, participants mentioned that they felt that the nurses' education and training they received in SA didn't prepare them for the international market (push factor towards migration); and that working in the KSA will provide them with a global experience and exposure (pull factor towards migration). According to Garner et al (2015:1880), South African nurses are dissatisfied with their remuneration and career development. Khunou and Davhana-Maselesele (2016:1) also further states that poor working conditions including low salaries in South African healthcare systems cause dissatisfaction amongst nurses. Opportunities to migrate, including capability improvement and career development is regarded as pull factors towards migration (Ruedin & Nesturi 2018:242).

In this study, South African expatriate nurses (data collected during Phase 1, Chapter 2) were either attracted to the KSA (pull factors) or push factors from SA forced these expats to leave their country of origin to work and live in the KSA. These push factors include: safety issues; job dissatisfaction; lack of remuneration; and lack of training opportunities in SA. Push factors according to Ruedin and Nesturi (2018:242) include: lack of training and economic opportunities; conflict; natural disasters; and climate changes and poverty.

During the NGT (Phase 2), experts agreed that financial gain, safety, job satisfaction and lack of training opportunities in SA is push factors towards migration. Participants, during the NGT, also agreed that the need for independence and career development opportunities is pull factors, which will motivate South African expatriate nurses to migrate to the KSA. Unfortunately, upon arrival in the KSA, these migrants felt like 'strangers in a strange land' and experienced disillusionment, almost is if their 'expectancies' hasn't been met. Migrant nurses might be misled by recruitment agencies (lack in migration preparation) regarding working conditions, foreign legislation and salaries (Shannon-Baker 2015:33). The researcher could not find any evidence of standardised practices from international recruitment agencies regarding their orientation or in-service schedule and practices pertaining to migration preparation.

Recommendations for implementation: International recruitment agencies recruiting South African expatriate nurses to migrate to the KSA to focus on awareness of push and pull factors towards migration, preparation to facilitate and support the migration process and adaptation of these migrants in the KSA.

Actions:

The role and actions of the international recruitment agency during South African expatriate nurse migration to the KSA is vital in preparation and support of the migration and adaptation process. Actions include:

- Questionnaires assessing the level of awareness of motivators towards migration (including push and pull factors) to be completed by all prospective expats as part of the application process of the international recruitment agency at least three months prior to departure. These questionnaires can identify gaps in awareness on the side of prospective expats that needs to be addressed.
- International recruitment agencies must facilitate clarification interviews (upon completion of questionnaires, at a venue suitable to both prospective expat and international recruitment agency representative) with all prospective expats to clarify expectations as to prevent sudden disillusionment. Clarification interviews on expectations can be facilitated by both the international recruitment agency and returning expats with prospective expats at least three months prior to departure.
- International recruitment agencies to facilitate workshops between returning and prospective expats to share experiences regarding expectations and lived experiences (to aid in adjustment in the KSA) at least three months prior to departure of prospective expats.
- International recruitment agencies to arrange and facilitate group discussions between returning and prospective expats to clarify expectations: during group discussions and orientation sessions unrealistic expectations can be identified and the adaptation process (as well as the time to adapt into the foreign culture in the KSA) can be documented and discussed. Unrealistic expectations will be linked with negative migration experiences and poor adaptation in the KSA.

Guideline 2

International recruitment agencies must facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.

Target population: International recruitment agencies, prospective expats.

Purpose of guideline: To enhance migration preparation as to limit the degree of culture shock experienced in the KSA (South African expatriate nurses working and living in the KSA).

Rationale:

According to Shannon-Baker (2015:34), all individuals should be prepared for culture shock when taking on international opportunities and experiences and knowledge about culture shock should commence earlier than the proposed international travel. Pascoe, as mentioned in EXPATICA (2016:NP) stated: *"…re-entry shock is when you feel like you are wearing contact lenses in the wrong eyes. Everything looks almost right…"*. With prolonged international experience, the expatriate has undergone both personal and professional changes, changed certain norms and values or worldviews and must adjust to the status before leaving their home countries (EXPATICA 2016:NP).

During Phase 1 of this study, all participants agreed that they experienced culture shock whilst working and living in the KSA. Factors that caused culture shock according to the participants included: 'unexpected disillusionment'; 'finding your feet'; lifestyle or living standards; 'reality kicks in'; social networks; personal and professional growth (Discussion Chapter 2, Theme 2). During the NGT experts agreed that culture shock experienced in a foreign culture, especially the move from a Western to Eastern paradigm is a reality.

Recommendations for implementation: International recruitment agencies to re-design orientation and preparation packages focused on South African expatriate nurses to include factors that will lead to culture shock experienced in the KSA.

Actions:

As to prevent or limit the degree of culture shock in expatriate nurses:

- International recruitment agencies (representative who are actively involved in recruiting South African nurses for the KSA) to provide in-depth orientation (programs well developed that focus on mental, spiritual or physical preparation on cultural behaviours and traditions exhibited in the KSA) at a setting suitable for both the prospective expat and the recruitment agency representative regarding the cultural diversity and exposures in the KSA. These programs can also be presented in the structure of workshops, by the recruitment agency least three to six months prior to departure.
- All prospective South African expats should do research on the KSA diversity (diverse behaviours, traditions, gender segregation, treatment of women and communication skills) before departure (at least three months prior to allow for proper investigation and understanding of the extreme diversity). Mentorship programs (in the form of discussion or focus groups as facilitated by the

international recruitment agency, at a venue suitable for all parties involved at least three months prior to departure) can assist in this process by preparing and supporting the prospective expatriate nurse.

- Group or individual discussions facilitated by the international recruitment agency (including personal lived experiences in the KSA referring to 'treatment by Saudis', 'expectations not being met') between expatriates (who returned from the KSA which have personal lived experiences). Expatriate experiences should be make available either in print or electronic (facilitation by the international recruitment agency, either through personal contact sessions or social media) to all South African expatriate nurses leaving for the KSA prior to departure (at least three to six months prior to departure as to allow ample time to receive enough information and allowing the expatriate nurse) to make an informed decision of he or she will be able and willing to face the possible challenges in the KSA.
- The international recruitment agency (person in charge of active recruitment of migrants) to provide for accurate and in-depth orientation and induction by means of support groups (done by returning expatriate nurses) on the KSA traditions, behaviours and possible challenges at least three months prior to departure.
- The international recruitment agency (person in charge of active recruitment of South African expatriate nurses) to provide orientation sessions (at least three months prior to departure) in the form of workshops on issues reflected by the data and literature, including: language barriers; working conditions; and the role of the female in the KSA at a venue which is available and accessible to all stakeholders involved.
- The international recruitment agency to provide and facilitate discussions between prospective and returning expats on how to overcome loneliness and how to manage stress and conflict. These facilitated discussion sessions facilitated by the international recruitment agency can be planned as formal or informal mentoring programs and coordinated by the recruitment agency. Returning expatriates can share their lived experiences with the prospective expats. These programs can be done at a venue, which is accessible and suitable for both parties. This session needs to be facilitated at least six weeks prior to departure to the KSA.

Guideline 3

South African healthcare regulatory bodies and nurse education institutions must encourage trans-cultural nursing as a crucial competent in all NEIs are responsible to

prepare South African trained nurses for the global health market with diverse cultural context and cultural competent nurses' skills will enhance adaptation into a foreign setting like the KSA).

Target population: Nurse education institutions, nurse educators, nursing students, healthcare regulatory bodies.

Purpose of guideline: Promote standardisation of nurse education programs to include culturally competent care, with the focus on cultural diversity and adaptation into a diverse healthcare setting.

Rationale:

Cultures are constantly changing and reforming as a response to environmental, physical and social realities and nurses are expected to deliver culturally competent care (Dauvrin & Lorant 2015:202). In order to be fully functional in the new environment the expatriate nurse must become culturally competent. This process of becoming has no time limit connected to it.

Cultural competence can be explained as a process of becoming rather than accomplishment and is a never-ending process (Dauvrin & Lorant 2015:202). Globalisation and ultimately migration of nurses brought changes in the healthcare setting with a demand for culturally appropriate and competent care. The global migration of nurses created culturally different and competent knowledge (Dauvrin & Lorant 2015:202). Cultural competence, as explained from a nursing perspective, is the ability to understand cultural differences, to be culturally sensitive to issues like race and gender and to provide holistic quality care to all diverse patients (Dauvrin & Lorant 2015:202).

Cultural competence' ultimate goal is to achieve optimal and effective work relations with patients from diverse cultural backgrounds. Cultural competence can be learned through role modelling, but recognising and applying sensitivity to individual and contextual factors (Dauvrin & Lorant 2015:209). Cultural behaviours can be learned through fieldwork or prolonged exposure to a foreign culture. Active participation instead of mere observation would increase the chances of really getting to terms with cultural understanding. Culture primarily relate to how individuals would react and interact with one another. It is believed that long-term exposure to a foreign culture is needed in order to experience the full range of cultural behaviours (Palomar.edu 2016:NP).

According to Lacoma (2016:NP) is it believed that cultural behaviour refers to the behaviour or the local or national culture. Activities, mind-sets and workplace attitudes also play a vital role during cultural behavioural display. During Phase 1, participants agreed that diverse behaviours, traditions, gender segregation, treatment of women and communication skills in the KSA was strange and unknown to them as they did not receive cultural training during their formal nurse training courses. Although participants during the NGT agreed on the importance of trans-cultural training in nursing programs, the focus should remain on proper orientation and induction from the recruitment agencies and encouraging nurses to do their own research about the country they wish to emigrate to.

Recommendations for implementation: SANC, nurse education institutions and South African healthcare regulatory bodies to re-visit nurse education training and make trans-cultural nursing training a crucial point of focus in the curriculums of all training programs.

Actions:

- SANC and South African healthcare regulatory bodies to oversee standardisation of nurse training and education programs to include culturally competent and sensitivity care.
- International recruitment agencies to arrange and facilitate transcultural training sessions in the form of workshops. Topics relevant to trans-cultural nursing and cultural sensitivity to be presented in focus groups relevant to the diverse traditions and behaviours exhibit in the KSA as to create cultural awareness. These sessions to be attended by all prospective expats at least six months prior to departure.
- Mentorship programs for expats arranged by the healthcare facility (facilitated in the KSA by the KSA Education Department) should cover culturally sensitive issues, how to identify and manage these sensitive aspects and completed by all expats within the first month of arrival in the KSA.

Guideline 4

South African healthcare regulatory bodies, including private and public healthcare providers must facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs upon return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.

Target population: South African healthcare regulatory bodies, South African healthcare

providers.

Purpose of guideline: To promote cooperation opportunities between international recruitment agencies and South African healthcare providers; to support re-integration of returning South African expats from the KSA into the South African healthcare environment; to support returning South African expat adjustment into the South African working and living environment.

Rationale:

When South African expatriate nurses return from the KSA they experience the country, which was known to them before as strange and felt like '*strangers in their own land'*. The adaptation process of immigrants into a new social and cultural environment is regarded as a multi-faceted process (Almajwal 2016:191). Adaptation is the process of change and adjustment and the individual must go through the process of reversed culture shock, which has its own effects on the migrating nurse (Brown 2016:4).

There are two aspects of inter-cultural adaptation namely socio-cultural and psychological adaptation (Brown 2016:4). According to Brown (2016:4), socio-cultural adaptation refers to the practical and behavioural aspects when encountering face-to-face interactions with a new culture; whilst psychological adaptation refers to the feelings (respect, comfort and happiness) experienced when encountering a new culture. Socio-cultural adaptation is based on the nurses' previous cultural learning and approach, which are reflected in her ability to engage in interaction with a foreign culture. Although South African expatriate nurses used to work with colleagues from SA prior to migration, they were used to the ways and traditions exhibited in the KSA, which made SA felt foreign and strange upon their return. Psychological adjustment involves the nurse's sense of wellbeing, enhanced by the positive appraisal of situations and general feelings of satisfaction (Almajwal 2016:191). Poor adaptation patterns among nurses relate to higher levels of depression, low self-esteem, anxiety and other psychological disturbances (Almajwal 2016:191).

Integration by immigrants is linked to successful adaptation (Brown 2016:4). Cultural maintenance practices (including religious and ethnic behaviours or identities) can be predictions of positive adaptation processes amongst migrant nurses (Brown 2016:4). Guideline 4 will focus on re-integration of South African expatriate nurses when returning from the KSA. In this study, findings from Phase 1 indicated that returning expats struggled to adapt to the South African environment when returning from the KSA, both

workforce and living environment has felt strange to them and they felt like '*strangers in their own land'.*

During Phase 1 of this study, when the expatriate nurse realises all the family responsibilities and gatherings she missed out in SA, it reality hits home. Once she realises that the time spent away from home will only be temporary, they make the best of the new adjustment and settle into the culture. The South African expatriate nurses settle into the new cultural ways in the KSA, but then struggle to adapt back into the South African workforce upon return. This difficult adjustment can be described as reversed culture shock.

The researcher could not find any evidence of standardised counsellor programs, which aid in expatriate adjustment upon return to the country of origin. Davies, Kraeh and Froese (2015:171) mentioned that cross-cultural adjustment can be improved through prolonged positive interaction and communication. There is a gap in literature on mentoring of South African expatriate nurses and adjustment back to SA.

Experts during the NGT agreed that expatriate nurses who return to SA after working and living in the KSA may have re-adjustment issues, especially after being exposed to the Eastern paradigm for a period, and the responsibility rests on the employer to provide enough guidance and support to these expatriate nurses to aid in re-adjustment.

Recommendations for implementation: Supportive, collaborative and mentoring roles adapted by the international recruitment agencies, South African healthcare regulatory bodies and healthcare facilities or providers to facilitate return migration of South African expatriate nurses into the SA context.

Actions:

- South African healthcare providers in healthcare facilities must facilitate, provide and coordinate mentorship programs (senior nurses appointed as mentors) to orientate South African expatriates back into South African healthcare systems and continue for the first three months on-the-job mentoring and support.
- International recruitment agencies must facilitate mentorship programs for returning expatriates upon their return. The recruitment agency can act as a gatekeeper for this process, which can last up to six months upon return to SA. Mentoring programs can either be arranged to be done in the workplace, or as individual discussions at a venue, which is accessible and suitable for both parties.

These programs will assist in creating a sense of meaning and belonging in the expatriate and aid in re-adjustment back in to the South African environment.

- Mentorship programs ('buddy-systems') must be arranged by the healthcare facility and be available (for a period of at least two weeks) by private and public healthcare employers to orientate these expatriates (regarding the South African healthcare system, processes, staffing, equipment or stock usage) back into the South African healthcare systems. This mentorship programs will create a sense of belonging in the returning expatriate nurse, create meaning on both personal and professional levels. Should there be identified issues (re-adjustment issues, stress, depression, isolation or physical illness) after this two-week orientation sessions an on-board counsellor should be made available immediately by healthcare employers to address adjustment issues (aid in adjustment and assist in settling into the 'new' healthcare environment other than the KSA).
- The healthcare facility must appoint or connect them to counsellors (either professionals or individuals who had experience with migration and adaptation) available to support returning expats, aid in adjustment and adaptation, be available upon request at a private venue which is accessible and suitable for both parties, within six months upon arrival back into the South African healthcare environment.

Guideline 5

South African healthcare regulatory bodies must advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

Target population: South African national healthcare regulatory bodies, National healthcare government, prospective South African expats.

Purpose of guideline: Control of skilled migration to the KSA, improvement of South African healthcare systems, promotion of professional development opportunities in SA.

Rationale:

Issues related to the healthcare workforce in SA, especially nurse shortages, brain drain and poor nurse' performances influence the overall perception of healthcare in the country (Armstrong et al 2015:3). South African trained nurses are attracted to the KSA (pull factor towards migration) as this study shows (in Phase 1, Chapter 2) which result in nurse

shortages and ultimately brain drain in SA are supported by the author Armstrong et al (2015:3). As a result of nurse migration, countries like Africa and the Philippines is experiencing severe 'nurse brain drain', resulting in high nurse turnover and even the closure of hospitals (Vartiainen 2016:32). According to Masanjala (2018:17) healthcare development goals in African countries cannot be reached due to nurse migration and brain drain, resulting in poor health indicators and low capacity to deliver optimal patient care.

Recommendations for implementation: When considering the push and pull factors towards migration, the South African healthcare environment should eliminate the push factors, which will control out-migration of skilled and trained Professional nurses to the KSA.

Actions:

- South African healthcare regulatory bodies to oversee that all South African trained nurses receive monetary compensation (through services delivered at healthcare provider facilities, monthly paid and overtime additionally calculated, equal to skills and experience); benchmarked against international standards, which are reviewed annually by the national health regulatory bodies.
- South African healthcare regulatory bodies and healthcare providers to advocate for free training and development opportunities that are ongoing and available for all nurses. Training opportunities should be set, documented and circulated in writing by the healthcare provider to all nurses on a continuous basis, reviewed quarterly by the national health regulatory bodies, with the input of the employee as to optimise their skills and knowledge in healthcare settings.
- National healthcare government and SANC should monitor continuous (annual) training and developmental opportunities attended by nurses and document proof of completion, as it will enhance patient care and satisfaction. Continuous professional development (CPD) must be made compulsory by SANC, enforced by healthcare facilities as to improve the skills and standard of nursing on national levels.
- National healthcare government must set reasonable annual career advancement opportunities (promotion to a higher level of seniority, improved monetary compensation) based on job performance evaluations to all trained and experienced South African nurses in an effort to keep these nurses in SA (create job satisfaction and motivation for junior nurses).

The following section will discuss Step 4 of the guideline development process: draft guideline development with AGREE ll instrument domains.

4.4.1 Step 4: Application of the AGREE ll tool to develop guidelines

The role of the AGREE ll instrument in this section of the study was to finalise the draft guidelines and to prepare them for validation during Phase 3. The AGREE ll instrument can be viewed in Chapter 3 (Figure 3.1). The AGREE ll instrument consists of six domains which include: (i) scope and purpose; (ii) stakeholder involvement; (iii) rigour of development; (iv) clarity of presentation; (v) applicability; and (vi) editorial independence (AGREE 2017:NP). Table 4.4 below will provide information pertaining to the AGREE ll domains, items and implementation to this study.

Table 4.4 Implementation of the AGREE ll domains

AGREE ll Domain	Items	Implementation
Domain 1: Scope and Purpose	Include the overall aim of guideline, specific health questions and target population (AGREE 2017:NP).	The purpose of guidelines applicable to this study has been discussed earlier in this Chapter: guidelines to support preparation, migration and adaptation of South African expatriate nurses working and living in the KSA and upon their return to SA (see Table 1.1, Chapter 1). The guidelines developed in this study may be useful for prospective expatriates as well as recruitment agencies: the preparation and support for the South African expatriate nurse on migration and adaptation issues in the KSA and upon returning to SA. In this study, guidelines would be essential to assist South African expatriate nurses' migration and adaptation between the KSA and upon their return to SA. The South African expatriate nurses might struggle to adapt (according to literature as reflected in background in Chapter 1 and the conceptual map Chapter 2, Figure 2.1) and that can influence their job performance and health during migration and adaptation to the KSA. Adaptation also refer to when these expatriate nurses return to SA when they experience a lack of integration into their community and workplace of origin.
Domain 2: Stakeholder Involvement	Focus on the stakeholder involvement during guideline development and representation of the views of the intended users.	In this study, stakeholder (South African expatriate nurses migrating to the KSA and returning to SA) involvement refers to stakeholder or participant's data gathered during Phase 1 if this study by means of unstructured phenomenological interviews (nine in total). The views of the intended users (South African expats) will be associated with participants' views reflected during

		Phase 1 of this study (South African expatriate nurses). The views of these participants (including push and pull factors) have been reflected on a conceptual map (Chapter 2, Figure 2.1). Push and pull factors towards migration will encourage international nurse migration and ultimately influence South African nurses' retention in the country if these nurses chose to migrate (to the KSA in this study). The lack in migration preparation will result in culture and reversed culture shock, poor adjustment in the destination country and challenges in adaptation upon their return to SA. The international recruitment agency who assisted in identification of prospective participants was also recognised as an integral stakeholder during Phase 1 by referring prospective participants to the researcher and acted as gatekeeper between these two parties. Professional stakeholders also refer to experts during the NGT and e-Delphi. Experts represented in the NGT included nurse managers or educators with knowledge and experience in expatriate migration and adaptation.
Domain 3: Rigour of development	Include the processes used to gather and synthesise evidence and methods used to formulate recommendations (AGREE 2017:NP).	During Phase 1 of this study, data was collected by means of unstructured phenomenological interviews and data was analysed manually by means of Coliazi's' data analysis method as described in Chapter 1. Trustworthiness was maintained by the way the researcher collected, sorted and classified the data. The process followed during the guideline development process included: inductive and deductive reasoning; development of a conceptual map; synthesised of data into the essence; and constituents. The NGT was used to rank, vote and prioritise the draft guidelines compiled by the researcher and an audit trail was kept of all the processes and can be made available upon request.

		Rigour was enhanced by the validation process during the e-Delphi. This resulted in combining recent empirical evidence with existing evidence in literature (see Chapter 6 for recommendations made).
Domain 4: Clarity of presentation	Include language, structure and format of the guideline.	In this study, the researcher used English as communication and reporting language. All participants who participated during the guideline development process were fluent in the English language and therefore had a good understanding of the process followed. The draft guidelines developed by the researcher (15 in total) were based on South African expatriate nurse retention, migration and adaptation. These guidelines have been structured according to the domains described in the AGREE ll instrument (AGREE 2017:NP).
Domain 5: Applicability	Include barriers and facilitators to implementation.	In this study, the guidelines are applicable to all prospective or returning South African expatriate nurse' migrating or who migrated to the KSA, adjustment to the environment in the destination country and adaptation upon their return to SA. Potential barriers to implementation could include the lack of support and cooperation between international recruitment agencies, returning South African expatriate nurses towards prospective expats and private and public healthcare facilities. Aspects that can assist with the facilitation of the application include cooperation strategies between the international recruitment agencies and prospective or returning expats and include 'buddy systems', orientation and mentoring programs and communication of clear expectancies on what to experience in the KSA and upon their return to SA. The two research contexts included both the KSA and SA.

Domain 6: Editorial independence	Focus on the formulation of recommendations free from bias and competing interest (AGREE 2017:NP).	Editorial independence is not applicable to this study. No known competing interest known and the study was free of bias.

Table 4.5 will provide an overview of the draft guidelines (final draft) with incorporation of the AGREE ll instrument.

Table 4.5 Draft guidelines (final draft) with domains extracted from AGREE ll instrument (AGREE 2017:NP)

Draft guideline	Domains extracted from AGREE ll instrument					
	Scope and purpose	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**
Guideline 1 International recruitment agencies to facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.	**Scope:** Migration support of South African expatriate nurses. **Purpose:** To provide prospective South African expatriate nurses with a positive migration experience. The rationale for this guideline has been discussed in section 4.5 of this Chapter.	Prospective expatriate nurses. International recruitment agencies.	Based on data collected from Phase 1 and literature control.	Guideline 1 scored the **highest** during the NGT (91%)		Audit trail kept and available upon request. Guideline can be generalised to other settings. Link with the essence of South African expatriate nurses working and living in the KSA.
Guideline 2 International recruitment agencies must facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.	**Scope:** Focus on culture shock. **Purpose:** Prevention or limitation of effects of culture shock in South African expatriate nurses.	Prospective expatriate nurses. International recruitment agencies.	Based on data collected from Phase 1 and literature control.	Guideline 2 scored the second highest during the NGT (consensus 90%). Although the guideline is clear, the movement of migrants cannot be controlled and the input of South African healthcare regulatory bodies cannot be guaranteed.		Audit trail kept of all findings and can be made available upon request. Link with the essence of

	The rationale for this guideline has been discussed in section 4.5 of this Chapter.				South African expatriate nurses' experiences of migration.
Guideline 3 South African healthcare regulatory bodies and nurse education institutions must enforce trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to prepare South African trained nurses for the global health market with diverse cultural context; and cultural competent nurse' skills will enhance adaptation into a foreign setting like the KSA).	**Scope:** Lack of trans-cultural skills and knowledge in South African trained nurses. **Purpose:** Preparation of South African trained nurses for the international healthcare market. The rationale for this guideline has been discussed in section 4.5 of this Chapter.	Nurse education institutions. Nurse educators. Nursing students. Healthcare regulatory bodies.	Based on data collected from Phase 1 and literature control.	Guideline 3 scored the **lowest** during the NGT (54%). Participants argued that the SANC is inadequate to regulate private training institutions.	Audit trail kept of process and can be made available upon request. Link with the essence of South African expatriate nurses' experiences of migration.
Guideline 4 South African healthcare regulatory bodies, including private and governmental healthcare providers must facilitate South African expatriate nurses' re-integration back into the South African healthcare environment	**Scope:** Re-adjustment of South African expats upon return to SA. **Purpose:** Migration and adjustment support of	South African healthcare providers (private and public). South African healthcare regulatory bodies.	Based on data collected from Phase 1 and literature control.	Guideline 4 scored the third highest during the NGT (83%).	An audit trail was kept of findings and can be made available upon request.

through mentorship and supportive programs immediately upon their return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.	South African expatriate nurses. The rationale for this guideline has been discussed in section 4.5 of this Chapter.				Link with the essence of South African expatriate nurses' experiences of adaptation upon returning to SA.
Guideline 5 South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA**.**	**Scope:** South African trained nurses, prospective expats. **Purpose:** Retainment of South African trained nurses. The rationale for this guideline has been discussed in section 4.5 of this Chapter.	South African national healthcare regulatory bodies. National healthcare government. Prospective South African expats.	Based on data collected from Phase 1 and literature control.	Guideline 5 scored the second lowest during the NGT (73%) as participants felt that migration is a personal choice and the KSA remains a favourable destination (financial gain) for migration.	An audit trail was kept and can be made available upon request.

These final draft guidelines will be presented for validation during Phase 3 of this study (Chapter 5).

The following section will describe Step 5 of the guideline development process: refinement of guidelines through validation with an e-Delphi technique.

4.4.2 Step 5: Refinement of guidelines through validation with an e-Delphi technique

During Step 5 of the guideline development process, the final five drafted guidelines (second draft) were submitted for refinement using the e-Delphi. Full discussions will follow in Chapter 5 (Table 5.2). The following section will describe the final Step (Step 6) of the guideline development process.

4.4.3 Step 6: Modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds

During Step 6 of the guideline development process (modification and finalising of guidelines), two rounds of e-Delphi was used to validate the final guidelines. Full descriptions will be illustrated in Chapter 5, Table 5.5.

The next section will provide a summary of this Chapter.

4.5 SUMMARY

Chapter 4 focus on the development of the draft guidelines (Phase 2 of this study) to facilitate migration and adaptation of South African expatriate nurses; methodology, data analysis; interpretation; and a literature control. Chapter 5 will address Phase 3 of this study: refinement and validation of guidelines, methodology and final guidelines.
The guidelines voted and prioritised during Chapter 4 (Phase 2) which will be presented in Chapter 5 (Phase 3 of this study) included:

- International recruitment agencies to facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.
- The international recruitment agency to deliver migration preparation of South African nurses as poor preparation will result in culture shock (KSA).
- South African expatriate nurses to be prepared (by nurse education institutions) for the global health market with diverse cultural context as to enhance adaptation

into a foreign setting like the KSA.

- International recruitment agencies in collaboration with South African healthcare regulatory bodies, including private and governmental healthcare providers to facilitate South African expatriate nurses' migration and re-integration back into the South African healthcare environment which will aid in re-adaptation and ultimate re-adjustment of these expats.
- South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

The discussion on the finalising and validation process of these five draft guidelines during Phase 3 (3A and 3B) of this study, will be presented in Chapter 5.

CHAPTER 5

PHASE 3:
REFINEMENT AND VALIDATION OF GUIDELINES, METHODOLOGY AND FINAL GUIDELINES

5.1 INTRODUCTION

After the draft guidelines were developed (Phase 2, Chapter 4) it was refined and validated (objective 3) during Phase 3 by experts with an e-Delphi technique (Phase 3A) and a stakeholder discussion or consensus (Phase 3B). The same process was followed during Phase 3 (3A and 3B) and the presentation of these 2 Phases will be addressed as one. The development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses; methodology; data analysis and interpretation and literature control was discussed in Chapter 4. The implementation of the AGREE II tool with domains during the development of draft guidelines is reflected in Table 4.4.

The following section will discuss the methodology applicable to Phase 3 (3A and 3B) of this study.

5.2 METHODOLOGY PHASE 3 (3A and 3B)

The first 4 Steps of the guideline development process, as depicted in Figure 5.1 has already been discussed in the previous Chapters. Chapter 5 will focus on Step 5 and 6 of the guideline development process (see Figure 5.1).

This section of the guideline development process as related to the e-Delphi technique will include population, sampling as well as descriptive information of the experts for the e-Delphi technique used during Phase 3A and the stakeholder discussion or consensus during Phase 3B.

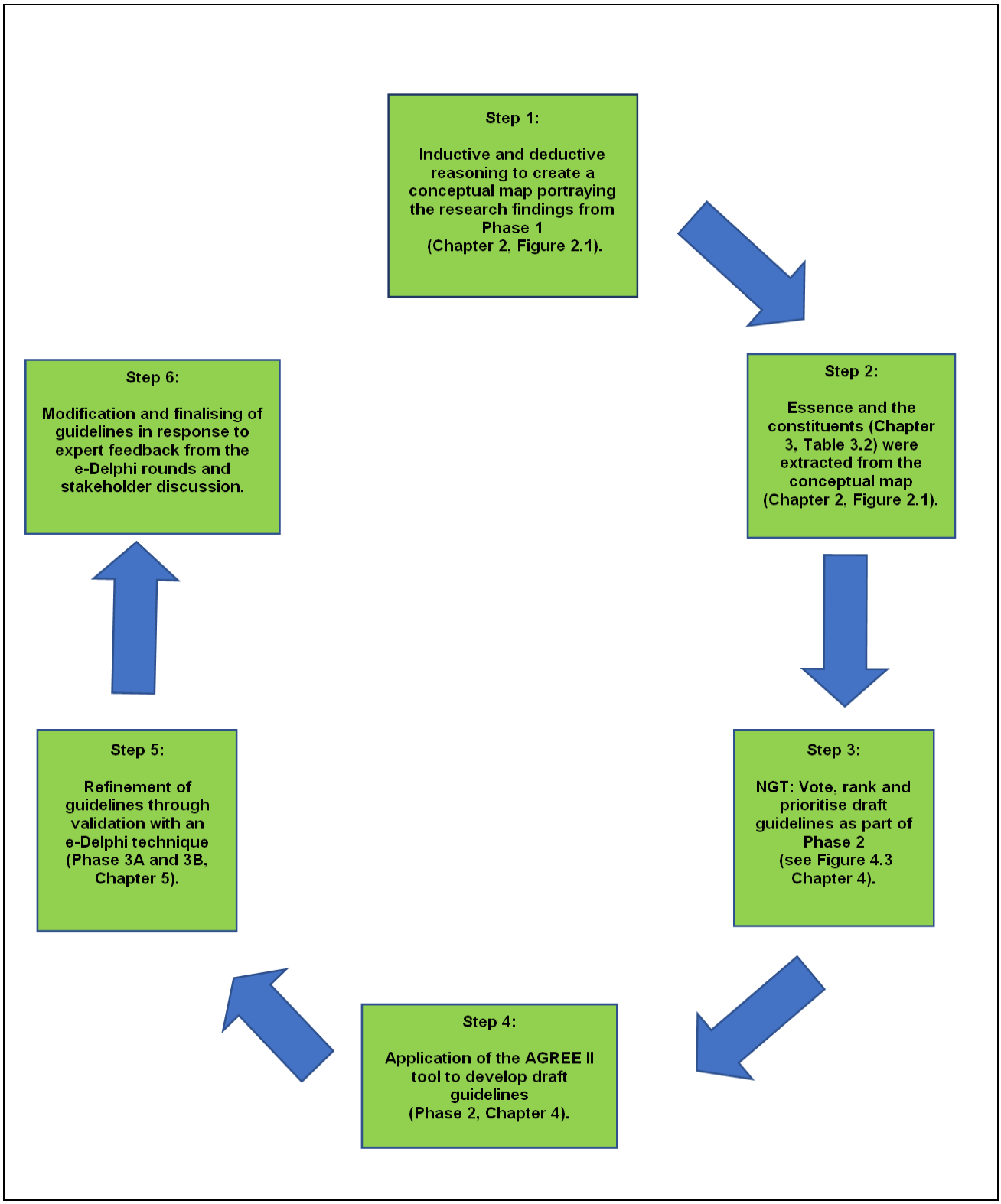


Figure 5.1 Steps followed during the guideline development process

Figure 5.1 provided a schematic view of the Steps followed during the guideline development process. The following section will focus on Step 5: Refinement and validation of guidelines.

5.2.1 Step 5: Refinement of guidelines through validation with an e-Delphi technique

During Step 5, Phase 3 (3A and 3B) in this study, refinement and validation of guidelines using e-Delphi technique also included stakeholder involvement through consensus or discussion.

According to Humphrey-Murto et al (2017:15), the three consensus methods used in health care research include: the NGT; Delphi method or technique; and the RAM (RAND Appropriateness Method). During the NGT, experts ranked ideas in order of personal preference during a contact session (Humphrey-Murto et al 2017:15). The Delphi method focuses more on the generation of ideas and there is no face-to-face interaction (McMillan et al 2016:655). In this study the e-Delphi technique was useful because of the different geographical locations of participants (not being able to get all of them at the same venue and on the same time); as well as the time demands required from each participant (they could complete the round within the time frames but according to their own time schedules).

The following section will provide information pertaining to the e-Delphi – as applied to this study.

- *e-Delphi technique as applied to this study (Phase 3A)*

The Delphi technique was first introduced during 1950s and this technique is still used for problem solving (Henderson et al 2016:111). According to McMillan et al (2016:655), the Delphi technique is a complex technique to elicit anonymous consumer priorities: with a risk of a bias response.

As per McMillan et al (2016:659) Delphi technique allows for highly structured group interaction via questionnaires, with no face-to-face communication and was originally sent by post. The original response time for the Delphi technique took up to 40 days (McMillan et al 2016:659). The e-Delphi allows for questionnaires to be sent via e-mail which makes

the response time shorter (McMillan et al 2016:659), and for this reason the researcher made use of the e-Delphi technique in this study for refinement and validation of guidelines. As per Henderson et al (2016:110), the e-Delphi technique is a useful structure which aims to produce critical discussions and examinations. This technique is useful when developing guidelines, predicting trends or setting standards.

The e-Delphi technique request participants to engage in multiple rounds of questionnaires, whereby the results of each round or questionnaire are interpreted, collated and communicated to the stakeholders (Henderson et al 2016:111). This can be very time consuming and participant' drop-out rate might increase due to these demands. The e-Delphi technique can be particularly useful and cost effective when applying it on a large scale (Henderson et al 2016:111). The Delphi technique typically consists of two to three rounds as to reach undeniable consensus (Mukherjee, Huge, Sutherland, McNeill, Van Opstal, Dahdouh-Guebas & Koedam 2015:1098). In this study, only two rounds of the e-Delphi were applied as consensus was reached after the second round. Typically, a *Likert Scale* of three to 10 items is used, depending on the group size. In smaller groups, a questionnaire distribution of more than one round is recommended and a minimum of two rounds as to provide feedback and discussions (Mukherjee et al. 2015:1099). The validation tool used was based on the AGREE ll domains (discussion Chapter 3, Figure 3.1).

The following section will discuss the advantages of the e-Delphi technique.

- *Delphi technique advantages*

As per Mukherjee et al (2015:1099), due to the Delphi techniques' anonymous nature, it prevents social pressure and group-based approaches. Social pressure as per Mukherjee et al (2015:1099) include:

- **Groupthink:** Groupthink did not apply to this section of the study as there was no direct contact with other participants. In this study, participants were emailed and no face-to-face contact or interaction took place. Info gathered from participants were consolidated by the researcher and then circulated amongst participants as to gain a group-feel.
- **Halo effect:** Perceptions and decisions of the participants are true and accurate of themselves without negative influences from other participants. All participants

during the e-Delphi technique remained anonymous and therefore could not consult with other participants or compare opinions or scoring.

- **Egocentrism:** No influence from dominant participants (who view themselves more important in a group setting). In this study, participants were anonymous; emails send individually and no interaction and communication between participants occurred.
- **Dominance:** Each participant can voice their opinions or scoring freely without pressure from a group setting or pursuance from dominant members.

The following section will discuss the limitations of the e-Delphi technique.

- *e-Delphi technique disadvantages*

The e-Delphi technique disadvantages (Mukherjee et al 2015:1105) include substitution of quantitative data collection methods, lack of accountability to responses (due to anonymous nature), large population sizes are timeous, no direct interaction between participants and controlled feedback given by the researcher or facilitator.

The disadvantages of the e-Delphi technique (lack of accountability to responses) in this study were managed through selection of participants – all were nursing professionals' representative in senior managerial or educational positions. The sample size was small enough to manage response time and feedback.

In this study, the disadvantages of the e-Delphi were managed by the researcher through proper preparation and information sharing (via email correspondence) with experts.

The following section will provide information on the population relevant to the e-Delphi.

- *Population*

This section will describe the population of Phase 3A (using e-Delphi technique) and Step 3B (Stakeholder consensus or discussion).

During this section of the study (Phase 3A, refinement and validation of guidelines) the population refers to professional nurse managers or educators (either local or international). The target population for Phase 3A included professional nurse managers or educators who had in-depth knowledge or experience or exposure on South African

expatriate nurse migration and adaptation. The target population (Phase 3B) included one representative from SANC and two representatives from international recruitment agencies. During Phase 3 (3A and 3B) there were a total of 10 participants. The reason for continuing to Phase 3B in this study was because the researcher realised that not all stakeholders were represented during Phase 3A, which warrants a continuation into Phase 3B.

The following section will address sample and sampling applied during the guideline validation process.

- *Sample and sampling*

Non-probability, convenient and purposive sampling techniques were used – as only those participants from private institutions were included and were accessible to the researcher (definition and discussion Chapter 1, section 1.10.4).

- *Selection of participants*

Experts were identified through non-probability purposive sampling techniques (explanation and definitions provided Chapter 1, section 1.10.4). During Phase 3A, a list of all the senior nurse education institutions with their clinical managers was available to the researcher (as the researcher was actively involved in private nurse' training and education in SA, contacts were identified by other training institutions – both current and previous positions held). The reason for using purposive sampling was the expert knowledge required for this section of the study. The database available to the researcher had 16 potential participant contact details, all who had extensive experience with nurse migration and adaptation.

The researcher initially invited 16 experts (informed consent was sent via email to all prospective participants, explaining the objectives and purpose of this study, conditions of participation and how the e-Delphi fits into the study – see Annexure G for e-Delphi round 1 and Annexure I for e-Delphi round 2) to participate in this study, but only 7 responded by indicating their willingness to take part in this study. In order to reach data saturation and representation of the population for which the guidelines were developed, another three participants were recruited through purposive and snowball sampling. The sample size in this study consisted of ten experts for Phase 3 (3A and 3B). Expert participations were registered nurses residing in both the KSA (2) and SA (5) used during

Phase 3A. From the nurses residing in SA, three had international exposure but were not part of the unstructured phenomenological interview process.

- *e-Delphi participant selection and requirements*

According to Humphrey-Murto et al (2017:16) when selecting the participants for the e-Delphi technique' experts they should satisfy the following requirements:

- Be willing to acquire experience and knowledge through investigation. In this study, all participants (Phase 3A) were selected to refine and validate the draft guidelines and not to share or create new knowledge. Phase 3B involved a consensus or discussion on the draft guidelines.
- Willing to participate in the study. In this study, seven out of 16 participants (During Phase 3A, 16 participants originally invited, but only seven consented to partake in this section of this study). During Phase 3B, another three participants were recruited through purposive and snowball sampling as to achieve stakeholder involvement.
- Have sufficient time. In this study, participants were all full-time employed and were given timelines for completion of Phase 3.
- Exhibit effective communication skills. In this study, non-verbal communication skills through written text applied as the participants remained anonymous and only communicated through email.

Table 5.1 below will provide demographic details of participant used during the e-Delphi.

Table 5.1: Descriptive information of the e-Delphi technique participants Phase 3 (3A and 3B)

No	Professional qualifications	Employer	Age	Gender	Experience in the field of nursing, migration and adaptation
1	D-Ed, Master's Degree in Health Studies	HOD Private NEI	58	F	Previous contract in the KSA: Dubai, Egypt, Oman and Madinah. Worked with expatriate nurses, adjustment or adaptation with self and colleagues.
2	Clinical Master's Degree	Riyadh Military Hospital Night Supervisor	56	F	The KSA and South African nursing experience, continuous interaction with expatriate nurses. At the time of this study residing in Riyadh. Previous employment with international recruitment agency.
3	Bachelor's Degree in nursing; Master's Degree in Psychology and Counseling	Assistant HOC Private NEI	53	F	Previous contracts in London and the KSA. Personal and collegial experience on migration and adaptation.
4	Bachelor's Degree in nursing; Advanced Management and Primary Health Care	Nursing Manager Government Institution	49	F	Previous one year contract in the KSA. Personal and collegial experience with migration and adaptation.
5	Diploma in General Nursing, Honors Degree in Primary Health Care	Operational Manager Private Nurse Institution	45	F	More than 25 years of nursing and managerial experience both in private and government institutions.
6	Doctorate Degree in Health Studies	King Abdulaziz's Medical Center Nursing Manager	55	F	The KSA and South African nursing experience, continuous interaction with expatriate nurses. Worked for international recruitment agencies. Facilitated expatriate placements in Oman, Jeddah, Riyad and Taif. At the time of this study residing in Riyad.
7	Master's Degree in Health Studies	Head of Private NEI Institution	63	F	More than 38 years of nursing managerial experience, a member of professional nursing bodies and interaction with returning expatriate nurses.

8	Master's Degree in Public Health	SANC Representative	41	M	Previous advisor in SANC, currently at the SANC registration department.
9	Diploma in General Nurse, Critical Care; Diploma in Marketing	International recruitment agency: administrative and marketing	34	F	Previous working experience in healthcare facilities. Working at recruitment agency for more than five years.
10	B-Cur Health Studies.	International recruitment agency: placement coordinator	47	F	Previous working experience in healthcare facilities. Working at a recruitment agency for more than 10 years.

Participants 8, 9 and 10 displayed in Table 5.1 were representative of stakeholder involvement (Phase 3B) of the guideline validation process.

The following section will provide the inclusion criteria during the e-Delphi.

- *Inclusion criteria*

The inclusion criteria for this selection included:

- Participants must have expert knowledge (expert knowledge was defined by the researcher as a senior nurse educator or nurse manager who had more than 10 years' experience in the field of nursing or migration and adaptation for use during Phase 3A) and representatives of the stakeholders included representation from the SANC and recruitment agencies for Phase 3B. All participants were classified as experts as they have senior education positions in private nurse educational institutions in SA (either current or previous), or representative of the stakeholders to guidelines will be aimed at.
- Participants must be actively involved in either research pertaining to the topic or working experience with expatriate nurses who emigrated to the KSA and returned to SA (current or previous employment either in private or governmental healthcare settings).

Exclusion criteria included individuals who were not fluent in English.

The following section will discuss the data collection process and analysis followed during Phase 3 of this study.

5.3 DATA COLLECTION AND ANALYSIS

Data collection during Phase 3 (3A and 3B) of this study apply to refinement and validation of the draft guidelines (Phase 2, Chapter 4, section 4.4.2). The following section will describe the process and instrument used for the refinement and validation Step 5.

- *Instrument used for the refinement and validation process*

The validation tool used during Phase 3 (3A and 3B) of this study was based on the AGREE ll tool (Table 3.3), discussion Chapter 3. The participants during the e-Delphi were requested to rate and validate the draft guidelines according to applicability, clarity,

flexibility and validity on the circulated instrument (Henderson, Johnson & Sheila 2016:111).

According to Awang, Afthanorhan and Mamat (2016:13), the *Likert Scale* is used in research focussed on from social science and healthcare issues to measure a respondent's attitude through the use of a measure scale ranging from totally disagree (zero response) to strongly agree (five response). During this section of the study, participants were requested to classify or score guidelines using the *Likert Scale*. As per Mukherjee et al (2015:1110) it is important for members to rate guidelines on the following criteria rated on a scale of 1 to 5. Mukherjee et al (2015:1101) suggest a scale of 1 to 5 to be used for classification of guidelines from a level of not to be used (number 1) to an essential guideline (number 5).

The following section will describe the steps followed during the refinement and validation process.

- *e-Delphi Steps followed during the refinement and validation process*

According to Mukherjee et al (2015:1100) there are certain Steps to follow when applying the Delphi process: Step 1 included the issue formulation and how the guidelines will be formulated and phrased. Step 2 requires exposing different options available to the problem. Step 3 will be discussing agreeable issues, identify those who are important and that which can be discarded (Mukherjee et al 2015:1100). Step 4 aims to obtain reasons for disagreement, explore underlying assumptions and the panel's respective positions and Step 5 will be evaluation of the individual arguments and reasons for separate arguments (Mukherjee et al 2015:1100).

In contrast with the above five recommended Steps, during Phase 3 of this study, only three Steps were followed. The two Steps that were left out of this study included exposing of different options available to the problem and discovering reasons for disagreement. The focus of this Phase was refinement and validation of guidelines, not generation of new ideas and during the first round of e-Delphi it was already noted by the researcher that there was no disagreement amongst the expert participants. Step 1 included the presentation of the developed or draft guidelines (by the researcher using data from Phase 1 and a literature review) and orientation of participants on how it was developed. In Step 2 participants reviewed the draft guidelines and added comments for

refinement through the first round of the e-Delphi and during Step 3 participants reviewed and validated the draft guidelines during the second round of the e-Delphi.

The following section will discuss the Step followed during the e-Delphi in detail.

- ***Step 1: Refinement and validation process with an e-Delphi (presentation of the developed draft guidelines and orientation of participants on how it was developed)***

The draft guidelines emailed to all participants can be viewed in Chapter 4, section 4.5.
All seven participants were informed of the ethical approval obtained from the Higher Degrees Committee, Department of Health Studies, UNISA (HSHDC/268/2013) and attached as Annexure A in this study. Before the commencement of the data collection process, all prospective participants were emailed an information sheet by the researcher. The information collected during the e-Delphi technique was shared with the research supervisor. These participants were required to give or return signed consent to the researcher (Annexure G).

All participants during Phase 3 (3A and 3B) were asked to review the draft guidelines (developed during Phase 2, Chapter 4), rate it according to the guidelines of the AGREE ll instrument: applicability; scope and clarity; flexibility; reliability; and validity using a *Likert Scale* (Annexure H). Separate spacing was allowed for participants to give comments or suggestions to refine the draft guidelines, or reasoning for their score. Participants had the chance to scrutinise these criteria and or make additional suggestions. The purpose of Step 5 of the guideline development process was refinement of the developed guidelines. Participants were requested to scrutinise and refine the guidelines by allocating scores to each guideline. A score of 1 indicated that it should be removed and 5 indicated an essential guideline that should be implemented. A *Likert Scale* of 5 points are often used to investigate levels of agreement but might cause disagreement when a score of 3 is allocated to a statement as it reflects a neutral value (Mukherjee et al 2015:1101). Table 5.2 below will provide an overview of the
e-Delphi round one scoring and discussions.

Table 5.2: e-Delphi round 1 scoring and discussion

No	Guideline (theme)	Votes received (see validation tool Annexure H) and Table 5.4	Total score (overall score)	Ranking (1) – lowest and (5) - highest	Ranking classification	Participants comments
1	International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.	P1=5 P2=4 P3=4 P4=5 P5=5 P6=5 P7=4 P8=4 P9=5 P10=4	45	4.5	The score of 4.5 was the **highest** from all draft guidelines received.	*"Expatriate South African nurses are attracted to the KSA because of good monetary compensation, but do not receive adequate orientation about the possible obstacles they might face, which include adaptation difficulties and culture shock"* (P2). *"This guideline should be essential; the understanding of the culture could facilitate adjustment and prepare prospective expatriate nurses for completely different living conditions"* (P3). *"South African nurses who are employed in the KSA experience feelings of isolation and depression. It would be good to have a point of reference e.g. a counsellor which could assist with their adjustment into the country"* (P1). *"…nurses should know that 'all that glimmers are not gold' – these nurses see the attraction in the KSA (financial gain) without considering the implications on themselves and their families and friends"* (P8).

2	International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.	P1=3 P2=4 P3=4 P4=5 P5=5 P6=4 P7=4 P8=4 P9=3 P10=4	40	4	This draft guideline received the second highest ranking.	*"Expatriate South African nurses are expected to work with patients from diverse cultures (both in SA and the KSA) …"* (P1). *"To migrate is a personal choice and even when benefits will be improved the choice to migrate will outweigh the benefits offered to stay in SA…"* (P5). *"Culture shock will occur when facing diversity which was unknown to the expat prior to migration"* (P6). *"We recruit South African trained nurses for the KSA and the orientation preparation sessions are two days only which are not sufficient for culture shock preparation or these nurses think that it will never happen to them…"* (P9).
3	South African healthcare regulatory bodies and nurse education institutions must enforce trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to prepare South African trained nurses for the global health market with diverse cultural context; and cultural competent nurse' skills will enhance adaptation into a foreign setting like the KSA).	P1=2 P2=2 P3=2 P4=1 P5=1 P6=1 P7=2 P8=2 P9=1 P10=2	16	1.6	This guideline received the **lowest** score from the participants.	Participant 3 felt that we are living in a culturally diverse environment in SA: *"…SA is so diverse; we have different cultures from all over the world now residing in SA".* *"…training and development are crucial to stay up-to-date with trends in nursing"* (P4). *"We concur that this can be a recommendation but not a requirement. We are aware of the below standard of training in some of the other countries and it surely*

						would not be nice if you are sent home for failing basic competencies." (P5). *"It would be very difficult to provide generic trans-cultural guidelines for various destinations in the KSA or other countries."* (P3). *"This is surely a novel idea but may not be practical and feasible. Principles of trans-cultural nursing should be included in all nursing programs and then customised according to specific needs or areas of training"* (P6). *"In my professional opinion, it would be a good idea as to standardise all nurse training programs. Should a nurse then want to emigrate to another country, there would be no separation of standards – all the nurses would perform duties in similar ways"* (P7). *"Trans-cultural nursing is not a pre-requisite in nurse education programs, although nurses are expected to treat patients from diverse backgrounds with sensitivity and respect"* (P1). *"When these nurses are exposed to trans-cultural training, they might have a better understanding about the cultural traditions exhibited in the KSA, which might aid in adjustment…"* (P2).

						"To enforce cultural training and competencies might be seen as culturally insensitive and not allowed by regulatory bodies" (P5). *"This transcultural training which are enforced might also be that it is in contrast with basic human rights which allows free movement and to place restrictions on it to be perceived as unconstitutional and not to include this guideline into final presentation…"* (P7). *"We will prescribe guidelines on the content to be covered in nurse training programs but cannot enforce prescriptions as each faculty can argue that certain content is more important than the others. Private NEIs compile their own curriculums and as you know it is also now under the Council Higher Education (CHE) which will not be prescriptive in nurse training content"* (P8).
4	South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats.	P1=3 P2=3 P3=4 P4=4 P5=3 P6=3 P7=2 P8=4 P9=4 P10=4	34	3.4	This guideline received the third highest ranking from the participants.	Participants argued that the South African government don't even supply enough nurses to work in healthcare settings, so to expect of them to provide counsellors or mentors would be 'wishful thinking': *"…to even think that the government will allow for counsellors when they don't even want to appoint enough nurses is really wishful thinking"* (P1).

						"When expatriate South African nurses return 'home' they are often shocked with the condition of healthcare facilities…" (P2). *"The mentorship program might assist these expatriate nurses in gaining a sense of belonging…"* (P4). *"We have shortage in equipment and staff which does not make re-adjustment any easier…"* (P5). *"These nurses often feel the urge to return to the KSA because they don't get enough support to adjust back to the South African environment…"* (P6). *"I am aware that South African nurses struggle to incorporate into the South African environment upon return from the KSA…"* (P10).
5	South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.	P1=1 P2=3 P3=2 P4=3 P5=2 P6=2 P7=2 P8=4 P9=3 P10=3	26	2.6	This guideline scored the second lowest score.	"*Expatriate nurses only see the positive things communicated by the agency e.g. financial gain"* (P2). "*Personal contact sessions will give objective and subjective view comparisons"* (P3). *"South African nurses want to leave the country because of bad perception of the profession, working conditions and not getting paid for the work they perform and the hours worked…should this*

						improve these nurses might just stay in SA…" (P4). *"SA have enough trained nurses and we are aware of the number of nurses who migrate abroad for financial reasons…we just cannot force stop migration…"* (P8). *"Recruitment and placement of nurses is our business and promote or advertise our business with the benefits for the nurses…"* (P10).

The following section will provide an overview of the e-Delphi round 1.

- *e-Delphi round 1 (Table 5.2) discussion*

Participants scored each guideline as per the set criteria and the highest and lowest guidelines were tabulated with participant' comments. After all the information received from the e-Delphi round 1 was analysed, the researcher made the necessary adjustments to the draft guidelines. All participants' comments and suggestions were considered and incorporated into the revised guidelines. After the researcher compiled the final draft guidelines it was circulated back to the participants and the third Step of the e-Delphi, Step 6 of the guideline development process commenced.

5.3.1 Step 6: Modification and finalising of guidelines in response to expert feedback from the e-Delphi rounds

The similar approach was used as during e-Delphi round 1. After all the changes were made, the guidelines were circulated via email to all participants for their input during round 2. The same experts and the same number of participants participated during both rounds of the e-Delphi.

The following section will discuss the data collection method and instrument.

- *Data collection method and instrument*

The 10 participants from the e-Delphi round 1 were contacted by email, including a cover letter explaining the instructions and deadline for submission (five-day-deadline). The cover letter included a summary of the e-Delphi round 1 (Annexure I), as well as the purpose of refining and validating the revised guidelines during the e-Delphi round 2 (Annexure J).

- *Data analysis*

Data analysis occurred in the same manner as during the e-Delphi round 1. When a consensus was reached about the revised guidelines, it was used to draft the final recommended guidelines.

The following section (Table 5.3) will discuss draft (round 2) guidelines circulated to participants during the second round of the e-Delphi.

Table 5.3: e-Delphi round 2, Guidelines (draft 2)

Guideline	e-Delphi round 1 (Feedback, *track changes* and adapted guidelines)	e-Delphi round 2 (final validated guidelines)
Guideline 1 International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.	This is an essential guideline. This guideline should be the second recommended guideline. This was changed to Guideline 2. However, *no changes to the content were made.*	**Guideline 1:** The international recruitment agency should deliver migration preparation for potential South African expatriate nurses as poor preparation will result in culture shock (KSA). **Additions to guideline:** All prospective South African expatriate nurses should be informed by the international recruitment agency (in writing) to do research (in their own capacity) on cultural and reversed culture shock experienced during and after migration. Online assessment tools as developed by the international recruitment agency can be completed by all potential expatriates and submitted for evaluation at least six months prior to departure to the KSA. Individual research pertaining to culture and reversed culture shock will provide the prospective expat with insight into this phenomenon and how to identify and manage culture shock when it occurs whilst working and living in the KSA.
Guideline 2 International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.	This is an essential guideline and should be the first recommended guideline. Was changed to guideline 1. *More focus should be applied to the actions stipulated in reference to preparation and limitation of culture shock.*	**Guideline 2:** International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.
Guideline 3 South African healthcare regulatory bodies and nurse education institutions must enforce trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to	One cannot predict standards and content to be covered during nurse training. To impose such content might be regarded as unconstitutional.	Guideline removed.

prepare South African trained nurses for the global health market with diverse cultural context; and cultural competent nurse' skills will enhance adaptation into a foreign setting like the KSA).		
Guideline 4 South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats.	Focus more on support offered to nurses by the South African healthcare government. *As guideline 3 will be removed – guideline 4 will become guideline 3.*	**Guideline 3:** South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' migration and re-integration back into the South African healthcare environment *through offering of supportive and mentorship programs,* which will aid in re-adaptation and ultimate re-adjustment of these expats. Re-adjustment into the South African healthcare environment can be facilitated by mentorship and supportive programs within the first three months of arrival back to SA.
Guideline 5 South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.	Although this guideline is needed, we do not know how feasible this is – to migrate remains a personal choice, especially with the healthcare conditions in SA, poor image of nurses or nursing, support from healthcare regulatory bodies etc. *Keep the guideline – incorporate promotion of positive image of nurses in SA. As guideline 4 became guideline 3, guideline 5 became guideline 4.*	**Guideline 4:** International recruitment agencies should collaborate with South African healthcare regulatory bodies to advocate for retention of skilled and trained staff in SA. **Additional content:** South African healthcare regulatory bodies are responsible to create awareness and promote the positive image of nursing within the South African context**.** Awareness campaigns can be arranged annually on national level, advertised on social media and notice boards in and around the country, which will confirm the positive attributes towards nursing. **Final guideline 4:** International recruitment agencies should collaborate with South African healthcare regulatory bodies to advocate for retention of skilled and trained staff in SA, create awareness on the importance of nurses and promote positive image of nurses within the South African context.

The following section will provide an overview of e-Delphi round 2.

- *e-Delphi round 2 discussion or feedback*

As indicated on Table 5.3, the comments and scoring of the participants during e-Delphi round 1 has been considered and applied, which left the researcher with only **four** draft guidelines (draft 2). The tool used for the validation process was identical to the e-Delphi round 1 discussed earlier in this Chapter (Annexure H). During the e-Delphi round 2 discussion, only the **four** final guidelines were emailed to the participants. The guidelines' validation tool allowed space for scoring (discussed earlier in this Chapter with separate spacing for participant' comments). The participants were requested (via email) to score the final guidelines the same as during round 1 of the e-Delphi (see Table 5.4 below for the validation scale).

The following (Table 5.4) will provide the scoring followed by the classification of guidelines draft 2.

Table 5.4: Classification and scoring guidelines (draft 2) (Key: G = guideline)

Criteria	Number of participants or responses using Likert Scale
Applicability	G1: 3,5,5,4,5,5,5,5,5,5 (average 4.7) G2: 5 2,3,3,5,4,5,4,3,4 (average 3.8) G3: 5,4,4,4,4,4,5,4,5,4 (average 4.3) G4: 5,4,5,5,4,4,5,4,4,4 (average 4.4)
Clarity	G1: 4,4,5,5,4,5,5,5,5,4 (average 4.6) G2: 4,3,3,3,4,3,3,4,3,3 (average 3) G3: 5,4,4,3,4,4,3,4,5,4 (average 4) G4: 5,4,5,5,5,4,5,4,5,5 (average 4.7)
Flexibility	G1: 4,5,5,4,5,4,4,5,4,4 (average 4.4) G2: 3,4,3,3,4,3,3,4,4,3 (average 3.4) G3: 3,4,3,3,3,4,3,3,3,3 (average 3.2) G4: 5,4,5,5,5,5,4,5,5,4 (average 4.7)
Reliability	G1: 4,5,5,5,4,5,4,5,5,4 (average 4.6) G2: 3,3,3,3,4,4,3,4,4,3 (average 3.4) G3: 3,4,3,3,3,3,4,4,4,4 (average 3.5) G4: 4,5,4,4,5,4,4,4,5,4 (average 4.3)
Validity	G1: 4,5,5,4,5,5,5,5,5,4 (average 4.7) G2: 3,3,3,4,3,3,3,3,4,4 (average 3.3) G3: 3,3,3,4,3,3,3,3,4,3 (average 3.2) G4: 5,5,5,5,5,5,4,3,4,3 (average 4.6)

During the scoring of the draft 2 guidelines (as depicted Table 5.4) guideline 1 scored the highest on applicability, reliability and validity. Guideline 4 scored the second highest on applicability, reliability and validity and the highest on clarity and flexibility.

The following section will discuss the classification of guidelines with the implementation of the AGREE ll tool.

5.3.2 Classification of guidelines

The feedback from participants received during round 2 of the e-Delphi enabled the researcher to classify the guidelines into **essential**, **novel** and **luxurious** guidelines as final guidelines. In this study, luxurious guidelines refer to opulence guidelines (nice to have), novel guidelines to original, not knowing something before; and essential guidelines refers to basic, necessary and indispensable guidelines (Gagliardi & Alhabib 2015:NP). During this last Step, the researcher implemented the AGREE ll tool domains (already discussed Chapter 3, Table 1). The following section will discuss the classifications of the final guidelines, followed by Table 5.5 which will provide an overview of the incorporation of the AGREE ll (AGREE 2017:NP) during Phase 3 of this study.

During the second round of the e-Delphi, participants classified each guideline to the classification discussed in the previous section and included:

Guideline 1
International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on *culture shock* to all prospective expatriate nurses who apply to work in the KSA prior to migration.
Classification: Essential Guideline.
Target population: International recruitment agencies, prospective and returning expats.
Purpose of guideline: To advocate proper migration preparation as to limit the degree of culture shock experienced in the KSA (South African expatriate nurses working and living in the KSA and upon their return to SA).

Rationale:
The researcher could not find any evidence of standardised practices from international recruitment agencies regarding their orientation or in-service schedule and practices.

According to Shannon-Baker (2015:34) all individuals should be prepared for culture shock when taking on international opportunities and experiences and knowledge about

culture shock should commence earlier than the proposed international travel. Pascoe as mentioned in EXPATICA (2016:NP) stated: *"…re-entry shock is when you feel like you are wearing contact lenses in the wrong eyes. Everything looks almost right…"*. With prolonged international experience the expatriate has undergone both personal and professional changes, changed certain norms and values or worldview and must adjust to the status before leaving their home countries (EXPATICA 2016:NP). In this study, participants all mentioned that they experienced changes on different levels, both personal with their own health being affected and social when they lost personal relationships. All participants agreed that they achieved international and professional growth and experiences.

During Phase 1 of this study, all participants agreed that they experienced culture shock whilst working and living in the KSA and reversed culture shock upon return to SA. Factors that caused culture shock included: unexpected disillusionment; finding your feet; lifestyle or living standards; reality kicks in; social networks; personal and professional growth (Discussion Chapter 2, Theme 2). During the NGT, experts agreed that culture shock experienced in a foreign culture, especially the move from a Western to Eastern paradigm is a reality.

Recommendations for implementation: International recruitment agencies should re-design orientation and preparation packages, to include workshops for all prospective expats, which focuses on South African expatriate nurses to include factors that will lead to culture shock experienced in the KSA and reversed culture shock upon return to SA.

Actions:

As to prevent or limit the degree of culture shock in expatriate nurses:

- International recruitment agencies (representative who are actively involved in recruiting South African nurses for the KSA) should provide in-depth orientation (programs well developed that focus on mental/spiritual/physical preparation on cultural behaviours and traditions exhibit in the KSA) at a setting suitable for both the prospective expat and the recruitment agency representative regarding the cultural diversity and exposures in the KSA. These programs can also be presented in the structure of workshops, by the recruitment agency at least three to six months prior to departure.
- All prospective South African expats should do research on the KSA diversity (diverse behaviours, traditions, gender segregation, treatment of women and

communication skills) before departure (at least three months prior to allow for proper investigation and understanding of the extreme diversity). Mentorship programs (in the form of discussion or focus groups as facilitated by the international recruitment agency, at a venue suitable for all parties involved at least three months prior to departure) can assist in this process by preparing and supporting the prospective expatriate nurse.

- Group or individual discussions (including personal lived experiences in the KSA referring to treatment by Saudis, expectations not being met) with other expatriates (who returned from the KSA which have personal lived experiences) and their experiences should be make available (facilitation by the international recruitment agency, either through personal contact sessions or social media) to all South African expatriate nurses leaving for the KSA prior to departure (at least three to six months prior to departure as to allow ample time to receive enough information and allowing the expatriate nurse) to make an informed decision if he or she will be able and willing to face the possible challenges in the KSA.
- The international recruitment agency (person in charge of active recruitment of migrants) to provide for accurate and in-depth orientation and induction by means of support groups (done by returning expatriate nurses) on the KSA traditions, behaviours and possible challenges at least three months prior to departure.
- The international recruitment agency (person in charge of active recruitment of South African expatriate nurses) will provide orientation sessions (at least three months prior to departure) in the form of workshops on issues reflected by the data and literature, including language barriers, working conditions and the role of the female in KSA at a venue which is available and accessible to all stakeholders involved.
- The international recruitment agency to provide and facilitate discussions between prospective and returning expats on how to overcome loneliness and how to manage stress or conflict. These facilitated discussion sessions can be planned as formal or informal mentoring programs and coordinated by the recruitment agency. These programs can be done at a venue which is accessible and suitable for both nurses. This session needs to be facilitated at least six weeks prior to departure to KSA.
- All prospective South African expatriate nurses should be informed by the international recruitment agency (in writing) to do research on cultural (whilst working and living in the KSA) and reversed culture shock experienced during and

after migration (upon return to SA). Online assessment tools as developed by the international recruitment agency can be completed by all potential expatriates and submitted for evaluation at least six months prior to departure to the KSA. Individual research pertaining to culture and reversed culture shock will provide the prospective expat with insight into this phenomenon and how to identify and manage culture shock when it occurs whilst working and living in the KSA.

Guideline 2

International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.

Classification: Essential Guideline.

Target population: International recruitment agencies, prospective and returning expats.

Purpose of guideline: To create awareness of the push and pull factors towards migration.

Rationale:

According to Wickramasinghe and Wimalaratana **(**2016:22), the reasons towards migration (pull factors) can be classified into economical, demographical, socio-cultural, political and miscellaneous factors. Economic factors are regarded as the primary motivator for people to migrate from developing countries where the income is low to countries, which can provide for better economic opportunities (Wickramasinghe & Wimalaratana 2016:15). Migration will only occur when the pull factors at the destination country outweighs the plus or positive factors in the country of origin (Wickramasinghe & Wimalaratana 2016:15). In this study, the pull factors are linked to participants seeking greener pastures. The greener pastures included financial gain and the need for independence as reflected in Table 2.2, Chapter 2. Individual decisions to migrate (between countries) are based on push-pull effects and where the positive aspects of the destination country outweigh the negative aspects in the country of origin; migration trends will continue (Ruedin & Nesturi 2018:240).

Socio-cultural factors include: history of family conflict; communication facilities (including no access to internet or telephone services); discrimination based on education; job opportunities; access to medical services; and the need for independence (Wickramasinghe & Wimalaratana 2016:15). In this study, participants mentioned that

they felt that the nursing education and training they received in SA didn't prepare them for the international market (push factor towards migration); and that working in the KSA will provide them with a global experience and exposure (pull factor towards migration).

According to Garner et al (2015:1880), South African nurses are dissatisfied with their remuneration and career development. According to Khunou and Davhana-Maselesele (2016:1) poor working conditions including low salaries in South African healthcare systems cause dissatisfaction amongst nurses. Opportunities to migrate, including capability improvement and career development is regarded as pull factors towards migration (Ruedin & Nesturi 2018:242).

In this study, South African expatriate nurses (data collected during Phase 1, Chapter 2) were either attracted to the KSA (pull factors) or push factors from SA forced these expats to leave their country of origin to work and live in the KSA. Push factors from the country of origin according to Ruedin and Nesturi (2018:242) include: lack of training and economic opportunities; conflict; natural disasters and climate changes; and poverty. The push factors towards migration in this study included: safety issues; job dissatisfaction; lack of remuneration; and lack of training opportunities in SA.

During the NGT (Phase 2), experts agreed that the lack in financial gain and safety, job dissatisfaction and lack of training opportunities in SA are push factors toward migration. Participants during the NGT also agreed that the need for independence and career development opportunities is pull factors, which will motivate South African expatriate nurses to migrate to the KSA. Unfortunately, upon arrival in the KSA, these migrants felt like strangers in a strange land and experienced disillusionment, almost as if their 'expectancies' hasn't been met. Migrant nurses might be misled by recruitment agencies (lack in migration preparation) regarding working conditions, foreign legislation and salaries (Shannon-Baker 2015:33). The researcher could not find any evidence of standardised practices from international recruitment agencies regarding their orientation or in-service schedule and practices pertaining to migration preparation.

Recommendations for implementation: International recruitment agencies recruiting South African expatriate nurses to migrate to the KSA should focus on awareness of push and pull factors towards migration, preparation to facilitate and support the migration process and adaptation of these migrants in the KSA.

Actions:

The role and actions of the international recruitment agency during South African expatriate nurse migration to the KSA is vital in preparation and support of the migration and adaptation process. Actions include:

- Questionnaires assessing awareness of motivators towards migration (including push and pull factors) should be completed by all prospective expats as part of the application process of the international recruitment agency at least three months prior to departure.
- International recruitment agencies should have clarification interviews with all prospective expats to clarify expectations as to prevent sudden disillusionment. Reflective sessions or discussion groups on expectations can be facilitated by both the international recruitment agency and returning expats with prospective expats at least three months prior to departure.
- International recruitment agencies should facilitate workshops between returning and prospective expats to share experiences regarding expectations and lived experiences (to aid in adjustment in the KSA) at least three months prior to departure.
- International recruitment agencies to arrange and facilitate group discussions between returning and prospective expats - during group discussions and orientation sessions unrealistic expectations should be identified and the adaptation process (as well as the time needed to adapt into the foreign culture in the KSA) should be documented and discussed. Unrealistic expectations will be linked with negative migration experiences and poor adaptation in the KSA.

Guideline 3

South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.

Classification: Novel Guideline.

Target population: South African healthcare regulatory bodies, South African healthcare providers.

Purpose of guideline: To promote cooperation opportunities between international recruitment agencies and South African healthcare providers; to support re-integration of

returning South African expats from the KSA into the South African healthcare environment; to support returning South African expat adjustment into the South African working and living environment.

Rationale:

When South African expatriate nurses return from the KSA, they experience the country (SA) which was known to them before as strange and felt like ‘strangers in their own land’. The adaptation process of immigrants into a new social and cultural environment is regarded as a multi-faceted process (Almajwal 2016:191). Adaptation is the process of change and adjustment and the individual has to go through the process of reversed culture shock which has its own effects on the migrating nurse (Brown 2016:4).

There are two aspects of inter-cultural adaptation. According to Brown (2016:4), socio-cultural adaptation refers to the practical and behavioural aspects when encountering face-to-face interactions with a new culture, whilst psychological adaptation refers to the feelings (respect, comfort and happiness) experienced when encountering a new culture.

Socio-cultural adaptation is based on the nurses’ previous cultural learning and approach, which are reflected in the ability to engage in interaction with a foreign culture. Although South African expatriate nurses used to work with colleagues from SA prior to migration, they were used to the ways and traditions exhibit in the KSA, which made SA feel foreign and strange when returning to SA. Psychological adjustment involves the nurse’s sense of wellbeing, enhanced by the positive appraisal of situations and general feelings of satisfaction (Almajwal 2016:191). Poor adaptation patterns among nurses relate to higher levels of depression, low self-esteem, anxiety, and other psychological disturbances (Almajwal 2016:191). Integration by immigrants is linked to successful adaptation (Brown 2016:4). Cultural maintenance practices (including religious and ethnic behaviours or identities) can be predictions of positive adaptation processes amongst migrant nurses (Brown 2016:4).

During Phase 1 of this study: when the expatriate nurse realises all the family responsibilities and gatherings, she misses out in SA and reality hits home. Once the nurses realised that the time spent away from home will only be temporary, they make the best of the new adjustment and settle into the culture. The expatriate nurses settle

into the new cultural ways in the KSA, but then struggle to adapt back into the South African workforce upon return. This difficult adjustment can be described as reversed culture shock.

The researcher could not find any evidence of standardised counsellor programs, which aid in expatriate adjustment upon return to the country of origin. Davies, Kraeh and Froese (2015:171) mentioned that cross-cultural adjustment can be improved through prolonged positive interaction and communication. There is a gap in literature on mentoring of South African expatriate nurses and adjustment back to SA upon return from the KSA.

Experts during the NGT agreed that expatriate nurses who return to SA after working and living in the KSA will have re-adjustment issues, especially after being exposed to the Eastern paradigm for a period and the responsibility rests on the employer to provide enough guidance and support to these expatriate nurses to aid in re-adjustment.

Recommendations for implementation: Supportive, collaborative and mentoring roles adapted by the international recruitment agencies and South African healthcare regulatory bodies to facilitate return migration of South African expatriate nurses into the South African context.

Actions:

- South African healthcare providers should facilitate and coordinate mentorship programs (senior nurses appointed as mentors) to orientate South African expatriates back into the South African healthcare systems and continue for the first three months on-the-job mentoring and support.
- International recruitment agencies to facilitate mentorship programs for returning expatriates upon their return from the KSA. The recruitment agency can act as gatekeeper for this process, which can last up to six months upon return to SA. Mentoring programs can either be arranged to be done in the workplace, or as individual discussions at a venue, which is accessible and suitable for both parties. These programs will assist in creating a sense of meaning and belonging in the expatriate and aid in re-adjustment back to the South African environment.
- Mentorship programs (‘buddy-systems’) should be arranged by the healthcare provider and available (for a period of at least two weeks) by private and government healthcare employers to orientate these expatriates (regarding the

South African healthcare system, processes, staffing, equipment or stock usage) back into the South African healthcare systems. This mentorship programs will create a sense of belonging in the returning expatriate nurse, create meaning on both personal and professional levels. Should there be identified issues (re-adjustment issues, stress, depression, isolation or physical illness) after this two-week orientation sessions an on-board counsellor should be made available immediately by healthcare employers to address adjustment issues (aid in adjustment and assist in settling into the 'new' healthcare environment other than the KSA).

- The healthcare provider should appoint or make counsellors (either professionals or individuals who had experience with migration and adaptation) available to support returning expats, aid in adjustment and adaptation, be available upon request at a private venue which is accessible and suitable for both parties, within six months upon arrival back into the South African healthcare environment.

Guideline 4

The South African healthcare regulatory bodies must advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

Classification: Luxurious Guideline.

Target population: South African healthcare regulatory bodies, national healthcare government, prospective South African expats.

Purpose of guideline: Control of skilled migration to the KSA, improvement of South African healthcare systems, promotion of professional development opportunities in SA.

Rationale:

Issues related to the healthcare workforce in SA, especially nurse shortages, brain drain and poor nurse' performances influence the overall perception of healthcare in the country (Armstrong et al 2015:3). Study findings (Phase 1, Chapter 2) shows that South African trained nurses are attracted to the KSA (pull factor towards migration) which result in nurse shortages and ultimately brain drain in SA are supported by the author Armstrong et al (2015:3). As a result of nurse migration, countries like Africa and the Philippines are experiencing severe 'nurse brain drain', resulting in high nurse turnover and even the closure of hospitals (Vartiainen, Pitkänen, Maruja, Raunio & Koskela 2016:32). According

to Masanjala (2018:17) due to nurse migration and brain drain sustainable healthcare development goals in African countries cannot be reached, resulting in poor health indicators and low capacity to deliver optimal patient care.

Recommendations for implementation: When considering the push and pull factors towards migration, the South African healthcare environment should eliminate the push factors towards migration, which will control out-migration of skilled and trained professional nurses to the KSA.

Actions:

- South African healthcare regulatory bodies should oversee that all South African trained nurses receive monetary compensation (through services delivered at healthcare provider facilities, monthly paid and overtime additionally calculated, equal to skills and experience); benchmarked against international standards, which are reviewed annually.
- South African healthcare regulatory bodies and healthcare providers should see that training and development opportunities are free, ongoing and available for all nurses. Training opportunities should be set, documented and circulated in writing by the healthcare provider to all nurses on a continuous basis, reviewed quarterly with the input of the employee as to optimise their skills and knowledge in healthcare settings.
- National healthcare government and the SANC must monitor continuous (annual) training and developmental opportunities attended by nurses and document proof of completion, as it will enhance patient care and satisfaction.

National healthcare government must set reasonable annual career advancement opportunities (promotion to a higher level of seniority, improved monetary compensation) based on job performance evaluations to all trained and experienced South African nurses in an effort to keep these nurses in SA (create job satisfaction and motivation for junior nurses).

The following section will discuss the application of the AGREE ll tool to Phase 3 (3A and 3B) of the study (Table 5.5).

Table 5.5 Final validated guidelines with implementation of AGREE ll tool (AGREE 2017)

Validated guideline	Domains extracted from AGREE ll instrument					
	Scope and purpose	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**
Guideline 1 International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.	**Scope:** Focus on culture shock **Purpose:** Prevention or limitation effects of culture shock in South African expatriate nurses.	International recruitment agency South African healthcare government. South African healthcare employers. Prospective expats.	Guidelines have already been developed during Phase 2, description Chapters 3 and 4. During Phase 3A refinement and validation of the drafted guidelines took place. Phase 3B involved stakeholder consensus or discussion.	Refer to Table 5.4 for scoring on clarity – done during e-Delphi round 2, Step 6 of guideline development process.	Refer to Figure 5.1 for application of guideline – culture shock experienced by South African expats in the KSA.	n/a
Guideline 2 International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.	**Scope:** Migration support of South African expatriate nurses. **Purpose:** To provide prospective South African expatriate nurses with a positive migration experience.	Prospective expatriate nurses. Returning expatriate nurses. International recruitment agencies.		Refer to Table 5.4 for scoring on clarity – done during e-Delphi round 2, Step 6 of guideline development process.	Refer to Figure 5.1 for guideline application – migration and adaptation support through awareness of push and pull factors.	n/a

Guideline 3 South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.	**Scope:** Re-adjustment of SA expats upon return to South African. **Purpose:** Migration and adjustment support of South African expatriate nurses.	International recruitment agencies. South African healthcare government. Prospective expats Returning expats.	Guidelines have already been developed during Phase 2, description Chapter 3 and 4. During Phase 3 (3A and 3B) refinement and validation of the drafted guidelines; and stakeholder involvement for consensus or discussion took place.	Refer to Table 5.4 for scoring on clarity – done during e-Delphi round 2, Step 6 of guideline development process.	Refer to Figure 5.1 for guideline application – migration support during re-integration into South African healthcare environment.	n/a
Guideline 4 South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.	**Scope:** South African trained nurses, prospective expats. **Purpose:** Retainment of South African trained nurses.	South African healthcare regulatory bodies. South African national healthcare government. South African nurses and student nurses.		Refer to Table 5.4 for scoring on clarity – done during e-Delphi round 2, Step 6 of guideline development process.	Refer to Figure 5.1 for guideline application – retainment of skilled staff in SA.	n/a

The following section will describe consensus or agreement as applied during Phase 3 (3A and 3B) of this study.

5.4 CONSENSUS OR AGREEMENT DURING PHASE 3A (e-DELPHI)

All participants during e-Delphi round 2 reached consensus and agreed with the final guidelines and it was accepted for recommendation. Additional comments received from participants, which can be considered for futuristic research included the following:

- *"Focus and attention should be given to the apathetic and complacent attitude on local South African nurses who have no interest to learn, even if they have never been exposed to high-tech equipment, electronic patient documentation and ongoing in-service training"* (P7).
- *"The South African government must apply more effort to retain staff locally"* (P3).
- *"South African health care institutions are failing. There is inadequate nurse: patient ratios which cause staff' despair, frustrations and burnout"* (P2).
- *"Failure of South African health care systems which does not require compulsory continued medical education (CME) from nurses on an ongoing basis"* (P1).

As discussed in Chapter 3, the consensus agreement refers to the rating scale (score 1 to 5) achieved by each topic for inclusion into the guideline (Waggoner, Carline & Durning 2016:667). In this section of this study, the consensus was 81%. According to Schumaier, Kovacevic, Schmidt, Green, Rokito, Jobin, Yian, Cuomo, Koh, Gilotra and Ramirez (2020:675) consensus using the Delphi technique is set at 70%. As per Schumaier et al (2020:675) the consensus measured in this study is acceptable. This consensus calculation has been calculated by adding all the scores (ranging from zero minimum to maximum of 5) allocated by participants, then converting the total number of scores into a percentage (calculation can be viewed in Table 5.2).

After the recommendations and validation was received from the expert panel during the last step in the e-Delphi, the researcher correlated the validated guidelines against

the research findings (described in Chapter 2). She was satisfied that the guidelines covered and adhered to the content discovered in this study. The conceptual map of the research findings (discussed Chapter 2, Figure 2.1) was linked with the final validated guidelines. Figure 5.2 will indicate the incorporation of the validated guidelines with the previously developed conceptual map.

As seen on Figure 5.2 (conceptual framework derived from the research data), adjustment and adaptation to a foreign culture; an inability to adjust leading to culture shock, in this study was a reality (discussion Chapter 2). Guideline 1 will cover these findings based on migration and adaptation. When the participants were exposed to the traditions and behaviours in the KSA and returned to SA, poor adjustment and reversed culture shock occurred. Guideline 3 will apply here. Some participants found it easy to adjust to the strange and unfamiliar environment in the KSA, whilst others experienced culture shock before the adjustment phase. Strangely enough, all participants experienced (reversed) culture shock and displacement when returning to SA as they struggled with adjustment. Guideline 2 will apply when the decision is made by the prospective expatriate to migrate to the KSA (preparation, recruitment and retention). Guideline 3 will support re-adjustment of South African expatriate nurses back into the South African environment (both working and living) upon return from the KSA.

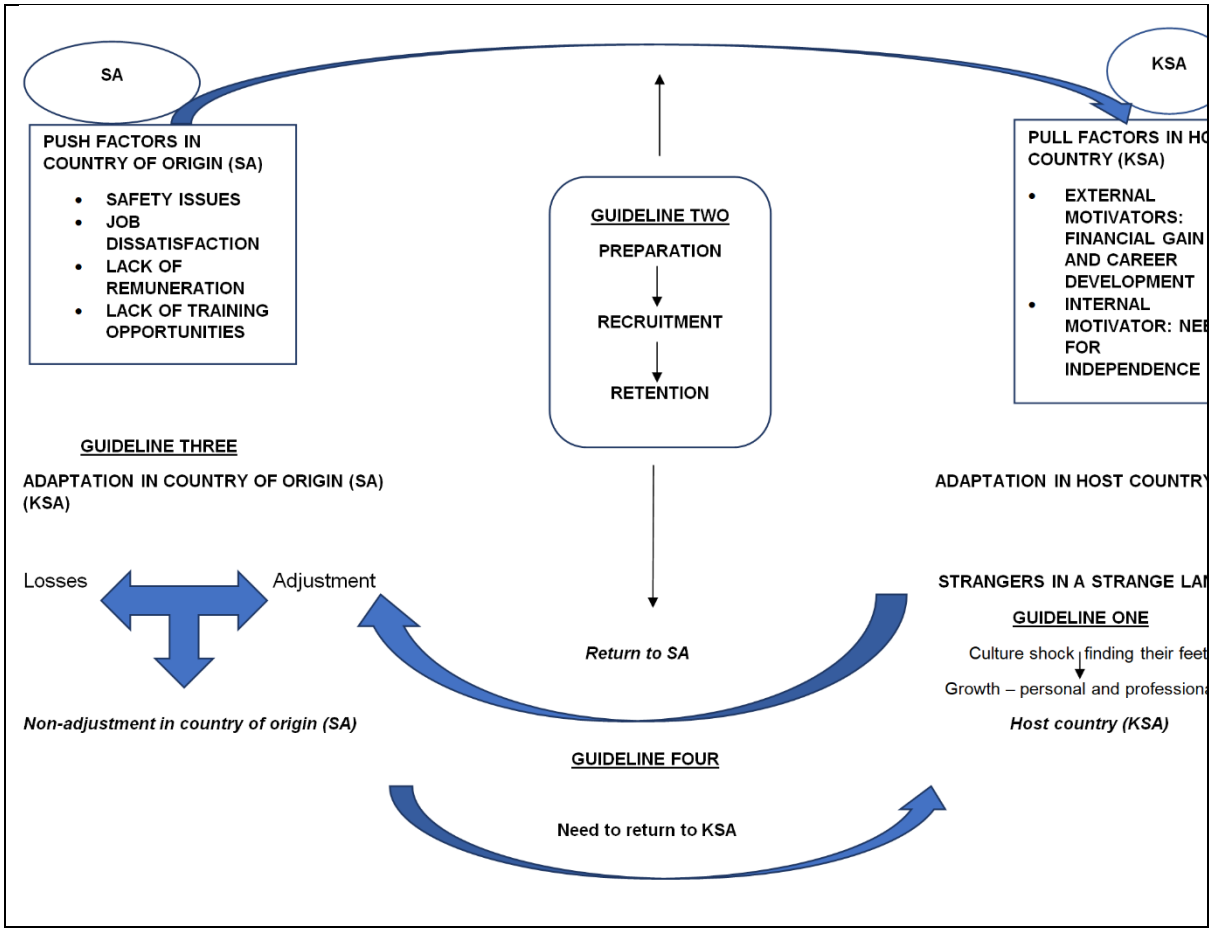


Figure 5.2 Integration of conceptual map with validated guidelines

5.5 SUMMARY

Chapter 5 focussed on refinement and validation of guidelines (Phase 3A and 3B, Steps 5 and 6 of the guideline development process), methodology and final guidelines. The final validated guidelines developed included two essential, one novel and one luxurious guideline. Chapter 6 will conclude this study with conclusions of findings, limitations and recommendations.

CHAPTER 6

CONCLUSIONS OF FINDINGS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Chapter 1 provided an overview of the research process, aim and objectives of the study, research methodology of all 3 Phases.

Chapter 2 described Phase 1 of this study: Empirical Phase for exploration and description of lived experiences of migration and adaptation of South African expatriate nurses: research methodology, data analysis, interpretation and literature control. This Chapter provided a presentation of finding (data collected by means of unstructured phenomenological interviews) and a conceptual map of findings.

Chapter 3 provided a literature review on the guideline development process (Phase 2 of this study) (Principles and process according to literature).

Chapter 4 described Phase 2: The development of draft guidelines to facilitate migration and adaptation of South African expatriate nurses, methodology, data analysis and interpretation with a literature control. During this Phase, the NGT was used to rank, vote and prioritise the draft guidelines with the AGREE ll instrument.

During Chapter 5, Phase 3 (3A and 3B) of this study has been addressed: Refinement and validation of draft guidelines, methodology and final guidelines. During this Phase, the e-Delphi was used with the AGREE ll instrument to validate the final guidelines.

In this Chapter, the conclusions of findings, limitations and recommendations of this study will be presented. The aim of this study was to gain an interpretation of the lived experiences of migration and adaptation of South African expatriate nurses who lived and worked in the KSA and who subsequently returned to SA to live and re-enter the workforce in this country. Understanding their lived experiences of migration and adaptation while working in the KSA and their adaptation upon return to SA will provide

information for the development of guidelines to facilitate expatriate nurses' migration and adaptation in the KSA as well as adjustment when returning to SA. The guidelines can be implemented by international recruitment agencies, nurse migration regulatory bodies, prospective and returning expats to support migration and adaptation.

6.2 REVIEW AND SUMMARY OF THE MAIN FINDINGS

This study was conducted in 3 Phases. A descriptive phenomenological approach was employed during Phase 1 of this study as discussed in Chapters 1 and 2. During Phase 2, the NGT with an expert panel and the AGREE ll instrument was used to vote, rank and prioritise draft guidelines, as developed by the researcher through inductive and deductive reasoning, using the data collected during Phase 1 and a literature review. During Phase 3A, the e-Delphi with an expert panel and the AGREE ll instrument was used to refine and validate the final drafted guidelines. During Phase 3B, a stakeholder discussion or consensus was held to validate the final guidelines

The following section will provide an overview and summary of findings derived from each Phase of this study.

- ***Phase 1***

A full description of the findings from Phase 1 was presented in Chapter 2 (Table 2.3). Participants in this study (South African expatriate nurses) described themselves as *'nomads seeking greener pastures*', motivated by financial gain (external motivator) or by the need for independence (internal motivator). When the South African expatriate nurses arrived in the KSA they felt like '*Strangers in a strange land'*, confronted by *'culture shock'* when exposed to different cultures, religious practices, language barriers, different dress codes and strict gender separation. These South African expatriate nurses also experienced *'unexpected disillusionment'* when they did not receive their pay on a regular basis in the KSA, had no translators, the migration experience affected their own health, they lived through extreme climate changes (heat) and experience safety issues.

Apart from all these experiences and adjustment issues they '*struggled to find their feet'.* They were lonely and isolated, not familiar with the language that affected their ability to make new friends. Participants indicated that they struggled with their professional adjustment as they were exposed to different terminologies, procedures and working conditions in the KSA. The lifestyle and living standards in the KSA compensated for some of these issues as they received paid accommodation and transport. After some periods of adjustment, *'reality kicked in'* and these South African expatriate nurses' experienced first-hand the different world views (exhibited in the KSA compared to SA first and third world countries), the disrespected treatment by Saudis against other nationalities and the constant mistrust amongst colleagues.

Participants in this study also stated the construct of *'social networks'* whilst working and living in the KSA was challenging, as they struggled to make friends from diverse cultures. They also felt that their social networks with friends and families in SA has been damaged or lost. Limited social networks resulted in loneliness and depression. Although their *'personal growth'* was enhanced through the opportunities to travel that exposed them to new situations where attained survival skills and obtained independence. All participants agreed that they enhanced their own *'professional growth'* whilst working and living in the KSA, as they were given numerous training and learning opportunities, gained global exposure and experiences and therefore increased their clinical competence before returning to SA.

When these South African expatriate nurses returned to SA they felt like *'strangers in their own land'*, experienced losses in different dimensions, including relationship losses, they felt like an outsider not fitting in, felt disconnected, lonely and lost their sense of belonging. These feelings experienced by the returning South African expatriate nurses complicated their re-adjustment back to SA when they struggled to fit in, struggled to find a job, felt totally disorientated and wanted to return to the KSA. Complicated re-adjustment to the South African environment was exaggerated when the participants experienced the differences between first and third world countries as they observed limited human resources, lack of equipment, lack of remuneration, decreased in quality of patient care, non-acceptable patient ratios, poor nurses' caring attitudes and safety concerns in SA's healthcare settings.

There are various reasons, which can motivate South African expatriate nurses working and living in the KSA to return home. When these individuals achieved their goals, either educationally, financially or socially, they were ready to return to SA. The additional training the participants received in the KSA equipped them with certain skills and knowledge to advance in the South African workforce. Unfortunately, the South African workforce did not accommodate them or even acknowledge their additional skills or training when considering employment or promotions.

Participants in this study described cultural and reversed culture shock as a reality. Re-adjustment time periods back to SA was noted as a concern. The participant who stayed the shortest (two years in the KSA) took between six months to a year to re-adjust back to the South African environment. The participant who stayed the longest (14 years in the KSA) took three years in the work and additional two years socially to re-adjust to normality expected in SA; whilst one participant is still not fully adjusted after almost seven years back in SA. This could be because the participants were immerged into the foreign culture, developed a new identity and was now a foreigner in their home country.

The essence of this study' findings during Phase 1 was explained by the participants as *'nomads seeking greener pastures'* that started off as '*strangers in a strange land'* and became '*strangers in their own land'*. In an effort to find themselves, they lost a part of themselves and experienced losses in different dimensions of their lives. They moved from a stage of shock and discomfort to accepting the *'new reality'* as well as unexpected surprises or disillusionment. The exposure facilitated personal and professional growth. They lost their sense of belonging and felt disconnected and isolated.

From the essential meaning (Phase 1), the essence of findings were extracted and linked to the lived experiences of South African expatriate nurses working and living in the KSA: essence of South African expatriate nurses' experiences of migration to the KSA, essence of South African expatriate nurses' experiences of adaptation whilst working and living in the KSA and essence of South African expatriate nurses'

experiences of adaptation upon returning to SA (Table 3.2). The essence of findings or lived experiences was linked to constituents representing the factors causing the lived experiences. Constituents of lived experiences of South African expatriate nurses working and living in the KSA include push and pull factors. Pull factors include external and internal motivators. Push factors from country of origin (SA) included poor remuneration, lack of training and career development opportunities, job dissatisfaction and safety issues. Pull factors from destination country (KSA) include external motivators (pull factors) inclusive of financial gain and career development. Internal motivator (pull factor) includes the need for independence (Chapter 3, Table 3.2). The essence of South African expatriate nurses' experiences of adaptation upon returning to SA included the following constituents: lack of adequate preparation prior to migration resulted in culture shock whilst working and living in KSA (Chapter 3, Table 3.2).

The essence of South African expatriate nurses' experiences of adaptation upon returning to South African constituents included exposure to personal losses, awareness of differences between country of origin and destination country (first and third world countries) and adaptation issues resulted in reversed culture shock (Chapter 3, Table 3.2).

The following section will discuss the summary of findings, Phase 2 of this study.

- ***Phase 2***

During Phase 2, the researcher applied: (i) inductive and deductive reasoning to create a conceptual map portraying the research findings (Chapter 2, Figure 2.1); (ii) the essence and the constituents (Chapter 3, Table 3.2) were extracted from the conceptual map (Chapter 2, Figure 2.1); (iii) applied the AGREE ll instrument to draft guidelines; (iv) use the NGT to refine vote, rank and prioritise draft guidelines; (v) refine the draft guidelines; and (vi) refinement and validation of final guidelines with the AGREE ll instrument during an e-Delphi (Phase 3A) and stakeholder discussion or consensus (Phase 3B).

During the NGT, a panel of seven experts in the field of nursing (focus of migration and adaptation) participated to refine the draft guidelines. Originally there were 15 draft guidelines which were reduced to five during the NGT. The final draft guidelines were then refined and validated during Phase 3 (3A and 3B) of this study. The guidelines ranked, voted and prioritised during this round included:

Guideline 1: International recruitment agencies must facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.

Guideline 2: International recruitment agencies must facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.

Guideline 3: South African healthcare regulatory bodies and nurse education institutions must encourage trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to prepare South African trained nurses for the global health market with diverse cultural context and cultural competent nurses' skills will enhance adaptation into a foreign setting like the KSA).

Guideline 4: South African healthcare regulatory bodies, including private and public healthcare providers must facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs upon return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.

Guideline 5: South African healthcare regulatory bodies must advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

The following section will discuss summary of findings, Phase 3 (3A and 3B) of this study.

- ***Phase 3 (3A and 3B)***

During the final Phase (3A and 3B) of this study, the e-Delphi technique was used (10 experts) to refine and validate the guidelines to facilitate migration and adaptation in South African expatriate nurses working in the KSA and upon their return to SA. The first seven representatives included nurse managers or educators residing in the KSA or SA (Step 3A) and three participants (one SANC and two from the international recruitment agency) represented stakeholder involvement during Step 3B. A modified e-Delphi (2 rounds) with the AGREE ll instrument was used when consensus was reached on guideline validation (four guidelines in total).

The final validated guidelines as reflected in Table 5.5 included:

Guideline 1: International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.

Guideline 2: International recruitment agencies should facilitate South African South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.

Guideline 3: South African healthcare regulatory bodies, including private and governmental healthcare providers, should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats.

Guideline 4: South African healthcare regulatory bodies must advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.

The consensus reached as discussed in Chapter 5 (Phase 3A and 3B) was 81% (calculation can be viewed in Table 5.2).

The following section will discuss the significance of this study.

6.3 SIGNIFICANCE OF THIS STUDY

There is a gap in literature pertaining to South African expatriate nurses' experiences of migration and adaptation in the KSA, as well upon their return to SA (re-adjustment). This study provided participant views and experiences described from a descriptive phenomenological perspective without the use of a theoretical framework.

The focus of this study was migration, adaptation and re-adjustment, which could assist South African expatriate nurses to consider migration options carefully prior to departure, to assist these expats with migration and adaptation issues, as well as re-adjustment when returning to SA. This guidelines can be used to provide migration and adaptation support used by recruitment or governmental agencies (when nurses leave their country of origin as well as upon return) to assist in preparing prospective South African expatriate nurses to adjust to the KSA and to SA upon their return.

The final validated guidelines may guide and support migration and adaptation of South African expatriate nurses and can be implemented by international recruitment agencies, South African healthcare regulatory bodies, prospective and returning expats. This may contribute to making migration a positive experience and aid in adaptation into a foreign culture like the KSA and support re-integration and adaptation into the South African context.

The significance of South African expatriate nurse' adaptation support during migration include job satisfaction to the KSA and upon their return to SA, improvement in patient care standards and higher degree of adaptation when these expatriates know what is expected of them (both SA and KSA).

Validated guidelines can be incorporated for nursing management to take note of the experiences of the nurses to facilitate their adjustment in the workplace.

Overview of the strengths of this study to be addressed in the following section.

6.4 STRENGTHS OF THIS STUDY

As discussed in previous Chapters the absence of a theoretical framework was chosen by the researcher to keep the research free-flowing and descriptive from the views of the participants; to extract the true essence of lived experiences. Similar process could be repeated in other parts of the country.

The researcher could not find any existing guidelines supporting South African expatriate nurse migration and adaptation, so this study will contribute to the body of evidence in nursing research with the focus on migration preparation, migration and adaptation.

The following section will discuss the limitations of this study.

6.5 LIMITATIONS OF THIS STUDY

Some of the limitations that could be included in this study are:

- The research was conducted with South African nurses who only resided in the Western Cape region and who emigrate to the KSA, using purposive and convenient sampling techniques. The use of purposive and convenient sampling in the Western Cape region might be viewed as bias.
- The research reflected only on a one-sided perspective from the South African nurses and the receiving or host cultures' opinions were not included.
- Although it is a guideline to use a small sample during phenomenological studies, the sample size could be questioned by other researchers which might view the sample and data gathered as inadequate. In this study, the researcher kept an audit trail to contribute to the validity and accuracy of findings.

The following section will describe the recommendations of this study.

6.6 RECOMMENDATIONS

The recommendations of this study are written for implementation by international recruitment agencies, South African healthcare regulatory bodies, prospective and returning South African expatriate nurses to prepare and support migration and adaptation. These recommendations can link to future research with the focus on migration and adaptation.

The list of recommendations is not exclusive and more could be added by future studies within this area of focus. Recommendations derived from this study included:

- Migration and adaptation relevant to South African expatriate nurses need more research. There was no evidence found of nurse migration statistics, nor nurse' adaptation issues relevant to a specific country like the KSA. Either SANC or the national government is responsible to keep accurate updated statistics on South African nurse migrants, which include the reason or motivation for migration.
- Further exploration of the international recruitment agency' perspectives pertaining to migration and adaptation are recommended.
- Exploration of the family members views and perspective relevant to the migration and adaptation process are recommended.
- Re-adjustment assessment of nurses who worked in the KSA for an extended period need to be developed and implemented to identify cultural and reversed culture shock issues. Culture shock was identified by all participants when entering the KSA and reversed culture shock when returning to SA. Specific attention (guidance, counselling and emotional support) needs to be given to these returning expats by the healthcare employer or dedicated counsellor or mentors to assist in re-adjustment back into the South African environment (as support and mentoring is needed to aid in re-adjustment). The critical impact on the destination country also merits attention.
- Nursing education standards and practices need to be revised to include cultural exposures, diversity and sensitive care. South African trained nurses need to understand different international training standards and terminology used. This might assist or prepare them for when they might choose to work in a diverse context.
- International nursing programs need to be revised to include cultural diversity and sensitivity training. This will enable students to know exactly what to expect when exposed to a foreign culture. Guidance and counselling services need to be readily available from orientation time and during employment to advice students on adaptation issues or behavioural choices.

- Testimonies and success stories of nurses who successfully emigrated to the KSA need to be made available (by the recruitment agency via social media) immediately upon their return to SA to all prospective expats prior to departure which must include their adaptation times and coping strategies. This will allow for true and accurate publications of lived experiences which can be scrutinised by prospective expats prior to departure and which can ultimately influence their decisions to depart in either positive or negative ways.
- Social efforts (including counselling, mentorship) are needed in the KSA to accommodate Western expatriate adjustment. This mentorship programs can be facilitated by the international recruitment agency and managed by the returning and prospective expatriate nurse.
- The image of nursing in SA and the KSA (globally) need to improve through campaigns and short skill awareness initiatives to make the public aware of the service nurses deliver.
- Recruitment agencies should include training on culture care and patient safety during their orientation programs. South African nurses who emigrate to the KSA are trained from a Western paradigm but will be expected to treat patients from a spiritual paradigm. The different worldviews and paradigms need to be included in nursing curriculums. Culturally sensitive programs need to be developed by the Saudi government as a crucial attempt to aid in adaptation of foreign nurses, minimise social isolation and negative impacts of victimisation or racism.
- International recruitment agencies should develop migration preparation for potential South African expatriate nurses as poor preparation will result in culture shock (the KSA). Facilitation of group sessions or shared experiences delivered by returning expats, or self-directed research and evaluation of migration preparedness could help expats to identify and learn management and coping skills on how to deal with culture shock in the KSA.
- Suggestions for future research include an indication of the value of this study to the body of knowledge of nurse welfare and mental health.

The following section will conclude this study with conclusive remarks.

6.7 CONCLUDING REMARKS

Phase 1 of this study's aim was to gain interpretation of lived experiences of migration and adaptation of South African expatriate nurses. The research objectives were:

- To explore, interpret and describe the lived experiences of adaptation of South African expatriate nurses when they return to SA.
- To develop and validate guidelines to facilitate South African expatriate nurses' migration and adaptation to the KSA and adaptation upon their return to SA.

The aim and objectives of Phase 1 was reached through data collection and was done by means of unstructured phenomenological interviews. Phase 2 of this study's aim and objectives was to develop guidelines to support South African expatriate nurse migration and adaptation. In this Phase, the NGT was used to vote, rank and prioritise drafted guidelines (with a literature review and the AGREE ll instrument). Phase 3's aim and objectives were to refine and validate the draft guidelines from Phase 2. A modified e-Delphi technique was used to validate four guidelines during Phase 3 (3A and 3B) as presented in this study with application of the AGREE ll instrument.

There is a strong socio-economic structure in the KSA, which makes it a favourable destination for nurses to emigrate to. The shortage of skilled nurses in the KSA (and globally) necessitate international recruitment agencies to employ nurses to work abroad. The aim of this study (as explained in Chapter 1) was to gain an understanding of the lived experiences (migration and adaptation) of South African expatriate nurses who lived and worked in the KSA and who subsequently returned to SA to live and re-enter the workforce in this country. As to extract the true essence and meanings connected to the participant' lived experiences a descriptive phenomenological approach was followed.

Although the financial and educational needs will be met in the KSA, nurses need to be made aware of the cultural and reversed culture shock they might experience. This shock could impose on their work and social performance and re-adjustment back to the private life and workforce when returning to SA.

From the above it is evident that there need to be an increased awareness of migration and adaptation for South African expatriate nurses. The researcher will contribute towards this awareness by presenting this study's findings on national and international congress forums, as well as publication of a research article in accredited journals. Further research is needed to calculate the impact factor on prolonged cultural immersion as to determine the degree of culture shock expected and to connect time frames for re adjustment. This will enable expatriate nurses to take informed decisions before accepting foreign employment.

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Annexure A: Ethical clearance

UNISA university of south africa

UNISA HEALTH STUDIES HIGHER DEGREES ETHICS REVIEW COMMITTEE

Date 8 July 2020

Dear Michelle van Bommel

NHREC Registration # : REC-012714-039
ERC Reference # : **HSHDC/268/2013 AMENDED 2020**
Name : Michelle van Bommel

Student #: 30791308
Staff #:

Decision: Ethics Approval from
8 July 2020 to 8 July 2025

Researcher(s): Name Michelle van Bommel

Address
E-mail address michellevanbommel@yahoo.com, telephone # 0664834508

Supervisor (s): Name Prof ES Janse van Rensburg
E-mail address jvrenes@unisa.ac.za, telephone # 0737870896

Working title of research:

Guidelines to facilitate adaptation in South African expatriate nurses working in the Kingdom of Saudi Arabia and upon their return to South Africa

Qualification: PhD

Thank you for the application for research ethics clearance by the Unisa Health Studies Higher Degrees Ethics Review Committee for the above mentioned research. Ethics approval is granted for five (5) years.

*The **low risk application** was **expedited** by a Sub-committee of URERC on 8 July 2020 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment. The decision will be tabled at the next Committee meeting on 4 August 2020 for ratification.*

The proposed research may now commence with the provisions that:

1. The researcher will ensure that the research project adheres to the relevant guidelines set out in the Unisa Covid-19 position statement on research ethics attached.

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2. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
3. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Health Studies Research Ethics Committee HSREC@unisa.ac.za.
4. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
5. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
6. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
7. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
8. No field work activities may continue after the expiry date (8 July 2025). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **HSHDC/268/2013** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signatures :

Chair of HSREC : Prof JM Mathibe-Neke
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Annexure B: Comparison between the Kingdom of Saudi Arabia and South Africa

	The Kingdom of Saudi Arabia	South Africa
Geographical layout and population	The Kingdom of Saudi Arabia is regarded as one of the **largest countries** in the Middle East with a surface area of 14 million km² which covers about 80% of the Arabian Peninsula and has one of the largest oil reserves in the world (Aldossery, While & Barriball 2008:125; Alboghdady & El-Hendawy 2016:3). The surface area is covered with more than **87% desert** (Alboghdady & El-Hendawy 2016:3). The KSA has a **population of 24 573 000** (Aldossery et al 2008:125; Alboghdady & El-Hendawy 2016:5). Neighbouring countries to the northwest include Jordan, northeast is Iraq and Kuwait, to the east is Bahrain and Qatar and south-east is the UAE, with Oman and Yemen to the south (Lefdahl-Davis & Peronne-McGovern 2015:418).	South Africa has an estimated **population of 50.8 million** people, the age, gender and density structure varies dramatically across the different provinces (Massyn et al 2013:220). South Africa is marked by **diversity** in animal and plant life, landscape as well as natural resources. Within this **multi-ethnic nation** 79. 5% is African, Whites 9%, Asian/Indian 2.5% and Coloured 9% (Stats SA 2016). Within SA there are 80% Christians, 2% Hindu, less than 2% Muslims and the remaining adhere to "traditional indigenous belief" (Gritzner 2010:293). South Africa is renowned for its' natural environment. All the resources being harvested from the nine provinces are export quality and include coal, petroleum, gold, crude oil, fisheries and wines. During some seasons, there is a depletion of water. Inhabitants can move freely across the provinces.
Climate variants, transportation and travel opportunities	There are **four international airports** in Saudi Arabia namely: Dammam, Jeddah, Madinah and Riyadh. There is a **public bus service** [Saudi Public Transport Company SAPTCO)] that can transport passengers to neighbouring countries. The most popular mode of transport is by **car** which only men can drive, but there are no traffic rules and regulations in the KSA. Saudi Arabia is first on the ranks for traffic accidents globally. Individuals who cannot drive a private car need to rent a taxi. Unfortunately, there are no	According to Fitchett, Grant and Hoogendoorn (2016:1) the South African climate is diverse and poses a real flooding threat to low-lying coastal areas (during 2050). Risks include flooding, biodiversity shifts and severe water shortages. Travel opportunities is freely available but at high costs (Fitchett et al 2016:1). Transportation varies from public to private (Fitchett et al 2016:1).

	street names in the Kingdom and one has to explain to the driver the district where they want to travel to (Lefdahl-Davis & Perrone-McGovern 2015:418). Saudi Arabia has no railroad systems, but there is remanence of the Hejaz railway that existed to Damascus. Ferries and passenger boats are available and provide connection between neighbouring countries, but Western travellers are frequently denied (Lefdahl-Davis & Perrone-McGovern 2015:418).	
Language and communication	According to Mahboob and Elyas (2014:128), English in the KSA is not regarded as a neutral language because it is surrounded with economic, social, political and religious overtones. Within the KSA there is a strong belief in the **Arabic language** as an Islamic language as cited in the Qur'an: *"…and among His signs are the creation of the heavens and the earth and variations in your language and your colours, verily in that are signs for those who know…"* (Mahboob & Elyas 2014:129). The Arabic language consists of standard, classical and Qur'anic Arabic. Educated Arabic speakers might mix their words and own dialects depending on the communication variations required (Arabic without walls 2004). In this study participants couldn't communicate with patients or colleagues which were Arabic speaking.	South Africa is marked by **diversity** and is known as the rainbow nation and has 11 official languages (Gritzner 2010:292; Stats SA 2016).

Healthcare systems	According to Almalki, Fitzgerald and Clark (2011:785) was the first healthcare department developed in Mecca during 1925 by King Abdulaziz. This center provided free healthcare to the inhabitants and pilgrims. The Kingdom is divided into **18 health regions** and is accountable to the Minister of Health (MOH) (Aboul-Enein 2002:229). The MOH was established in 1950 (Almalki et al 2011:786). The Hospitals are **operated under strict Islamic codes** and the role of the mother is critical in the Muslim society (Aboul-Enein 2002:230). The WHO classified the KSA healthcare system as 26th from 190 healthcare systems (Almalki et al 2011:786). The Saudi population will reach 39.8 million inhabitants by 2025, with 54.7 million by 2050; with a birth-rate of 23.7/1000 (Almalki et al 2011:786). The MOH is the largest governmental healthcare provider, have 244 hospitals, 33 277 beds, 2037 primary health clinics (Almalki et al 2011:787). The majority of healthcare professionals in the KSA is expatriates (total healthcare workers 248 000); and Saudis only constitute 54% of these totals (Almalki et al 2011:789).	Although it is argued that the South African history is undeniable not contributory to the health care system improvement, there has been improvements in the overall health of individuals within SA (Connolly 2012:6). The diseases SA is still burdened with include: HIV/AIDS; TB; high maternal and infant mortality rates; a series of communicable diseases and violence (NHI SA 2015:8). Non-communicable diseases in SA like Diabetes, Hypertension and chronic heart diseases are driven by risk factors such as smoking, poor diet, alcohol and lack of exercise. Resource imbalance, personnel distribution inequities, the burden of infectious and non-communicable disease and the migration of healthcare workers limits the achievement of primary healthcare services in SA (Kautzky & Tollman 2008:24; Dookie & Singh 2012:1). Primary healthcare facilities need to be strengthening to relieve the burden on the tertiary level which is understaffed, underfunded and underequipped to supply care to all unnecessary patient referrals (Mohapi & Basu 2012:79). The magnitude and rise of the HIV in SA is undeniable since the early 1990s and efforts towards stabilisation during 2004. During 2010, a total of 30.2% of pregnant South African women was HIV positive and it is projected that for the next 20 years this numbers will still increase. The total number of South Africans who are receiving life-long anti-retroviral therapy is increasing yearly (Barron, Pillay, Doherty, Sherman, Jackson, Bhardwai, Robinson & Goga 2012:70).

		District health expenditure has increased over the last eight years from R659 to R1 327 per capita in 2012/13. Primary health care expenditure also increased from R324 to R780 over the same period. The under 18 delivery rates has decreased from 9.2.% to 7.7%, but acute malnutrition in children below five years is still 4.3 cases per 1000 children (Massyn et al 2012:221).
Border security and defence	The KSA security and defense is influenced by the 'Mutaween' or religious police, which has been allowed to do the following unthinkable acts and made international headlines (Cunnings 2015:121) • During 2002, a total of 15 girls were burned to death after the building in which they lived caught fire, but they were not allowed to exit the building because they were not properly dressed. • During 2007, a 28-year-old man was beaten to death because of suspicious alcohol usage. • During 2013, two brothers' (22 and 24 years) car was forced off a bridge because of loud music playing from their car. • During 2014, a British couple were beaten in a mall because they withdraw money marked as a 'female only' ATM. • During 2014, two women were arrested when they attempted to drive a car and was transferred to a terrorism court	Within the Criminal Procedure Act (Section 49 of 2012) there is provision made as to 'shoot to kill' expand police powers during self-defence. Strikers believe that it was a successful event if violence was used and is frequently used for political demobilisation. During the past few years there has been increasing xenophobic attacks in especially KwaZulu-Natal when foreign nationals were accused of stealing inhabitant's jobs (Collins 2013:30). Rapes of even small babies are commonly committed by close family members, religious leaders, acquaintances or even teachers (Collins 2013:30). Attacks on farmers ('Boere') increased over the past decade and the implementation of farm patrol plans aims to protect minority interests (Humphreys & Smith 2014:818).

	The Saudi Ministry of Defense and US army have ties stemming back to 1953. The National Guard was established in 1973 and supports the United States Army Security Assistance Command (USASAC) (Cummins 2015:122). As part of this program, the Facility Security Forces (OPM-MOIFSF) was establish in 2008 for border and infrastructure protection, security, civil defense and coast guard operations (Cummins 2015:122).	
Housing, accommodation and currency	The Saudi population consists of 26 090 555 inhabitants, three fourths are natives and the remaining immigrants (Abdul Salam, Elsegaey, Khraif & Al-Mutairi 2014:531). Approximately **60% of the population resides in major cities** (25.5% in Makkah Al-Mokarramah and 24.9% in Riyadh). The high population in Makkah could be due to the strategic location of the holy mosque (Abdul Salam et al 2014:532). Saudi coins (silver Riyal) was initiated during 1925 and the Saudi Monetary Agency (SMA) was established during 1952 (Al-Timimi 2013:77). The issue of the coins was under the control of the Minister of Finance. During the period 1952-1954 the Saudi Guinea (gold coins) was used but it caused financial instability due to the fluctuations in the gold prices (Al-Timimi 2013: 78). Currency changes are reflected during the 17th and 18th century trade boom (Al-Razzak &	The former Apartheid regime in SA is still remembered through the **informal and semi-formal township** locations in the peripheral areas of cities (Neumann, Roder & Joubert 2015:138). Throughout the different provinces there is visible variations in cultural housing and structures (rural and urban development variations). During 2015, 1.5% less electricity was produced than during 2014. The volume that electricity providers (ESCOM) has available for distribution decrease each year by 1.5% (Statistics SA 2016). Due to the high unemployment rate (24.5% during 2015) people are still relying on State subsidised or free housing (Statistics SA 2016). The currency used in SA is the ZAR or South African Rand and consists of 100 cents. The value of the Rand is fluctuating but poor when compared to the USD or Pounds. South African currency is often influenced by political mismanagement as during the December 2015 period when the rand dropped considerably when the President replaced the Finance Minister and damaged international confidence in

	Al-Maani 2014:188). According to El Bcheraoui et al (2015:44) the average income in the KSA is 7 611 Saudi Riyals per month.	the country (Statistics SA 2016). Despite the end of Apartheid, half of the population still lives below the poverty line and one quarter of all inhabitants are unemployed (Gritzner 2010:293).
Laws and political control	Globalised trends diminished physical boundaries and exacerbated national and ethnic rivalries (Kim 2015:359). Saudi Arabia is known for its extremely restrictive travel policies. Foreigners who want to enter the Kingdom require an advance visa. Israeli nationals are denied visas based on their Atheist/Jewish religious practices. Unaccompanied woman is also frequently denied a visa with the exception of work permits e.g. nurses, maids or teachers. People entering the country are prohibited from taking alcoholic beverages, pornographic material and DVD's are censored before allowing entry into the Kingdom as this might be contrary to the Islamic religious practices (Throneburg Butler 2015:1238). Saudi Arabia is considered a "non-constitutional monarchy" (Throneburg Butler 2012:1238). The government consists of legislative, executive and judicial powers. The King and the Council Ministers oversee the executive branches. Members of the Council are appointed by the King himself and are responsible for drafting and implementation of educational, defensive financial, social and economic matters. The King also has the responsibility to oversee the	Due to the political transformations in SA, a range of new discriminatory practices and also victims arose. SA became a magnet for other African nationals who were seeking the benefits of a more stable governance, but instead became exposed to racism and Xenophobia (Adjai & Lazaridis 2014:237). The Constitution of the Republic of SA number 108 of 1996 makes provision for respect of human rights, embracing of economic and liberal policies as well as ruling of the law (Adjai & Lazaridis 2014:237). There are more than one million immigrants currently residing in SA (Adjai & Lazaridis 2014:238). Political control is governed by inhabitants voting for a President, who appoints the reigning government and can change and or amend legislation. South African inhabitants must pay tax on all goods (Statistics SA 2016).

	implementation of the Sharia law (no inhabitant pays any tax as it is against the Islamic law). Emirs (governing figures) are appointed in each of the fourteen states within the KSA as authority figures and must report back to the King (Throneburg Butler 2012:1239). The Shura Council handles all legislative and deliberative issues within the KSA. The Sharia courts consists of three sections namely the courts of appeal, the courts of first instance and the Supreme Judicial Council. All Saudi judges are trained in Islamic law (Throneburg Butler 2012:1239). Domestic violence and abuse against women and children are common in the KSA, but it is debatable if it is allowed under Sharia law. Abuse and violence are not recorded or reported in fear of further humiliation should a divorce and child separation be recommended (Throneburg Butler 2012: 1240). Sharia law is the religious guidance of all Muslims. These laws are derived from the Quran and have been in existence for more than 1000 years (Throneburg Butler 2012:1234). Punishment for severe crimes like theft and sexual abuse can include amputations or even decapitations. It was only during 2013 that the domestic violence was classified as a criminal act (Throneburg Butler 2012:1245).	

Religious practices and traditions	The term **Islam** refers to the Arabic word for peace. Muslims practice Islam from an Islamic worldview and see their holy book (Qur'an) as the only truth (Ibrahim & Dykeman 2011:388). It is believed that the Qur'an was revealed by Allah (God) as a guide for all mankind. Allah is at the centre of the universe and peace will only be achieved through submission towards Allah. Islam is built on five pillars and include belief in Allah (as the only and one God) and his messenger Mohammad, scheduled five prayers a day, giving charity or alms to the poor, fasting during the month of Ramadan from sunrise to sunset and a holy pilgrimage to Mecca once in a lifetime (Hajj) (Ibrahim & Dykeman 2011:389). The Muslim faith has two main branches namely the Sunni and Shi'ite. Although there are many differences in the beliefs, they adhere to Sharia laws (Throneburg Butler 2012:1235).	According to Smit and Chetty (2016:134) has the South African religious frameworks witnessed a shift from **Christianity towards a multi-religious approach**, encompassing and encouraging free religious practice (including Christianity, Hindu, Islam). Within SA there are Protestant Christians 36%, Zion faith 11%, Muslim 1.5%, Hindu or Buddhism 1.2%, Traditional believers 1% and 15% of the inhabitants declare themselves as none believers (Smit & Chetty 2016:135). Within the rural areas of SA (due to poverty and educational levels) people are still practicing traditional medicine, healing and supernatural beliefs (calling on spirits for guidance and support) (Semenya & Potgieter 2014:2). As per Semenya and Potgieter (2014:2) are there contrast in South African traditions and practices, with the traditional beliefs on one side and the developed modern train of thoughts and practices in line with Westernisation on the other side.
Image of women	**Westernisation, modernisation and globalisation marked the image of women in the KSA**. Women were granted more educational opportunities and females are representation in all occupations. Women in the KSA account for 8.1% of the workforce (Elamin & Omair 2010:746). It is well known that the social and cultural characteristics of Muslim or Arab men differ from those in	The image of women is very different from that of modest countries like the KSA because they are allowed to wear clothing of choice. The national history of SA still shapes the image perceived. There is an ongoing struggle to have **gender equality** amongst all spheres where women are fighting to be recognised as authority figures (Byrne 2015:NP). The traditional dress codes in SA also differ amongst the different cultures.

	the West. In the KSA, which is known as a tribal and conservative country, the Islamic teachings and cultural values are strictly followed and adhered to. Women are expected to work in sectors that are traditionally female orientated like teaching, medicine and nursing, whilst adhering to a strict code of gender segregation (Ibrahim & Dykeman 2011:389). Male nursing in the KSA is in severe shortage and they make use of emigrants to fill the gap. The Muslim Arab world is diverse in social, economic, historical and political dimensions. Countries like Egypt, Iraq and Lebanon are more relaxed in actual practices like modesty and religion. Most Muslim Arabs share the same language (Arabic), adhere to strict Islamic principles as religion. The KSA retain extreme control over economics, political participation and women (Ahmad 2015:128). The guardianship system policy in the KSA impose on women's rights by stating that "every Saudi woman must have a male guardian, normally a father of husband, who is tasked with making a range of critical decisions on her behalf…women generally must obtain permission from a guardian to work, travel, study or marry. Saudi women are similarly denied the right to make even the most trivial decisions on behalf of their children…" (Throneburg Butler 2012:1242).	Heritage Day in SA is set one day each year as to celebrate cultural heritage and to embrace different traditions. The dress codes differ across cultures from naked breasts amongst the Khoi to very modest long dresses amongst the early 'Voortrekkers'. Each culture prescribes its own dress code and level of modesty expected (Byrne 2015:NP).

Annexure C: Participant consent form

Information letter for the participants and their signed consent form

Dear registered nurse

I am Michelle van Bommel, a registered doctorate student with the University of South Africa. As part of my studies, I am required to collect information and write a research report. The University of South Africa has approved my research proposal.

The purpose of the interviews is to develop guidelines to facilitate adaptation in expatriate South African nurses working in the Kingdom of Saudi Arabia and upon their return to South Africa a. The knowledge and understanding gained from these interviews could be used to design orientation programmes that would enhance adaptation to and from South Africa.

You are under no obligation whatsoever to participate, but I do value your experiences and will appreciate it if you were willing to be interviewed. You may discontinue with the interview at any stage and you may refuse to answer specific questions, without incurring any verbatim. Only I, my supervisor and one data analyst will have access to the recorded and transcribed interviews. I will keep the information securely locked up. No names will be mentioned in any research report. All nurses participating in the research will have access to the research report.

If you are willing to participate in this study, kindly sign this form for record purposes only. You can scan the signed consent and email it back so i can keep record of it. No name will be attached to your interview, so that no one can link the interview with a specific person.

I have read the information about Ms. M. Van Bommel's research and I agree to be interviewed by her.

_____ _____

Signature Date

Annexure D: Interview guide – Unstructured phenomenological interview

Participant 1: Date: Duration:

The grand tour questions asked during the unstructured phenomenological interview will include:

- Please describe your lived experiences when adapting to the KSA environment (both private living and workforce).
- Please describe your lived experiences when you returned to the South African workforce after living and working in the KSA.

Probing questions that could be asked during the interviews will be non-directive or leading. Participants will be encouraged to give full, detailed explanations of events, emotions thoughts or memories. Probing questions can include the following guidelines in order to reach the 'grand tour' questions answered:

- Were there any challenges or highlighted events you faced when you arrived in the KSA or during the process when you started working in the KSA?
- How did you experience living and working in the KSA?
- What were the challenges or highlighted events you faced upon your return to South Africa?

Annexure E: Data collection dates

Date	Time	Interview number	Venue	Duration
28/04/2016	10h00	1	Cape Gate	70 minutes
02/05/2016	12h30	2	Kuilsrivier	45 minutes
16/05/2016	13h30	3	Rondebosch	45 minutes
28/05/2016	14h00	4	Athlone	50 minutes
03/07/2016	10h00	5	Rondebosch	55 minutes
28/8/2016	11h00	6	Grassy Park	45 minutes
26/09/2016	Cancelled date and venue 3 times, participant terminated			
05/06/2017	11h00	7	Kirstenhof	50 minutes
26/06/2017	12h00	8	Hermanus	55 minutes
03/08/2017	13h00	9	Muizenberg	60 minutes

Annexure F: Nominal Group Technique (NGT)

Information letter for the participants and their signed consent form

NGT (nominal group technique)

Dear registered nurse

I am Michelle van Bommel, a registered doctorate student with the University of South Africa. As part of my studies, I am required to collect information and write a research report. The University of South Africa has approved my research proposal.

The purpose of the interviews is to learn about expatriate nurses' experiences when returning to South Africa. The knowledge and understanding gained from these interviews could be used to design orientation programmes that would enhance adaptation to and from South Africa.

You are selected to partake in the nominal group technique session as to generate or validate data already collected. The first step is to answer all of the questions on the sheet below, and email it back to me. Once I received all the documents back, you will be invited to a group session with other experts as to explain your responses and to prioritise our findings. My final aim would be to develop guidelines to facilitate adaptation of South African nurses who emigrated to the KSA and upon their return to South Africa.

You are under no obligation whatsoever to participate, but I do value your experiences and will appreciate it if you were willing to be part of the focus group. You may discontinue with the session at any stage and you may refuse to answer specific questions, without incurring any verbatim. Only I, my supervisor and one data analyst will have access to the recorded and transcribed interviews. I will keep the information securely locked up. No names will be mentioned in any research report. All nurses participating in the research will have access to the research report.

If you are willing to participate in this focus group, kindly sign this form for record purposes only. You can scan the signed consent and email it back so i can keep record of it. No name will be attached to your answer sheet, so that no one can link the interview with a specific person.

I have read the information about Ms. M. van Bommel's research and I agree to be part of the focus group set up by her.

_____ _____

Signature Date

Annexure G: e-Delphi Round 1 Consent and guidelines

Information letter to the participants (using the modified e-Delphi technique) and their signed consent form

Dear registered nurse

I am Michelle van Bommel, a registered doctorate student with the University of South Africa. As part of my studies, I am required to collect information and write a research report. The University of South Africa has approved my research proposal.

The purpose of this study is to learn about expatriate nurses' experiences when returning to South Africa after working in the KSA. The knowledge and understanding gained from the unstructured phenomenological interviews was used to design guidelines to facilitate these expatriate nurses' adjustment when working in the KSA and upon their return to South Africa.

You are under no obligation whatsoever to participate, but I do value your experiences. If you are willing to participate in this study, kindly sign this form for record purposes only. You can scan the signed consent and email it back so I can keep record of it. No name will be attached to your comments, so that no one can link the data with a specific person.

During the first round of the e-Delphi technique a set of recommended guidelines will be forwarded to each member on the expert panel. These need to be critiqued and returned to the researcher for refinement. The data analysis together with the final set of guidelines will again be forwarded during the second round to all panel members for their input and suggestions. If all of the members are in agreement, the guidelines will be accepted and presented in the study. This exercise should not take you longer than 10-15 minutes. You are encouraged to make any suitable comments or suggestions on the guidelines made.

I have read the information about Ms. M. Van Bommel's research and I agree to partake in the expert panel (modified e-Delphi technique).

_____ _____

Signature Date

Annexure H: e-Delphi Round 1

Instructions to participants' e-Delphi Round 1: Please score the draft guidelines according to scope, purpose, clarity, applicability, flexibility, reliability and validity. A score of 1 is the lowest and 5 is the highest.

No	Guideline	Scope	Purpose	Clarity	Applicability	Flexibility	Reliability	Validity
1	International recruitment agencies should facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the host country.							
2	International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who							

	apply to work in the KSA prior to migration.							
3	South African healthcare regulatory bodies and nurse education institutions must enforce trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to prepare South African trained nurses for the global health market with diverse cultural context; and cultural competent nurse' skills will enhance adaptation into a foreign setting like the KSA).							
4	South African healthcare regulatory bodies, including private							

	and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats.							
5	International recruitment agencies should collaborate with South African healthcare regulatory bodies to advocate for retainment of skilled and trained staff in SA. Retainment of staff can be achieved							

	through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.							

Additional comments:

Annexure I: e-Delphi Round 2 Consent

Information letter to the participants (using the modified e-Delphi technique) and their signed consent form

Dear registered nurse

I am Michelle van Bommel, a registered doctorate student with the University of South Africa. As part of my studies, I am required to collect information and write a research report. The University of South Africa has approved my research proposal.

The purpose of this study is to learn about expatriate nurses' experiences when returning to South Africa after working in the KSA. The knowledge and understanding gained from the unstructured phenomenological interviews was used to design guidelines to facilitate these expatriate nurses' adjustment when working in the KSA and upon their return to South Africa.

You are under no obligation whatsoever to participate, but I do value your experiences. If you are willing to participate in this study, kindly sign this form for record purposes only. You can scan the signed consent and email it back so I can keep record of it. No name will be attached to your comments, so that no one can link the data with a specific person.

The purpose of the e-Delphi round 2 is to scrutinise the data provided by all members during the e-Delphi round 1 and to finalise the guidelines. This exercise should not take you longer than 10-15 minutes. You are encouraged to make any suitable comments or suggestions on the guidelines made.

I have read the information about Ms. M. Van Bommel's research and I agree to partake in the expert panel (modified e-Delphi technique).

_____ _____

Signature Date

Brief feedback on e-Delphi round 1:

- All participants were in some level agreement to the suggested guidelines
- The comments made are valued and incorporated into the new structured guidelines

Annexure J: Developed Guidelines

Instructions to participants' e-Delphi Round 2: All information gathered during e-Delphi Round 1 has been considered and incorporated during Round 2. During this round you are kindly requested to review the four remaining guidelines and confirm your agreement or additional comment on each guideline.

No	Guideline description	Confirmation of agreement or comment
1	**Guideline 1:** International recruitment agencies should facilitate workshops relevant to migration preparation with the focus on **culture shock** to all prospective expatriate nurses who apply to work in the KSA prior to migration. **Classification:** Essential Guideline	
2	**Guideline 2:** International recruitment agencies should facilitate the South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country. **Classification:** Essential Guideline	
3	**Guideline 3:** South African healthcare regulatory bodies, including private and governmental healthcare providers should facilitate South African expatriate nurses' re-integration back into the South African healthcare environment	

	through mentorship and supportive programs immediately upon return to SA which will aid in re-adaptation and ultimate re-adjustment of these expats. **Classification:** Novel Guideline	
4	**Guideline 4:** South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA. **Classification:** Luxurious Guideline	

Annexure K: Researcher's reflective journal

"I just couldn't believe the call (I) just received...telling me that I must be ready for flight 747 leaving for Jeddah 4th March 2004. I was still on holiday with my parents before departing on my lifelong dream to work abroad...or maybe it just wasn't a lifelong dream but rather an accumulation of circumstances, including (two) young kids and a divorce that force you to escape reality and pressure, especially financially and seek a better life. Somewhere or somehow life should be better and work not so demanding.

I have just completed my ICU qualification and was accepted in the military hospital in Jeddah, KSA. Although having more than 10 years ICU experience I was excited, scared, challenged and an array of emotions never felt before. Maybe the desert and the Arabian nights as displayed in movies were real and wonderful. I greeted all my friends, families and kids at that stage and got onto the plane – my first long distance flight without any familiar faces. I cried for hours without end and eventually fell asleep, not knowing what to expect. With my South African roaming cell phone tucked secure, I promised to call everybody I knew once I landed in Jeddah.

After what felt like forever – (seven) hours later we landed in Jeddah. When the Arabic announcement came up the air hostess told us to "cover now" and I saw other females also covering their heads with a black veil. Luckily, we had an orientation session with the recruitment agency which told us what to wear, how to wear it and how to pack your suitcase. We were warned that it will be male guards searching your luggage and personal belongings...

When exiting the aeroplane I couldn't breathe – although it was 02h00 in the morning it was so hot that I experienced first-hand Bronchospasm. It was shocking, the temperature on the entry door showed 55 degrees. Within walking time and distance from the aeroplane to the airport doors – which was about 100 metres my clothes were soaking wet.

The entrance into the airport was chaos. We were warned but it was nothing like this. Rows and rows of individuals trying to enter the visa control: only male attendees and everybody speaking Arabic. Whilst on holiday I decided to cut my already blonde hair short and to bleach it even more. This was a sight very unfamiliar to the Arabic men as they kept staring at me – maybe disgusted who should know?

The guards kept asking me questions in Arabic which I didn't understand and eventually a "Captain" came and told me to follow him in English. He was carrying my passport so I though he knew where I was heading. I was taken through a second security gate and then my passport was handed to another guard. This "Captain" told him "Riyadh". Certainly I read up that it was different from Jeddah and I refused to go through the second gate. After arguing for a while a female came and took me, also mumbling something in Arabic. I was getting locked up...

The room where I was kept was about 15x15m, no windows, (four) toilets to my left side without any doors on them. There were already about estimating more than 100 females from all different nationalities in this room. Everybody was crying, shouting, hitting the door or even urinating on the floor. The stench was terrible. I never felt so scared and alone and just wanted to go home. So I just sat and cried. Nobody could speak English, nobody could understand me. I wanted a phone to call my family, but they were all left in SA. What did I do? I was hungry and thirsty and all alone...

I stayed lock up for a few hours, the same female attendant who locked me up came and called out certain names and a few of my 'inmates' left. I stayed and waited for someone to come and collect me. It was already morning when eventually I recognised a faint resemblance to "Van Bommel" with a very strange accent. The hospital that recruited me sent a driver – a Pakistanian which also couldn't speak English very well.

At least he showed me the letter from the hospital and instructions for him to take me to my accommodation. It was hot, everybody was speaking a different language and I was scared. In the minivan he handed me a brown box, but I was very scared to open it. We all knew about the bombing issues in the KSA...Eventually he said "eat" so I reluctantly opened the box to find old sandwiches, a hot juice and something that resembled an old orange and apple. I humbly thanked him and kept my box besides me – this was my survival kit.

When leaving the airport with my only acquaintance – the Pakistanian driver that couldn't understand me – I nearly died, and this time literally again. Apart from the heat, the driving is much desired [P2] recalled the heat and I can envision myself standing on the aeroplane, unable to breath as it is a suffocating heat, compressing your chest]. Although the robot lights indicate red one can drive if you reached the light first. Crossings and

circles are really just for decoration and there are no speed restrictions, or age limits. I am sure the fellow road users ranged from 12 – 100 years. It was like living nightmare on Elm Street for real...

After about an hour we reached the compound where I was allocated to stay, only to be greeted with armed guards shouting something at the driver. He just instructed me "still" and I didn't dare to breathe. Surely they could shoot me if I decided to run now? After checking my passport and shouting at the driver again I was taken to my apartment – which I didn't knew then – shared with (two) fellow South Africans. The driver handed me the apartment key and left me at the door. Sneaking inside, looking for a place to sleep, the air conditioner making too much noise to open the windows – very bad idea – nearly getting heat stroke and attack of the killer mosquitoes...I slept and cried and prayed.

Early morning I was woken by female voices – Afrikaans. I just jumped up and went out to the dining room. They greeted me and said that they will take me to the shops for breakfast. There was a phone which I could use to call my family, I needed coffee and sleep.

After a disastrous start, the next week was spent on work orientation, obtaining "mobilee" which is the slang reference for cell phone number and shopping. It was surreal. Never have one experienced such extravagant malls, houses, architecture, shops and the list goes on. Downtown was something different. Western nurses didn't really want to go to "Al Ballad" because the "Chop mosque" was situated there. When asking around about the meaning of this I was told that public executions take place there on a Friday. For real? (Two) of the paramedics – also from SA – actually witnessed a public beheading, in daylight for everyone to see. Oh my...

It was good to see the total amount of South African nurses, physicians, pharmacists and technicians in the hospitals. At least you could speak Afrikaans at times. Although an overall OK experience I decided to stay for one year only, then to go home. I missed my family. Of course life does not go as plan and I was offered another promotion with benefits, so decided on staying another year, which eventually became (seven). Where did the time go? At what point did time escape and I become Saudi? I dressed, talked, shopped, ate and talked like them. I started to like them and they adored me in return. I was respected by the physicians, except the one I reported for abusing schedule drugs –

every day or night he would send another nurse to the pharmacy for certain prescriptions, only to use it on himself. The pharmacy staff was very friendly – if you knew somebody you can just ask what you need without a prescription...or say that you will send a script later. Most of these staff was from the Filipinos.

The hospital was well run. With more than 1 000 inpatient beds and the Royal suite – of course decorated with 24 carat gold and marble operated daily. 24 hour service. Patients, relatives or acquaintances from military members were welcome. Nobody was rejected and nobody paid for any services. It was unreal. Staff salaries were paid on time without any delay. Transferring money to SA was a nightmare. Banks would have one female counters and endless male counters and you dare not stand in the male row. Mattawas or religious police patrolled the areas with walking sticks and would use it to hit somebody if needed.

Shopping during prayer times was stressful. Either the shops closed or if you were busy shopping when the call for prayer was announced you got locked up in the shop while the men left. All the lights (were) turned off, so you had to wait until somebody returns to let you out. This really took getting used to. People would stop their cars in the middle of the street, block the traffic as to get out and pray on the tar. Ramadan was crazy – no shopping centres open during day time, only from sunset until sun break. There was lot of specials on all household items in preparation for the holiday Eid which is similar to our Christmas celebrations.

Between work and studies there were some free weekends to travel. It was so cheap and safe. Travelling alone as a female to another area like Dubai was wonderful and affordable. Something that was not possible on the South African salary previously earned.

Working with other cultures was exhausting. There are remarkable differences in standards of care, communication skills to name a few. Cultures included Indian, Filipino, Jamaican, American, Polish, French, Pakistanian, Sudanese, Saudi, Egyptian and of course my beloved South Africans. It was crazy. The Saudi staff really disliked the Egyptians – for reasons unknown.

After living, eating, working, shopping and exhausting the Arabian culture it was time to return home. My children spent the last four years with me in the KSA and it was time to return to normality. What was I thinking? It was horrible being home, not because of my loved ones but we missed Saudi. We missed the heat, the crazy midnight grocery shopping; taking a taxi to town...We just could not adjust back to our beloved SA for reasons not yet known. Everything was strange – the people, time, procedures, communication, ways and attitudes. Every single day, for almost (two) years, I wanted to go "home". Problem is that I was already home, but my mind told me something else.

Within (two) years I applied twice to return to the KSA and was accepted both times, but at the last minute I withdrew, maybe for reasons suppressed in my sub-conscious. How could it be that something so terrible could have this effect on a person? Was there something I missed and couldn't understand at time of departure and arrival to and from the KSA (or) SA? I had no idea that I underwent this total transformation into a person I didn't recognise anymore. Wearing a head scarf and Abaya, studying the Islamic religion and even reading the Quran apparently isn't part of the Christian religion. But my mind was convincing me that it was normal and should be applied- for almost (two) years my normality was distorted in ways not understood. Could it be that this long time spent away from home immerged one so deep into a culture that realities cannot be separated anymore? Was I the only expatriate nurse experiencing this distortion or are there more like me? What are the factors that influence these changes in realities, views etc.?

Four years back in SA...time to look for other expatriate nurses who might have similar or shared experiences in the KSA like me. Important aspects to consider are that there were both positive and negative aspects associated with the KSA – both working and living. The worst adjustment was communication – not understanding each other. The Filipino nurses (are) using the "V" and "P" sound but rather exchanging it with "B". The Indian girls not talking a lot but rather indicating expressions with shoulder movements...Saudi staff just not showing up for work because the family said no...Each person will have their own ideas and experiences and I cannot let my experiences influence them. They don't even know me, they only know that I also spent some time in the KSA – we already have a shared bond.

My first interview was with this vibrant lady. The meeting place was set but not knowing if this person will actually show up or what she looks like was scary. Maybe she was not

showing up at all...but she did and she was so excited to share her experiences. According to her the wild Arabian nights with the love she never thought she would have been real. Living for every moment together, travelling and diving which compensated for the horrible working conditions where she was not recognised as a professional. In a world where there is male dominance and you are not allowed – as a female - to express your own ideas and thoughts. She was shaken by the other cultures, she obviously is a very assertive person, but felt inferiorated by them, especially the "American standards" that she was not accustom to back in SA. Just like me she lived, ate and (drank) the culture, she fell in love with the call for prayer and was seeking it as a sign of her missed memories back in the desert. I could feel her longing and fears as she explained her events with so much passion – I was there, but at no point did our mutual experiences (meet). I wasn't allowed to influence her way of explanation but rather be a silent observer with me own thoughts and ideas. I could see the Henna tattoos she so well explained, part of the cultural mark...having different Abayas for special events.

The second interview was much different. A more mature woman who absolutely lived Saudi but then "Americanised". She really adopted all of the American ways – studying; even her speech and communication styles were no longer South African. She also explained in much detail how she travelled, how good some of the Saudis were to her, but that the working environment was terrible. All of this goodness was soon destroyed when she returned to SA and was told that she cannot get a management post, that all of her additional qualifications was not recognised and that she has to accept a position that was available if she wanted to work – at the salary offered non-negotiable. I could see her sadness, if it was not for the grandchildren she would have been gone a long time ago. She was living in her own home but with no friends, they were alienated when she left the country. She was lonely.

The following interviews became easier. I already felt a much deeper connection with people "like me". All of these ladies shared similar experiences, they were still in some way lost – one lady departing again in less than a week – this will be her third time. I am still not sure what the attraction to the KSA is. Can it only be financial gain or is there something out there – the mystic nights?

One thing is evident in my mind. Leaving SA for the KSA is much easier than to return to it. Entering a foreign country will have its issues – adjustment, differences, conflicts or

more; but when returning to SA you have changed. Maybe on a physical, emotional, psychological and spiritual level. It is almost like experiencing a shift between (two) existing realities – your physical body is in SA, but everything else stuck in the KSA. I am still uncertain about this phenomenon, how to explain it. One thing is for sure – we (all of us involved in the research) were not prepared on a psychological level to adjust back to SA. Living here seems normal, but leaving and returning expose all the issues, corruptions, low standards of care etc. I still want to connect the time frames of how long re-adjustment or reversed culture shock will last? Could this be associated with post traumatic shock?"

Annexure L: Person-Environment-Correspondence Model

Although the researcher opted to stray from using a theoretic framework during this study, it was decided by the researcher to incorporate certain concepts from the *Person-Environment-Correspondence Model* (2013) as a conceptual framework for guidance during the guideline development process. The researcher was of the opinion that all the aspects covered in the *Person-Environment-Correspondence Model* relates to South African expatriate nurse migration and adaptation. The 'person' thus refers to the South African expatriate nurse, the 'environment' relates to both the KSA and SA, whilst correspondence refers to migration and adaptation.

The *Person-Environment-Correspondence Model* (1984) as developed by Dawis and Lofguist during 1984 is adapted from Haslberger, Brewster and Hippler (2013:335) to indicate the adjustment of three interlinked dimensions and include the behavioural, cognitive and feelings or emotional dimensions. The *Person-Environment-Correspondence Model* relates to congruence, which explains the continuous process of adjustment (as influenced by financial gain, skills, training or personal characteristics) (De Jager, Kelliher, Peters, Blomme & Sakamoto 2016:13).

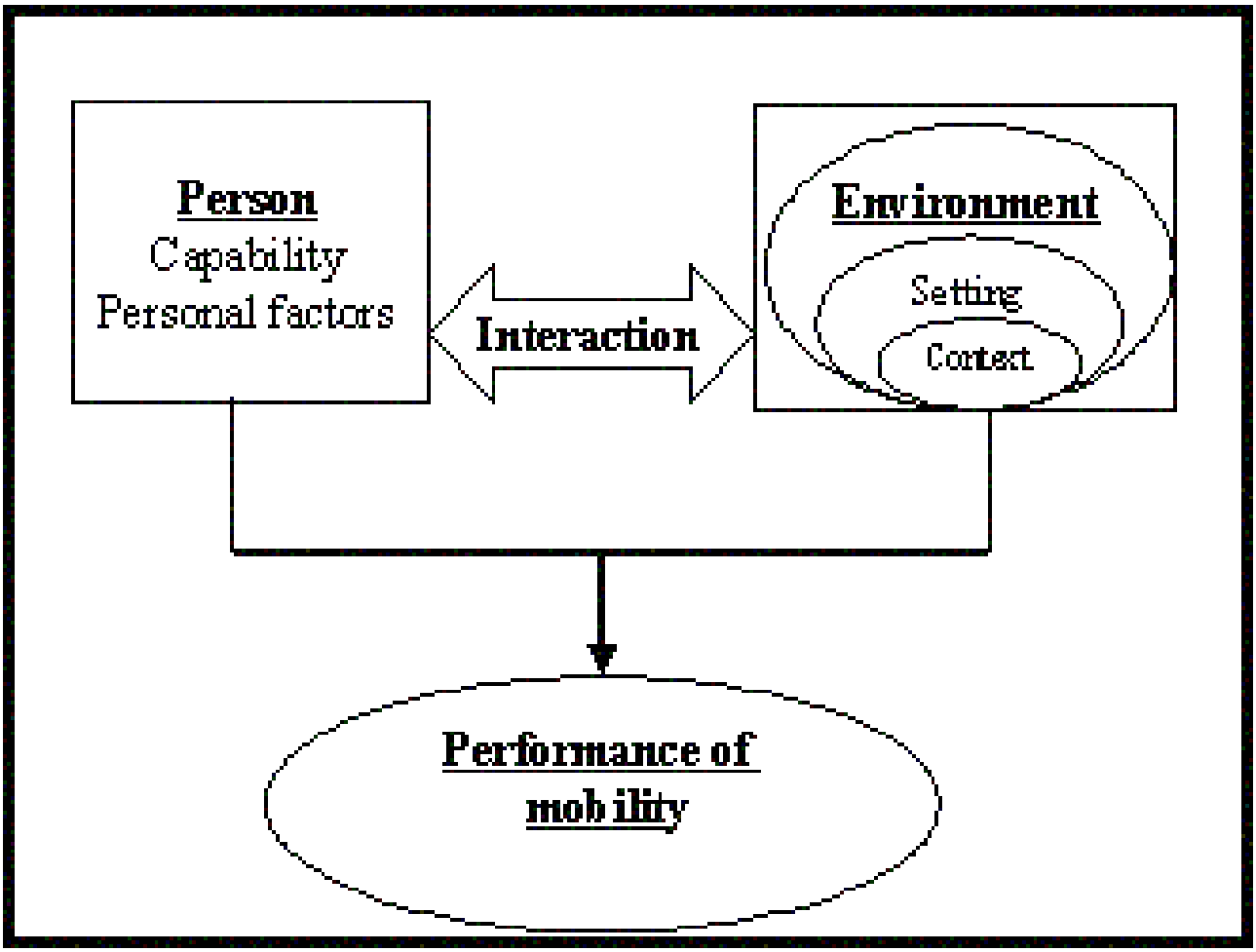
The *Person-Environment-Correspondence Model* indicate the individual's job satisfaction, environmental satisfaction, work culture and environmental conditions, fulfilment of career developmental needs and career aspirations and expectations (Potgieter, Coetzee & Ferreira 2018:2). In this study, job and environmental satisfaction, work culture and career development needs were identified by participants as motivators for migration to the KSA. Individual career developmental needs are evolving and changeable and adjusting to personal-career-life along with changing working conditions is inherent in to process of achieving good Person-Environment-Correspondence (Potgieter et al 2018:2). In this study, participants mentioned that once they achieved their career developmental needs or professional growth in the KSA, they returned to SA.

The final objective of this study was to develop guidelines to facilitate migration and adjustment in South African expatriate nurses between the KSA and SA. The *Person-Environment-Correspondence Model* fit into this Phase, as the South African expatriate nurses' career needs were changeable as were their working conditions. First, they had

to adjust to the changing environment in the KSA and then re-adjust back to SA upon their return. After these expatriate nurses reached their saturation point in the KSA (on toleration when negative reality kicks in, personal or professional growth has been achieved or financial goals set) they returned to SA. The information gathered during Phase 1 (Interviews) indicated that the participants (Person) interacted with the setting in the KSA and SA (Environment) and through this interaction there has been adjustment issues in both environments which influenced the participant's work performance (even physical and mental health affected through this environmental interaction). Only the concepts described in the *Person-Environment-Correspondence Model* was used in the guideline development process as it encompasses the essence of this study (factors underlying migration, adjustment and work experiences). See Chapter 4 for more detail.

The following section will provide discussion related to the relationship between the person, environment and the interaction of the individual between the two processes. The *Person-Environment-Correspondence Model* was used by the researcher during the guideline development process (as a conceptual framework to develop guidelines) to facilitate migration and adjustment of South African expatriate nurses who lived and worked in the KSA and re-adjustment upon their return to SA. The decision to use these concepts during the guideline development process was supported by the findings and interpretation from Phase 1 and a literature review that indicated that all South African expatriate nurses who worked and lived in the KSA before returning to SA had migration and adjustment issues which altered their behaviour, cognitive processes, feelings and emotions.

Person-Environment-Correspondence Model



Adapted from (Haslberger, Brewster and Hippler 2013)

Available from: https://www.bing.com/images/search?q=person-environment-correspondence+model&FORM=HDRSC2

As seen in above Figure and confirmed during the data analysis process of this study, the participants (person) all experienced similar lived experiences (correspondence) in the KSA and SA (environment) pertaining to migration preparation and support during adjustment. Participants in this study had similar experiences relating to diverse cultural traditions (context) and behaviours (setting) which resulted in culture shock and reversed culture shock (interaction between the person and the environment).

According to Potgieter, Coetzee and Ferreira (2018:2), the *Person-Environment-Correspondence Model* include overall job satisfaction, working conditions, culture, development and satisfaction of career needs, expectations and aspirations. In this study, participants varied in opinion regarding job satisfaction in the KSA, but all were in agreement that the working conditions was superior to those in SA and career needs have been satisfied prior to return to SA.

Once the individual experienced job fitness, both objective and subjective adaptation to other role players in the environment can take place; objective or subjective changes can be made to the environment to match desired attributes; or adjustment to the self and or the environment simultaneously to create a fitting relationship (Lu et al 2014:2395). In this study, participants all stayed in the KSA for different periods of time, which implicate that these expatriates adjusted to the KSA 'environment'. These participants all ultimately returned to SA after they reached their personal goals.

According to Haslberger and Dickmann (2016:6) correspondence refers to the satisfaction of individual needs supplied by the environment as well as the individual meeting the environmental requirements. In this study, the person will link with the South African expatriate nurses' capability (ability, prospective or skills) and personal factors (personality; age, eagerness or willingness to adjust into new environment). The 'Environment' refers to the context of both the KSA and SA. Within the 'Environment' there is a setting and a context. Setting in this study refers to the place and time in which the South African expatriate nurses worked (the KSA and SA) and 'Context' refers to the conditions and surroundings under which these South African expatriate nurses worked in both the KSA and SA. 'Correspondence' refers to adjustment and adaptation of the South African expatriate nurse between the KSA and SA, how well they adjusted and the issues these expatriate nurses experienced.

There is a constant interaction between the 'Person' and the 'Environment'. This implicates that the South African expatriate nurse (person) is in constant interaction with the new or strange environment and culture in the KSA. The environment consists of a setting and context, implicating South African expatriate nurses in this study didn't stay in the KSA for the same period or years. Some of the participants experienced 9/11 whilst working in the KSA, so the surroundings or context influencing their adjustment in the

KSA might vary with external contextual influences. As described by the participants in this study, some of the participants found it easier to adjust to this strange environment than others.

Annexure M: Drafted guidelines with literature control

No	Drafted guidelines	Data from Phase 1	Literature control
1	The South African government need to see as a matter of urgency that South African trained nurses' salaries are increased and comparable to international set standards (living conditions could be improved and luxuries like travel could be afforded with better remuneration). These returning South African expatriate nurses' exposure and experiences should be considered when negotiating salaries upon return from the KSA. In order to retain South African nurses' in the country, the government should state regulate standardise compensation for all locally trained nurses between private and government facilities. Although it can be argued that this might not be feasible, the standards and compensation structure for nurses in the government and private healthcare facilities should be the same.	In this study, the participants could be seen as *'nomads seeking greener pastures'* with **financial gain** as external motivator and **need for independence** as internal motivator.	According to Lagardé and Blaauw (2016:1), SA struggle to attract nurses due to poor salaries. South African expatriate nurses might prefer to work in the KSA environment purely for the benefits attached to their employment contracts which include financial (the Saudi Riyal) and educational gain. During Phase 1 of this study, participants mentioned their remuneration in the KSA was much higher than in SA, which ultimately improved their living conditions. When these participants returned to SA, they were expected to be content with the salaries offered to them (see description Chapter 2).

2	The South African healthcare governing bodies is responsible to create favourable healthcare **working conditions** by ensuring there is adequately trained staff and equipment to deliver a high standard of care to address patient needs. The South African government is responsible to set standards for minimal healthcare workers (nurse-patient ratios) per facility (both private and government), make available resources (financial and human resources) to train additional nursing staff if needed. The South African government is responsible to provide adequate resources in terms of human resources (adequate number of professional nurses for patient ratios and fiscal resources in terms of equipment (fully functional and regular maintenance done) in all healthcare facilities.	In this study, the participants were viewed as *'nomads seeking greener pastures'* due to poor working conditions'.	According to Janse van Rensburg, Engelbrecht, Yassi, Nophale, Bryce and Spiegel (2016:8), South African nurses perform their duties in precarious conditions. Nurses are at risk for occupational illness including infectious diseases (Janse van Rensburg et al 2016:8).

3	In order to **establish a sense of belonging and create meaning** for South African expatriate nurses' in the country, the recruitment agencies and healthcare employers should facilitate support groups for returning expats. Support groups can be facilitated by previous expats. These support groups can enhance meaning for them by mentoring prospective expatriates before they leave SA to prepare them in terms of expectations and adaptation as well as mentoring those that return and seek employment by creating a 'sense of belonging' back in SA.	The South African expatriate nurses could feel like *'strangers in their own land'* when returning to SA. They might feel that they do not fit in or belong in SA.	There is a gap in literature on support for South African expatriate nurse' migration and adaptation between the KSA and SA and how to create a sense of meaning and belonging in returning expatriates. In this study, it is proposed that the returning and prospective expatriate forms a support structure, the prospective expatriate learning from the returning expatriate and when the South African expatriate nurse ultimately return from the KSA a support structure to be in place to establish a sense of belonging as to create meaning.
4	South African expatriate nurses returning from the KSA and resident nurses all need to be protected in healthcare settings. As safety concerns and violence in the workplace is not only relevant to nurses but nationally, the government is responsible to provide enough (daily coverage) and adequately trained safety	In this study, the participants could all identify with safety issues as a push factor towards migration.	Transportation, transport services, equity of services and the distribution of needs is a great concern in SA (Jennings 2015:765). The distances to travel to work, exposure to crime, injuries and fatigue is all causes of the poor transport system (Jennings 2015:765).

	officers or police for protection of citizens (crime identification, prevention and control). As mentioned by the participants, the KSA offer free and safe transportation to and from work. Safety can also refers to crime or public transportation in SA which are limited and sometimes dangerous therefore it is the responsibility of the government to provide for enough public transport (especially for essential service delivery such as healthcare workers) as well as safety and security officers to protect the travellers (nurses on or from their way to work).		Healthcare work related violence is a global problem as reported by nurses (Madzhadzhi et al 2017:29).
5	Nurses could be motivated by healthcare managers to leave the country (migrate and explore other countries and cultures) when having enough experience in their speciality, to gain more experience on culturally diverse patients, opportunities, experiencing new cultures, working with diverse cultures and patients and travel opportunities to foreign	Professional growth was identified by participants.	International migration constitutes to approximately 3.1% or 214 million people and 9% thereof is destined for African countries. It is assumed that this migration numbers are likely to expand in the future. Freedom to choose in which country one wants to reside, establish, engaging in employment or the undertaking of industrial or commercial activities is a basic human right (Donoghue 2016:4). Emigration refers to the person exiting his or her homeland to either go work, live or stay in another country (Donoghue 2016:4).

	countries like the KSA. These knowledge and skills obtained whilst working and living in the KSA can be brought back and implemented into the South African healthcare systems, which can improve patient care and contribute of the body of nurse knowledge and understanding. It can be argued that healthcare facilities might not want to let go of their skilled staff, but these nurses will return to the healthcare facility with international exposure which can be applied in the local healthcare setting in SA to improve health care.		South African nurses take personal decisions about their career opportunities and might decide on the KSA as a favourable destination to go and work for periods only they can decide on. The term immigrant refers to a person entering a foreign country to either work or live in (Donoghue 2016:4). Immigrant nurses face challenges towards successful integration into the immigrant workforce. Communication obstacles and different nursing standards and practices elaborate this integration processes. Interpersonal conflicts, discrimination, prejudice, attitudes and cultural clashes could be unpreventable (Donoghue 2016:4).
6	Adjustment can be facilitated through optimal and well-structured information sessions and orientation offered by the recruitment agency at least three to six months prior to departure (trained and experienced staff members who either worked and lived in the KSA herself, or have in-depth experience and understanding of the KSA to all prospective expatriates) about the working and living conditions in the KSA (vast difference as compared to SA), including	Struggling to fit into the KSA environment was identified by most participants.	Expatriate and cross-cultural adjustment consists of work, general and interactional adjustment. General or cultural adjustment refers to factors relating to the wellbeing of the expatriates' physical, psychological and living conditions. Expatriate work adjustment is concerned with the extent to which the expatriate can adjust to their new role, job, responsibilities, expectations or performance standards (Ditchburn & Brook 2015:338). In this study, South African expatriate nurses experienced cross-cultural adjustment both in the KSA and also when returning to SA when they are

	the culture (traditions, behaviours) and government control (Islamic law and religion).		expected to adjust to a variety of cultures in the working environment. Expatriate interactional adjustment refers to the level of comfort and satisfaction when socialising and interacting in the destination country. Interactional adjustment is influenced by language barriers, non-verbal behaviours, expressions and eye contact. Social interactions are needed for effective adjustment in the destination country, which will reduce anxiety and stress and allows for intercultural competence development (Ditchburn & Brook 2015:337). The desire and willingness to communicate within the social context and the ability to establish positive relationships will promote the expatriates' interactional adjustment (Ditchburn & Brook 2015:338). In this study, expatriate interactional adjustment was experienced by the South African nurses in the KSA when interacting with the patients, colleagues from foreign countries as well as when returning to SA when interacting with different nationalities and cultures both in the work and living conditions. Expatriate adjustment is explained by Ditchburn and Brook (2015:338) as the measured degree of psychological comfort experienced by the expatriate during a new situation. Nurses' primary intent is aimed to enhance patient's health. Trained nurses

			tend to work where the environmental including financial factors are best. Adjustment is a state where changes occur in the individual. Expatriate adjustment could be regarded as a predictor of an expatriate nurses' job performance (Donoghue 2016:4). When the South African expatriate nurse enters the KSA, her adjustment will be reflected in her work performance and satisfaction. It is assumed that there are no specified time periods for cultural adjustment to occur. In this study, there was no link between the time spent in the KSA and the adjustment Phase. In this study, the adjustment Phases to the KSA differed from three months to one year and the re-adjustment back to SA 18-24 months. It would seem that the longer time spent away from SA would extent the adjustment period back into the culture. The South African expatriate nurses' adjustment to the new culture could therefore be linked to their performance in the KSA. Participants who mentioned that they were emerged into the culture and wanted to discover more about the traditions adjusted better into the KSA environment, whilst participants who were very critical about the culture experienced adjustment issues. Descriptions were presented in Chapter 2. According to Gudmundsdóttir (2015:177), people establish adjustment patterns within a six month period. This can be

			influences by previous international experiences, cultural novelties, cross-cultural training, language acquisition and the ability to adjust. Adaptation to the new culture is more likely to occur with increased intercultural contact. Increased inter-cultural contact is also assumed to lead to acculturation or cultural identity change (Noels & Clément 2015:460). Cross-cultural adjustment can be divided in two categories namely psychological and socio-cultural (Gudmundsdóttir 2015:178). Psychological adjustment included experiences lived in the new society, familiarity perceived in the new environment and the degree of psychological comfort experienced. Socio-cultural adjustment includes effective social behaviour, practical social skills and attitudinal factors (Gudmundsdóttir 2015:178). Processes to facilitate adjustment into a new culture should include maintenance of hereditary practices like community centres (Noels & Clément 2015:461). Unsuccessful expatriate adjustment patterns could be detrimental for the healthcare setting and include factors such as working conditions, organisation and contextual aspects (Huff, Song & Gresch 2014:151). It is also stated that a higher degree of cultural intelligence will be a motivation for the individual to adjust to the new culture (Huff et al 2014:155). Cultural intelligence refers to the

			ability and capability to function in culturally diverse settings and occur inter-personal (Ang, Rockstuhl & Tan 2015:433). Cultural intelligence composes of a set of capabilities to enable effective cross-cultural adjustment and is culture free (Ang et al 2015:433). According to Brzostek, Brzyski, Kózka, Squires, Przewozniak, Gajda, Gabrys and Ogarek (2015:412) all countries need a national nursing workforce survey, with tools and instruments developed in English to ensure effective cross-cultural adjustment which makes provision for nurses' perceptions on contextual factors.
7	South African trained nurses should receive basic need benefits like housing support from employers [nursing homes or accommodation facilities (provided by government or private healthcare institutions), medical aid and pension funding to retain these nurses in South African healthcare facilities, support them emotionally and physically].	Lifestyle or living standards was identified by participants to be superior in the KSA compared to SA.	According to Zweig (2015:1) the vast population growth in SA is a leading cause for poverty. There is an influx of people into industrial areas looking for economic opportunities. Due to this influx and the increase in rental prices, nurses are often residing in backyard dwellings, which are unsafe to live in (Zweig 2015:1).

	Retainment benefits offered to prospective expatriate nurses might limit migration and brain drain from SA.		
8	Trans-cultural nursing programs which included diverse cultures, traditions and religious practices should be part of all nurse training programs as offered by private and government nurse education institutions and oversee by the SANC. South African healthcare government should make cultural diversity and sensitivity program training compulsory to all skilled and trained nurses as to improve cultural interactions, patient care and satisfaction. This training can either be included in basic nurse training programs or a state-regulated qualification after nurses have qualified.	Strangers in a strange land, culture shock and exposure to different religious practices were identified by all the participants.	The term culture has an allusive status according to the work of the phenomenologist Heidegger (Baerveldt 2015:538). Culture is used in reference to 'being' and a 'supreme Being' at source. It is also referred to as clearing, allowing ideas and things to happen as to show the concealed and the coordination of practices to become intelligible for intellectual interpretation. Culture therefore cannot explain or mediate individual activities (Baerveldt 2015:539). Philippine nurses working in the KSA reported low salaries (both public and private sector), poor working conditions, outdated healthcare technologies and lack of employment opportunities as pull factors for international migration (Vartiainen et al 2016:31). Although all of the participants in this study mentioned that there were a huge number of Filipino nurses working in the KSA, these nurses were unhappy about the way they were treated. The participants mentioned that the salary structures of the Filipino nurses were much lower than those of the Western nurses and therefore could be regarded as a 'cheap labour' opportunity. The Philippines are experiencing disparities in health due to the

			poverty levels in the country. Hospitals cannot carry the burden of the growing population whilst the number of healthcare workers including nurses is declining. Due to the high number of Filipino nurses and the poor salary wages most of them opt to migrate to countries, which will offer them better benefits (BMI Research 2016:6). Similar to the Filipino situation is also the Indian and Jamaican nurse migration trends from other developing countries. In this study, some participants also mentioned that they experienced working with Canadian nurses in the KSA and found it difficult to associate with their ways of working (referring to procedures and the use of certain terminology).
9	National healthcare regulatory bodies should set standards for nurse' promotion opportunities, reviewed annually and statistics kept on promotions as to motivate nurses to stay in SA (retention). Private and government healthcare institutions should set realistic career advancement opportunities for South African trained nurses as to promote job satisfaction and if not		According to Armstrong, Rispel and Penn-Kekana (2015:2) nurse competencies (professional development) is a determinant of patient outcomes, whereby nurse managers play a crucial part in coordinating patient care and ensuring safety. Nurse managers are promoted through performance appraisals and held accountable for all patient care related issues and management responsibilities (Armstrong et al 2015:2). As per Armstrong and Rispel (2015:2) there is a discourse in nurse education which influences quality patient care. With the

	available in the facility, other possibilities should be made available to deserving nurses (based on years' experience, overall performance and appraisals) (professional development as gathered during Phase 1 of the study).		misdistribution and weak leadership in healthcare settings the system needs to improve (Armstrong & Rispel 2015:2).
10	Expatriate nurses must have the opportunity to talk or interview previous expatriates as to gain first-hand feedback about the social or isolation challenges in the KSA. These sessions should be arranged by the recruitment agency and prepared at least six months prior to departure to KSA as to allow for clarification of concerns Expatriates nurses should do research about the KSA (diversity, traditions, behaviours, geographical layout, temperatures) and social aspects (communication, interaction with other expats and Saudis) in the KSA at least six months prior to departure as to allow for mental and emotional understanding of this	Participants mentioned that they felt like *'strangers in a strange land'*.	Effective communication in the healthcare setting is influenced by the setting and use of specific standardised protocols as well as the interpersonal relationship between nursing staff (Clayton et al 2016:8). Expatriate nurses from multi-cultural backgrounds have their own communication styles and training. Cultural identity includes language skills (Szabo & Ward 2015:13). Kim (2015:4) stated that cross-cultural communication could be inherently stressful as it is a challenge towards previously taken assumptions. Difficulties in communication with members of the healthcare team could lead to adverse outcomes in patient care (Clayton, Isaacs & Ellender 2016:7). Nurses in the KSA, irrespective of the cultural background, communicate in English with one another. Even with English as main communication language it is assumed that nurses are uncomfortable to speak openly about their concerns on patient

	diversity in the KSA.		care. Cultural and language differences could lead to unsafe behaviours when nurses fail to report adverse events. According to Alayed, Lòòf & Johansson (2014:591) within healthcare systems, nurses were satisfied with their jobs in the KSA and had overall positive experiences in the country, but were looking for greater appreciation, improved communication from management, competence development and further educational opportunities (Communication and intercultural contact might enhance cultural adaptation) (Kim 2015:4).
11	The national healthcare government must make immediate provision for more trained and skilled nurses in SA as to improve patient care and improve outcomes.	Lack of remuneration and decrease in quality of patient care in SA was identified by participants (linked to migration pull factors).	

	The healthcare regulatory bodies and healthcare employers must make nursing an attractive job opportunity through provision of favourable healthcare environments (adequate nurse-patient-staffing ratios, financial compensation and benefits when occupations of choice are compared). In the case of limited healthcare staff locally in SA, which is measured annually, the government should consider recruiting trained and qualified nurses from abroad to assist in healthcare settings to assist with patient care, lessen burnout and improve patient outcomes.		
12	Healthcare employers both private and government must appoint enough skilled and trained nurses, limit the number of overtime hours (state regulated) as to prevent burnout and stress of nurses who are forced to work additional hours to deliver patient care. Retention of staff can be controlled by skilled human resource management.	Participants mentioned that they felt like strangers in their own land and could observe the difference between first and third world countries.	According to Lagardé and Blaauw (2016:1) there is a 50% shortage of nurses in SA's public health sector. As per Khamisa, Peltzer, Ilic and Oldenburg (2017:254), South African healthcare systems have staff issues, shortage of staff, which cause higher workloads and affect job satisfaction.

13	Healthcare regulatory bodies should encourage skilled and trained nurses to stay in SA through offer of improved benefits like career promotion opportunities, setting realistic career advancements and achievements, training and development opportunities should be free and ongoing. South African statutory regulations must control migration of skilled nurses out of SA – this can prevent brain-drain and retention of skills within the country where it is needed. The application towards migration should be State regulated and limited according to skills and experience, previous training.	Training and learning (professional growth), gained global exposure and experience and enhancing clinical competence was identified by participants to be more advanced in the KSA.	It is argued that skilled people, like nurses, emigrating from a poor country might reduce the productivity in that country or so called 'brain drain'. African countries experience the largest outflow of nurses and this trend will systematically worsen health conditions in other parts of the country (Khamisa et al 2017:254).
14	Culture shock training (including: causes; signs; and symptoms), proper preparation and induction (regarding aspects related to culture shock) done by the person self (expatriate and the recruitment agency prior to the expatriate departure (at least three months prior) to three KSA (as to limit the degree or level of culture	*'Strangers in a strange land'*: Participants indicated that exposure to different cultures (Saudi's and colleagues from Europe), exposure to different religious practices, language barriers limiting communication,	Some of the participants mentioned that they felt useless when working with other nationalities and not understanding certain terminologies. Most of the participants mentioned that the way they handled their loved ones back in SA, fellow colleagues or even strangers changed dramatically as what they were used to. These changes included impatience, rudeness or even feelings of irritation

	shock). Work groups with other prospective South African expatriate nurses who want to live and work in the KSA (as arranged by the recruitment agency) who experienced culture shock (whilst working and living in the KSA) should be arranged by the recruitment agency (and made available to these prospective expatriate nurses) as to prepare the expatriate nurse prior to departure to the KSA.	dress code and gender segregation caused culture shock.	when explaining events (which made them feel like strangers in their own land). Ways to handle and cope with reversed culture shock include sharing of experiences with others, to be flexible and maintain a basic lifestyle (including eating habits and evolving personality adjustments) and to ask for training and support in repatriation. Effects of reversed culture shock also include criticality towards the home country, marginality when the newly formed identity conflicts with the home' identities, exhaustion when performing additional tasks and fitting back into routines; as well as resistance to change and depression (US Department of State 2016:NP).
15	Prospective South African expatriate nurses should undergo coping skills and resilience workshops (arranged by the recruitment agency) prior to departure (at least weekly intervals for a period of three months) as to prepare them for possible challenges faced (cultural conflicts) and how to handle these challenges (adjustment and adaptation issues) culturally sensitive and effectively.	Survival skills as part of finding your feet as *'strangers in a strange land'* and coping skills.	One of the biggest distortions in the global economy is the binding constraints on emigration from poor or developing countries (Silvestri, Blevins, Afzal, Andrews, Derbew, Kaur, Mipando, Mkony, Mwachaka, Ranjiti &Vermunda 2014:750). There is a gap in literature on migration and adaptation and how adjustment and adaptation issues can be overcome. In this study, the researcher presented a guideline that proposed presenting coping skills workshops to all prospective South African expatriate nurses prior to emigration.

			Often children can be separated from their mother or father and could lead to feelings of insecurity. Normal family structures and daily routines become disruptive and inherent value conflicts could occur.

Annexure N: Guideline (draft 2) scoring during NGT

No	Proposed draft guidelines (draft 2) developed during NGT	Category	Average scoring	Average score received with %
1	International recruitment agencies to facilitate South African expatriate nurses' migration and adaptation to the KSA by creating awareness of push factors from the country of origin and pull factors from the destination country.	Migration Facilitation	P1=5 P2=5 P3=5 P4=5 P5=4 P6=5 P7=4 P8=5 P9=4 P10=4	4.57 = 91%
2	International recruitment agencies to facilitate workshops relevant to migration preparation with the focus on culture shock to all prospective expatriate nurses who apply to work in the KSA prior to migration.	Migration preparation/ Culture shock	P1=4 P2=4 P3=4 P4=4 P5=4 P6=5 P7=4 P8=4 P9=4 P10=4	4.14 = 83%
3	South African healthcare regulatory bodies and nurse education institutions to encourage trans-cultural nursing as a crucial competent in all nurse training programs (as NEIs are responsible to prepare South African trained nurses for the global health market with diverse cultural context; and cultural competent nurse' skills will enhance adaptation into a foreign setting like KSA).	Adaptation through standardisation of nurse training	P1=3 P2=2 P3=3 P4=3 P5=2 P6=2 P7=2 P8=2 P9=2 P10=2	2.7 = 54%
4	South African healthcare regulatory bodies, including: private and public healthcare providers to facilitate South African expatriate nurses' re-	Re-adjustment back into the South African	P1=4 P2=4 P3=5	4.5

	integration back into the South African healthcare environment through mentorship and supportive programs upon return to SA, which will aid in re-adaptation and ultimate re-adjustment of these expats.	context	P4=5 P5=4 P6=5 P7=5 P8=4 P9=5 P10=4	
5	South African healthcare regulatory bodies to advocate to national healthcare government for retainment of skilled and trained staff in SA. Retainment of staff may be achieved through gradual improvement of healthcare systems, offering of annual promotional and developmental opportunities for nurses to remain in SA.	Migration control/ Retainment	P1=4 P2=4 P3=3 P4=4 P5=4 P6=4 P7=4 P8=4 P9=4 P10=4	3.9 = 78%

Annexure O: Proofreading and Editing Declaration

To whom this may concern

I, Zenna Naudé, Proofreader, situated in Pretoria, South Africa, sincerely declare that the Phd dissertation titled: "**Guidelines to facilitate adaptation in South African Expatriate Nurses working in the Kingdom of Saudi Arabia and upon their return to South Africa**" is the original and completed work of Ms Michelle van Bommel submitted to the Department of Health Studies at the University of South Africa.

I declare that:

- I have formatted the dissertation: all grammar, punctuation and capitalisation, references, presentation and layout, editing and proof reading changes have been identified and checked by me.
- All content changes, irregularities and queries have been identified and discussed with the student.
- I have fully read the dissertation.

I further acknowledge that all the information stated in the declaration is true and correct.

Zenna Naudé

Proofreader
(August 2020)

Annexure P: Turnitin Report

GUIDELINES TO FACILITATE ADAPTATION IN SOUTH AFRICAN EXPATRIATE NURSES WORKING IN THE KINGDOM OF SAUDI ARABIA AND UPON THEIR RETURN TO SOUTH AFRICA

by Michelle van Bommel

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