

ANGLIA RUSKIN UNIVERSITY

FACULTY OF HEALTH, EDUCATION, MEDICINE AND SOCIAL CARE

**EXPERIENCES OF NIGERIAN MIGRANT NURSES AND HEALTH CARE
ASSISTANTS OF PEOPLE WITH DEMENTIA IN THE NATIONAL
HEALTH SERVICE**

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**A thesis submitted in partial fulfilment of the requirements for the degree
of
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“No duty is more urgent than giving thanks.” - James Allen

A Vietnamese proverb says that *“When eating fruit, remember the one who planted the tree.”* During my PhD research, I received so much support from start to finish, and although it is difficult to mention everyone who has been of immense help to me, I shall mention a few and hope that those not mentioned will take no offence.

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DEDICATION

To my mom and dad

ANGLIA RUSKIN UNIVERSITY

ABSTRACT

FACULTY OF HEALTH, EDUCATION, MEDICINE AND SOCIAL CARE

DOCTOR OF PHILOSOPHY

EXPERIENCES OF NIGERIAN MIGRANT NURSES AND HEALTH CARE
ASSISTANTS OF PEOPLE WITH DEMENTIA IN THE NATIONAL HEALTH
SERVICE

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December 2020

This study explores the experiences of paid Nigerian migrant health care assistants (HCA) and nurses for people living with dementia (PLWD) in the United Kingdom (UK).

Demographic changes across the UK have resulted in an increasingly ageing population and a significant number of these older people are living with dementia. With changing family and work patterns, many PLWD are now residing in care homes and hospitals, and this has increased the demand for care workers, including migrant care workers.

This qualitative study analysed the experiences of twenty-one Nigerian migrant care workers (HCAs and nurses) working on two different NHS wards caring for PLWD. Informed by hermeneutic interpretive phenomenology (and drawing on the work of Gadamer and van Manen), the researcher utilised in-depth interviews to gain an understanding of the care workers beliefs about dementia, the significance of training and the role of culture in everyday care work for PLWD.

Migrants working in the care sector are often assumed to be poorly educated, however, this study found that my participants were highly educated and majority of them did not migrate to the UK to undertake care work. Also, all the participants found caring for PLWD rewarding as well as challenging. Although the study did not originally aim to examine racial discrimination in the workplace, most of the participants identified racism as one of the more significant challenge in care work. The study highlights the value of training in changing paid Nigerian migrant care workers' traditional/cultural beliefs about dementia and suggests some cultural values that in fact promoted respect for older adults in care settings. The thesis concludes by highlighting the importance of understanding the role of culture and training in professional caregiving.

Key words: caregiving, Nigerian, migrants, dementia, paid care worker, culture, interpretive phenomenology, lived experience.

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TRANSCRIPTION CONVENTIONS

Indented extracts in italic font indicate interview transcripts or direct reference to another author unless otherwise stated.

All interviews were transcribed verbatim.

[...] means that words, phrases or sentence of the extract omitted.

[Descriptive material added to make the context clear and/or meaning clear]

Data have been edited to preserve anonymity.

All names of people are pseudonyms.

LIST OF ABBREVIATION/NOTATION

AARP – American Association of Retire Persons

ADL – Activities of daily living

DLMT - Dual Labour Market Theory

EM – Extrinsic motivation

GDP - Gross Domestic Product

HCA – Health Care Assistant

HTFT – Herzberg Two Factor Theory

IM – Intrinsic motivation

IRAS – Integrated Research Application System

n – Number of participants

NAC – National Alliance for Caregiving

NCOA – National Council on Aging

NHS – National Health Service

ONS – Office for National Statistics

PCF – Participant Consent Form

PIS – Participant Information Sheet

PLWD – People living with dementia

R&D – Research and Development

RCCG – Redeemed Christian Church of God

REC – Research and Ethics Committee

RMN – Registered Mental-Health Nurse

SDT – Self Determination Theory

SLMT - Segmented Labour Market Theory

UK – United Kingdom

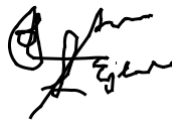
US or USA – United States of America

WHO – World Health Organisation

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I declare that this thesis was composed by myself and that all data were collected and analysed by me, with supervision from academic staff. The work presented in this thesis was done in accordance with the Regulations of Anglia Ruskin University. It is original except where it is indicated by special references in the text. Neither this thesis nor the original work therein has been submitted to this or any other institution for a higher degree either in the United Kingdom or overseas. Any views expressed in this thesis are those of the author and not those of Anglia Ruskin University.

Signature:

A handwritten signature in black ink, appearing to read 'Ojeiu J. Ejere', written in a cursive style.

Ojeiu J. Ejere

Date: 8th of December 2020.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1. Introduction

This is a qualitative study exploring the lived experiences of Nigerian migrant care workers (nurses and health care assistants, HCAs) caring for people living with dementia (PLWD) within the National Health Service (NHS) in the United Kingdom (UK). The research aims to understand the experiences of migrant care workers by examining their motivation to care for PLWD. It also aims to explore their cultural beliefs and perceptions about dementia and whether the identified beliefs or values influenced how they deliver care. This is an essential aspect of the study because all the nurses and HCAs originated from a country where there is limited awareness about dementia (Ferri, Ames and Prince, 2004).

This introductory chapter provides a brief overview of the thesis and begins with a personal reflection of my underlying motivation to undertake this research. The fact that I am Nigerian, and currently work part-time as an HCA for PLWD played a major part in my decision to undertake this research. However, the overarching reasons for conducting this research was the fact that across the UK, health and social care services are reaching a crisis in the recruitment of care workers (Crawford and Read, 2015; UNISON, 2016; Skills for Care, 2018; Dayan *et al.*, 2018). Therefore, understanding cultures of care and experiences of care workers are significant, as migrant care workers are frequently recruited to fill the care support needs across the country.

I begin this chapter with a personal reflection on the dual roles of researcher and care worker and the contextual background to the study relating to dementia and caregiving (discussed in more detail in Sections 1.3). This is followed by an outline of the study and my aims and objectives and finally, an overview of the structure of this thesis, with a summary of each chapter.

1.2. Reflection: my gaze into the study of paid Nigerian migrant nurses and health care assistants in the UK

The research topic and my choice of methodology were informed by my professional background and personal experiences. I originally migrated to the UK to pursue a master's degree. While I was undertaking my studies, I also engaged in part-time jobs through a temporary employment agency which supplied workers to companies in industrial settings. I continued this work until some of my co-students told me about their experiences of working in care homes and they suggested that this work offered greater flexibility that might suit my needs as a student. Although my initial reaction was to dismiss this, after some months, influenced by the lack of regular working hours in the industrial sector, I joined a care agency so I could work as health care assistant (HCA). I began working in care with little awareness of what it meant for someone to live with dementia. Although I had a basic understanding of the pathology-physiology of dementia due to my background in the medical sciences having a Bachelor of Science degree in Human Physiology and a Master's in Public Health.

I initially considered dementia as a condition that only affected people in Europe and North America. However, when I began work as a carer, I noticed that most of my care recipients diagnosed with dementia were not different from some of the older adults that I knew back in Nigeria. Over time, it dawned on me, that dementia was not what I thought it was and that my understanding of the condition might be incorrect. This realisation was the first thing that ignited my interest in dementia as a research area.

A further factor that drew my attention to dementia was the level of publicity the condition received in the UK between 2012 and 2014. During this time, the then UK Prime Minister, David Cameron, launched the Prime Minister's Challenge on Dementia (Department of Health, DoH, 2012) as a follow up to the UK National Dementia Strategy developed in 2009 (DoH, 2009a). Not only was the media coverage of dementia extensive, but also more money was pledged to tackle its increasing prevalence in addition to what was already being spent to care for PLWD. This was surprising to me as an African because having lived in Nigeria, West Africa, it was somewhat unthinkable that such attention was given to what I thought was 'a natural

state' in the human life-course. I recollected how my paternal grandmother who passed at the age of 99 showed signs of mental decline in her later years and how her children often joked that their mother was beginning to behave like a child. I reflected that this was part of a wider cultural belief that child-like behaviour was considered as a natural part of growing old. In contrast, my great maternal grandmother who lived for longer did not experience the same level of cognitive decline as my paternal grandmother and was still able to engage in a coherent conversation with her family before she died in 2002 at the age of 115.

Moreover, it was through my own experiences, combined with my training in public health that I could see that it was vital to explore the experiences and cultural perception of other care workers. I observed that increasing number of Africans (many of them Nigerians) were taking jobs in health and social care, and it became apparent to me that there might be an issue with how they coped with the role (which I personally found demanding). I felt that their willingness to seek help for stress associated with care work might somehow be influenced by their perception of the disease, and so I decided to focus on Nigerian care workers working with PLWD.

Before I decided to study paid Nigerian migrant nurses and health care assistants specifically, I originally planned to conduct a wider study on 'Black African migrants' who were working as family carers. This proposal though met resistance from some cultural groups who were unwilling to lend their support and assist me in recruiting study participants. Many were even upset that I had singled out the Black African community as the subject of my research, while others reminded me of why it would be difficult to recruit participants, considering that, as one gatekeeper puts it, "*most of our African brothers do not consider dementia as a thing common amongst Africans*". "*They*", she continued, "*view it as an illness common with the Whites*". In an attempt to overcome the discouragements, I decided to try snowball sampling, but after trying for over two months to recruit people to my study, I concluded it was necessary to switch focus to paid Nigerian care workers because I already had contact with many.

I conducted a literature search to identify and document gaps in the paid migrant caregiving literature. I discovered that most studies on paid migrant caregiving for

PLWD focused on the experiences of nurses, with little consideration for care workers. This may be because we are often considered to hold a low status within the health care system, even though we are often the frontline staff who maintains constant contact with the people in our care.

Most importantly for my doctoral studies, I found that there was no research that had examined the lived experiences of paid Nigerian migrant nurses and health care assistants caring for PLWD. Thus, this phenomenological research on paid Nigerian migrant nurses and health care assistants emerged out of my personal experience and the need to extend the caregiving research relating to paid care workers.

Consequently, I did not enter the research field as an outsider. Instead, I entered as an insider and approached the study with an 'emic' view. Hence, both the research topic and the way the research was conducted was informed by my background and experience as a Nigerian migrant care worker in the UK. In addition, my choice of interpretive phenomenology used for this study demanded that I would be a part of the process of data generation, and it was clear from reading the literature that my positionality would influence how the data was interpreted.

Prior to recruiting study participants, I had acquaintance with most of the participants in this research, having worked together previously. Clearly, this raised a number of issues in the research process that needed to be addressed (and this is discussed in some detail in the methods section of this thesis (see chapter 6), which also resulted in some rich findings. Because the thesis focuses on care work for PLWD, I thought it would be useful to offer a brief overview of dementia and some of the specific care issues relating to PLWD as this tends to differ from many other forms of care giving (Twigg, 2000a, 2000b).

1.3. Dementia: meaning, risk factors, trends and care needs

1.3.1. Meaning and types of dementia

Dementia refers to a syndrome of cognitive impairment that causes a decline in memory, cognitive abilities and behaviour of an individual, which interferes with their ability to carry out normal daily activities (World Health Organisation, WHO, 2018).

This is often ascribed to a range of symptoms including progressive decline of memory, judgement, thinking, emotional control, social behaviour, relationships as well as motivation, which is associated with gradual brain cell death (Vallet *et al.*, 2016; WHO, 2019). However, people living with dementia may also present with an increase in non-cognitive symptoms, such as aggression, agitation, wandering behaviour and depression (Alzheimer's Association, 2014).

There are many different forms of dementia including Alzheimer's disease, dementia with Lewy bodies, vascular dementia, fronto-temporal dementia, Parkinson's dementia, and many others. Alzheimer's disease is the most common, accounting for about two-thirds of dementia diagnoses (WHO, 2019). In this study of the lived experience of Nigerian migrant nurses and health care assistants caring for PLWD, dementia is used broadly to refer to all kinds of diseases and conditions that develop as a result of the death or dysfunction of nerve cells in the brain, leading to increased need for long-term by care workers.

Although the course and progression of dementia varies widely within and across the different types and there is presently no cure for the condition, current interventions centres on its management, which promotes slowing down the disease progression as well as helping PLWD have good quality of life (Frankish and Horton, 2017; Blank, 2019).

1.3.2. Risk factors for dementia

One of the risk factors in the aetiology of dementia is ageing, but researchers suggest that the risk of developing dementia increases with age, although it does not exclusively affect older adults and it is not an inevitable part of the ageing process (Ganguli *et al.*, 2004; Lopez *et al.*, 2007; Livingston *et al.*, 2017). Other risk factors include mid-life hypertension, cognitive inactivity; diabetes mellitus, physical inactivity, obesity, unbalanced diets, tobacco, and alcohol use as well as social issues, such as mid-life depression, low educational attainment and social isolation (Alzheimer's Association, 2013).

1.3.3. Trends: the social and economic impact of dementia prevalence/incidence in the UK

Globally, the economic cost directly related to dementia is estimated at US\$ 818 billion, which represents 1.1% of global GDP (WHO, 2015a; 2017a; 2017b). Dementia is one of the major public health challenges of the 21st century and in the future, it may have an impact on national economies, causing significant barriers to international economic development (Alzheimer's Disease International, ADI, 2015). In 2018, it was estimated that globally, 50 million people were living with dementia and that figure is projected to reach an approximated 82 million people by 2030 and 152 million people by 2050 (WHO, 2017a; 2017b; 2018). Currently, dementia is estimated to be the second biggest cause of disability for people who are aged 70 years and older, making it the seventh leading cause of death (WHO, 2017b; 2018).

In the UK, about 850,000 people are currently estimated to be living with dementia, costing about £26.3b annually (Prince *et al.*, 2014) and it has been suggested that the number of PLWD would double for each five years increase in age (Brodaty and Donkin, 2009; Jagger *et al.*, 2009). The prevalence and incidence of dementia in people over the age of 65 years is also predicted to rise in the coming decades (ADI, 2015). This prediction was made based on two main factors; increased life expectancy and the measures initiated by the government to improve diagnosis, which means more people live long enough to develop dementia and many more are diagnosed with the disease (Tom *et al.*, 2015). However, according to recent studies, the prevalence and incidence of the disease have seen a decline overall (Matthews *et al.*, 2013; Langa, 2015). Matthews *et al.* (2013) studied dementia prevalence in three geographical areas of England and found there was a decline in the prevalence and incidence in those areas. The decrease in prevalence follows the improvement in the prevention and treatment of heart diseases and an increase in early life education, which has both been shown to reduce the risk of dementia. However, it is notable that Matthews *et al.* (2013) reported a 24% increase of dementia prevalence within care settings (from 56% to 70%), despite the decline in prevalence in the community. This may imply that more people are being taken into formal care setting in the last couple of years and it may also have severe

implications for formal caregiving services, whose workload increases as more people are admitted.

The rise in the number of people taken into care maybe due to the increase in the number of people presenting with early onset dementia (Alzheimer's Association, 2013). Early onset dementia accounts for at least 10% of all cases of dementia (Alzheimer's Association, 2013). Whether dementia occurs in people who are older than 65 years of age or younger (as in early-onset dementia), the symptoms are the same. They may include behaviours such as aggression, restlessness, agitation, wandering, etc. (Turner, 2005), and other personal care needs which make the caregiving process very demanding (Tadros *et al.*, 2013).

1.4. Dementia caregiving and trends

1.4.1. Dementia caregiving

Much of the literature on caregiving tends to focus on unpaid or voluntary care provided by family members or friends. Drentea (2007) described it as the act of supporting family and friends who have physical, psychological, or developmental needs without being paid to do so, however, this description excludes the support provided by parents caring for their children (i.e. parenting) and the care offered by paid care workers. Although Drentea (2007) observed that a parent providing care for an adult child who is sick or terminally ill is caregiving rather than parenting. Meanwhile, some have discussed caregiving considering familial duties or a duty of commitment to an existing relationship. For example, Pearlin *et al.* (1990, p.583), describes caregiving as the behavioural "*expression of one's commitment to the well-being or protection of another person*" and others have highlighted the role of emotion in caring (Romero-Monero *et al.*, 2011). Conversely, other authors suggested that apart from emotional attachment to their relatives, some carers may have different motives for caring (Wallhagen and Yamamoto-Mitani, 2006), and for many women, there is often a cultural expectation that they will undertake the caring role within the family (Chao and Roth, 2000).

Regardless of motivations for caregiving, Twigg (2000a, p.160) suggests that dementia caregiving involves different dynamics from other forms of caregiving as the emotional

work experienced by many dementia carers involved "*both working on and through the feelings of others, with the aim of producing an effect on their emotional state*". Moreover, Twigg (2000a) suggests that caring for PLWD requires one to interact with the person who is often emotionally distressed, and this results in the caregiver becoming emotionally distressed. Later work by Twigg (2010) highlights the significance of 'bodywork' in dementia care, i.e., personal care, and the role of carers in maintaining the personhood of the person living with dementia.

While the lack of an acceptable working definition for caregiving makes it difficult to assess its impact or compare findings from research studies, Hermanns and Mastel-Smith (2012) suggests that caregiving may be simply defined as an act done to support those who cannot do it themselves.

1.4.2. Trends in dementia caregiving in the UK

In the UK, there are estimated to be around 550,000 people in England acting as the primary, family, or informal carers for people with dementia- saving the nation nearly £11 billion every year (Alzheimer's Society, 2014). Managing a chronic condition such as dementia relies on the ability of family members to assume, master, and maintain their caregiving role and they often need to act as an advocate for the person they are caring for, and work with different professionals during the care recipient's journey with the disease. However, as suggested above, caregiving can come at a personal cost to the carers, affecting their physical and mental health which may lead to additional stress on the family and risking social isolation (Langa *et al.*, 2001; Boerner, Schulz and Horowitz, 2004). In addition to the cost on their health, family carers usually bear most of the financial costs of care, especially community care, either through out-of-pocket expenditures or the direct provision of care (Department of Health, 2012). Whilst the prevalence and incidence of the disease have seen a decline overall, there remains a need for institutionalised care, as families can become overwhelmed by the challenges of caring as the condition deteriorates (Matthews *et al.*, 2013).

1.4.3. The profile of a family caregiver

A family caregiver (or simply a carer) maybe under an obligation to care because of the close kinship or emotional bond to the care recipient. They can also by extension include neighbours and friends who are close to the care recipient. Most carers are unpaid and hence are described as unpaid caregivers. Some people in the UK can access the carer's allowance, but older carers may not receive the full carer's allowance and a state pension simultaneously (Her Majesty's Government, 2008; 2010; 2012; Department of Work and Pensions, 2014).

In the literature, family carers are described by several terms including non-professionals or informal carers (Harris, 2010; Kemp *et al.*, 2009). However, Hughes, Locock and Ziebland (2013) suggest that many informal carers do not identify with the term 'carer', as they see their role as a continuation of family relationships while others reject the term and do not see caring as part of their identity.

Consequently, although it is convenient to describe close relatives and friends as a family or informal caregiver providing care for people with dementia, the nature of a typical family caregiver is more complex. For instance, Walker, Pratt and Eddy (1995, p. 402) described the act of caring as one which demands, "*one or more family members [to] give aid or assistance to other family members beyond that required of normal everyday life*", which makes caregiving different from the act of friendship. Research into 'family caregiving' has covered a wide range of issues, for example, Essex and Hong's (2005) work on caregiving burden, Bernard and Guarbaccia (2003) work on strain, Pinquart and Sörensen (2005) on stress, Shaffer, Dooley and Williamson (2007) on aggression, Gallagher-Thompson and Coon (2007) on carer's distress, Cicirelli (1995) on emotional attachment in caregiving, and Pinquart and Sörensen (2005, 2006) on the gender differences in caregiving.

1.4.4. The profile of a formal caregiver

The term 'formal caregivers' includes a wide range of professionals including HCAs or support workers, nurses, social workers, occupational therapist, and doctors, etc.), all of whom provide varying levels of support for PLWD. Of these groups of caregivers, HCAs and nurses are regarded as front-line staff because they are most involved in care for PLWD and form the main body of workers in care homes, residential homes and

specialist acute mental health unit for PLWD (Ball and Pike, 2009). HCAs who are entry-level employees with minimal job qualifications have more direct personal contact with the patients more than nurses (Spilsbury and Meyer, 2004).

Even though the number of HCAs is on the rise, there is little known about the specific number in the workforce, with minimal statistics on how many are caring for PLWD. Johnson *et al.* (2002) reported that the over 300 titles used to describe the role of HCA in the UK adds to the confusion in classifying formal caregivers. However, it appears that in a typical nursing or residential home settings, there are usually more assistant workers than nurses (Buchan and Seccombe 2003), acting to complement qualified nurses in the delivery of care.

Although there are limited demographic statistics on the actual number of care workers for PLWD in the social care setting, analysis of the 2017/2018 National Minimum Data Set for Social Care (NMDS-SC) offers some insight into the gender and age composition of paid care workers. By gender, women accounted for about 82% per cent of all care jobs including nurses and HCA (Skills for Care, 2018). Specifically, the gender composition for both groups of care workers were similar. While 16% of HCAs were men and 84% were women, for nurses, 14% were men and 86% were women. The gender disparity in both groups reflects the persistent stereotypical view that care related jobs are traditionally women's (Twomey and Meadus, 2008), although there are increasing number of men taking up roles in nursing (Bartfay *et al.*, 2010; MacWilliams, Schmidt and Bleich, 2013). Additionally, for the same period, the age profile of care workers in social care shows that 10% of the social care workforce were under 25 years, 67% were between the 25 and 54 years and 24% were over 55 years (Skills for Care, 2018), indicating that three-quarters of social care workers were below 55, which is similar to the 2017/2018 Labour Force Survey statistics for economically active population in the UK (ONS, 2017).

Despite having similar gender and age characteristics, nurses and HCAs are different in terms of their professional skills, qualifications, and regulations. While nurses are trained and are regulated by the Nursing and Midwifery Council (NMC), HCAs do not have a regulatory body, although they are usually offered some form of compulsory

care training before they commence work as HCA or support workers. In this thesis, I used the term, 'care workers' to refer to both HCAs and nurses.

1.5. Background of the study

Caring for PLWD has been the subject of research since the recognition of dementia as a significant health problem and condition affecting the rising aging populations, not only in Europe but across the globe (Rimmer *et al.*, 2005; Wu, Brayne and Matthews, 2015; Wu *et al.*, 2016; Brayne and Miller, 2017). Most research on caregiving has focused on the impact of the role on caregivers, although, much of this literature focuses on family (primary) or informal caregivers (Connell, Janevic and Gallant, 2001; Coen *et al.*, 2002; Chumbler *et al.*, 2003; Butcher *et al.*, 2016).

There is evidence linking dementia caregiving to physical and psychological stress in caregivers, whether carers or care workers (Coen *et al.*, 2002; Zimmerman *et al.*, 2005; Etters, Goodall and Harrison, 2008; Miyamoto, Tachimori and Ito, 2010; Willemse *et al.*, 2014; Barbosa *et al.*, 2015; Chiao, Wu and Hsiao, 2015). Other research suggests that family carers of PLWD develop physical morbidities such as hyperlipidaemia (high levels of lipid or fat), hyperglycaemia (high levels of glucose), poorer immune function, slower wound healing, lower perceived health status and elevated blood pressure (Irwin *et al.*, 1997; Vendhara *et al.*, 1999; Mills *et al.* 2004; Thomson *et al.*, 2004). They have also been found to have psychological morbidities like depression and anxiety (Clyburn, *et al.*, 2000; Bell, Araki and Neumann, 2001; Abreu *et al.*, 2017) which tend to persist even after their loved ones are taken into formal care or dies (Van der Lee *et al.*, 2017; Corey and McCurry, 2018).

These adverse health and psychological impact of dementia caregiving on caregivers raises questions about how best to deal with the situation because family carers form a considerable proportion of caregivers for PLWD (Schulz and Martire, 2004; Alzheimer's Society, 2014). With the increasing prevalence of dementia worldwide, family carers are predicted to increase in number because of the expected rise in health care costs and an overstretched formal healthcare system (Macdonald and Cooper, 2007; Wimo *et al.*, 2013). This might account for the reason family carers have received more attention in the literature than care workers. Moreover, another reason that care

workers may have received less attention compared to family carers might be because they are paid to undertake the role, whereas most family carers do so voluntarily. However, considering that one-third of PLWD live in care homes in the UK (Alzheimer's Association, 2013) and around 70% of care home residents in the UK have dementia or significant memory problems (Alzheimer's Society, 2014), care workers play a vital role in the care of PLWD. Most importantly, care workers often provide care at a time when the condition has deteriorated considerably, and when informal carers are no longer able to cope with the demands of providing care to their relatives or friend with dementia (Seitz, Purandare and Conn, 2010; Helvik *et al.*, 2015). As a result, care workers do face an adverse caregiving burden as the condition deteriorates for their care recipients, and they continue to provide care from when the care recipient is placed in the institution, until they eventually die (or in some cases, are transferred to another institution) (Knopman *et al.*, 1999).

Research also suggests that it is often at the later stages of dementia and as the condition deteriorates that an informal caregiver may contemplate giving up their caregiving role and make the critical decision to take the person living with dementia into institutional care (Knopman *et al.*, 1999; Helvik *et al.*, 2015). It has been hinted that some family carers may also have to contend with 'caregiver's guilt', at this time (Knopman *et al.*, 1999; Helvik *et al.*, 2015). While taking a loved one living with dementia to live in a care home reduces the direct care obligations on family carers, it does not necessarily reduce 'caregiver distress', as this is often transferred to the care workers (Lee-Treweek, 1996; Kim, Young and Berry, 2017).

1.6. The rationale for undertaking this research: why study caregiving among paid Nigerian migrant nurses and health care assistants?

As mentioned above, I was initially inspired to conduct this study due to my own experiences. However, there were also a number of academic reasons, which includes; (i) the paucity of literature on the experiences of migrant care workers in general and Nigerian migrant care workers in particular, (ii) the increasing number of migrant care workers in the health and social care sector in the UK, (iii) the demographic trends indicating that the older population care needs will potentially increase (vi) the changes

in family structures which mean that many older PLWD will be unable to depend on the family to meet their care needs.

Although there have been a few studies on migrant care workers (Aboderin, 2007; McGregor 2007; Dyer, McDowell and Batnitzky, 2008; Hussein, Stevens and Manthorpe, 2011), this is the first study in the UK to specifically examine the lived experience of paid Nigerian migrant nurses and health care assistants working in the NHS. My study also examines the impact of cultural beliefs and understanding of dementia and the influences of these dynamics on everyday care for people with dementia.

1.7. Research question

What are the lived experiences of paid Nigerian migrant nurses and HCAs of PLWD in the UK?

1.8. Research aim

The main aim of this study is to explore and gain an increased understanding of the lived experiences of paid Nigerian migrant nurses and HCAs of PLWD in the UK.

1.9. Research objectives

To achieve the aim of the study, and answer the research question, the research objectives include to:

- ❖ examine what motivates Nigerian migrant nurses and HCA to assume and remain in their role of caring for PLWD.
- ❖ understand how Nigerian migrant HCAs and nurses coped with the challenges associated with caring for PLWD and the coping strategies they employed.
- ❖ identify what common cultural beliefs about dementia are held by Nigerian migrant HCAs and nurses and examine how the identified cultural beliefs/values influence their care for PLWD.

- ❖ explore how the participants' cultural beliefs and values shape their overall experience of dementia caregiving.

1.10. Thesis Structure

The thesis is structured into eleven chapters (this first chapter presented the context of the research offering an introduction and background to the study). Chapters 2, 3 and 4 review the literature relevant to support this thesis.

Chapter 2 examines theories of international migration and the factors that drive the employment of migrant workers in the care sector. This is followed by *Chapter 3*, with an exploration of what motivates people to assume and continue in their role as care workers, with emphasis on motivation. I also looked at some of the debates in motivation theories in relation to care work, concluding with consideration of the positive aspects or rewards of caregiving with a focus on all forms of paid care jobs. The focus of *Chapter 4* is dementia as a condition and the concept of caring for PLWD, with discussion of the positive aspects of caregiving and some of the different challenges that care workers face when caring for PLWD. Finally, the chapter examines the cultural/ethnic perspectives to caregiving, reviewing the literature on the differences in perception, beliefs, norms, and values among care workers of different ethnic groups.

Chapter 5 discusses my research methodology and the philosophical assumptions which informed the basis for conducting this phenomenological study. Here, I clarify the ontological, epistemological, and methodological positions underpinning the research question 'What are the lived experiences of paid Nigerian migrant nurses and health care assistants for people with dementia in the UK'? Also, chapter 5 examines phenomenology as the research methodological perspective from which interpretive phenomenology emerges, and it examines the core phenomenological concepts that informed this study.

Chapter 6 presents the research methods comprising the ethical application process, participant recruitment process, the data collection methods, and the approach to data analysis. The ethics application process for the NHS through the Integrated Research Application System (IRAS) and the ethical issues anticipated as well as some of the

challenges encountered while undertaking the research are outlined. I explained how I gained access to the study site and how the research participants were recruited as well as my data collection and analysis. I also highlight some of the challenges encountered in the data collection stage and how they were managed. Chapter 6 concludes with an explanation of my approach to rigour during the data collection and analysis stages.

Chapter 7 is the first of four chapters to present the research finding of this study. It begins by exploring the background of the participants who migrated to the UK from Nigeria and discusses their motivation for migrating to the UK.

Chapter 8 presents and discusses the findings on the motivation and rewards of caring for PLWD and examines the nuances in their motivation to become care workers for PLWD in the UK.

Chapter 9 gives an overview of the lived experiences of paid Nigerian migrant nurses and health care assistants including motivations to become care workers, rewards, and challenges of the role, and how they cope with the challenges identified.

Chapter 10 reveals some of the cultural beliefs and values held by the participants, and how this influenced their caring for people with dementia.

Finally, *Chapter 11* discusses the study findings and the implications of the findings to the wider literature on migrant care workers and conclude with my contribution to knowledge and suggestions for future research.

1.11. Summary

This introductory chapter aims to provide a brief account of my personal reflections on the motivation to undertake this research into the lived experiences of paid Nigerian migrant nurses and health care assistants for PLWD. Having outlined the background of the study, it emphasises the appropriateness of the research in relation to the care sector that is becoming increasingly reliant on migrant labour. It also gives an overview of the significance and contribution that this study makes to the literature on paid migrant caregiving. This is followed by stating the research aims and objectives. Lastly, an outline of the structure of the thesis which includes brief highlights of each

of the chapters. In the next chapter, I undertake a review of existing literature on the global migration of migrant care workers and review the key theories underpinning the movement of migrant labour into the care sector in developed countries like the UK.

CHAPTER TWO

CONCEPTUALISING THE GLOBAL MIGRATION OF CAREWORKERS

2.1. Introduction

The aim of this literature review is to synthesize knowledge from existing literature on the international migration of care workers for people living with dementia (PLWD). Due to the huge volume of international migration and dementia caregiving literature, discussing all existing literature is beyond the scope of this study. Nevertheless, the literature review is organised in a coherent flow to address the main points relevant to this study on the experience of paid Nigerian migrant nurses and health care assistants (HCAs). A detail of the literature review process comprising of the literature search strategy, key words or search terms used and the scope of the review is in Appendix 2.1.

The entire literature review consists of three chapters. This chapter is the first of the three and it considers some of the dominant theories of international migration and the factors that tend to drive the employment of migrant workers into the institutional care settings in developed countries. To establish the context for understanding the experiences of paid Nigerian migrant care workers for PLWD in the United Kingdom (UK), some of the theories concerning global migration are also discussed. The next chapter explores the motivation of nurses and HCAs caring for PLWD. Chapter four, examines the impact of caring and the different cultural/ethnic perspectives to caregiving.

Historically, human migration has been a subject of interest to scholars for a very long time (Klein, 2009; King and Skeldon, 2010; Piguet, 2012; Petraglia and Groucutt, 2017), and has always been and remains politically and economically contentious as it continues to dominate social debates today (Rettberg and Gajjala, 2016; Smith, 2016).

Recent debates around the concept of global migration have often focused on some of the most divisive aspects of migration, such as issues concerning economic migrants leaving economically deprived countries to look for new opportunities in relatively wealthy countries and the migration of people fleeing conflict and seeking asylum (KhosraviNik, 2010). These narratives have regularly been seized on by right-wing-

leaning media and has been cited as one of the factors that have fuelled nationalism in the last decade (Musolf, 2015), even though some scholars have also emphasised the benefit of migration to the economy of the destination countries (Bansak, Simpson and Zavodny, 2015; Simpson, 2017). However, because the migration of humans as a subject is broad, it is not within the scope of this review to consider all theories of human migration. Instead, this chapter focuses on some of the dominant ideas in international migration theories and some of the factors that influence the demand for migrant care workers. Hence, it is essential to start by highlighting the types and scale of international migration.

2.2. International migration: types and trend

2.2.1. Types of international migration

International migration can be described as the movement of people across international borders, leading to a temporary or permanent settlement (Borjas, 2001; Bartram, Poros and Monforte, 2014). It has received substantial research attention over the years with migration patterns taking on different forms in the UK, Europe and across the world (Arango, 2000; Castles, 2010). Typically, international migration has been classified in oppositional categories as either forced (involuntary) or voluntary, legal or illegal, skilled or unskilled and temporary or permanent (Richmond, 1993; Fussell, 2012; Castle, De Haas and Miller, 2014), depending on the structural constraints involved. For instance, within the context of international migration, forced migration can be described as an involuntary act of migration, characterised by an element of coercion in the movement of people from one country to another (International Organisation for Migration, IOM, 2011). On the contrary, voluntary migration is one in which the migrant (the individual undertaking migration) exercises some level of volition in deciding whether to migrate (Castles and Miller, 2003; Ottonelli and Torresi, 2013).

Although historically the literature on migration (Peterson, 1958; Willis, 1974) has viewed these different categories as two opposing classes of migration, in more recent years much of the literature suggests that the distinction between these two categories has blurred (Turton, 2003; Erdal and Oeppen, 2018). Turton (2003) observed that the form of migration that is often described as ‘voluntary’ is frequently beset by

constraints (for example, limited options of possible place to migrate to), while forced migration might also include some element of agency (making the decision to go as the individual must have to leave). Richmond (1988; 1993) noted that forced and voluntary migrations are two sides of a continuum, with many migrants falling in the middle of the continuum.

Bearing this in mind, this review of the literature on global migration of workers and the relevant theories centre on debates concerning the economic aspects of voluntary migration because this study is on Nigerian migrants who came to the UK voluntarily. However, like Bartram, Poros and Monforte (2014) noted, reference is made to the other aspects of international migration (such as geographical, political, social, economic, and cultural aspects) where necessary.

2.2.2. The trend of international migration

The latest figures on international migration by the United Nations Department of Economic and Social Affairs (UN DESA, 2015a; 2017; 2019), shows that in 2019, the number of people living in a country other than their country of birth was an estimated 272 million (UN DESA, 2019). This represented 3.5% of the global population in 2019 which was up from the 258 million (3.4% of world population) recorded in 2017 (UN DESA, 2017), and it is a significant increase from the 153 million (2.9% of world population) and 173 million (2.8% of world population) recorded in 1990 and 2000 respectively (UN DESA, 1998, 2008, 2015a, 2015b; 2017; 2019).

In terms of the geographical migratory flow, a breakdown of the most recent figure shows that in 2019, more than half of international migrants resided in Europe and North America. Of the 272 million people living outside their place of birth, 82 million resided in Europe while 59 million resided in North America (UN DESA, 2019). This increasing trend in voluntary international migration is often attributed to increasing globalisation which has led to an increased demand for migrant labour in developed countries (Stalker, 2000; Czaika and de Haas, 2013). The influence of globalisation coupled with some demographic factors in the destination or receiving country (which are discussed later in this chapter) has also been suggested to contribute to the increased demand for migrant labour (Browne and Braun, 2008; Aleshkovski, 2016).

In addition, although the UN DESA's figures for international migration comprises of both voluntary and forced migration, a report for the McKinsey Global Institute, by Woetzel *et al.* (2016) estimated that in 2015, about 90% of international migrants were largely voluntary migrants who migrated mainly for economic reasons while only 10% of international migrants constitutes those who can be described as forced migrants. However, the UN DESA estimates do not include figures for illegal migration, which different reports put at between 10-15% of the total number of international migrants (Aleshkovski, 2016). Thus, the type and scale of international migration are extensive, and in the next section, I shall consider some of the debates concerning the voluntary migration of workers to the UK.

2.3. Migrant workers in the UK

2.3.1. The trend in labour migration to the UK since the 1940s in brief

The migration of workers to the UK since the 1940s is well documented (Peach, 1968, 1991; Goulbourne, 2009). To highlight this in brief, I shall discuss two of the most recent waves of post-World War II migration, namely;

- (i) Wave one which occurred immediately after the end of World War II (including the migration of people from Commonwealth countries to the UK from 1948 and 1973), and;
- (ii) Wave two that covers the most recent migration of people from Europe following the 2004 expansion of the European Union, EU (Garapich, 2008; Holland *et al.*, 2011).

Although other changes such as a cap on migrants from non-European Economic Area countries has occurred post the 2004 expansion, the above two waves mark a significant highlights of migration into the UK.

Wave One - post World War II: Following the end of the Second World War, there was a need to rebuild the infrastructure in the UK which necessitated the use of migrant labour, with many of them actively recruited from the Commonwealth nations (Goulbourne, 2009). At this time citizens from the Commonwealth had a British passport and were considered to be British citizens. However, the 1962 Commonwealth

Immigration Act (amended in 1971) (House of Common, 1962; 1971), made migration to the UK much more restrictive and monitored by putting an end to the universal Commonwealth citizenship which in some sense could be seen as a final acceptance to the end of the British Empire (Consterdine, 2017). Consequently, migration from many of the Commonwealth countries which peaked in the 1960s had by 1973 effectively come to an end. Although in the years that followed the recruitment of migrant workers continued, it was mainly through the direct recruitment of workers mostly from Commonwealth countries (Buchan *et al.*, 2005). It is important to note that Nigeria, being part of the Commonwealth during this wave of migration into the UK, was subject to the same migratory rules that applied to the Commonwealth at the time (Slaven and Boswell, 2019).

Wave Two - more recent migration: Apart from migration from the Commonwealth, the UK also has a history of migration from the rest of Europe, particularly Eastern Europe. The most recent wave of European migration to the UK occurred in 2004 after the expansion of the EU, with over 1.4 million people from Eastern Europe migrating to the UK in the space of 5 years (James and Karmowska, 2012). This was due in part to the UK's decision (along with Sweden and Ireland), to allow unrestricted permission of residence and work to citizens from the EU A8 Ascension countries.

While migrants have not always been made welcome in the UK (Green and Hogarth, 2017), it can be argued that people who migrated to the UK in these two waves of migration were mostly of the working age (Ruiz and Vargas-Silva, 2018). They offered the UK the much-needed workforce at the time and contributed to the national economy (London School of Economic and Political Science, LSE, 2007). Also, it might be suggested that their demographic characteristics support their suitability for employment (Migration Observatory, 2016).

2.3.2. Demographic characteristics: age and gender

Although migrants in the UK are a diverse group, typically, they arrive the UK as young adults (Office for National Statistics, ONS, 2016), with the Labour Force Survey indicating that about one-third of foreign-born migrants living in the UK are under the age of 30 (ONS, 2016). Notably, the 2011 UK Census suggests that approximately 83%

of foreign-born migrants in the UK were under the age of 35 years (ONS, 2016), while another research suggests that half of those people who arrived in recent years have been under the age of 25 (Markaki, 2015). Estimates indicate that in 2016, about 17.9% of the UK working-age population were migrants, up from 8.2% in 1995 (Wadsworth, 2017).

The gender composition of international migrants globally shows that about 47.9% are females, but it ranged between 43.4% in the less developed regions to 51.5% in more developed regions (UN DESA, 2019). This is similar to statistics in the UK which shows that in 2018, 52% of migrants in the UK were women (Migration Observatory, 2019; Sturge, 2020). Although the gender representation in the UK workforce is evenly divided, there is a significant imbalance in the gender composition with reference to migrant workers in the social care sector (Ashcroft, 2014; Learner and Nazarko, 2014). The traditional characteristic of care being a gendered work or profession is also reflected in the number of men working in the care sector in comparison to women. Although women have dominated the sector for a long time, recent statistics shows the proportion of men taking up work in care is rising particularly amongst migrants with 31% of male migrants working in care, compared to just 13% of UK-born men working in care (Hussein *et al.*, 2014).

2.3.3. Educational background

Because the current study looked at the background of the migrant workers who participated in the study, I thought it would also be useful to take a brief look at the data on the academic qualification of migrant workers in the UK. National census figures indicate that more than half (57%) of EU migrant workers and 52% migrant workers from outside the EU had a degree (ONS, 2016), compared to just one-third (33%) of UK-born workers who had a degree or equivalent qualifications. Migrant workers, both men and women, showed more educational attainment than UK-born counterparts with recent figures showing that nearly one in two migrants were in the highest educational category compared to one in three UK-born workers (General Social Care Council, GSCC, 2010; Rienzo, 2018).

However, researches suggest that high educational attainment does not give migrant workers any advantage concerning the kind of job in which they are employed (Battu and Sloane, 2004; Lindley, 2006; Leuven and Oosterbeek, 2011; Baert *et al.*, 2013). Migrants with high educational achievements often end up doing an unskilled or a low-skilled job, such as working as a care worker, which does not require high professional qualification (Gospel and Lewis, 2011; Gospel, 2015). While the sections above have highlighted some of the characteristics of people who migrate to the UK, in the following section, an overview of some of the theoretical models that seek to explain why people migrate will be explored.

2.4. Migration theories

Although there are a wide range of theories that seek to explain why people migrate, some of the dominant theories are the ‘neoclassical theory’, the ‘push-pull theory’, ‘push-pull-moor framework’, the ‘new economic labour migration theory’, the ‘family migration theory’ and ‘family network theory’ (Massey *et al.*, 1993; Arango, 2004). However, as Massey *et al.* (1993, p.432) points out:

“Current patterns and trends in immigration, however, suggest that a full understanding of contemporary migratory processes will not be achieved by relying on the tools of one discipline alone, or by focusing on a single level of analysis. Rather, their complex, multifaceted nature requires a sophisticated theory that incorporates a variety of perspectives, levels, and assumptions.”

It therefore follows that to understand the complexity of migration, a cross-disciplinary approach involving the economic, sociological, psychological, as well as gender perspectives would be useful. Merging these perspectives involves recognising their strengths and acknowledging their weaknesses in explaining the global migration of care workers in general and the migration of care worker to the UK. In the following sections, I offer a short overview of these theories to establish the context for my study.

2.4.1. Neoclassical Theory

The neoclassical theory of migration is one of the oldest theories of migration. First proposed by Smith (1776) and later Ravenstein (1889), it developed as an economic

theory of migration. The neoclassical theory examines international migration using fundamental economic principles of demand and supply to explain individual-level motivation to migrate. The theory holds that migration is a process that consists of individual actors who assess the opportunities available to them (that is in their home country) and weigh it against the opportunities that are available in a different place (Piché and Dutreuilh, 2013). It was developed in the era of the industrial revolution when economies were rapidly moving from an agricultural-based economy to an industrial-powered economy. Hence it considers migration as a means through which an agricultural-based economy exports its surplus labour to a more industrial economy to benefit from the economic growth that might follow. Also, the neoclassical theory is a micro, individual-level theory and it emphasises the individual's sole intention to migrate. It particularly stresses the decision to migrate as being solely an individual choice of whether one should or should not migrate. As an approach, it supposes that an individual weigh the opportunities available in the sending and receiving countries against each other to reach a decision (Boswell, 2008). The idea thus created is one derived solely from economics, with key areas being demand, supply, and individual wants and preferences.

Later theorists advancing this approach tended to state the importance of 'push and pull' factors and a cost-benefit analysis of migration, suggesting that people only migrate when the benefits that are to be derived from the destination country outweigh those of the sending country. Massey *et al.* (1993) further suggested that this only happens if in the destination countries, employment is better, living conditions are improved, and wages offered are higher. For example, within this approach, it is suggested that regions with a shortage of labour relative to capital, have high wages, whereas regions with an abundant supply of labour relative to the endowment of capital have low wages (Massey, 2015). Therefore, this theoretical approach often highlights that it is this wage differential that causes a migration flow from low wage to high wage regions. The perceived benefits of higher wages and more opportunities in terms of employment in the country of destination stimulates people to migrate internationally (Bauer and Zimmermann, 1999).

However, while the neoclassical theory and pull-push theories may be useful in contributing to an understanding why individuals may choose to migrate, as a theoretical approach they fail to answer some key questions relating to wages and equality. They assume that wages in the sending country are lower than those in the receiving country and that migrants get an equal opportunity to wage and work in the receiving country. For example, Harris and Todaro (1970) deviated from the neoclassical assumption of full employment and looked somewhat at the probability of employment in the country of destination. In their analysis of rural to urban migration, they explain that for an individual to find a high paying job, they have to migrate from a rural area to urban areas.

The neoclassical theory also fails to consider the governing policies and legislations in the destination countries and does not consider possible ‘illegal’ migrants (Dustmann and Görlach, 2016). In addition, it does not address some of the complexity of individual situations and characteristics relating to race, class, ethnicity or gender. Therefore, while neoclassical theory considers migration as a product of the geographical imbalance of demand and supply that exist in developed and developing or underdeveloped economies, as a theory it seems to suggest that migrants are a homogeneous group, and this is not true.

2.4.2. The New Economics of Labour Migration Theory

The new economics of labour migration (NELM) theory explains the reason people migrate in terms of economic differences between two countries. It suggests that global migration of labour cannot be explained only by an individual’s reason to migrate but also by the broader social group to which they belong. For example, Stark (1991) suggests that the theory challenges some of the assumptions of the neoclassical approach by offering a new level of analysis and different nature of migration determinants as it shifted the focus of migration research from individual independence to mutual interdependence.

The key argument in this theory is that individuals do not make migratory decisions in isolation. Instead, they do so with their families and households, influenced by a

comprehensive set of factors shaped by conditions in the home country (Christensen, Hussein and Ismail, 2017). The theory explains a family's or household's response to both income risks and the failures of relevant markets (labour, credit and insurance markets) (De Haas, 2010). As an approach, it holds the view that migration will improve the income source diversification and differences in income risk profile with remittance seen as a steady source of income for the family left in the country of origin (remittances are sums of money sent to family members or other relatives or friends in their country of origin) (Christensen, Hussein and Ismail, 2017).

The NELM theory suggests that due to a lack of livelihood, risk insurance and limited or no access to credit, families often make the decision to support an individual within the family unit (for example an older child, or a father or a mother) to migrate abroad, so that remittance can be sent home to support the other family members. It is argued that this family strategy approach acts as 'risk insurance' for non-migrating family members (Stark, 1991). It views migration as a response not only to wage differentials between countries but also relative deprivation, that puts the sending and destination countries in different economic class. The NELM theory has been criticised for suggesting that remittances might be the purpose of migration for all families and that people may pursue migration for different reasons, however, it is suggested that migrants might not always want, or be able to send remittances back to their country of origin.

2.4.3. Dual Labour Market Theory

The Dual Labour Market Theory (DLMT), also known as the Segmented Labour Market Theory (SLMT), is one of the macroeconomic theories of migration which shows the significance of institutional factors in entrenching segmentation in the labour market (Castle and Miller, 2009). It is based on Piore's (1979) work on migrant labour in industrial societies, which suggest that the economic structure of developed countries makes it reliant on the influx of migrant labour and consequently leads to high rate of international migration. The theory whose diagrammatic representation is shown in Figure 2.1, works with the underlying assumption that there are two separate sectors of the economy in developed countries; the primary and the secondary sectors, where the

primary sector consist of high wage capital-intensive jobs and the secondary sector consist of the low-wage labour-intensive jobs. In the primary sector, skilled workers are required in responsible career jobs and employers invest in training the workforce to possess the technical know-how of the job whereas the secondary sector includes menial jobs requiring little skills and with no prospect of advancing career within the sector (Bulow and Summers, 1986; Massey *et al.*, 1993).

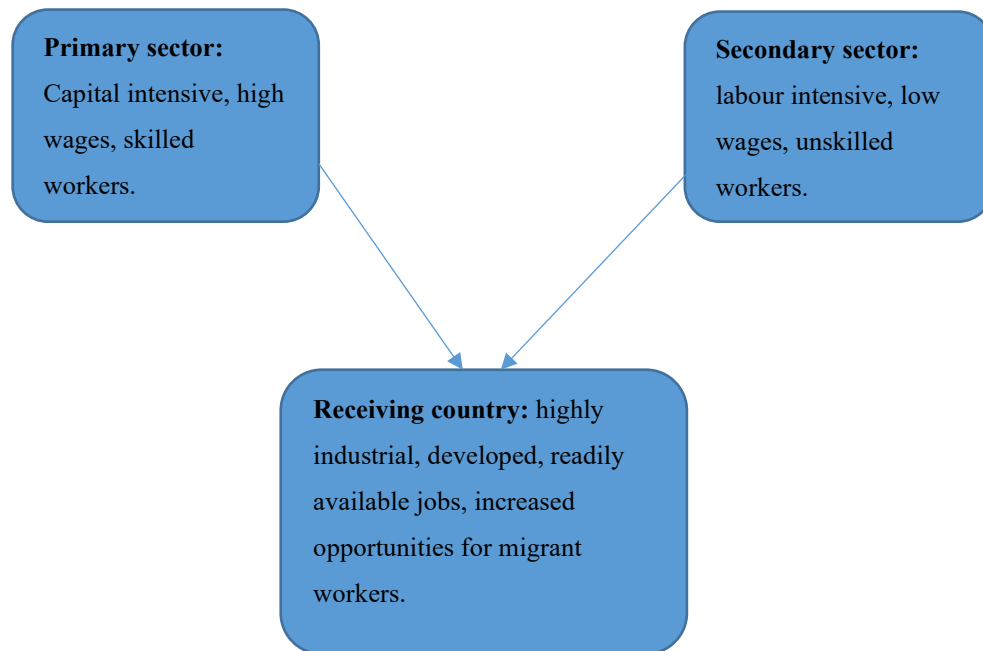


Figure 2.1: Explanatory model for the dual labour market theory (Adapted from Bulow and Summers, 1986, p.13)

The overarching significance of the DLMT to international migration is the nature of the ‘developed economy’ which supports international migration often arising from the needs created by the secondary job market sector in receiving countries. In describing the nature of the developed economy secondary job sector, Piore (1979) points to four characteristics in the receiving countries that makes the migration of workers possible. Firstly, the nature of jobs available in the secondary sector usually require relatively less formal skills, are unattractive in social status, have poorer working conditions and limited opportunities for workers to advance to a high-wage job. Secondly, the availability of jobs in the sector due to the high turnover of workers makes it a readily accessible job for migrants. Thirdly, the model assumes that there is a constant supply

of labour (in the developed economy), making it easy to initiate new source of cheap labour and lastly, the DLMT highlights that there can be a difficulty in halting migration once it has begun.

The DLMT has a similarity to the Marxian concept of the ‘reserve army of labour’, which suggests that employers in industrialised capitalist countries aim to have a constant supply of cheap labour and Marx (1947) argued that it is the supply of labour that determines wages. When supply is low, there is an increase in wages, but when supply is high, wages are kept low. Within this theoretical model, migrant labour is presented as a pool of labour to counter any labour shortages. For example, the influx of migrants from the Caribbean and other Common Wealth countries into Britain after the Second World War was used to help to rebuild Britain (McDowell, 2013) when the UK government took advantage of the vast pool of cheap labour from countries that it had previously colonized (which could easily be dispensed with when there was an over-supply) (McDowell, 2013).

The core strength of this theoretical approach is that it presents a wider understanding of labour markets and its influence on macro-level migration (rather than simply focusing on the individual as suggested by the new economics of labour migration theory). However, therein also lies its main drawback, which is the failure to distinguish between the different social, economic and political conditions that are present in sending countries, which may or may not motivate migration, regardless of the labour market conditions in the receiving societies.

Another fundamental criticism of the DLMT is that it ignores the rational decisions migrants make in deciding whether to migrate. What the theory does best is to highlight the structural demand for low-skilled workers that indigenous workers in developed countries are unable to fill, thereby prompting the inevitable demand for migrant workers (Massey, 1999). Unlike the neoclassical theory which considers migration as a product of the geographical imbalance of demand and supply that exist in developed and developing or underdeveloped economies, the DLMT concerns itself with the demand and supply dynamics in the developed countries, which fosters migration from developing economies. This is not entirely consistent with the neoclassical theory’s

view that individual makes the decision to migrate if they believe it will bring them positive return and the new economics of labour migration theory's notion that the decision to migrate is made by a collective group seeking to maximise the expected income from an individual within the group.

Hence, the theory is mostly criticised for ignoring the individual reasons and motivations for migration addressed by the neo-classical microeconomic and new economics of labour migration theories. The former views migration as the result of a geographical imbalance between demand and supply of labour. Individuals choose to migrate when they believe that migration will bring them a positive net return. The latter theory states that the decision to migrate is not only made by individuals, but by those within larger units of interrelated people like families or households, and that people cooperate to maximise expected income (Massey, 2001).

However, the SLMT does not state or deny that workers make rational, self-interested decisions like microeconomic theories predicts, instead, it demonstrates how structural demands for bottom level workers and limited native supply of such workers created an underlying demand for migrants in developed countries (Massey, 1999). The underlying premise of the theory is that in advanced capitalist economies, there are employment segments often crudely defined as primary and secondary employment sector. It asserts that there exists a social divide between high-wage, high esteem, capital-intensive primary sector jobs and Massey *et al.* (1993) suggest that employers invest in the training and education of workers at this level. In contrast, DLMT suggests that there are also low-wage, low prestige, labour-intensive secondary sector jobs. Moreover, the most desirable jobs are within the primary sector, yet often these jobs are not open to migrant workers.

2.4.4. World System Theory

The world systems theory brings a different perspective to the concept of global migration. It takes the view that the entire world is a single capitalist system where poorer and developing nations which constitute the periphery nations serve as a source of cheap labour to richer nations which constitute the core nations (Babones, 2006). Developed by Immanuel Wallerstein, the world systems theory takes its root from

addressing the criticism of the dependency theory which explains the place of more impoverished nations in a neo-colonial world (Frank, 1966; Wallerstein, 1974). The dependency theory considers poorer countries dependent on richer countries both politically and economically, and it is one of the theories that form the basis for the critiques of global capitalism (Agbebi and Virtanen, 2018).

World systems theory takes both a global and critical view that migration is a product of global capitalism, relying on Marxist political and economic perspectives of the unequal global distribution of political and economic power and resources. Hence, in relation to the global migration of workers from poorer countries to richer countries, the world system theory explains the mass labour migration from the global south (poorer countries in the southern hemisphere) to the global north (richer countries in the northern hemisphere) with the migratory trend being a continuation of colonial relations and control. Moreover, from this viewpoint, migration occurs as a feature that perpetuates a 'one world system', characterised by uneven development and an international division of labour (Sassen, 1988). As an approach, it argues that global migration follows the relationship created in the global stage, where capitalist countries in Western Europe and North America (core countries) form an economic relationship with both semi-peripheral (developing countries) and peripheral (underdeveloped) countries.

Apart from global migration being considered as a 'natural' consequence of the global capitalist market, the world systems theory also postulates that the flow of global labour migration and the flow of goods and capital also occurs in the opposite direction (Massey *et al.*, 1993). To put this into perspective, when people migrate from a labour surplus but capital scarce and economically deprived areas to labour scarce capitalist countries, capital flows into the capital scarce areas in the form of remittances (Kurekova, 2011). The world system theory suggests that the demand for unskilled labour is high in capitalist countries (Sassen, 1988), which is similar to the dual labour market theory. The world systems theory argues that wealthy core countries have a high need for low skilled labour, and due to the natives' lack of desire to take up low-skilled jobs and the apparent willingness for a migrant to take the jobs, it favours the global migration of migrants.

Furthermore, as Sassen (2001) discussed, the dynamics of global cities are seen as a product of globalisation. These global cities find themselves at the centre of all economic activity where high-powered firms are present and far-reaching decisions are made based on finance and administration. In these cities, skilled workers who are native to the core countries usually fill the positions offered by these firms. However, within this theoretical approach, it is argued that there is a strong pull for migrant workers to move to these highly developed countries of the world to fill the low-skilled, low-status jobs (Sassen, 1996; Sanderson *et al.*, 2015; Palát, 2017). This is due to the structural economic changes that ensue, which leads to the increasing demand for cheap migrant labour. For instance, a boom in the financial, media and technological sectors in the global cities of the core countries causes an influx of highly educated/high income, international finance/technology/creative workers, who need cheap labour (such as child-minders, domestics, caterers, etc.) to service their needs (Likic-Brboric, Slavnic and Woolfson, 2013; Van Hear, Bakewell and Long, 2018).

The world systems theory begins to explain the international movement of people across borders in terms of the developmental processes involved in the relationship between the capitalist countries and those belonging to the developing world. This relationship is understood to impact on the economy, politics and culture with the different economies. Within these confines, world systems theory explains the movement of labour. Different to the neoclassical theory, world systems theory offers a better understanding of migration from less developed nations to countries of the global North. It also takes into consideration factors relating to colonisation and the history of these regions, and it convincingly adds to the understanding of networks created and relationships formed through the integration of the world's economy. It acknowledges the vulnerability of immigrant workers and takes into consideration their status upon entering a new country and seeking employment. The relevance of the world systems theory to global migration is that while individual-level theories of global migration neglect the role of the state and other historical factors, the world system theory emphasises the role of historical and structural factors and underplays the role of the individual motives to migrate. This is a drawback which stands as one of the criticisms of the theory because it considers individuals who migrate as minor actors

in the structures of global capitalism, ignoring the complexity of individual migration (Shannon 1989; Arango, 2004; Castles and Miller, 2009).

The theory also highlights the historical relationship between colonialism and the importance of colonial states in mass migratory flow as well as the unequal economic and political relationship between hitherto colonies and their colonial powers (Faist, 2010). As a structural theory, the world systems theory explains global migration of migrant labour in terms of the neo-colonial developmental relationship between colonial powers, who are now capitalist and the developing countries (their previous colonies). Furthermore, this neo-colonial developmental relationship can be explained by the process referred to as structuration (Giddens, 1984; Goss *et al.*, 1995; Wolfel, 2002), where former colonial powers (developed countries) try to maintain pre-independent political and economic disequilibrium with developing countries, using whatever hegemonic power and advantage they have as leverage (Arango, 2004). It might be suggested that within the confines of this unequal relationship, the world systems theory explains the transition of migrant labour better than the neoclassical theory because it takes into consideration the colonial history of the developing states. In addition, it highlights the disadvantages that migrant workers face upon arrival in the destination countries and the challenges they face while seeking employment.

However, as stated, one of the drawbacks to the world systems theory in the understanding of mass migration of labour is its failure to highlight the role of personal characteristics such as gender in migration (Castles and Miller, 2009). As such, it tends to overlook issues such as female migration and does not account for long-term labour migration or chain migration (a phenomenon where the migration of a family member leads to others migrating). This is essential considering the dominance of female migrant labour in the literature relating to migrant care workers (Romero, 2012; King-Dejardin, 2019).

Another drawback to the world systems theory is the apparent failure to explain why some people choose to migrate and others do not. It does not consider the role of individual choices in the migratory decision but assumes that people from peripheral (developing) countries migrate solely for work. World systems theory has also been

critiqued for simply reducing capitalism to commercial relations, instead of the broad aspects of culture and identity which include ‘social relations, property patterns, ideologies’ as well as political institutions (Gonzalez and Fernandez, 2003, p. 48).

2.5. Factors influencing the global demand for migrant care workers

While the section above outlined some of the theoretical explanations why people migrate, this section specifically focuses on some of the factors that influences the global demand for migrant care workers. In addition to the increased prevalence of dementia (discussed in Section 1.3.3), different reasons have been identified in the literature which accounts for the increased demand for migrant care workers over the last decade. They include, the changing demographics, changing family structures, changing gender roles and the low and unattractive nature of paid care work. These reasons are discussed in further details below.

2.5.1. Changing demographics

World population is ageing as people are living longer, although a significant difference in life expectancy remains between developed and developing countries (Hassan *et al.*, 2017), which accounts for the varying cut-off points of ageing across the globe. However, the existing and widely used operational definition of ‘old age’ has emerged mainly from legal cut-off point set for retirement age and professional life in many countries which is not determined by use of objective criteria but is set for the purposes of inquiry and administration. Nevertheless, the World Health Organisation (WHO) and most geriatric studies uses the age of 65 as the cut-off point of when old age does begin in line with its 1972 Scientific Group Report on Psychogeriatrics which adopted the same age limit as the beginning of old age due to impairment in mental and physical functions that increasingly occurs in individuals over that age (WHO, 1972; 2015b).

The 2015 United Nations’ World Population Ageing Report used two main age brackets with reference to global rise in the population of older adults; those over 60 years and those over 80 years (referred to as the ‘oldest old’). The report showed that one in eight people were already aged 60 years or over (HelpAge International, 2015; UN DESA, 2015c; UN DESA, 2015d), which represented 12.3% of the world population. It further

projected that this would increase to 16.4% by 2030 (1 in 6 persons) and 21.3% (1 in 5 persons) of the global population by 2050 (UN DESA, 2015c). Similarly, the population of people aged 80 and over is predicted to increase from 14% in 2015 to >20% in 2050, exceeding 434 million people globally (UN DESA, 2015d). In the UK, the number of persons aged 65 and older continues to grow relative to those in the working ages of 15 to 64 (ONS, 2017). As of 2017 the population of people aged 65 or older was 18.2% of the UK population compared to 15.9% recorded ten years earlier and it is further estimated to increase to 20.7% by 2027 (ONS, 2018).

This increase in the population of older adults both globally and in the UK is partly attributed to an increase in life expectancy and reduced mortality and fertility rates (ONS, 2018). The reduced mortality rate due to advances in medicine means many more people are living longer than in previous decades. Today, life expectancy in the UK is 79.2 years for men and 82.9 years for women but by 2066, it is predicted that life expectancy for men and women will be 86.4 years and 88.9 years respectively, with 44.2% of boys and 50% of girls expected to live above 100 years (ONS, 2018). Together with the decreased mortality rate, there has been a reduction in fertility and combined with the changing structure of the family. In the future, it has been predicted that there will be more people needing long-term care and fewer people available to provide care as family carers, consequently increasing the demand for migrant care workers (Badkar and Manning, 2009). As the population ages, there is increased need for long-term care because of the increased risk of physical and mental impairments.

2.5.2. Change in family structures and caregiving roles

Another factor contributing to the demand for migrant workers is the impact of a change in the traditional family structures and roles which has resulted in older family members requiring institutionalised long-term care (Pickard, 2019). Although this change in structures and role is not a new phenomenon, family arrangement for care has become more complex in the last few decades, leading to an increasing trend of paying for the care provided to older family members with long-term care need (Cancedda, 2001; Atkins, Tumlinson and Dawson, 2017). This trend has been observed not only in Europe but also in North America, as well as in many other industrialised countries in Asia (for

example, Japan and South Korea) (Gamburd, 2000; Hondagneu-Sotelo, 2007; Niimi, 2017). This change in family structure and role is partly due to a rise in individualism (as opposed to the collectivism that often characterises extended families) (Rozario and Rosetti, 2012), a demographic trend in which people live far from their parents or relatives resulting in an increase in the numbers of long distant carers as well as increased demand for paid care (Thompson and Lovestone, 2002; Wolf and Longino, 2005). This adds to the overwhelming social pressures on family members caring for a relative with long-term care needs (Thompson and Lovestone, 2002).

Some researchers seeking to explain the shift to paid care have suggested that a culture of individualism has changed the relationships within families (An, 2018). Individualism is a cultural value that places the needs of a nuclear family or the individual over that of the extended family, with a family dynamic that favours weak relationships among family members, increased autonomy and independence (Hofstede, 2011). In contrast, the cultural value of collectivism considers the need of the extended family as central while those of the individual family members within the collectivist unit are subordinate. This dichotomy between individualism and collectivism has been used previously to categorise how different societies care for their older adults (Rozario and Rosetti, 2012).

It has been suggested that in relatively individualistic societies, such as Western Europe and North America, family members (usually adult children) are less willing to care for their older adults and those who do, often find themselves caring out of necessity (Folbre and Nelson, 2000). It has also been argued that societies that embrace the culture of collectivism are more likely to care for their older adult as a demonstration of intergenerational reciprocity, a show of affection and as a sense of duty or family responsibility (Ar and Karanci, 2017). This is illustrated in a longitudinal study conducted by Lüdecke *et al.* (2018), of unpaid care for older adults in six European countries (Germany, Greece, Italy, Poland, Sweden, and the United Kingdom). They observed that in Germany, Sweden and the UK, older adults cared for by family members were more likely to be put in residential care after a year. In comparison, older adults in relatively collectivist countries (i.e. Italy, Greece and Poland) were more likely to receive care for a more extended period. This is due to the state of the welfare system

in the countries as well as the normative system of family care provision. For instance, among the six countries studied by Lüdecke *et al.* (2018), Sweden has an outstanding structure of healthcare in comparison to say, Greece (Bień *et al.*, 2013). Also in Sweden, many people opt to use the long-term care institution as it is more widely accepted and the obligation to care for extended family members is not as strong as in Greece, where in contrast, there are fewer alternatives to care provided by family members and the moral obligation to care is much more evident and stronger (Alber and Köhler, 2004; Lamura *et al.*, 2008).

Apart from the growing acceptance of institutional care in relatively individualistic societies, an increased human geographical mobility over the years have also contributed to the absence of individuals who would typically be primary caregivers. They are not physically present to provide care to the care recipient (family member, relative or close friend), thereby leading to an increase in long distant caregiving which appears to be higher in individualistic society compared to collectivist society (Hofstede, 2001).

2.5.3. Changing gender roles

The traditional view that the role of a woman and a man in the home is that of a homemaker (charged with domestic responsibilities) and a breadwinner respectively, underwent a radical shift in the twentieth century (Damaske and Frech, 2016) with an increase in the number of women entering the paid labour market to support the family. Although Liggins (2005), Cook (2008) and DeVault (2016) argued that this shift might have occurred before the industrial revolution, it was further exacerbated by the impact of the revolution. In addition, the increased significance of access to education which led to the rise in the number of women engaged in the professional workforce also had a notable influence. With more women in work, roles such as caring for the young and elderly, previously considered exclusively and traditionally as ‘women’s work’ are now increasingly conducted by paid staff (for example nurseries and care workers).

Over the last four decades, the proportion of women in paid employment in the UK has continued to rise. For example, figures from the ONS’ 2018 Labour Force Survey shows that the rate of women aged 25-54 years old in paid employment was 78% in

2017, up from 57% in 1975. The same report also suggests that about 44% of women were in full-time employment in 2018 compared to 29% recorded in 1985 (ONS, 2018). Other factors that have contributed to more women taking up paid employment include having fewer children and delaying childbearing compared to previous decades (McKie and Jyrkinen, 2018). However, it is not only the numbers of women in paid work that is of interest with respect to the increased demand of migrant nurses and HCAs because the social care sector is characterised by extreme occupational gender segregation. This segregation is illustrated by the fact that while men comprise around 54% of the UK economically active population (Self and Zealey 2008), they make up only 16% of those working in social care (Skills for Care, 2007). In some occupations, such as nursery nurses or childminders, the proportion is even smaller (Cameron, 2001; Cameron *et al.*, 2001; Rolfe *et al.*, 2003; Rolfe, 2005).

2.5.4. Low status and unattractive nature of care work

The recruitment of care workers by care institutions and the NHS to provide care for PLWD relatively occurs regularly because of the high turnover of staff attributed to the nature of the role and the low status of the job (Skills for Care, 2019). Generally, jobs in the health and social care sector have been identified as one of the low-paid jobs that UK-born workers are reluctant to take (Duffy, 2011; Van Hooren, 2012; Duffy, Albelda and Hammonds, 2013). This is partly due to the perceived association of the care work role to ‘dirty work’, because of the bodywork (i.e., the physical and personal care of the bodies of others) that is inherent within caring for older adults (Van Iersel *et al.*, 2018; Hussein, 2018) (this is discussed in more detail under the findings of my study in Chapter 9). Moreover, working with older people is often seen to have a lower status than other care work. For example, in a mixed-method study conducted by Rusbridge and Ahmed (2017), the perception of students training to work in the health and social care sector were examined, and the researchers found that students on the health and social care courses considered working with an older adult to be unattractive.

The findings from the study highlighted the apparent lack of interest in care work among young students as one of the factors that contribute to the increasing staff shortage experienced in the social care sector (Moriarty *et al.*, 2009; Van Iersel *et al.*,

2016). This might, in turn, have a far-reaching impact on the number of natives (UK-born citizens) available to work in the sector which invariably leads the care institutions to look for an alternative source to recruit care workers (Aluttis, Bishaw and Frank, 2014). As noted earlier, the pool of migrant willing to work serves as an alternative source to fill the shortage of care workers (Anderson and Ruhs, 2010).

2.6. Summary

This chapter discussed some of the dominant theories that could be used to explain the migration of migrant workers. The chapter also considered some of the demographic changes that have led to the increased demand for care workers. Nevertheless, from the review, no one theory appears to suitably explain migrant care workers motivation to move because of the complexity of migration. The next chapter considers what motivates people to become carers and examines some of the main theories of work migration that might be extended to understand the motivation to assume and continue in the role of caregiving.

CHAPTER THREE

MOTIVATION FOR CAREGIVING

3.1. Introduction

This chapter gives an overview of some of the theories of work motivation and examines their relevance to the motivation of migrants to become care workers in the UK. It concludes with a brief discussion of the influence of culture on motivation to care and a summary of the chapter.

3.2. Defining motivation and the motivation to care

There is a wide-ranging literature on the motivation to work and there are different definitions for the term, 'motivation'. Guay *et al.* (2010, p.712) defined motivation as "*the reasons underlying behavior*", that is, it explains the motive for a behaviour. This notion of behaviour suggests that motivation is a psychological construct (Menninghaus *et al.*, 2015) and suggests that it comprises of "*various factors which incite an individual's actions*" (Atkinson, 1964, p.1), explaining why an individual engages in a particular act (such as the act of caring for someone). Significantly, motivation may arise from inner desire to do a task, or from outside pressures, caused, for example by the expectations placed on an individual to act (Guay *et al.*, 2010).

As suggested above, caregiving in general and caring for PLWD, both paid carers and unpaid care workers may be motivated to provide care for several reasons (Bernard and Guarnaccia, 2003). They may be motivated by intrinsic reasons (such as a sense of love and reciprocity, spiritual fulfilment, responsibility, a feeling of duty or expectation) and extrinsic reasons (such as financial benefits, guilt or social pressures) (Bernard and Guarnaccia, 2003; Brodaty and Donkin, 2009). What distinguishes an unpaid carer from a paid carer (or care worker) is the relationship to the care recipient. Whereas carers are family members and friends, care worker have no filial relationship to the care recipient (Kennedy and Gheera, 2018). In addition, care workers are paid to care whereas family carers are mostly not paid for the care they provide but they get paid in some instance (Department of Health, 1999; Kietzman, Benjamin and Matthias, 2013; Kennedy and Gheera, 2018).

Although most studies on motivation for caregiving has focused on family carers, research suggests that many of the theories applied to family carers may also apply to care workers (Essex and Hong, 2005; Gallagher-Thompson and Coon, 2007) and there is a growing ‘professional’ literature on the role of caring motivation in health and social care (Kietzman, Benjamin and Matthias, 2013). Before discussing different work motivation theories that can be extended to explain caregiving motivation amongst care workers caring for PLWD, it is important to consider what motivation is and how it applies to paid caregiving.

Authors from different fields of studies have developed theories of motivation to care, including social psychology, behavioural sciences, nursing research and economics (Deci and Ryan, 1980; Benson and Dundis, 2003; Moody and Pesut, 2006; De Groot and Steg, 2010; Atkins and Michie, 2013). In reviewing the literature on the motivation, I adopted a broad interdisciplinary approach represented by different theories of motivation. In the next section, these theories are discussed with specific emphasis on their relevance to the motivation to work as a carer or care worker for PLWD.

3.3. Economic, social exchange and needs-based perspectives on work motivation

Because my own study focuses on caring in the context of employment, I will take a brief look at some of the theories that account for general work motivation, although perspectives and work practices have shifted from the 20th to the 21st century. It is notable that many of the theories on work motivation reduced it to financial inducement or material gains (Shafritz, Russell and Borick, 2015), and most have been influenced by Frederick Taylor’s principles of scientific management, otherwise referred to as ‘Taylorism’, developed in the 1880s and 1890s (Shafritz, Russell and Borick, 2015).

3.3.1. Taylorism

Taylorism was designed to increase productivity and efficiency in the manufacturing industry, and it did lead to a direct increase in productivity. However, in order to improve efficiency, Taylor removed the autonomy related to the work of the craftsmen and instead made one craftsman repeat only a particular task in a production line, which consisted of several other small unskilled and simplified tasks (Rahman, 2012;

Ndaguba, 2018). Each worker stayed focused on the given role and gained expertise through the repetition of routine, but they lacked complete knowledge of the whole product output. On his analysis of this process, Taylor assumed that workers were only motivated by self-interest and that they require financial incentives to work effectively, otherwise they are bound to perform below productivity (Shafritz, Russell and Borick, 2015). Taylor espoused that the use of a pay system that rewards (or punishes) workers according to their measured outputs, would result in the highest level of productivity.

Although Taylorism worked to some extent in promoting work efficiency, it overemphasised the role of financial incentives on individual work motivation and much of the literature, which considered it as the sole motivator gave limited attention to the effect of meeting other needs that the workers may have (O'Neill, 2017; Cassar and Meier, 2018). It also placed little value on group productivity, suggesting that *“personal ambition always has been and will remain a more powerful incentive to exertion than a desire for the general welfare”* (Taylor, 1911, p. 95). However, despite these criticisms, Taylorism is still seen in many commercial care settings, for example, within some local authorities in the UK, only 15-minutes care slots are allocated for care workers to provide domiciliary care, a practice that is not necessarily based on care needs but on meeting organisational targets (Fiscella and Epstein, 2008; Glasper, 2013; Pennycook, 2013).

Although this approach might serve the organisational good to maximise staff efficiency (and increase profit), it might also be detrimental to the person in need of care, as well as the care worker.

3.3.2. Social Exchange Theory

Other economic perspectives on work motivation have been influenced by the ‘social exchange theory’, which considers work motivation as a product of the worker’s subjective cost-benefit analysis of the present social and economic realities in comparison with other alternatives (Cook *et al.*, 2013). Social exchange theory (SET) is an interdisciplinary macro-theoretical framework that considers the interactions between two or more individuals (or organizations), in a reciprocal relationship (Emerson, 1976; Cook *et al.*, 2013). This theory suggests that interaction produces an

obligation for one party to repay the other with something of equal value, or something that typifies fairness in the exchange and invariably justifies a continuation of that exchange (Blau, 1964; Gouldner, 1960; Cropanzano and Mitchell, 2005). Being a collection of conceptual models rather than a single theory (Cropanzano and Mitchell, 2005), the SET has been used widely in management research (Erdogan and Liden, 2002; Cohen-Charash and Mueller, 2007; El Akremi, Vandenberghe and Camerman, 2010).

Applied to the concept of care work, the SET could be used to explain the reward that an individual derives from engaging in a particular activity (like caregiving) as a product of the choice they made to maximize rewards (positive aspects of caring) and minimize costs (demands of the role) (Mitchell, Cropanzano and Quisenberry, 2012). This process of reciprocity is reflected in the three main features of the SET with which most proponents concur. An actor's (potentially the care worker) initial action toward a target individual (the care recipient), the target's reciprocal responses (behaviours and attitudes) to the action and the subsequent forming of relationships that inform more exchanges (Cropanzano *et al.*, 2017). Thus, in care work, the social exchange begins when the care worker's act of care (whether positive or negative), initiates a response from the care recipient, which may lead the care worker to consider it as a positive or negative reward. SET theory has been applied to research, for instance, Trybou *et al.* (2014) applied it to study staffs (nurses and health care assistants) working in care homes and found that those who perceived a high level of SET, were prepared to work more productively in the organization compared to those who had a low level of SET. Although Trybou *et al.* (2014) did not consider the effect of the exchange that takes place between these care workers and their care recipients, other authors have examined SET in care settings. For example, Nelson (2000) opined that the nature of dependence and control inherent in care homes might eliminate the fair exchange between the care worker and the care recipient in the context of the SET. Higgs and Gilleard (2015) referred to the observation as 'abjection' experienced by staff and care recipients in care homes, who may feel that they are without power in the exchange.

Moreover, with caring for PLWD whose cognitive capacity deteriorates progressively, it might be difficult to put their response to caregiving into context. In which case the

exchange the care worker receives is not limited to the interaction they have with the care recipients. Hence, the SET differs from Taylorism in that it does not reduce workers motivation to monetary gains. However, one of its drawbacks is its failure to completely account for the differences between actions and inactions, as it inherently assumes that the absence of a positive reward, equals the lack of a desirable cost (Lawler, 2001), which research suggests is not always the case (Robinson, 1996). Another major criticism is that it offers behavioural predictions that are overly simplistic, and it does not apply to all kinds of exchanges because of the limitations created by roles and social structures (Cropanzano *et al.*, 2017). For instance, some exchanges take place without the individual having to negotiate or assess cost and reward, and this may be applied to family caregiving (Garand *et al.*, 2007). The central concepts of the SET suggest that workers are motivated tacticians looking out for their best interest (Haslam, 2004), and it is on this premise that many psychological perspectives and theories of motivation are based (Fiske and Taylor, 1991; 2013; Poveda *et al.*, 2017).

3.3.3. Maslow's *Hierarchy of Needs*

Another well-known theory that considers work motivation is the Maslow's 'Hierarchy of Needs', which is also known as the theory of human motivation. It is one of the first psychological need-based theories that offered an alternative to the reductionist approach to work motivation underpinning Taylorism. Developed by Abraham Maslow, this theory created a pyramid-shaped hierarchy (see Figure 3.1), which displays an individual's need(s) and what motivates the individual to achieve a specific task to satisfy the need (Maslow, 1943).

In the hierarchy, needs are in levels ranging from basic animal needs for food, security and shelter, to social needs that demand the expression of love and a sense of belonging, and then to higher human needs such as self-esteem and self-actualisation. The working logic of Maslow's hierarchy of needs is that the key motivators of human behaviour in any setting are their level of unsatisfied need, such that it is the needs that are not satisfied that motivate the individuals, rather than needs that are already satisfied (Acevedo, 2018). Thus, while financial incentives are essential to motivating a

workforce (Wisener and Eva, 2018), the effect is not straight forward and once people are in receipt of a sufficient, regular income, the impact of their income is likely to be as Haslam (2004, p.61) pointed, “*an indirect consequence of its capacity to satisfy other needs, like a need for respect and self-esteem*”. Therefore, while the economic and social exchange perspectives discussed so far consider workers as motivated tacticians driven by the need to maximise reward, in contrast, the need-based theories (e.g. Maslow’s hierarchy of needs) take a more organic theoretical approach to human motivation because they view a worker’s disposition to personal growth as an integral part of a greater whole (Sheldon *et al.*, 2003; Sheldon, Arndt and Houser-Marko, 2003).

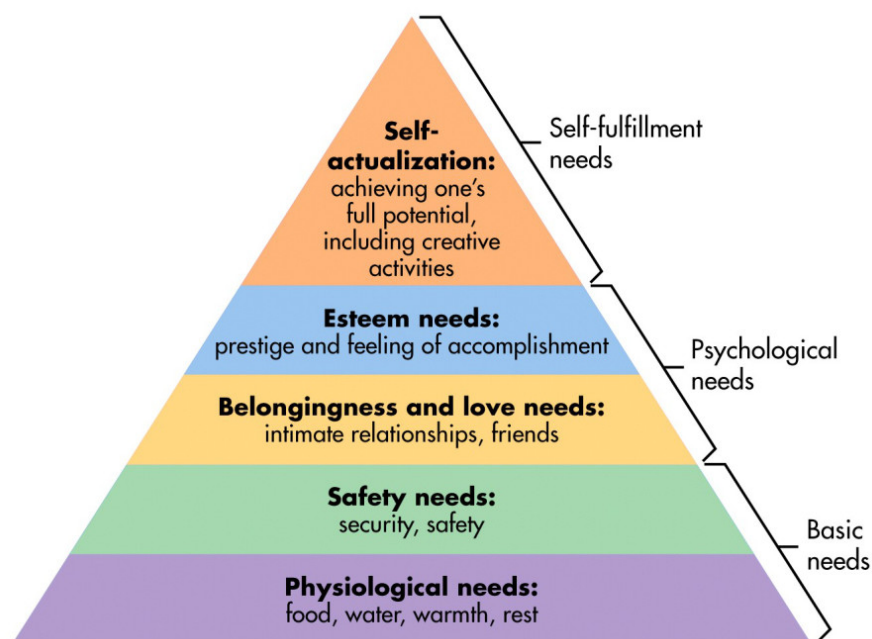


Figure 3.1: Maslow’s Hierarchy of Needs (also known as Maslow’s Theory of Motivation). Adapted from Maslow (1943, p.375). (Image courtesy of McLeod, 2018)

Although Maslow’s theory provided a new perspective to human motivation at the time it was developed, it appeared overly simplistic, assuming that everyone has the same needs. It presumes that before other needs in the hierarchy are achieved, basic physiological needs must first be attained (King-Hill, 2015). However, Maslow’s theory of motivation, like other theories in social psychology, examines motivation with an emphasis on ‘*how*’ and ‘*why*’ people are motivated to initiate certain behaviours in some particular circumstances (Markus and Kitayama, 1991). It is this ‘initiated

behaviour' that makes an individual want to do something to achieve or attain what Deci and Ryan (2000) described as a desire or willingness.

Relating carers experiences to Maslow's hierarchy of needs, clearly, it cannot be assumed that there is a common experience because not all carers are motivated to care for the same reasons. For example, a carer may be providing care for a purely altruistic reason, whereas another carer may be motivated by the sense of responsibility and duty to care because of societal expectation (Tay and Diener, 2011).

The next sections examines the motivation to care within the context of the two main types of caring motivation and explores some of the relevant theories and debates on motivation.

3.4. Theories on the extrinsic motivation and intrinsic motivation for caregiving

The motivation for caregiving is usually discussed in terms of extrinsic and intrinsic motivation. Intrinsic motivation (IM) stems from an individual engaging in an activity/role *"for the inherent satisfaction of the activity itself"* (Ryan and Deci, 2000a, p.71), the individual performs a behaviour voluntarily even in the absence of reward or external constraints. Deci and Ryan (2000) hold that IM stems from the need for competence and self-determination. In contrast, extrinsic motivation (EM) *"requires an instrumentality between the activity and some separable consequences such as tangible or verbal rewards, so satisfaction comes not from the activity itself but rather from the extrinsic consequences to which the activity leads"* (Gagné and Deci, 2005, p.331). EM includes external influences on an individual which may be social and/or environmental factors (Brodaty and Donkin, 2009). Such motivation maybe the financial reward derived from caregiving.

In IM for caregiving, the carer may seem to derive pleasure in the role. Gottfried, Fleming and Gottfried (1998) described IM as *"the performance of activities for their own sake in which pleasure is inherent in the activity itself"* (p.1448). The difference between intrinsic and extrinsic motivation for caring is the source of the behaviour or desire to care (Brodaty and Donkin, 2009). Whereas individuals motivated extrinsically do so because of what they derive from undertaking the caring role, individuals

motivated by a personal desire to care for people do so based on their convictions (Brodaty and Donkin, 2009). It is important to note that although care workers get paid, the pay they receive is relatively low (Low Pay Commission, 2014; Skills for Care, 2018), and therefore financial gain for undertaking the role may have little influence on why they continue in the role (Rakovski and Price-Glynn, 2010; Morgan, Dill and Kalleberg, 2013).

In the UK care workers have often reported that they receive low wages (Hirsch and Manzella, 2014; Hussein, 2017). For example, in a study conducted by Hussein (2017), between 10 to 13% of care workers working in the long-term care sector were paid less than the national minimum wage, yet, they often accepted low pay as part of their job. This could be explained in the context of emotional labour, which is consistent with the ‘prisoners of love’ framework (England, 2005). The ‘prisoner of love’ framework argues that employers often exploit care workers because of the intrinsic nature of caregiving (England, Allison and Wu, 2007; Hirsch and Manzella, 2014).

In the next section, both intrinsic and extrinsic motivation are discussed further within the context of the self-determination theory (SDT).

3.4.1. The Self-Determination Theory

An alternative psychological theory of human motivation used to explain individual behaviours is the self-determination theory (SDT) (Deci and Ryan, 1985a; Ryan and Deci, 2000b). SDT has gained empirical support over recent decades and holds that individuals are inherently self-motivated with natural predispositions to grow and pursue personal wellbeing (Deci and Ryan, 1985b; Ryan and Deci, 2000a). Hence, as an approach to understanding motivation, the SDT does not only attempt to account for the “*why*” people do what they do but also “*what*” behaviours underlies their actions (Sheldon *et al.*, 2004).

The “*why*” of behaviour encompasses the diverse reasons that make individuals act, while the “*what*” of behaviour refers to the nature of individuals’ goals. Although both concepts are linked, in the case of care work, SDT recognises the need to separate motivations from goals and this may help us to understand why care workers undertake

their jobs. Individual motivation has been shown to have different effects, with some care workers experiencing the negative impact of care work while others derive personal satisfaction from caring (Deci and Ryan, 2000; Sheldon *et al.*, 2004).

On the “*why*” of motivation, SDT emphasises the need to identify the source of individual behaviour to separate intrinsic behaviours from behaviours that originate externally. Deci and Ryan (2000) argued that if the source of the behaviour was from the self (internally), the individual has endorsed the behaviour and has integrated (that is, made it part of their life). Conversely, if the source of the behaviour is outside of self, the individual has not fully identified with the behaviour or has not integrated or internalised it in any way (Gagné and Deci, 2005). In this context, the internalisation of behaviour means an individual approves of the behaviour, which with reference to care work would be an individual engaging in caring for people. This dichotomy that SDT proposed in the internalisation of behaviour creates three main types of motivation; extrinsic, intrinsic, and ‘amotivation’ (lack of motivation), which are on a continuum, from self-determined (amotivation, external and introjected) and non-self-determined forms of behavioural regulation (identified, integrated and intrinsic). Introjected regulation refers to engaging in an activity that one has not fully accepted as one’s own. In the continuum, it is next to identified and integrated forms of non-self-determined regulations. As shown in Figure 3.1, individuals who are on the non-self-determined part of the continuum would engage in an activity, e.g., caregiving, to maintain self-worth, obtain rewards, avoid shame or punishment because they are more or less controlled or compelled to do so. On the other hand, individuals who are on the self-determined part of the continuum do not feel controlled but have autonomous control over what they do and do so because it is consistent with what they consider to be their life’s purpose and value (Deci and Ryan, 2000; Gagné *et al.*, 2015).

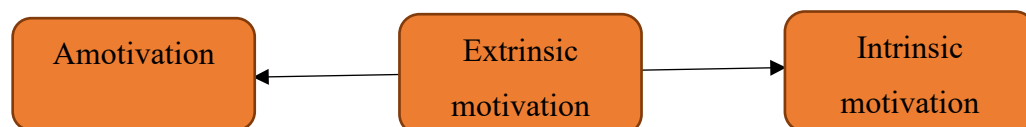


Figure 3.2: The self-determination continuum showing the three main types of motivation (Adapted from Gagné and Deci, 2005, p.336)

In contrast, the “*what*” of caregiving motivation, relates to the specific nature of the goal that the care worker seeks to pursue and according to the SDT individuals may pursue intrinsic or extrinsic goals (Vansteenkiste, Lens and Deci, 2006). While intrinsic goals (such as personal growth and wellbeing) derives from individuals’ propensity, to grow and connect with others, it is more inwardly oriented, since it tends to focus on the individual actualising their interest which is believed to be inherently related to satisfying the three basic psychological needs of autonomy, competence and relatedness (Deci and Ryan, 2008).

On the other hand, extrinsic goals (e.g., better pay) are outwardly oriented because they focus on what the individual can achieve outside of inward-oriented goals. However, Deci and Ryan (2000) observed that pursuing extrinsic goals can also diminish the ability of the individual to achieve the three basic psychological needs addressed by intrinsic goals. It is thought that the extrinsic goals can decrease intrinsic goals because they act as false needs that are not genuinely required for personal growth and wellbeing. The SDT’s continuum of motivational regulation also accounts for why it is possible for an individual to have different goals or motives to care as some of the motivational regulations are being more or less autonomous than others and some are more intrinsic while some are more extrinsic (Deci and Ryan, 2008).

While Maslow’s hierarchy of needs emphasises the importance of satisfying lower-level needs (such as biological and safety/security needs) before higher-level, or more psychological needs (e.g., self-esteem and self-actualisation) are satisfied, the SDT takes a different stance. Maslow theory suggests that there is a moderator relationship between lower-level needs and higher-level needs such that an individual cannot turn attention to higher needs without first achieving lower ones and conversely, having unsatisfied lower-level needs limits the effects of higher-level needs. On the contrary, the three psychological needs featured in the SDT (competence, relatedness and autonomy) represents Maslow’s higher-level needs (self-esteem, love and self-actualisation) nonetheless, where competence=self-esteem, relatedness=love and autonomy=self-actualisation (Rasskazova, Ivanova and Sheldon, 2016).

Despite some of the weaknesses identified, SDT offers some insight into the different extrinsic and intrinsic factors, which may be useful to explain why paid Nigerian migrant care workers assume and remain as carers for PLWD. Furthermore, another theory, the Herzberg Two-Factor Theory of work motivation, suggest that both IM and EM can influence one for another (Herzberg, 1968).

3.4.2. Herzberg Two Factor Theory

Another theory that could be applied to the experience of paid Nigerian migrant care workers is the Herzberg's Two-Factor Theory (HTFT) (Herzberg, 1968; Bassett-Jones and Lloyd, 2010). Also known as Herzberg's motivational hygiene theory, it holds that an individual will perceive a job as satisfying or dissatisfying depending on the range of discrete intrinsic and extrinsic variables (Herzberg, 1974a, 1974b). The focus of this theory is that one of the intrinsic or extrinsic variables can either influence the worker's satisfaction or dissatisfaction with the job but not both (Herzberg, 1974a). Herzberg, using his experience in occupational settings, found that factors associated with satisfaction could be placed in two subgroups defined as the "*motivators*" and "*hygiene*" factors.

This theory suggests that 'motivators' are more intrinsic factors (including such attributes as achievement, recognition and responsibilities), and they are capable of increasing job motivation and satisfaction when they are present, but they may not cause dissatisfaction when absent. Contrarily, the 'hygiene factors' are extrinsic environmental factors such as organizational policy, work status and a feeling of security, whose presence does not necessarily increase satisfaction but when absent, increases dissatisfaction leading to lower motivation (Herzberg, 1974a).

A distinctive characteristic of the Herzberg Two Factor Theory is its antagonistic feature, which allows it to challenge the notion that satisfaction and dissatisfaction are two mutually exclusive concepts that are one-dimensional and opposites. The theory also accounts for the possibility, that one variable that may function as a motivator does not necessarily function as a hygiene factor (Herzberg, Mausner and Snyderman, 1959). The theory has been applied in industry and other different occupational settings including such as health care (Shortell and Kaluzny, 2006).

This is interesting in terms of care work. For example, research by Sharp (2008) and Decker, Harris-Kojetin and Bercovitz (2009) demonstrated how the theory could be applied to understand the retention of registered mental health nurses and nursing assistants (same as health care assistants) overall satisfaction and intention to leave their job respectively. Sharp (2008) found that the psychiatric registered nurses surveyed expressed overall satisfaction with their jobs, citing a chance to utilise their ability (which is intrinsic) and achievement as what they found most satisfying about their job. They also reported being least satisfied with the compensation (pay) and although the nurses were least satisfied with their pay, it had little influence on their overall satisfaction with the job. It appears the satisfying aspects (motivators) of the job outweigh the least satisfying aspects. Decker, Harris-Kojetin and Bercovitz (2009) reported similar findings as Sharp (2008). In a study of nursing assistants working in a care home, they found that both extrinsic factors such as the nursing assistants' supervisor's behaviour and their wage were associated with intrinsic satisfaction.

Despite the strength of the Herzberg's theory, it is not without drawbacks, the main one being that it focuses on skilled and professional workers making it less suitable for application to studies on workers in unskilled jobs, where work schedules are mostly repetitive, uninteresting and monotonous. Herzberg Two-Factor Theory emphasised the role of satisfaction in productivity and appeared to suggest that the two variables have to correlate one to another, but it has been shown that satisfaction does not necessarily impact on productivity (Sanjeev and Surya, 2016).

In the current study, both the Herzberg Two-Factor Theory and the SDT may offer explanations for the motivation and experience of paid Nigerian migrant care workers as the two theories address individual and environmental workplace needs that might be essential to understanding their experience of caregiving.

3.5. Other theories on caregiving motivation

Apart from the theories above, there are other theories which explore aspects of motivation. Most of these focuses on individual components of caregiving motivation, without providing a unified multidirectional approach. While psychological theory of motivation focuses on the role of the individual, the sociological aspect pictures the

individual within a wider socio-structural context. Since motivation may be culturally oriented, the influence of culture on caregiving motivation is also considered (Brodaty and Donkin, 2009).

Psychological theories on the motivation to care seeks to explain the emotional or psychological factors that make a care worker to assume their caregiving role. It is interesting to note that some theorists have focused on the less benevolent motivations for caring. For example, Maner and Gailliot (2007) and Simpson and Willer (2008) have suggested that there can be ‘egoistic or self-serving’ motivation, ‘distress/arousal reducing egoistic’ motivation and ‘empathically evoked altruistic’ motivation (de Waal, 2008), with the first two types of motivation shown to lead to negative motivation while the last shows positive motivation. Egoistic or self-serving motivation and distress/arousal reducing egoistic motivation are often described as negative motivations because they are not inspired by a selfless attitude to help. It is inspired by the carer’s desire to obtain rewards or to reduce personal anxiety and distress. Although this was mostly examined within the context of unpaid caregiving, it might also be applied to paid care workers who might be motivated by extrinsic reasons to care (Quinn, Clare and Wood, 2010).

In contrast, emphatically inspired ‘altruistic motivation’ is a positive motivation because the care worker is driven by a genuine desire and empathy to help others (Revenson *et al.*, 2016a). One vital factor that is often discussed in the literature on the psychological motivations for caring is the mutual exclusivity of the individual motivating factors. It maybe that they relate to one another such that a carer can both empathise and still obtain rewards from their helping behaviours (Quinn, Clare and Wood, 2010). This would also apply to care workers who take on caregiving responsibility knowing they would be paid. A look at the altruistic motivation for caregiving offers further insight.

3.5.1. Altruistic motivation

The altruistic motivation for caring focuses on the emotional content of caring. If carers derive positive satisfactions for caring, it may be that the motivation, though emotional cannot be described as altruistic. Altruism has a distinctive feature of being selfless. It

serves to care for an individual's welfare selflessly (Batson and Powell, 2003). It has been suggested that people by nature can be altruistic, but they are drawn into exercising altruism, not because they are biologically endowed with an innate capacity to be altruistic but because they have learnt to be altruistic, just as they would with any other human social attributes (Rachlin, 2002; Carbonnier, 2014). Hence, altruism can be learned but Barasch *et al.* (2014) suggest that altruism is morally judged in different ways depending on the motivation of the actor, although altruism is not always compatible with benefits to the self.

Emotion has long been equated with caring motivation (Batson, 1990, 1991; Slovic, 2007). Loewenstein and Small (2007) opined that the feeling of sympathy could act as a motive for an individual's decision to take on caregiving responsibilities. Though this might be true of informal carers, it might not apply to care workers, who have no filial relationship or association. However, Slovic (2007) considers emotion as the most basic form of feeling that ascribes the quality of being good or bad to a thing. The fact that people often feel good after helping calls to question the real motivation for their behaviour which may be explained in terms of attachment theory.

3.5.2. The Attachment Theory

Attachment theory may also contribute to understanding caregiving motivation. It is based on the belief that the provision of care by a carer arises from the emotional attachment that exists between carer and care recipient. Providing care to the care recipient depends on the carer's previous experiences of receiving care (Feeney and Collins, 2001; 2019), a relationship which is also essential when taking up caregiving responsibilities. Kolmer *et al.* (2008) found that their relationship with the care recipient primarily motivated informal carers and it was the relational connection that prompted them to begin caregiving. However, in the case of paid care workers, there is little evidence of the role of attachment theory in becoming one, but it may be a reason for a care worker to continue in the role (Browne and Shlosberg, 2006). The next section highlights other factors that might motivate a paid care worker to care.

3.6. Other factors that might motivate care workers

Mickus, Luz and Hogan (2004) conducted a survey with 1,100 care workers to consider the factors responsible for the entrance of care workers into care work and they discovered that there are often positive accounts for their participants' involvement in care work. They found that care workers had a range of reasons for engaging in care work including: the desire to help others, relationships with others, willingness to engage in meaningful work, preference for part-time and flexible hours, and work commitment.

Lindquist *et al.* (2012) examined the motivation of individuals who chose the low paying job of paid care in the USA and found that most of the care workers chose their occupation because of their personal preference of being with seniors, or because it was the best work that they could find. The researchers also found that the salary the care workers received, flexible working hours and ease of workload were the best part of their job. This research appears to suggest that the desire to care for older adults was the primary motivating factor to take up the job but what made them continue in it was the financial reward that comes from it and the characteristic flexible nature of the work. Although Lindquist *et al.* (2012) reported that over 60.2% of care workers were motivated to become care workers because of their love to be with older adults, over a quarter (26.5%) of their participants cited financial reasons as the motives for taking up the role while only 8.2% considered the salary as the key motivator for staying in the role.

The motivating factors for caregiving highlighted by Lindquist *et al.* (2012) and other researchers such as Mickus, Luz and Hogan (2004) fit into the intrinsic and extrinsic classes of motivation. Feldman, Sapienza and Kane (1994) noted that intrinsic motivating factors, such as a sense of personal responsibility and the gratification of their clients are what motivate many care workers to assume and remain committed to their caregiving roles. For example, Gambino (2010), in a study exploring the relationships between registered nurses' motivation for entering the profession, occupational commitment and their intent to remain found that many of the nurses cited interest in health care as their motivation to enter the profession. Although wages were

not reported to be the most important factor influencing their decision to care, it is difficult to know what role monetary motivation plays in the motivation to take up and continue in paid caregiving roles. In addition, the motives are not mutually exclusive (i.e. people may enter paid caregiving because they like caring for others and they need paid employment).

One other factor to consider in the motivation of paid care workers is the cultural differences in caregiving that has been observed in the literature, and this is discussed in the next section.

3.7. Cultural differences in motivation to care

The motivation to care can be influenced by a number of factors including the social and cultural context of peoples' lives (Dilworth-Anderson and Gibson, 2002). This is due in part to the cultural expectations in some societies which requires younger family members to care for older relatives, and in part to the availability of care services. For example, research suggests that in many Western cultures, spouses of the care recipient are most likely to become carers, followed by adult children of the care recipient (Camden, Livingston and Cooper, 2011). In addition, studies indicate that even among adult children, a daughter, most likely the oldest, is expected to be the carer (Quinn, Clare and Woods, 2010; Schwarz *et al.*, 2010). However, this expectation may vary amongst carers of different ethnicities and cultures. For instance, carers of Greek origin were more likely to be motivated by expectations bestowed on them by their religion, while Korean carers were more motivated by filial responsibilities than American carers (Lee and Sung, 1997; Kabitsi and Powers, 2002). The kin relationship also determined motivation, with daughters more likely than daughters-in-law to report affection. In one study, carers who cited fewer personal reasons and more external pressures motivating them to care reported more mental health problems (Romero-Morena *et al.*, 2010). A detailed consideration of the influence of culture on caregiving is presented in the next chapter.

3.8. Summary

In this chapter, I explored some theories of work motivation that could explain the motivation of paid Nigerian migrant nurses and HCA (care workers) caring for PLWD. The economic/social exchange theoretical perspective on work motivation considers it a product of monetary inducement whereas needs-based theories view it as a consequence of unmet need. Considering these and other subsequent theoretical modifications, I concluded that no specific theory can completely explain care work motivation due to the complexities of people's needs and motives. However, while the motivational theories may have different levels of explanatory power, it is in the lived experience of care workers that we may find a deeper insight into their motivations and experiences of caring. Therefore, using a phenomenological approach, my thesis has sought to understand both the motivations and experiences of Nigerian care workers. In the next chapter, I continue to review the literature in the field looking at the positive and negative aspects of caring for PLWD, as well as the influence of cultural beliefs, values and practices on caregiving.

CHAPTER FOUR

THE EXPERIENCES OF DEMENTIA CAREGIVING AND THE CULTURAL PERSPECTIVES TO CAREGIVING

4.1. Introduction

The previous chapter examined some of the debates concerning people's motivation for caregiving. In this chapter, the first section focuses on the literature regarding the impact and experience of caring for people living with dementia (PLWD) while the second section examines some of the debates on culture and caregiving as well as the cultural perspective on dementia. There is limited research on the experience of paid care workers (Lloyds, Patterson and Muers, 2016; Yu, Cheng and Wang, 2018). Most of the literature on caregiving focuses on the experiences of family carers. This is nevertheless pertinent to this thesis because my findings (presented in later chapters) indicate that many of the experiences of unpaid carers highlighted in the literature also resonate with care workers (formal or paid caregivers).

4.2. The impact of caregiving

While some of the literature on the effects of caregiving dichotomizes the 'positive' and 'negative' aspects of the caring role, most of the research literature recognises that the caring role involves different dimensions (Cohen, Colantonio and Vernich, 2002; Hatton and Emerson, 2003; Blacher, Neece and Paczkowski, 2005; López, López-Arrieta and Crespo, 2005). It is notable that much of the research literature on dementia caregiving seems to be constructed around the 'burden of care', whereas there appears to be a relative paucity of research that explores the positive aspects of caregiving. While only a limited number of studies have been conducted, most of them indicate that both family carers and care workers not only cope with the burden that is inherent in caring for someone with dementia, but they also consider the role satisfying and rewarding (Farran *et al.*, 1991; Cohen, Colantonio and Vernich, 2002), howbeit, most of these studies focused more on family carers rather than care workers. The wider caregiving literature focuses on family carers probably because of the role they play in helping to reduce the care burden and cost for the health services (Buckner and Yeandle, 2011, 2015).

The literature covers a wide range of themes, some of which have been highlighted below.

4.2.1. Positive emotions

Research suggests that the caregiving role can elicit a feeling of fulfilment which can lower levels of depression and anxiety for carers (Cohen, Colantonio and Vernich, 2002; López, López-Arrieta and Crespo, 2005; Mausbach *et al.*, 2006). It is also suggested that those who had a positive feeling about their caregiving role were often less affected by the care recipient's 'problem' behaviours (Pinquart and Sorensen, 2004). This might be linked to the carer's ability to manage the care recipient's problem behaviours (Hirshfield, 1983), which has been associated with the meaning they attach to their role and the satisfaction they derive from it (Feast *et al.*, 2016). Notably, family carers who reported high satisfaction in their role as carers were often willing to continue to do so and less likely to place their relative in institutional care (Roff *et al.*, 2004). In addition, maintaining a positive attitude towards caregiving, finding meaning in and deriving gratification from the caregiving experience has also been associated with increased morale and a feeling of being more able to manage caregiving stress (Rapp and Chao, 2000).

Research suggests that there may be different cultural variation in attitudes to caregiving. For example, Roff *et al.* (2004) examined differences in the report of the positive aspects of caregiving among African American and White (non-Latino) carers as part of the National Institutes of Health's Resources for Enhancing Alzheimer's Caregiver Health (REACH) project. It was observed that while African American and White (non-Latino) caregivers both reported positive aspects of caregiving, when compared to their White counterparts, African American caregivers reported higher levels of the positive aspects of caregiving. Roff *et al.* (2004) attributed this to their religiosity. Although their findings offer some insights into the cultural variation in caregiving experiences, Hilgeman *et al.* (2007) argued that the length of time that a carer had been caring for PLWD might also influence their attitudes to the caregiving role.

Other research that focused on a positive appraisal of the caring role suggests that it can trigger positive outcomes in carers (Kinney and Stephens, 1989, Lawton *et al.*, 1989; De Labra *et al.*, 2015) and have a positive impact on their expression of self-esteem and mastery (Semiatin and O'Connor, 2012). Some studies also highlight the rewards derived from the dynamic reciprocity of the caregiving relationship (Cartwright *et al.*, 1994).

4.2.2. Role satisfaction

There is a substantial literature on carers and the satisfaction they derive from their role (Murray *et al.*, 1999; Jervis, Boland and Fickenscher, 2010; Shim, Barroso and Davis, 2012). This stems from the feeling that they are doing a good job (Jervis, Boland and Fickenscher, 2010) which includes ensuring their relatives are comfortable (Murray *et al.*, 1999) and safe (Peacock *et al.*, 2010). Family carers reported varying degrees of satisfaction with their caregiving role, and this might be related to having a sense of pride that they are delivering quality care to their relatives, although some carers provide care in a more practical and unemotional way because they felt they were giving their best (Ribeiro and Paúl, 2008). There can also be the disappointment of not being able to give more (Murray *et al.*, 1999).

Research by Shim, Barroso and Davis (2012) indicate that while some carers expressed a sense of pride and fulfilment in their role, others were ambivalent about their role, but they often found satisfaction in external activities (like visiting friends). It has been argued that the carer's level of satisfaction with their role may depend on the quality of the relationship they had prior to the care recipient's diagnosis (Steadman, Tremont and Davis, 2007). It is notable that there is minimal literature on paid care workers and role satisfaction for caring for PLWD. Although, McCauley and Irwin (2006) argued that role satisfaction for care workers may depend on the suitability of the working environment.

4.2.3. Coping with caregiving

Lazarus and Folkman (1984, p.141) define coping as “*efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the*

resources of the person”. In the caregiving literature, there is often a focus on how carers cope, including the ways and strategies that they employ to manage the demands of their role and how they manage stress. However, some of the literature on ‘coping’ and the attributions of ‘stress and burden’ in the caring role highlights the significance of the degree of cognitive impairment of the care recipient and other factors that may influence the way people cope with caregiving (Lazarus, 1993; Richards *et al.* 2003; Etters, Goodall and Harrison, 2008). For example, Lazarus and Folkman (1984) argue that a carer’s appraisal of stress is the primary predictor of their coping ability. When they perceive their role as highly stressful and receive little or no social support, they weigh their ‘caring burden’ to be higher (Vitaliano *et al.*, 1991).

Carers may use different coping strategies (Gilhooly *et al.*, 2016; Carlozzi *et al.*, 2018), however, Aminzadeh *et al.* (2007) observed that to ameliorate stress, many carers make use of positive coping strategies, such as information seeking and problem-solving approaches. For example, ‘problem-focused coping’ refers to strategies that involve information seeking, problem-solving, social support, positive outlook, and emotional expression (Stanton, Revenson and Tennen, 2007). In this manner, carers are focused on managing or changing the problem causing the stress by seeking alternatives, making other choices, and learning new skills. Other coping strategies that have also been shown to reduce care’s burden includes the use of support groups and cognitive behaviour therapy (Weuve, Boult and Morishita, 2000). However, Stanton, Revenson and Tennen (2007) propose that carers may not always use positive approaches to cope. Some may use strategies such as minimisation, avoidance, distancing, and seeking meaning in the negative events which are used to manage the problem. Another theme in the literature relates to the idea of ‘competency and mastery’ in a caring role which involves mastering vital skills for caregiving as well as learning and applying new skills (Narayan *et al.*, 1999; Netto, Goh and Yap, 2009; Sanders, 2005; Ribeiro and Paúl, 2008). As carers learn new skills, they may become more confident to share their knowledge with others (Peacock *et al.* 2010).

4.2.4. The emotional rewards of caregiving

Although much of the literature focuses on the ‘burden’ of the caring role, it is notable that many carers cope well with the distress inherent in caregiving role and view it as a rewarding and satisfying experience (Cohen, Colantonio and Vernich, 2002). Emotional reward (related to the feeling of being appreciated and valued) has been reported as a positive aspect of caregiving in several studies (Jansson *et al.*, 1998; Jervis, Boland and Fickenscher, 2010; Netto, Goh and Yap, 2009). Ribeiro and Paúl, (2008) highlights how family carers found that expressions of appreciation made by the care recipients made their role more rewarding. Furthermore, a study by Sanders (2005) also found that many carers experienced positive emotions resulting from engaging in activities that foster a mutual bond, spiritual growth, and feelings of satisfaction. Although, other researchers suggests that the personal characteristics of the carer (for example gender, ethnicity, age, and educational status, etc.) can also influence their view of caregiving (Haley *et al.*, 1996; Kramer, 1997; Rapp and Chao, 2000). For example, research by Brodaty (2009) suggests that older carers with lower educational status often expressed a more positive emotion towards their role than those who were younger and more highly educated. This might be due to more highly educated caregivers being aware of the stress they are facing.

4.2.5. Reciprocity in caregiving

The notion of reciprocity, an opportunity to return or give back care to elderly loved ones have often been noted as a positive aspect of caregiving (Murray *et al.*, 1999; Jervis, Boland and Fickenscher, 2010; Peacock *et al.*, 2010; Ribeiro and Paúl, 2008). Many adults caring for their parents stated that they enjoy being with their older relatives and this pleasure is linked to the desire to reciprocate the love and affection that they enjoyed while growing up (Jervis, Boland and Fickenscher, 2010; Peacock *et al.* 2010). This may also include the reciprocity found in a relationship with a spouse or partner. Some studies found that husbands who cared for their wives saw it as a way of ‘giving back’ love and wives who cared for their husbands viewed it as a way to continue their relationship with their husband (Ribeiro and Paúl, 2008).

Peacock *et al.* (2010) also noted that some adult children considered caring for their parent as an opportunity to demonstrate to their children how care should be provided to them in the future. Therefore, reciprocity is not only seen as a positive aspect of caregiving but can also be considered as a motivation to care. This idea of familial reciprocity as a motive to care is found in many cultures and particularly in cultures with a strong sense of collectiveness and extended family networks (Sabogal *et al.*, 1987; Losada *et al.*, 2020). As highlighted in Chapter 2, migrant care workers who grew up in a society where the family structures are mostly collectivist may demonstrate a high level of reciprocity even when caring for people who are not their relatives. Adams and Sharp (2013) also discussed the concept of ‘professional reciprocity’, denoting that care workers may also exhibit a sense of reciprocity towards their care recipients despite not being related.

4.3. Why do caregivers have very different experiences of caregiving?

Theorists have sought to explain why carers have very different experiences of caregiving, and in the following section, a few of the dominant theories will be highlighted. Although most of these theories were developed to understand informal (unpaid) family carers, some aspects of these theories will have resonance for paid care workers, as shall be discussed in later chapters (seven, eight, nine and ten) of this thesis.

4.3.1. *The Stress Process Model*

The Stress Process Model (SPM) developed by Pearlin *et al.* (1990) is one of the dominant theories influencing caregiving research and has also been used to explain the negative aspects of caregiving (see Roff *et al.*, 2004). The overarching theme of the SPM is the stressful nature of caregiving, highlighting the background and context of stress, the stressors involved, resources available to the caregiver and the outcomes (Judge, Menne and Whitlatch, 2010). The model works with the assumption that there is a relationship between stressors and the resources, for example, the level of social support available and the carer’s ability to cope. This model posits that when caregivers have sufficient resources to deal with their stressors, this results in a decrease in the impact of the stressors. In effect, this model suggests that the positive aspects of caregiving may depend on decreasing stressors through access to resources.

However, Lloyds, Patterson and Muers, (2016) focused on the personal resources of the carer and suggested that the negative aspects of caregiving are expressed when the caregiver expresses low self-esteem and how they can master their feelings of control in the caring role. Hence, theorists have used SPM to examine both the positive and the negative aspects of caregiving, although Boerner, Schulz and Horowitz (2004) indicate that they are simply on opposing ends of the same continuum.

However, other theorists have rejected the idea that the positive and negative aspects of caregiving are dichotomised (Gonçalves-Pereira *et al.*, 2010; Monin, Schulz and Feeney, 2015). For example, Rapp and Chao (2000) examined the effects on the psychological wellbeing of carers of PWLD and their study demonstrates that caregiver's positive appraisal of the situation could play an essential role in buffering stress. However, generally SPM theories tend to focus on the negative aspects of caregiving, and consequently, these theories may not adequately address the positive aspects of caregiving (Judge, Menne and Whitlatch, 2010).

4.3.2. A two-factor model

Lawton *et al.* (1991) studied spouses and adult children caring for people living with Alzheimer's disease. They identified the care recipients' behaviour as a stressor and the carers' wellbeing as the subject of the study. They found that there were differences in the way that spouses and adult children experienced the burden and satisfaction of caring which can have a different effect on their wellbeing.

Although the Lawton *et al.* (1991) study is mostly cited, as Lyons *et al.* (2002) suggests, caregiving involves an interrelationship (between the caregiver and care recipient), and the two-factor model fails to consider the quality of this relationship at different times. Similarly, a review by Kramer (1997) proposed a conceptual framework which indicates that caregivers' experience of positive or negative aspects of caregiving depends on their appraisal of the role. While the carer's appraisals of 'role gain' (i.e., what did they benefit from the role) can lead to positive outcomes, their appraisals of 'role strain' (what did they lose because of the role) results in adverse outcomes. Although Lawton *et al.* (1991) and Kramer (1997) both incorporate positive and negative aspects of caregiving, they do not show the influence of negative aspects of

caregiving on the positive outcomes since they considered the positive and negative aspects of caregiving as independent aspects of the experience (Iecovich, 2011). Broese van Groenou, de Boer and Iedema (2013, p. 301) alluded to this dichotomy of the aspects of caregiving in their study which evaluated the positive and negative outcomes of caregiving among family carers, noting that both aspects, '*seem to reflect separate dimensions of caregiving that have different predictors and differing outcomes....*'.

It is worth noting that even though a number of theorists have emphasised the presence of positive and negative outcomes in caregiving, they often do not sufficiently address the role of other variables or factors, for example, the caregiver's characteristics, levels of additional support, or cultural background (Aranda and Knight, 1997; Knight and Sayegh, 2010).

In the next section, I shall examine the differences in caregiving burden between caregivers caring for PLWD and those caring for people with other support needs.

4.4. Differences between caring for PLWD and caring for other illnesses

The impacts of dementia caregiving (rather than caring for other illnesses) is well documented and research suggests it often has adverse effects on the caregiver's physical and emotional health (Greenberger and Litwin, 2003), including a high prevalence of depression, perceived poor health and increased risk of mortality (Schultz *et al.*, 1995, Schultz and Beach, 1999; Kim and Schulz, 2008; Seidel and Thyrian, 2019). Some reports have suggested that carers of PLWD need to rely on a variety of support and services if they are to cope with the challenges of caring (Ham, 1999; Dupuis, Epp and Smale, 2004).

While carers caring for PLWD may have much in common with other caregivers, clearly the nature of dementia, as a degenerative condition, means that the caring role changes over time (Li, 2012). A study by Ory *et al.* (1999) offered an insight into the demands of dementia caregiving by investigating the differences between dementia caregivers and non-dementia caregivers. They observed that dementia caregivers spent a greater amount of time (in terms of hour per week) doing caregiving tasks as well as activity for daily living and other care activities than non-dementia caregivers.

4.5. Cultural beliefs/values and dementia caregiving

The UK has an increasingly ethno-culturally diverse society, and many migrants are now ageing in the UK (Centre for Policy on Ageing, 2013; Phillipson, 2015; Zubair and Victor, 2015; Ciobanu *et al.*, 2020). Therefore, it is increasingly important for professionals to be aware of issues concerning ageing and culture (Torres, 2015). As suggested earlier (see section 1.3.2), the aetiology of dementia means that the condition does not discriminate with respect to who can develop it (All Party Parliamentary Group on Dementia, 2013). Thus, the prevalence of dementia cuts across all ethnic groups and cultures, although, specific types of dementia are more prevalent among certain ethnic groups than others. For example, research suggests that Black and ethnic minorities have a higher risk of developing vascular dementia than Caucasians due to their susceptibility to cardiovascular risk factors such as hypertension, stroke, type II diabetes, etc. (Stevens, Leavey and Livingston, 2004; Tuerk and Sauer, 2015). The concept of cultural variations in the nature and impact of the dementia caregiving experience has been the focus of considerable research in the last two decades (Connell and Gibson, 1997), fuelled in part by the rapid diversification of ethnic groups around the world. However, the prevalence of dementia among ethnic minorities is believed to be underestimated (Pham *et al.*, 2018) as research suggests that there can be difference in caregiving patterns among different ethnic groups (Janevic and Connell, 2001; Adams *et al.*, 2002; Dilworth-Anderson, Williams and Gibson, 2002; Pinquart and Sörensen, 2005; Sun, Ong and Burnette, 2012; Roth, Fredman and Haley, 2015).

4.5.1. Rates of caregiving vary across ethnic groups

Traditionally, research on dementia caregiving experience is based on studies conducted with White carers and more recent studies indicate that services based on many cultural assumptions may result in inappropriate support for carers from different ethnic groups (Alegria *et al.*, 2010).

Several studies have shown that ethnic minority communities provide more care than their White counterparts (Weiss *et al.* 2005). Although this research is useful and it can result in the assumption that families from minority communities always ‘look after their own, however variations in the pattern of caregiving encompasses a wide range of

sociocultural variables, including socioeconomic status and cultural values (Knight *et al.*, 2000). It is also important to be cautious in making these cultural assumptions. For example, McCann *et al.* (2000) showed that carers from ethnic minority groups in the USA tend to provide more informal care to their loved ones than their White counterparts. There may be some reasons to account for this, and while this might be due to the differences in cultural values or filial obligations, it may also be related to wealth and the family's economic capacity to purchase care. Pinquart and Sorenson (2005) conducted a review of 116 studies and their analysis suggested that there are a few variables that may be responsible for the difference in care burden experienced by Black African caregivers (such as available psychological and social support, coping processes as well as physical and psychological health of the carer). Other researchers have suggested that the resources available to Black African carers are often underutilised due to the poor appraisal of their perceived caregiving burden (Haley *et al.*, 2004). However, what is apparent from the literature on culture and caregiving is that it is essential that we do not assume that everyone caring for someone with dementia has the same needs (Janevic and Connell, 2001).

4.5.2. Cultural perceptions of dementia

Culture is a contested term which is often used to describe the characteristics of a particular ethnic group or other groups who share common features which includes but are not limited to commonly held beliefs, values, language, traditions, beliefs, art, food, religion and social habits (Harwood and Ownby, 2000). Wong, Wong and Scott (2006) suggest that cultural values are often transferred from one generation to another generation within the group. However, this approach does not address the changes that may occur as an individual moves through the different stages of their lives, or how an individual's cultural beliefs may change in response to different factors, such as close interaction with people of other ethnic groups and education. Indeed, cultural beliefs and practices are dynamic due to the changing nature of the process through which an individual's cultural beliefs are formed and lives are lived.

4.5.3. Ethnic beliefs concerning dementia and caregiving

Research suggests that cultural perception of dementia varies from culture to culture around the world. In the Western world, it is usually constructed through the biomedical model (disease process model) that holds dementia as a disease, which leads to a progressive decline in cognitive function in the person living with it. However, in other parts of the world, dementia is accorded different meanings (Connell and Gibson, 1997; Dilworth-Anderson, William and Gibson, 2002; Dilworth-Anderson *et al.*, 2005; Gallagher-Thompson *et al.*, 2003; Janevic and Connell, 2001). Cultural values and beliefs about dementia influence the meaning carers ascribe to the disease and conditions, and this can often be understood as part of a larger belief system of values and norms that helps define caregivers and their perception of the disease (Henderson and Gutierrez-Mayka, 1992). Several studies have dichotomised traditional (folk) beliefs and the western view of the disease (as a pathological one).

Other studies suggest that the conceptualisations of dementia by the carer may affect their motivation to provide care (Milne and Chryssanthopoulou, 2005). For instance, a carer who believes that dementia is a consequence of the cognitive function will usually seek medical help for the care recipient (Guo *et al.*, 2000). However, the carer's response to the disease and help-seeking behaviour may be different if they believe that the care recipient is in gradual decline due to old age or is suffering because of past misdeeds (Dilworth-Anderson, Pierre and Hilliard, 2012). Gray *et al.* (2009) suggest that many White/Caucasian carers believe that the biomedical model is the only possible explanation for the disease and may consider that the disease has no specific treatment.

In contrast, a study conducted by Khonje *et al.* (2015) found that many Black Africans taking part in a study in the USA believed that traditional healers could heal someone with dementia because many of them believed that the forces causing dementia were outside of the body. Wigglesworth *et al.* (2010) and Prince (2004) highlighted some of the risks involved in this belief system and they suggested that the abuse of PLWD can sometimes be aggravated by the African cultural beliefs, especially if dementia is considered a sign of being possessed by a demon, or living under a curse, or as

punishment from the gods for past sins. Research by Castleman, Gallagher-Thompson and Naythons (2003) reported that those who believe in the biomedical explanation of dementia tend to seek for help sooner than those who hold alternative views and perception about the cause of the disease.

4.5.4. Dementia and normal ageing

Although it is well established that old age is associated with mild cognitive decline, severe memory loss or cognitive dysfunction are not a natural characteristic of ageing (Ardila *et al.*, 2000; Bischkopf, Busse and Angermeyer, 2002; Tervo *et al.*, 2004). Unfortunately, in many cultures, older adults presenting with memory loss and behaviours consistent with the symptoms of dementia are often perceived to be undergoing the normal process of ageing. For instance, in some parts of Africa, it is believed that when a man gets old, he returns to being a child and as such he begins to behave and talk like a child. Roberts *et al.* (2003) also found that African Americans often held on to this traditional view (i.e., that dementia and related symptoms is a normal part of the ageing process). This perspective has also been identified in other studies (see Gelman, 2003; Hughes *et al.*, 2009; Otilingam and Gatz, 2008) and much of this literature suggests that many African Americans may consider changes in personality and behaviour as completely normal in older adults. However, this view also seems to be prevalent in other cultural groups (Jones, Chow and Gatz, 2006; Otilingam and Gatz, 2008). For example, Braun, Takamura and Mougeot (1996) conducted a qualitative study to ascertain the perceptions of dementia among Vietnamese immigrants who recently migrated into Hawaii. They found that those who participated in the focus groups recognised the symptoms of dementia from their experiences with older adults who presented symptoms of dementia but believed those symptoms and behaviours were completely part of the natural process of old age. The study also found that many of the Vietnamese carers attributed any aggravation in symptoms (such as aggressive behaviour) to the person with dementia moving into a new environment and was therefore homesick. Lee, Lee and Diwan (2010) reported similar findings, observing the same perception of dementia as a part of the ageing process among Korean carers. Such constructions can affect carers' help-seeking behaviours whether for themselves or the care recipient.

4.5.5. Insanity and dementia

In addition to conceptualising dementia as a natural part of ageing, or caused by external spirits, research suggests that many caregivers of African, Asian, and Hispanic origin also view dementia as connected to mental illness (insanity) and this can be a symbol of shame. A study by Hinton *et al.* (2005) conducted with ninety-two (92) family carers from African American, European American, Asian American and Hispanic communities found that the majority of African American, Asian American, and Hispanic caregivers did not exclusively believe the biomedical explanation as cause of dementia, while 10% of them did not believe in the biomedical model but rather attributed dementia to insanity or other non-disease causes. Although this study was not representative, it may suggest that some carers from ethnic minority communities may be more likely to hold conceptions of dementia that may differ from the widely accepted biomedical model, and a twenty-year review of the literature on ethnicity and caregiving by Dilworth-Anderson and Gibson (2002) also reported similar findings.

4.5.6. Dementia and shame

In some cultures, carers may also view dementia as an object of shame and ridicule (Cheng *et al.*, 2011; Mukadam and Livingston, 2012). Chu and Sue (2011) have suggested that this behaviour is common in many Asian cultures, but this is largely due to the stigmatisation that is often associated with mental illness in most of Asia, Africa and across the world. For instance, research by Hinton *et al.* (2000) suggests that the stigmatisation of older Chinese adults with dementia is also noticeable among many Chinese caregivers who may believe that an individual is “unbalanced” or “undisciplined.” This brings to the fore the role of victim blaming in reinforcing the stigma attached to people with dementia, not just in China but elsewhere. For example, Henderson and Traphagan (2005) observed that the Japanese do not necessarily see the nature of ageing in the same way as in the West and they noted that older people are seen as having a duty to avoid senility through activity. In other words, mental decline is associated with a moral decline.

4.5.7. Socio-cultural constructions of dementia

Apart from the aforementioned cultural beliefs that influence a caregiver's social construction of dementia, there are other diverse cultural beliefs that are specific to a particular ethnic group. These beliefs may or may not exist in other cultural groups and migrants may seek to hold on to beliefs that originated in their culture, or at least they may try to blend these beliefs with the culture of the place where they are migrants (Hsueh, Hu and Clarke-Ekong, 2008). For instance, research suggests that Chinese American dementia carers often blended traditional Chinese folk models into their construction of the disease (Zhan, 2004). Zhan noted that dementia in Chinese culture was described in relation to an individual's "fate", or the consequence of wrongdoing or having too many worries. These descriptions are different from the traditionally held western view about dementia being an example of brain dysfunction (Hinton, Franz and Friend, 2004). One important implication for having different perceptions or misconception of dementia that is different from the biomedical model is that caregivers who hold such beliefs may be less likely to seek help.

Similarly, migrant carers may bring their cultural values to bear while caring for PLWD even outside their country of birth. This might be due in part to the nature of family that is dominant in their country of origin. Most collectivist cultures that promote the practice of family caregiving lay strong emphasis on the importance of cultural values that places the older adult in the family at the receiving end of care from the younger members of the family. Some examples of the cultural values that relates to caregiving are discussed in the next section.

4.6. Key cultural values

Cultural values and norms are important when discussing caregiving, especially considering the variance that exists between different cultures (Dilworth-Anderson, Williams and Gibson, 2002). To assess the caregiving experience among ethnic minority caregivers (such as Nigerian care workers), it is essential to understand the influence of cultural values which may be vital in the caregiver's coping process (Wallace *et al.*, 1998). This is because cultural beliefs and values are interrelated, and the prevailing values reinforce most cultural beliefs among a particular ethnic group.

In the last half a century, many studies have highlighted different cultural values about caregiving. The prevailing cultural values include: familism – where the needs of the family are seen as more important than the needs of the individual (Triandis *et al.*, 1984; Sabogal *et al.*, 1987; Gallagher-Thompson *et al.*, 2003; Losada *et al.*, 2020), filial responsibility (relating to children’s responsibility) (Finley, Roberts and Banahan, 1988; Seelbach and Sauer, 1977; Aires *et al.*, 2019), reciprocity (Kelley, 1994; Nkongho and Archbold, 1995; Nance *et al.*, 2018), respect for elders (Lee and Sung, 1997; Ar and Karanci, 2019), role modelling (Barresi and Menon, 1990; Nkongho and Archbold, 1995) and other religious and spiritually ingrained values (Lawton *et al.*, 1992; Begum and Seppänen, 2017). Although most studies on cultural values and caregiving are related to family carers, they may also be essentially significant to formal caregiver/care workers; hence I offer a brief overview of some of these debates below.

4.6.1. Familism

This refers to the pre-eminence of the family unit over individual desires, interests, priorities and decisions and it often involves a range of obligations, which one ascribe to the family. It often depicts the rights of the older members of a family and the obligations of younger members to meet the needs of the older, and in the context of dementia and caregiving, giving care to the aged (Sayegh and Knight, 2011). In conceptualizing familism, Triandis *et al.* (1982, p.1) described the concept familiar to most cultures, which consists of “*strong familial identification, the sharing of strong feelings of loyalty, reciprocity, and solidarity among the family members, the structures of mutual help and obligations held by family members, and belief in the high value assigned to both the nuclear and the extended family.*” For example, research suggests that many Black African cultures have strong familial ties, and this is often in contrast to North American and Western European cultures, which are often dominated by “individualism,” (Heller, 1970; Landrine, 1992). This difference in family ideologies may contribute towards developing an understanding of cultural caregiving practices. Killian and Ganong (2002) conducted small scale studies looking at families with more familistic ideologies and they found that they had a completely different approach to caregiving when compared with those from individualistic families. An earlier study by Pyke and Bengtson (1996) also reported that carers within individualistic families were

more reluctant to become carers. They lacked interest in caregiving and were limited in the amount of care they would provide to elderly family members and families. Often, they will only offer care out of obligation or duty, rather than reasons of affection or affinity for the care recipient. Thus, the assumption could be made that those holding familistic cultural values would be more likely to perceive the caregiving process as positive and a natural extension of family life, rather than appraising the experience as a burdensome interruption of their lives and health (Pyke and Bengtson, 1996). Also, more familistic focused people might justify the role as an expected commitment.

While this may be perceived as positive, in a study investigating the links between familism and coping with detrimental health outcomes among caregivers, Kim, Knight and Longmire (2007) observed that familism was often associated with avoidant coping which resulted in poorer outcomes in the caregivers and these findings are supported by other studies (e.g., Losada *et al.* 2010 and Sayegh and Knight, 2011).

4.6.2. Filial piety

The concept of filial piety is the belief in one's responsibility to care for family members (Gallagher-Thompson *et al.*, 2000; Gray *et al.*, 2009). It is common among Asian cultural groups, and it was evident in the interviews with the Chinese American carers (Gallagher-Thompson *et al.*, 2000). Filial piety normalises the interdependence between the older and younger generations which makes the onset of dementia to be perceived in a more positive light. In this way, the cultural meanings were reinforced through interaction with other family and community members.

Elliot *et al.* (1996) and Gallagher-Thompson *et al.* (2000) discussed the ageing process theme and filial piety as they relate to Chinese American caregivers and various groups of Asian American caregivers, respectively. However, the crucial relationships among filial piety, interdependence, and the ageing process for Chinese American caregivers warrant further attention.

4.6.3. Culture and reciprocity

The giving back or paying back for something that has been given, for example, the provision of care to a parent who had done the same for their children earlier in life, is

described within caregiving as reciprocity (Neary and Maloney, 2005). In a qualitative study by Nkongho and Archbold (1995), many respondents cited reciprocity as a significant reason for providing care to dependent family members. Those respondents who described reciprocal reasons for caregiving often described how the care recipient was a person who had cared a great deal for them (the caregivers) or other family members thus reciprocity was often considered as being borne out of great relationships with the care recipients (Nkongho and Archbold, 1995).

4.6.4. Religious and spiritual values

There are only a small number of studies that identify the provision of care to elderly family members based on standards rooted in religious beliefs. For example, Braun, Takamura and Mougeout (1996), suggests that philosophical imperatives, for instance Confucianism as present in individuals of Chinese descent, were often cited as reasons to care for Chinese elders. Research by Levkoff, Levy and Weitzman (1999) sought to understand the value of religion among four different ethnic groups who were all caring for people living with Alzheimer's disease. They suggested that the intersection of religious and ethnic factors both facilitates and impedes the help-seeking behaviour of caregivers.

4.7. Gaps in literature

Concerning the experiences of paid Nigerian care workers for PLWD, some gaps have been identified in the research literature which helped to inform the development of this study. For instance, there is little evidence for the motivation of paid migrant caregivers who presently work with PLWD as nurses or health care assistants, and how and why they became care workers. Although caregiving motivation is viewed through the prism of family carers caring for their relatives, the experiences of paid migrant care workers deserve attention, especially considering the ageing population and the increasing use of paid migrant care workers in health and social care services in the UK, Europe and in the USA.

Another gap identified in the literature is the limited knowledge regarding the influence of migrant's cultural beliefs and values on their role as caregivers. From the review of

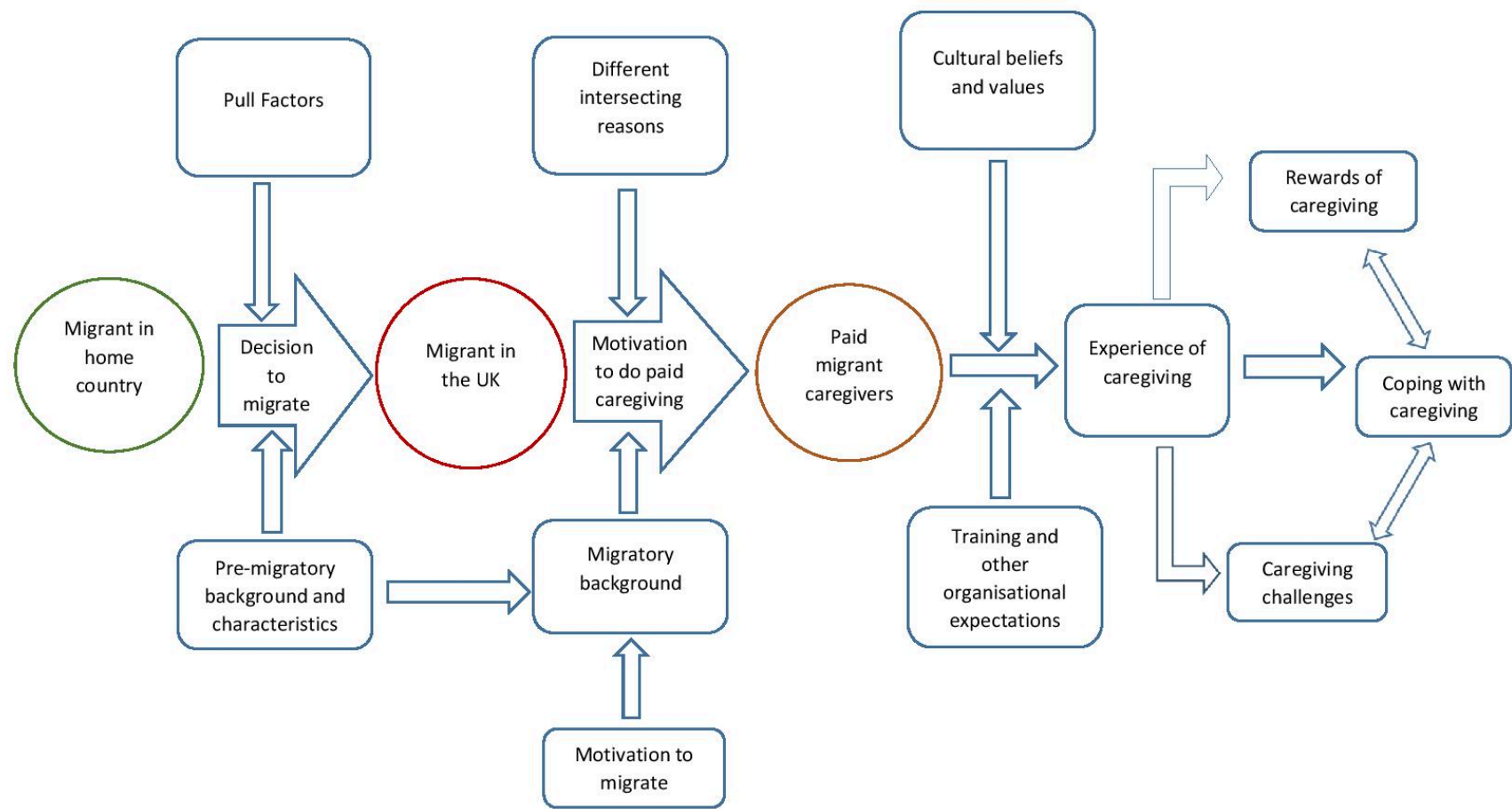
literature, it is evident that cultural beliefs and values can influence family carers' experience of caregiving. As the need to provide culturally competent care becomes high on the agenda due to the increasing ethno-cultural diversity in the UK, it is equally essential also to understand how migrant carers employed in the health and social care sector experience their role of caregiving coming from a culture that is different to the UK. The current study aims to achieve this using paid Nigerian migrant care workers as the study population. In the next section, I present the conceptual framework for this study.

4.8. The conceptual framework for this study

The following section presents the conceptual framework/model of the relationship between the different concepts in this study. This framework was informed by the review of literature presented in the earlier part of this chapter and the last two (Chapters 2 and 3), and it informed the research design adopted for this study. The research question, aim and objectives (outlined in sections 1.7 – 1.9) were also addressed using this framework as a guide.

Figure 4.1 presented below, shows the possible interactions between the major concepts identified for this study.

Figure 4.1. Proposed conceptual framework for the current study



4.9. Framework overview

4.9.1. The decision to migrate

Although the review of the literature in Chapter 2 suggests that simple economic analysis can be applied to most work migration in conjunction with the pull factors in the destination countries, this framework proposes that migrant's pre-migratory characteristics might also influence their migratory decision.

4.9.2. Motivation to do paid caregiving

This framework also suggests that paid Nigerian migrant care workers' motivation to engage in paid care might be a consequent of different intersecting motives and their migratory background characteristics.

4.9.3. Experience of caregiving

The paid Nigerian migrant's overall experience of caregiving might be related to how they culturally relate to their role. I believe migrants coming into paid caregiving from a different culture where the awareness of dementia is relatively low might have a different perspective to their caregiving practices. Such practices might be influenced by their cultural beliefs and values which they bring with them to the UK and certainly to their workplace depending on how they subsequently adjust to life in the UK through assimilation and acculturation.

Acculturation and assimilation can occur via dementia training, and this framework suggests that training might influence how paid migrant care workers perceive PLWD and how they care for them.

Lastly and most importantly, although the literature review suggests that both paid and unpaid carers have similar experience of caring for PLWD, this framework argues that migrant care workers coming from a different culture and with different cultural beliefs and values may experience their paid caregiving role differently.

In the light of the gaps in the literature identified and the possible relationship between the different concepts with respect to paid Nigerian migrant care workers as highlighted

in the conceptual framework above, the phenomenological approach was adopted as the most suited way to understand the lived experience of these care workers and in the next chapter, I will provide the rationale for the choice.

4.10. Summary

This chapter discussed the impact of caring for people with dementia. It examined the different positive and negative aspects of caregiving and highlights how they apply to care workers and how they cope with the challenges. The chapter also discussed cultural perspectives to caregiving, looking at the influence of cultural beliefs and values on caregiving. Lastly, the proposed conceptual framework of the paid migrant care workers experience was developed as a guide to the data analysis and the key concepts discussed. The next chapter (Chapter 5) covers the methodological approach adopted for the current study and set the stage for the methods used.

CHAPTER FIVE

RESEARCH METHODOLOGY

5.1. Introduction

This chapter discusses the philosophical underpinning of this research. It begins by first identifying and exploring the epistemological and other theoretical perspectives that informed the study. The methodological approach employed was then examined and provides a rationale for the choice of research paradigm. As suggested in Chapter 1, since the study sought to explore the experiences of paid Nigerian migrant care workers (nurses and health care assistants [HCA]) caring for people living with dementia (PLWD) in the United Kingdom's (UK) National Health Service (NHS), a qualitative approach was adopted.

5.2. Philosophical assumptions and paradigms

In situating this research within the context of existing literature on caregiving for PLWD, certain philosophical assumptions were made and informed the study's research design and approach. They were derived from the four guiding principles of research, namely, ontological assumption, epistemological orientation, methodological patterns, and axiological considerations (Guba and Lincoln, 1994; Creswell, 2014). Creswell (2014, p.6) referred to these assumptions as the “*general philosophical orientation about the world and the nature of research*” that a researcher brings to a particular study. Also referred to as philosophical paradigm or worldview (Mertens, 2010; Lincoln, Lynham and Guba, 2011), by holding these assumptions, the researcher makes an informed declaration of his personal philosophical position about the study (Pring, 2000). Moreover, like Creswell (2014), Crotty (1998) also believed that researchers hold philosophical assumptions regarding their research but argued that such assumptions mainly consist of their ontological and epistemological perspectives, reflecting their overall approach to that specific research. Furthermore, Pring (2000) pointed out that to make those ontological and epistemological reflections, a researcher would often have to rely on their historical, cultural, and philosophical backgrounds, without which they may not be aware of the philosophical premises on which to justify their research procedures and findings (Grix, 2019).

Hence, to examine the ontological and epistemological components of the research paradigm, Mertens (2010) argued that the philosophical underpinning should also include the researcher's axiological perspective and the nature of systematic inquiry they bring into the research. The researcher's axiological perspective is their view of the ethics of the research and the value the research has (Heron and Reason, 1997; Biddle and Schafft, 2015; Kelly *et al.*, 2018). Consequently, Mertens (2010) defined research paradigm as "*a worldview that includes certain philosophical assumptions about the nature of ethics, reality, knowledge and systematic inquiry*" (Mertens, 2010, p.451). Here, assumption about systematic inquiry implies the methods or procedures of data collection. These four different characteristics of research paradigm stated above are considered in the next section.

In summary, the main issues discussed in this chapter include the different philosophical paradigms and worldview and the basic beliefs that helped to place this research within the paradigm. This chapter serves as a prelude to the next chapter on the research methods which addresses more practical issues such as the research design, study setting, participant sampling, number of participants, data-collection methods and procedures, data management, data synthesis and analysis as well as the main ethical considerations.

5.3. Philosophical underpinning of this study

This study on the lived experience of Nigerian migrant care workers is a naturalistic inquiry, conducted within the interpretivist paradigm. With the naturalistic inquiry, the lived experiences of these care workers emerged without any initial recourse to having an advance knowledge of what their experiences might be. According to Lincoln and Guba (1985), naturalistic inquiry, which centres on how individuals behave and their true-life experiences in natural settings, are not given in advance but are rather left to unfold. They described naturalistic inquiry as a discovery orientated research, in which people's genuine life experiences are unravelled (Lincoln and Guba 1985; Patton, 2002; Athens, 2010). Similarly, because the inquiry takes place in the natural setting of the participant, in this case, the care workers' lived world, the researcher's capacity to manipulate the setting is somewhat minimised. Patton (2002) argued that by minimising

the researcher's ability to manipulate the study setting, naturalistic inquiry "*places no prior constraints on what the outcome of the research will be*" (Patton, 2002, p.39). The nature of the inquiry is such that it is situated in a context-specific real world setting that the naturalistic inquiry seeks to explore, in which the phenomenon unfolds itself naturally (Patton, 2002; Holden and Lynch 2004; Denzin and Lincoln 2005). This explains why the study was conducted within the interpretivist paradigm, an approach in exploratory research better positioned to gain understanding of the caregiving phenomenon as lived experiences of Nigerian migrant care workers.

Lastly, the decision to use this approach was also informed by my lived experiences both as a care worker and someone with a share ethnic heritage as the participants involved in the study as well as my position as a researcher with respect to the fundamental questions of ontology, epistemology and methodology (Fossey *et al.*, 2002). My position with respect to these fundamental questions is discussed below.

5.3.1. Ontology

In brief, the ontological question relates to my perception of the nature of reality (Guba and Lincoln, 1998). It is different but related to the epistemological question which provides a philosophical basis for what kinds of knowledge are possible regarding a phenomenon (*i.e.*, paid caregiving) and seeks to address my relationship with it, through the research participants or care workers (Guba and Lincoln, 1998; Crotty, 1998). Usually, the nature of research paradigms is such that a researcher's answer to the ontological question influences their relationship with what is to be known about the nature of the world. Consequently, if a researcher maintains that only a single reality exists, then they are left to search out what is already there to be known. On the other hand, if they consider the world as having multiple realities, as a relativist believes, subjectivity comes into play (Henn, Weinstein and Foard, 2009).

This study was conducted within the interpretivist paradigm with a relativist ontology that seeks to understand the subjective epistemological understanding of my participants' lived experience of caregiving (Guba and Lincoln, 1998; Crotty, 1998). Thus, the way I address the methodological question and issues raised in this study was

a direct consequence of my decision to adopt the aforementioned ontological and epistemological positions. Hence, in answering the methodological question about the procedures by which I sought to explore the experience of caregiving, my ontological and epistemological positions informed my choice of phenomenology as the methodological approach that was used to guide both my data collection stage as well the analysis of collected data. This will be discussed further in the later sections of this chapter.

5.3.2. Ontological assumption

Ontologically, this study was conducted within the interpretivist paradigm which perceives the world of individual experiences as it is lived and opposes the view commonly held by positivists and post-positivists that the world under study pre-existed reality and are driven by natural laws (Lincoln and Guba, 2000). As an interpretivist, I consider that people live within multiple and constructed realities. Otherwise known as relativism, the ontological leaning of interpretivism, the existence of multiple realities upholds the notion that each of the participants relates their experience from their own point of view. Lincoln and Guba (2000) observed that this concept of relativism espouses realities that are apprehended in the form of intangible mental constructions which are socially and experientially based. In this study, as with most study that subscribes to constructivism, the world of caregiving experience exists in forms of multiple realities and apprehending the participant's social and experiential mental construction of these realities meant that I needed to be aware of the complexities that is inherent in apprehending the 'realities' as expressed by my participants (Lincoln and Guba, 2000; Ponterotto, 2002).

The experiences as lived by care workers are understood in the form of multiple intangible mental constructions, which are socially and inherently specific to the individual care worker. In this vision of reality, knowledge is constructed rather than discovered by the mind (Guba and Lincoln, 1998; Lincoln and Guba, 2000). In other words, the reality of the world of caregiving experiences is pluralistic, as there are different constructions of the phenomenon of being a Black African or Nigerian migrant care worker to be specific (Guba and Lincoln, 1998). This is consistent with the

relativistic nature of constructivism which holds that every individual have their unique understanding of reality as humans generally ascribe different meaning to a particular phenomenon or reality (Schwandt, 1994; 2000; Krauss, 2005).

In this study, the experience of caregiving as captured from the lived experience of care workers of Nigerian descent is the compilation of my interpretation of the multiple realities as espoused by the individual participants through the interviews (Crotty, 1998; Frowe, 2001; Black, 2006; Scotland, 2012). My role as the researcher was to interpret the multiple realities put forward by the participants. The position of relativism that I have adopted in this research is subjective in nature. This is primarily because it is influenced by the context of the situation, which consist of my participant's personal experience and perception, the social environment and the interaction between the participant and myself. To this end, a formal care setting represents a typical example of social environment, in which comprise the immediate physical surroundings as well as social relationships and cultural milieus within which the care workers function and interact with their care recipients, fellow care workers and the culture of care (Barnett and Casper, 2001). My view as a relativist is emic (internal or inward-looking) in nature and are products of human intellects and constructs (Ponterotto, 2005).

5.3.3. Epistemological assumption

Epistemologically, I decided to take a subjective and situated view of knowledge. This is because constructivism as a paradigm emphasizes interpreting and understanding human experiences from the standpoint of the social world in which they live. Gaining insight into the experiences of Nigerian migrant care workers of PLWD means I have had to interpret the individual subjective experience of each of the participants. I could not adopt positivism as a paradigm because its objectivist epistemological basis makes it difficult to study an individual's lived experiences. Unlike the interpretivist, the positivist has a different approach to knowledge and understanding of the world under investigation. The positivist believes that there can only be a single reality discoverable through the systematic and rigorous application of a scientific methodology (Madill and Gough, 2008). Hence, scientific inquiry is objective rather than subjective in nature. Studying the experience of any group of people (such as Nigerian care workers),

required that I take a more subjective stand, with emphasis on interpreting and understanding the care workers' experience as an inseparable part of the social world they live in. Doing this meant that as the researcher, I am, or at least will be, interactively linked with the participants, such that findings which eventually emerge from the research are constructed as the exploration into the world of the participants as the investigation proceeds (Guba and Lincoln, 1998).

Exploring the world of the participants involved the researcher entering every investigation or interview with a subjective and transactional approach, understanding that the findings are a construction of both the minds of the researcher and the participant (Ponterotto, 2005). This is an important aspect of the research considering that I share similar cultural and work affiliations to the participants, being Nigerian myself, who also works as HCA on a part-time basis.

5.3.4. Methodological assumption

This research adopted the phenomenological approach to study the lived experience of Nigerian migrant care workers of PLWD. I chose this approach due to the methodological assumptions I made regarding the study. Interpretivist and researchers of related paradigmatic orientation, like the constructivist and critical theorists, hinge their methodological assumption on the centrality of an intense researcher-participant interaction which demands that the researcher become somehow immersed in the participants' world over a period (Guba and Lincoln, 1994; Gray, 2009). This was the stand I adopted in this study as understanding the life world of paid caregiving meant that I form a relationship with the participants and become enmeshed in it. This approach chimes well with the naturalistic mode of inquiry which uses a naturalistic design that ensures that I am immersed in the community and day-to-day life of Nigerian care workers (Gray, 2009).

In this research into the experience of Nigerian care workers, as the researcher, I bring a host of assumptions which forms the basis of my investigation. First, I believe that understanding the experience of care workers can only be made when viewed from the perspective of those who have lived through it, particularly as care workers themselves. According to Becker (1992),

“...experience is a valid and fruitful source of knowledge. Any person’s knowledge is based upon what a person experiences, whether it be first-hand experience or vicarious hand experience. Experience is the source of all knowing and the basis of behaviour. Experience, what we are aware of at any point in time, is the foundation of knowledge of ourselves, other people, and the world in general. Without human experience, there would be no human world.” (Becker, 1992, p.10- 11).

This emphasis on the value of experience in the acquisition of knowledge played a vital role in my choice of phenomenology as an approach in this research. However, despite the experiences of care workers underpinning my theoretical perspective, the findings generated from this study were both the care workers’ (participants’) interpretation of their experience of caregiving and my interpretation of their accounts (Van Manen, 1990).

5.4. Methodological approach to qualitative research

Methodology refers to the process and procedures undertaken while doing research (Ponterotto, 2005). It derives its meaning from the two words, ‘method’ and ‘logy’ which implies the aspect of knowledge that concerns the principles, process and procedures for the generation of new knowledge. It is the rationale and the philosophical assumptions that guide research inquiry and methods (Gray, 2009). Methodology shows how a researcher’s ontological and epistemological beliefs inform the research (Guba and Lincoln, 1994). Crotty defined methodology as *“the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of the methods to the desired outcomes.”* Crotty, (1998, p.3). This study employed the qualitative approach to the research process.

Denzin and Lincoln (1994) defined qualitative research as a multi-method approach involving *“an interpretive, naturalistic approach to its subject matter”* (p.1). As a research approach, qualitative research methodologies emphasise examining variables in the natural setting in which they are found with the researcher’s involvement in the investigation central to any meaningful discovery made (Gray, 2009). There is a conscious attempt by the researcher to make sense of or interpret a phenomenon in terms of the meaning the research participants bring to them (Denzin and Lincoln,

2000a). As Denzin and Lincoln (2000b) puts it, qualitative researchers “*study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them.*” (p.3). Being a naturalist approach, qualitative research aims “*to investigate the meaning of social phenomena as experienced by the people themselves.*” Malterud (2001, p.398)

The links between methodology and the philosophical assumptions that inform it is even made more apparent by Holloway’s definition of qualitative research. According to Holloway (1997), qualitative research can be defined as “*a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live.*” (p.2). It seeks to gain understanding. Holloway (1997) stated further that the main reason why researchers use the qualitative methodological approach is to explore “*the behavior, perspectives and experiences of the people they study.*” (p.2). They do this relying heavily on the interpretive approach to social reality, which Holloway (1997) argues is the basis of qualitative research.

Qualitative data sources include participant observation (fieldwork), interviews, open-ended questionnaires, documents and texts, and the researcher's impressions and reactions (Myers, 2009). Data may be obtained through the “*direct observation of behaviours, from interviews, from written opinions, or from public documents*” (Sprinthall, Schmutte, and Surois, 1991, p.101). Data can also be obtained singly or in combination from the written descriptions of people, events, opinions, attitudes and environments.

5.5. The Phenomenological Approach

The phenomenological approach to studying human experience is one of the many approaches under the broad group of qualitative research methodologies. I adopted phenomenology for my current study because I believe that generating knowledge on a care worker’s caregiving experience is made possible by the understanding of the phenomenon through an individual care worker’s interpretation of the phenomenon, which is in turn based on their assumptions regarding the world of caregiving. This approach helped me explore the lived experiences of Nigerian migrant care workers and the different components that formed their experiences.

Phenomenology sets out to understand albeit at least descriptively (the very essence of human lived experience). As implied, the term ‘phenomenology’ has its root meaning from the Greek word, “*phainómenon*”, meaning “thing appearing to view”. In a broad sense it denotes both a philosophy and a methodology. The foundation of phenomenology as an approach of systematic inquiry which is based on exploring an individual’s experiences highlights its suitability for this research. In understanding the lived experiences of Nigerian care workers of people living with dementia, the phenomenon of ‘being’ a care worker is examined within the context of having the experience first-hand as a care worker of Nigerian origin.

In philosophical terms, a phenomenon is an observed or perceived object, fact or occurrence. In ancient Greece, ‘phenomena’ was used to refer to objects of the senses as against what is understood by the intellect (Holloway and Wheeler, 2002). Hence the Greek verb “*phainesthai*” meant “*to seem*” or “*to appear*” and not necessarily what it appears to be as perceived. For instance, in Aristotelian ethics, what is good is what seem good to a man rather than what is really good (Yu, 2007). Later Greek philosophers viewed the concept of an observable phenomenon separate from theories developed to explain them as have become widely used in the 17th century to the present day. This follows from Immanuel Kant use of the German word “*Erscheinung*” meaning “*appearance*” to refer to what is now the English word “*phenomenon*” (Allison and Heath, 2002). This represents the immediate object of sensory intuition, in simple datum, what becomes an object only when interpreted through the categories of substance and cause.

There are two main branches of phenomenology named after the theorists who developed them. The first is the Husserlian or descriptive phenomenology, which refers to the branch of phenomenology developed by Edmund Husserl (1859-1938) and the other Heideggerian or hermeneutic phenomenology developed by Martin Heidegger (1889-1976). Each of these approaches to phenomenology differs in their basic ontological and epistemological stance (Holloway and Wheeler, 2002).

5.5.1. Husserlian or descriptive phenomenology

Edmund Husserl (1859-1938) considered a leading light in the German phase of the phenomenological movement is generally credited as being the father of phenomenology because he developed the phenomenological method into a distinctive method of research (Rapport, 2005 Dowling, 2007). Husserlian phenomenology is also known as descriptive phenomenology, transcendental phenomenology and pure phenomenology. The central feature of Husserlian phenomenology is its distinct ability to identify the essence of phenomena in an individual's lived experiences (Sadala and Adorno, 2002). Husserl considered the study of consciousness different from the study of nature. Whereas the study of nature (naturalism) involves investigating everything that belongs to the natural world through the scientific method, the study of human consciousness truly emerges from insights into their experiences. This intense study, Husserl asserts, could be performed through the phenomenological method arguing that phenomenology did not deny the existence of the real world, but instead sought to clarify the sense of this world (which everyone accepts) as existing. Husserl considered typical acts of consciousness as consisting of two spheres; they are worldly, and they are psychological. That is, Husserl espouses the subject-object divide, which holds that an individual and the world in which they live are linked in a case of "*conscious knowing*" (Rapport, 2005). Husserl believed that such knowledge evolved from our human existence and experience within the world (Langdrige, 2007). Husserl's view of phenomenology agrees with the fundamental tenet of the Cartesian tradition which considers man's relationship to the world as one of subjects knowing objects (Walter, 1995; MacDonald, 2001). Husserl's view of phenomenology espoused a rigorous scientific approach in relation to human life concerns. Although this view appears to suggest that he endorsed an objective reality and his idea of bracketing echoes the positivist's approach, it brings forward the possible underlying suggestions that, by endorsing an objective, reality exists separately from the researcher, the concept of bracketing actually echoes positivism (Guba and Lincoln, 1998). However, what Husserl meant by the notion of 'totally transcendent ego', void of pre-suppositions is a philosophical view of phenomenology as the basis of all knowledge rather than the scientific concept of being objective.

Hence, as was the position I took in this research, like Beech (1999), I sought to enter the 'lifeworld' of each of the care workers as free of preconception as possible, but I also acknowledge where possible those preconception and account for them in the study. For example, being a care worker myself, means that I come into the research with a considerable understanding of some of the issues which is a product of my lived experience that is highlighted in the research.

According to Heidegger (2000), there are three elements to his phenomenological views, namely, essences, intuition and phenomenological reduction. Essences, in this case, mean the true meaning and understanding of the phenomenon in question while intuition centres on the subjective understanding of the phenomenon. Phenomenological reduction refers to the introduction of extraneous influences in investigating the phenomenon to enhance the objectivity of data analysis. Sadala and Adorno (2002) believed that at the core of Husserlian phenomenology is 'the intentionality of consciousness', which refers to the ability of the human consciousness to understand the world. Husserl (2000) believed that intentionality remains the key concept in his view of phenomenology. Intentionality relates to an individual's 'consciousness' or 'awareness' (Spinelli, 2005). Husserl contended that how we react with the world is demonstrated through our consciousness; when we are conscious, we are conscious of some 'thing', and objects or 'things' direct our consciousness.

Consciousness in this sense means a descriptive phenomenologist is concerned with human interactions with the world and how things appear to them within that world (Spinelli, 2005; 2007). Husserl sought to find a way through which a person might come to know their experience of a phenomenon so they can identify the 'essential' characteristics of the experience. Husserl noted that intentionality was determined by the relationship between the *noema* and *noesis* (Gallagher, 2012). *Noema* referred to the object (or what is experienced) while *noesis* is the way in which it is experienced by the subject. Understanding the *noema* is the first thing most phenomenologists do (Gallagher, 2012). It involves allowing the participant to describe their experience of the phenomena in a case of 'returning to the things themselves' before they reflect on their experience and what it means, which is *noesis* and relates to understanding the way in which the phenomenon is experienced (Spinelli, 2005).

5.5.2. Bracketing (*Epoché*)

Husserl considered experience as the source of knowledge (Racher and Robinson, 2003) and phenomenology as the accurate and unbiased study of things as they appear, based on human consciousness and experience (Valle *et al.*, 1989). Husserl contends that the “lifeworld” is discovered only through the consciousness of human experience without necessarily relying on the interpretation of the experience to understand it (Lavery *et al.*, 2003). Thus, exploring lived experience from Husserl’s perspective involves an immediate but pre-reflective consciousness of life (Lavery *et al.*, 2003). To reach that point where the phenomena under study are allowed to emerge, the researcher has to make use of ‘bracketing’ or *epoché*, which Husserl argued would help the researcher withhold their subjective viewpoints and develop the phenomenological approach of studying things through the pre-reflective consciousness of life (Racher and Robinson, 2003). Spinelli (2005) further argued that using ‘bracketing’ as Husserl suggested ensures that the researcher suspends or ‘bracket’ their consciousness of what they believe or know about the phenomenon under study. This suggests that the researcher can in fact ‘return to the things themselves’ by taking a neutral approach through the suspension of their belief, attitude and assumptions with respect to the phenomenon being investigated (Langdridge, 2007). Langdridge noted that using bracketing, individuals could recover the originality of their experience and go “*back to the things themselves*” (Langdridge, 2007, p.17). However, the use of bracketing continues to divide most phenomenologist as critics of the process argue that the researcher’s engagement with the social world makes the process difficult to achieve (Spinelli, 2005; Langdridge, 2007). This led to the further development of phenomenology, giving rise to a new process called phenomenological reduction (Langdridge, 2007).

5.5.3. Phenomenological reduction

Phenomenological reduction deals with returning to the original source of experiences (Heinonen, 2015). Heinonen (2015) posited that phenomenological reduction is the term used to describe phenomenological bracketing that allows the researcher to discover the ‘lifeworld’ of the participants. Heinonen (2015) further noted that when a researcher brackets a participant’s lived experience, there is the experience of meaning.

In contrast, phenomenological reduction aims to bring together the specific aspects of meaning that is consistent with the phenomena of our lifeworld (as a researcher). Through the method of reduction, the actual uniqueness of the phenomenon of interest to the researcher is brought into focus and becomes central to the study (van Manen and Adams, 2010; Heinonen, 2015). This is what Adams and van Manen (2008) believed helps the researcher to re-establish direct and primal contact with the world as we humans experience it. In this study, reduction was considered a vital tool as opposed to bracketing. From a personal perspective, as a care worker and a Nigerian and Black African myself, I consider that bracketing is challenging to implement, since it demands that I suspend my consciousness as a care worker and as a Nigerian/Black African and therefore, through my literature review I have decided that Husserl approach to bracketing was not appropriate, but that phenomenological reduction would be useful.

According to Langdridge (2007), phenomenological reduction comprises of three distinct components, which makes it a better approach to exploring experience than bracketing. These include description, horizontalisation and verification or clarification. During the process of description, the researcher describes the experience of the participants without trying to make sense of it (Spinelli, 2005). While describing the experience, I am supposed to remain focused on the participant's first impression of the experience so that it is described in terms of my consciousness rather than interpreted.

The process of horizontalisation in phenomenological reduction demands that I treat every experience described by the participants as uniquely important and equal with no particular description superior to another in any particular hierarchy. Langdridge (2007) noted that when the contents of participant's description of their experiences are treated equally, the researcher becomes better positioned to avoid or minimise the degree of bias and prejudgement they bring to the eventual interpretation of the described experience (Spinelli, 1989, 2005; Milton, 2016). Horizontalisation can be described as the compilation of these experiences without placing an aspect of the participant's account of their experience over the other. Spinelli (2005) compared horizontalisation with the piecing together a large jigsaw, without prior knowledge of what image it

represents. The process of horizontalisation is essential in this study as it is ideal for treating every aspect of the account of the participant's experience as equally important.

Lastly, phenomenological reduction involves a final stage known as the process of verification or clarification. During the stage of verification, the researcher is required to revisit the completed interview transcriptions and start to develop hypotheses relating to their order of importance and meanings. After an examination of the phenomenon through this approach, a final description of the experience can be provided (Langdridge, 2007). Following epoche and reduction, 'imaginative variation' or 'imaginative free variation' can be used to explain the meaning of the experience further. This demands that I imagine alternatives to the participant's experience by trying to see the phenomenon of care work from different perspectives (Moustakas, 1994). The need to do this is to tease out the essence of the experience by filtering out the richness and depth (transcription) to unearth different themes and subthemes of the participants' lived experiences. The change to the participant's experience, through 'imaginative variation' is expected to reveal the essence of their experience, enabling different perspectives of the experience to be revealed (Langdridge, 2007). Husserl believed that the principles of epoché, reduction and imaginative variation assists the researcher in identifying the 'essences' or understanding of the phenomenon to "go back to the things themselves".

5.5.4. Hermeneutic or interpretative phenomenology

This is the broad branch of phenomenology that challenges some of the ideas within Husserl's descriptive phenomenology. Key among leading figures that contributed immensely to the development of hermeneutic phenomenology is Heidegger. Martin Heidegger (1889-1976) was a student of Edmund Husserl. Heidegger's interpretive or hermeneutic phenomenology is a description of a participant's real world with a subjective perception that allows the researcher to focus on '*Dasein*' (the German word for "understanding being-in-the-world") (Heidegger, 1962). Heidegger offered a new dimension to the understanding of human experience through tentative interpretation rather than definitive interpretation.

Other leading figures in the development of hermeneutic phenomenology are Gadamer (1900-2002) and Ricoeur (1913-2005). Gadamer believed that understanding is central to human existence and that this can be obtained via language based on historical and cultural influences (Gadamer, 2004; Langdrige, 2007). Gadamer maintained that conversation is core to understanding, which promotes a shared understanding to reveal the ‘things themselves’. This is essential in phenomenological research into the lived experience as what the conversation reveals is generated from a shared understanding with the researcher accepting the experience of the participants while recognising the role of his/her own experiences in understanding those of the participants (Langdrige, 2007).

5.5.5. Fusion of Horizons

Like Heidegger, Gadamer (2004) also considered it impossible for the researcher to bracket his/her experience of the phenomenon and in effect make *epoché* unachievable. Gadamer posited that instead of seeking to bracket their experience, researchers must first understand themselves before attempting to understand their participants. Doing this involves the researcher developing an understanding of the pre-judgements they bring into the research which depends mainly on their cultural and historical experiences. Rees (2003) observed that Gadamer uses the concept of horizon to describe how the interpretation of text occurs. Gadamer defined horizon as, “...*the range of vision that includes everything that can be seen from a particular vantage point*” (Gadamer, 2004, p.301). A researcher’s vantage point is the belief system, desires, and imaginings within which his/her horizon is formed through history, both personal and socio-cultural (Rees, 2003).

The researcher’s horizon encapsulates the range of vision that he/she brings to the interpretation of text obtained via conversing with the research participants. When researchers blend their horizon with the meaning expressed by their participants, Gadamer stated that a process called the ‘fusion of horizon’ occurs (Gadamer, 2004; Rapport, 2005). The fusion of horizon is repeated in a circular process known as the hermeneutic circle, in which the researcher’s interpretations becomes fused with the interpretations of the theme through an iterative and cyclical process that occurs in a back-and-forth manner (Rapport, 2005). As Rapport observed, “*With no beginning or*

end, top nor bottom, interpretation is revealed as a process of circular movement – a continuum” (Rapport, 2005, p.130). Smith, Flowers and Larkin (2009) noted that the researcher engages the text in the data collected in a back-and-forth manner at different levels, interpreting new meanings rather than waiting to complete the process in stages.

In my study, I engaged with the transcribed text using Gadamer’s concept of the cyclic process. This process was critical in the analysis of data as I sought to make sense of the meaning participants make of their lived experiences and this was used in the entire process of analysing and interpreting the text. Equally crucial to the analysis of the text is the work of Ricoeur (1976) contribution to hermeneutics. Ricoeur (1976) in support of Gadamer (2004), appreciated the importance of ‘being-in-the-world’ and adopted some of Gadamer’s principles in his approach to hermeneutics. Like Gadamer, Ricoeur considered language significant in the revelation of meaning. Ricoeur (1976) emphasized the role of discourse and discussion in the uncovering of meaning and not the mere interpretation of text through breaking down language, which does not adequately reveal meaning. Ricoeur’s (1976) approach to hermeneutics was one in which the researcher maintains suspicion by analysing text to uncover the hidden meaning within language, analysing metaphor and narratives (Langdridge, 2007; Knotts, 2014). It is essential to note that this study was informed by elements of Gadamer approach (the hermeneutic circle) to interpretive phenomenology and van Manen approach (phenomenological reflection and writing, which is addressed in the data analysis part of the next chapter).

5.6. Rationale for the choice of methodological approach

The methodological approach the researcher decides to adopt is partly determined by his personal philosophical assumptions as well as the nature of the research and partly by the research questions that are drawn up for the study (Gray, 2009). To explore my participant’s experiences, I adopted the qualitative approach because it seeks to gather data on the experiences of the care workers. Although there may be other numerical indicators (e.g., number of work hours) that can relate numbers to experience, it will not be appropriate to explore experience only based on that. As already stated under the sections on my ontological and epistemological assumptions, the reason I chose to adopt the interpretivist paradigm also informed my choice of methodology.

In brief, early in the planning of this study, I decided not to take a quantitative or positivist approach. I opted for the qualitative approach which has a firm base in constructivism because of the subjective nature of the research into care workers' experiences. Doing so involves exploring the experience of individuals involved in a particular task as well as eliciting comments from them, and the quantitative approach will be ineffective in undertaking this exploration. Secondly, on the nature of paradigms, interpretivism is the choice of the paradigm used in previous literature to examine experience. Since the paradigm involves an interaction between the research participants, in this case, the care workers and the researcher, it is hoped that meaningful reality about the nature and pattern of caregiving will be uncovered through this interaction. Thirdly, the quantitative approach or positivist was rejected because it is not compatible with the aims and objectives set for the study. The quantitative approach uses a survey or related methods that will not provide the detailed experience sought in this case. A survey would not allow the researcher to interact with the participants to create an exchange that will elicit and reinforce preconceived core assumptions, beliefs and values. I looked to explore the experience of the care workers which will be subjective. The decision was therefore made to adopt an interpretive paradigm, undertaking a naturalistic, qualitative study to understand these experiences.

5.7. Summary

In this chapter, I examined the philosophical underpinnings of my research by looking at the epistemological and ontological perspectives that informed the study of Nigerian migrant care workers. I provided a detailed rationale for my choice of interpretive phenomenology to understand the lived experience of my participants, and I explained what my role as a researcher is in the data collection stage. In the next chapter, I present the steps undertaken to collect data from my participants. The specific way data was collected, coding and analysis are also presented.

CHAPTER SIX

METHODS

6.1. Introduction

This chapter discusses the practical activities undertaken during the research to study the lived experience of paid Nigerian migrant care workers for people living with dementia (PLWD). It describes the specific methods I used for data collection, data coding and analysis, which were informed by both my research topic and theoretical perspectives on the methodology. Phenomenology influenced my choice of data collection methods, sampling techniques, ethical considerations and method of data analysis. The study was in two phases; the pilot study with four participants followed by the main study involving twenty-one participants.

Before undertaking the research, I reflected on the ethical issues that I might encounter during and after the research (Emanuel, Wendler and Grady, 2000; McDonach, Barbour and Williams, 2009). The identified issues informed all the key decisions I made in the planning, implementation and reporting stages of the research (Gray, 2009). By paying attention to all possible ethical issues and setting out a clear plan to address them throughout the course of the study, I was able to set the stage for the credibility and reliability of the research which Homan (1991, p. 1) describes as the “science of morality”. This was in keeping with good research practices which the Economic and Social Research Council (ESRC, 2004) holds as the moral principles that should guide any research.

6.2. The ethical and research governance approval process

Ethical considerations are an important component of the research process because it mitigates against any concern that may put the research participants or the researcher in danger (Creswell, 2014). The main ethical issues addressed in this study includes seeking informed consent, maintaining confidentiality during and after interviews and minimising emotional harm during interviews. Ethical issues related to post data generation and publication of research findings were also addressed.

During the planning stage of this research, a multicentre ethical approval was sought from the Health Research Authority (HRA) of the National Health Service (NHS) and the University Ethics committee. Similarly, approval was sought via letters of permission from four local churches in Chelmsford from where I recruited participants for the pilot study (see Appendices 6.1A, 6.1B, 6.1C and 6.1D). The application process to the NHS Health Research Authority (HRA) was completed on the Integrated Research Application System (IRAS). Amendments were requested and addressed before approval was granted (see Appendices 6.2A, 6.2B and 6.2C). However, a minor amendment was later sought from the HRA when there was a change of study focus from paid African migrant care workers to paid Nigerian migrant care workers. Once the approval from the HRA was granted (Appendix 6.2A), ethical approval from the Faculty Research Ethics Panel (FREP) of Anglia Ruskin University (ARU) was also confirmed (Appendix 6.3) and this marked the commencement of the data collection stage.

Approval was also sought from Research and Development (R&D) department of the participating NHS Trust to allow participants from the two wards within the Trust to be recruited (Appendix 6.2C). Obtaining Research Governance approval from the R&D Department of the NHS Trust required sending the R&D manager the approval obtained from the HRA who in turn issued a letter of approval via email. In the process of obtaining HRA approval, copies of the invitation leaflet (Appendix 6.4), full university indemnity letter (Appendix 6.5) and other documents relating to the research were submitted. Other research documents submitted (and included in the appendices) include the interview guide (Appendix 6.6), front page of the completed IRAS application form (Appendix 6.7), letter of invitation (Appendix 6.8), participant consent form (PCF) (Appendix 6.9), participant information sheet (PIS) (Appendix 6.10), research protocol (Appendix 6.11) and the summary of my curriculum vitae (Appendix 6.12) and those of my supervisors (not included).

6.3. Addressing research ethical issues

The ethical issues related to this study were derived from the key ethical principles which ultimately guided the moral choices of behaviour between me as the researcher

and the research participants (Redman, Hill and Fry, 1997). The principles include non-maleficence, autonomy, beneficence, justice and veracity (Gillon, 1994; Westra, Willems and Smit, 2009).

6.3.1. Risk to participants

The principle of non-maleficence refers to my responsibilities as the researcher to ensure that research participants did not come to harm (Redman and Fry, 1996; Redman, Hill and Fry, 1997; Redman and Fry, 2000, 2003; Liaw and Tam, 2015). Due to the nature of this study, the principle of non-maleficence with respect to participants coming to physical harm was not applicable. However, another form of harm (emotional harm) was considered, and it was decided from the outset that should it become clear that if a participant becomes distressed because of the interview questions they were being asked, the participant would be given the opportunity to discontinue the interview (Sanjari *et al.*, 2014). No such incident arose in this study although an interview was discontinued and rescheduled because the participant had to attend to an urgent family need. All the preliminary procedures that precede an interview were repeated when the rescheduled interview was conducted.

Another risk to participants considered was the financial risk incurred when travelling to the interview venue (the University). Because funds were not available to pay or reimburse the participants for travelling expenses, it was made clear in the participant information sheet (PIS) that they would not be reimbursed, and participation was completely voluntary as the research was purely for academic purposes.

6.3.2. Freedom to participate

The principle of autonomy demands that research participants are given enough time and space to make meaningful choices, without any controlling interference on their decision to participate in the research (Redman and Fry, 2003). Apart from providing participants with the opportunity to give their consent to taking part in the study, I took practical steps to ensure that they had the freedom to make the decision whether to participate. To make an informed consent, along with the letter of invitation to participate in the study, participants were also provided with the participant information

sheet (PIS) and a copy of the consent form to read and familiarise themselves with the details of the research. They were given a discretionary period of at least 7 days to read and decide whether to participate before the interview was scheduled (for details, see Appendix), and were given the participant consent form (PCF) to sign before the face-to-face interview session began.

The principle of autonomy guiding research of this nature is closely related to the principle of veracity which refers to my duty as the researcher to communicate all risk associated with the research to the participants involved in the research. Doing so honestly and providing the participants with adequate information necessary for them to make an informed decision on whether to participate is the principle on which informed consent for research participants is founded (Gray, 2009). It holds that participants deserve the right to know any risk associated with the research. I was bound by the principle of veracity to disclose the risks and benefits associated with the research to the participants using language that is clear and unambiguous (Gray, 2009). The participant information sheet (PIS) was therefore designed to provide potential participants with the information they required to make an informed decision. The PIS was reviewed by the Faculty Research Ethics Panel (FREP) and used in the pilot phase of the study before it was used in the main study phase.

6.3.3. Addressing trust issues in the research

In the design of the participant information sheet (PIS), consideration was given to the ethnic background of the study participants. Historically, low rates of participation have been reported in research involving participants of African origin (Corbie-Smith, 1999; Corbie-Smith *et al.*, 1999). This is often due to trust issues. Fear of deception by the researcher, lack of understanding of the true purpose of a study and the fear of being used as a ‘guinea pig’ have been reported (Corbie-Smith, 1999; Katz *et al.*, 2006; Quinn *et al.*, 2007; Williams, Beckmann-Mendez and Turkheimer, 2013; Somayaji and Cloyes, 2015). Consequently, I ensured that these concerns were addressed. In addition, being an African of Nigerian descent placed me in a position of strength, as the study participants potentially could identify with me because of our shared ethnic background. Our shared ethnic background helped break that barrier that could exist

between Black African research participants and White researchers (Bond and Harrell, 2006).

6.3.4. Confidentiality and recording

Steps were taken to ensure confidentiality was maintained throughout the study. First, participants were informed of the need to record the interview session using an audio recorder. This was highlighted in the participant information sheet and reiterated before the interview session began. The audio recording was sometimes complemented with note taking, writing down some points or anything that I thought I might need to further probe into or that I might need to explore further after the interview. This practice was explained to each of the participants before every interview session began and they were told not to hesitate to inform the researcher if they find it distracting.

As part of the preliminary interaction with the participants before the interview began, I also re-emphasised the procedure for storing and managing the audio recording and other materials relating to the interview. All audio recordings were assigned pseudonyms chosen by the participants and were transferred from the audio recording device to a password-protected computer (Newing, 2010; Galletta, 2013). The time required by the University for storing the audio-recording was also explained. All the participants accepted the data storage procedures and signed the consent form before the interview began.

The study strictly observed to the Data Protection Act 1998 (Great Britain, 1998; Granger, 2018). Although, the Data Protection Act of 1998 is now superseded by the General Data Protection Regulation (GDPR) of 2018, it was in use at the time of ethical approvals and the data collection stage. Moreover, both the Act and the regulation have at their core the protection of the participants (Lovell and Foy, 2018). The actual names of the participants were written on the consent form being an official document and consent forms were kept securely in a locked cupboard.

6.3.5. Benefit of participating

Another key principle in research ethics is the principle of beneficence, which refers to research being conducted for “the benefit of others” (Redman and Fry, 1996; Orb,

Eisenhauer and Wynaden, 2001). Participants were made aware of the possible benefits that participating in the study may bring either to themselves or to promoting good care for people with dementia, and this information was provided in the participant information sheet (PIS). In brief, although there were no individual benefits likely to be directly accrued to the participants, their participation in the study might produce findings that could be used to improve services to migrant care workers (especially those of Nigerian origin) and the relevant authorities directly focusing on coping strategies that works best for them. Another benefit to the participants is that the findings might provide information on Nigerian migrant care workers' motivation to assume and continue in their role. Having this understanding might provide insight on the caregiving experience of staff of Nigerian or African origin (Lepore, 2008), which may benefit care workers of other ethnic groups.

6.3.6. Ethical dilemmas during interviews

Participants were advised prior to consenting to interview, that if they revealed information concerning dangerous practice, harm to others or a criminal offence, an appropriate authority would be informed. However, no revelations were forthcoming during interviews.

6.4. Study setting and location

The study was conducted with participants recruited from two National Health Service dementia wards in Essex. However, during the pilot study, participants were recruited from four churches attended by Nigerian migrant care workers located also in Essex. The initial plan was to recruit participants only from the care setting in which they currently work but this changed due to challenges faced while seeking the consent of potential gatekeepers. These challenges are highlighted in the later part of this chapter. The difficulty in recruiting all the participants from one location prompted me to look at other avenues through which participants could be recruited including the eventual use of snowballing sampling techniques (Creswell, 2014).

6.5. Data collection methods

Face-to-face in-depth interviews were used to gather data on the lived experiences of Nigerian migrant care workers caring for people with dementia in formal care settings in Essex. The interviews were transcribed and analysed using interpretative phenomenology informed by Van Manen (1997; 2014). To understand the experiences of migrant care workers, this study was tailored to investigate three main but interwoven concepts on their caregiving experience, namely: their journey into care, their cultural perception of dementia and how that informed their caregiving practices, their motivation for taking up and continuing in the role as care workers and the strategies they employed to cope with the demands of the role if they find it demanding.

The use of in-depth interviews is consistent with the phenomenological approach adopted for the study. In-depth interviews apart from being frequently used in health research are suitable to explore personal and intimate experience of caregiving as it allows for the use of open, direct or verbal questions to gather narratives on their time as care workers (DiCicco-Bloom and Crabtree 2006; Whiting, 2008). The use of individual in-depth interviews allowed me to discuss the lived experiences and beliefs of paid Nigerian migrant registered mental-health nurses (RMNs) and health care assistants (HCAs). Twenty-one participants were recruited for the main study phase, the sampling procedure and the inclusion and exclusion criteria are detailed below.

6.5.1. Inclusion criteria

- a. Age requirement: Care workers between the ages of 18 and 65 took part in the study because this was a study focused on adult Nigerian migrant care workers. The minimum age limit of 18 years was set to reflect the definition of adult in Nigeria and the UK, and the maximum age limit of 65 years was set because it is the average state pension age in the UK (Storey, 2018). However, the youngest of the participants was 28 years while the oldest was 56 years old.
- b. Birthplace: Preferably Nigeria. However, participants who were born outside Nigeria but self-identified as Nigerian and have spent most of their early years in Nigeria were also considered. Nigerians born in the UK who have spent most of

their lives in the UK were excluded from the study. All but one of the participants were born and lived in Nigeria.

- c. Duration of caregiving: I recruited participants who had been in their paid caregiving roles, working as nurses or HCAs, for at least a minimum of 6 months and were currently still in the role. This was to ensure only care workers who had experience with caregiving and currently doing so were recruited for the study.
- d. Language proficiency: Participants were also required to be fluent in English language and be willingly able to complete and sign the participants consent form.

6.5.2. Exclusion criteria

- a. Young care workers who under 18 years.
- b. Care workers who have not spent up to three months on the role.
- c. Nigerians born in the UK or those who self-identified as Nigerians but were born elsewhere and spent most part of their lives outside Nigeria.

6.5.3. Sampling

Sampling refers to the process through which the study participants were recruited from the wider study population of paid Nigerian nurses and HCAs (Seaman, 1987). Burns and Grove (2003) described sampling as “*a process of selecting a group of people, events or behaviour with which to conduct a study*” (p. 31). It is argued that sampling is important because it results in a study sample that represent the study population (Polit, Beck and Hungler (2001). The study sample of care workers were recruited using the ‘invitation leaflet’ designed for the study and by word of mouth from two hospital wards in an NHS Trust within Essex. It included permanent, bank staffs and care agency workers, who worked as HCAs, senior HCAs, support workers and nurses. This group of care workers were chosen because they worked directly with the patients on the ward and maintained almost daily contact with people living with dementia.

Participants in the main study phase were drawn from two NHS wards with a combined number of 34 beds providing care for older adult (usually over the age of 65). They include an assessment and treatment ward for older adults with dementia, organic and

other functional illnesses. These wards were chosen because staff, particularly those on the flexible-hours contract can work in either of the wards. The inclusion criteria also included anyone who worked regularly in either of the wards whether as regular or bank (temporary) staff on zero-hours contract.

Participants for the pilot study were recruited from four churches mostly frequented by Nigerian migrant worshippers using convenient sampling and snowballing. These methods of participant recruitment were chosen due to their effective use in previous research involving similar populations (Gorelick *et al.*, 1996; Gordon-Larsen *et al.*, 2004; Scharlach *et al.*, 2006). I was also aware from personal experience that sometimes, Nigerian migrants do have an affiliation to a church and the church has been identified as one of the commonly used organisations for recruiting Nigerian migrants because it often serves as a source of social support (Taylor, Lincoln and Chatters, 2005; Taylor, Chatters and Jackson, 2007; Chatters *et al.*, 2011). Other religious houses of worship (for example, the mosque) were not considered as only a small sample were sought to participate in the pilot study.

Informal contact was made with each of the identified church pastor/head to discuss the research and what their role would be in the recruitment process. After discussion with the church pastors, I sent them a copy of my research proposal and a letter briefly outlining my research and requesting their permission to let me invite their members to take part in my study. In each of the churches, the pastor/head been the gatekeeper introduced me to the congregation so I could ask them to participate in the study. On my visits to each of the churches, the pastor allowed me to speak to the church secretary who suggested that I speak with an identified care worker. Before I spoke to anyone about the research, I handed them the invitation leaflet and requested that they call me if they would like to participate in the pilot study. The entire process of recruiting study participants for the pilot study commenced after an amendment to the final approval for the study was granted by the Anglia Ruskin University's Faculty of Medical Science's Faculty Research Ethics Panel (FMS-FREP). Four participants eventually took part in the pilot study, three were from one church, and one participant was from another.

6.5.4. Sampling methods for recruiting participants

Qualitative research uses non-probability sampling because it does not seek to obtain a statistically representative sample required to make statistical inference. With a purposive non-random sample, the number of care workers interviewed is not as important as the criteria used for their selection (Gray, 2009). To be included, participants had to meet the inclusion and exclusion criteria and be willing to sign the consent form to show their willingness and consent to take part in the study.

Using purposive non-probability sampling, I was required to use my judgement to select participants who would participate in the study based on their knowledge of the phenomenon (Oisín, 2007). The nature of this study favoured the use of purposive sampling technique during which I made a conscious effort to select participants who specifically met the criteria for inclusion in the study (Devers and Frankel, 2000).

In addition to the purposive sampling, snowball sampling was also used. Snowballing techniques complement the purposive sampling technique to ensure that an adequate number of participants who met the criteria for inclusion were included in the study. Snowball sampling technique is a sampling method that involves recruiting research participants via a chain process in which an eligible participant informs the researcher of another potential participant who in turn recommends another and the chain continues (Vogt, 2005; Gentles *et al.*, 2015). This develops into a chain of participants recommending each other to participate in the study. It is best suited for studies where the study participants might be hard to access. In this study, whilst there are many Nigerians involved in care work, I was specifically interested in those Nigerian care workers who were actively involved in caring for people with dementia. The profile of the participants is presented at the beginning of Chapter 7.

6.5.5. Interviewing: language of choice

The face-to-face in-depth interviews were conducted in English. However, participants who use the colloquial ('broken') or pidgin English, were invited to discuss some issues in more detail to make sure I understood what they were really saying when they spoke in pidgin English.

6.5.6. Phase One: Pilot interviews with paid Nigerian migrant care workers

Prior to conducting the main study, a pilot study was conducted to test the interview guide and to practice interviewing skills. A pilot study is a small size version of a main study and has been defined as a “*small scale version or trial run in preparation for a major study*” (p. 467) (Polit, Beck and Hungler, 2001). In this study the pilot was conducted to pre-test or try-out the data collection instrument (interview guide) developed for the study (Baker, 1994). The interview guide was an essential tool in the interview process as it helped to guide me and focus on the core issues of the interview. The interview guide was developed from the literature as well as the research questions (Chan, Fung and Chien, 2013). The piloting process enhanced my confidence and helped me develop and refine the interview guide further in terms of clarity, content, and length. It also helped me develop my ability to stimulate and maintain interactions and sharpen my transcribing skills.

Although conducting a pilot study does not imply that the main study will be automatically successful, Simon (2011) noted that it helps the researcher do better research by making adjustments that might improve the quality of the data collection tool. Simon (2011) also suggested that pilot study can help the researcher address some of the logistical issues associated with a study. The use of pilot study was very beneficial in this study as it helped me check the wording of the interview guide. Turner (2010) observed that conducting a pilot study can assist the researcher in determining the flaws, limitations and weaknesses associated with the interview design. As Turner (2010) argued, the beauty of the pilot study is that it acts like the imperfect prototype of the main study whose eventual refining and adjustment produces the main study that has less weakness. Although the role of pilot study in research has sometimes been undermined by the limited numbers of pilot study published, they have been found to aid the researcher in addressing any concerns raised with the design of the interview guide (Mason, 2010). I presented a part of the findings from the pilot study in a research student conference and received feedback on issues that I needed to address before moving on to the main study phase.

One of the issues addressed in conducting the pilot study was rephrasing poorly asked questions (Lancaster, Dodd and Williamson, 2004; van Teijlingen and Hundley, 2002). Poorly asked questions limit the amount and quality of description obtained from research participants (Lancaster, Dodd and Williamson 2004). During the pilot phase of this study, my conceptualisation of culture as the way of life undertook serious scrutiny which demanded that I define in clear terms what I sought from the participants when I asked them how they thought their culture as Nigerians influenced their care as care workers. Another lesson learnt was the way I asked my questions. With an early research background that was based on empirical research rooted in the quantitative research tools, I initially struggled with trying to be present with the participant as opposed to extricating myself, which is the bane of quantitative research. However, once I completed the first two pilot interviews, I adjusted into the role of being a researcher indeed present in the research and being the main data collection tool. Lastly, my confidence as a qualitative researcher improved from feeling nervous in my first interview to becoming relaxed. The pilot study was a confidence building process for me.

The pilot study helped me to rephrase inappropriately developed questions to allow for thick description of the phenomenon of caring for PLWD. In this research project, there were no notable differences between participants in the pilot interviews and the main study. However, participants involved in the pilot study were not allowed to participate in the main study as I was opposed to re-interviewing participants who would know what to expect in the interview. They were therefore excluded from the main study to allow for new participants to be recruited and the data from the 4 pilot interviews were not included in the data analysis. Another reason for doing this was to allow for the adjusted interview guide to be tested on participants new to the research. With respect to sample size, there is no fixed number of participants required for a pilot study. Baker (1994) suggested that an appropriate size for a pilot study should be about 10-20% of the sample size required for the main study. However, in this present study, it was difficult to predict the final number of participants who would participate in the in-depth interviews. This was due in part to recruitment rates, and whether new themes were observed during data collection (data saturation) (Guest, Bunce and Johnson, 2006; Mason, 2010). I eventually interviewed a total of 21 participants (15 HCAs and

6 RMNs) in the main study and only stopped once I was convinced that saturation has been achieved (Mason, 2010).

6.5.7. Challenges of recruitment

Following all the necessary ethical approvals, I handed out information sheet and consent form to each of the participants and ask them to complete and return. Once these were completed and returned, I contacted them via their preferred medium to arrange the place, date and time of interview. Most of the interviews took place in a pre-booked room at the University. This was chosen because it offered an environment with little distraction, and it was mutually agreed by the participant and the researcher (Turner, 2010). One of the interviews took place at the participants own home. I observed the lone working guide as outlined in my application for ethics and all risk were addressed.

It was initially planned to recruit participants directly from care homes, nursing homes and other care settings without using the snowballing sampling technique. However, gate keepers (contact persons) in the care settings who were informally contacted were unwilling to allow me to recruit their staff. This was despite assurances that participants would not be linked to where they work and that the recruitment sites would remain anonymous. Their reluctance may not be unconnected with the media spotlight on care homes in recent times with reports of some abuse in some and poor quality of care in others (British Broadcasting Corporation (BBC), 2016; Gordon, 2016; Trigg, 2019) and fear that interviewees might inadvertently reveal the nature of care within the care setting.

The initial challenges encountered whilst trying to recruit participants directly from the places they work did not result in any changes to the inclusion or exclusion criteria. Participants recruited from the two hospital wards to take part in the main study or those recruited from churches to take part in the pilot study had everything in common with respect to meeting the inclusion criteria set for the study. I am aware that participants recruited from churches in the pilot study may have systems/values that are different from those recruited from the hospital mental health wards, so I took account of this during the analysis and discussion of findings.

6.5.8. Phase Two: Interviews with Nigerian migrant care workers

The second phase of this study is the main in-depth interview phase involving participants from the study setting. One of the benefits of doing interview in this phase is to allow me to capture the experience of the participants in a face-to-face discussion (Smith, 1995; Gall, Gall and Borg, 2003; Willig, 2008). The complete interview guide is shown and presented on Appendix 6.6.

A typical interview began with me introducing myself to the participant. I then proceeded to explain the purpose of the research in brief. I also explained to each of the participants why they were chosen and reassured them of complete confidentiality (Wiles *et al.*, 2008). I also gave them a consent form to sign before the interview began with me asking them to tell me a bit about themselves as well as their caregiving background. Beginning on this general note served to get to know them and allowed them to relax. As the interview progressed, I proceeded to ask them questions relating to their perception of dementia, motivation as care workers and the support they receive to cope with the demand of the role.

6.5.9. Withdrawing from the study

Participants were informed of their right to withdraw at any time if they felt they no longer wanted to participate in the study or interview for any reason. They were also told that they are free to withhold any information if they did not wish to share it. Participants were informed that there would be no consequences if they chose to withdraw as this is within their legal right. Hence, throughout the course of the interview, participants had a copy of the signed consent form which also include a withdrawal form. They were told that those who withdraw from the study and subsequently changed their mind would gladly be welcomed back. However, nobody withdrew from the study.

6.6. Data Analysis

Analysis involved organisation of the data in a well-structured manner to elicit the meaning and implications of the data. Data analysis in qualitative research is generally

an active and interactive process involving the active involvement of the researcher (Polit, Beck and Hungler, 2001). Data analysis commenced immediately after conducting an interview. Precisely, it was done simultaneously with data collection (Holloway and Wheeler 2002; 2010). To begin, each interview was transcribed verbatim. This process included listening to an interview recording over again, pausing and rewinding when necessary, checking for mis-hearings and making sure all words from the recorded piece are well captured in the transcript.

The transcripts were analysed using interpretative phenomenology informed by Van Manen's (1997) phenomenological reflection and Gadamer's (1990) hermeneutic circle. Following transcription, the interviews were re-read to make sure everything from the recordings was captured. After manual coding of data, it was processed using NVivo, a software specifically designed for use in qualitative research. Coded data was then arranged in themes before the final process of making meaning of the data commenced. This process of analysing the data was undertaken in a structured way to enable the researcher do a thorough interpretation of the participants' experience (Wimpenny and Gass, 2000; Smith, Flowers and Larkin, 2009).

6.6.1. The role of the researcher in data analysis

Since the process of data analysis in qualitative research is a very active and interactive one, I was actively involved to tease out meaning from the collected data. Usually, in a phenomenological study of this nature certain analytic practices are employed by the researcher, which includes reflexivity, bracketing and intuiting. However, I did not use bracketing. The essence of following through these practices is to ensure that as the researcher, I can put my preconceptions regarding the phenomenon under study aside. However, as noted in the discussion on the study methodology and methodological underpinning for this research, I discussed why I felt at the time, that I would not be doing any bracketing during data analysis. Just to reemphasise, my position both as a researcher who has and is still actively involved in the care of people with dementia and the added advantage of being a Nigerian makes it difficult to successfully apply bracketing to this study. Despite not bracketing or actively intuiting, steps were taken

to apply reflexivity to the analysis, as informed by phenomenological reflection and phenomenological writing (Van Manen, 2007).

In reflexivity, I continuously reflected on my personal preconceived values as well as those of the participants. I reflected on how data collected will be influenced by how the participants perceives me as the researcher (Holloway and Wheeler, 2010; Holloway and Galvin, 2016). I also reflected on my personal actions, feelings and conflicts experienced throughout the research. To successfully do this would require that I maintain a self-critical stance to the study, the participants, my personal assumptions, role as researcher and relationship to the research and study participants. The main motivation to engage in reflexivity was among other things to help me self-monitor the research, to analyse data and to minimise my personal bias as the researcher and increase the study's trustworthiness.

6.6.2. Analytical process informed by van Manen's reflection and writing

It was possible to generate emergent themes from my research interviews by directly participating in the data generation process, transcribing and conducting thematic analysis. The entire process of data analysis was guided using two research activities proposed for interpretive phenomenology by van Manen (1990, 1997, 2014), that is, phenomenological reflection and writing.

6.6.3. Phenomenological reflection – discovering themes through detailed, selective and holistic reading of transcripts

According to van Manen (1990; 2016), to undertake a phenomenological reflection of the lived experience of paid Nigerian nurses and HCAs, the researcher would have to have “a more direct contact with the experience as lived” (van Manen, 2016, p.78). Explaining this, van Manen (1990, 1997 and 2016) gave further description of what phenomenological reflection entails using the analogy of a teacher and a parent. He pointed that if one wants to grasp the pedagogic essence of being a teacher or parent so as to live it fully with children of his or her own, the individual will have to phenomenologically reflect on the lived experience of a teacher or parent as a teacher or parent. In other words, it is not enough to simply reflect on the lived experience of

paid Nigerian migrant care workers in the UK, but it is important to reflect phenomenologically on the experiences by capturing the essence of lived experiences of caring for PLWD as lived by paid Nigerian nurses and HCAs in the UK.

To engage with the essence of caregiving, I considered the multi-layered nature of what it means to care. Hence, I did not reduce the meaning of caregiving to a simple definition. As acknowledged in the review of literature on the concept of caregiving, no standard definition of caregiving is widely accepted. Therefore, in this study, the meaning of caregiving was described through participants' narratives of their experience of it. After transcribing the narratives into texts, it was important to reflectively engage with the text to explicate the experience of caregiving. To fully grasp the structure of the meanings in the texts, their experiences of caregiving was described in themes. Consequently, phenomenologically reflecting on the lived experience of caregiving thus becomes reflectively analysing the themes captured in their experiences.

Thematic analysis is common to other methods within qualitative research but what makes van Manen's interpretive phenomenology thematic analysis different is that it is *"the process of recovering structures of meanings that are embodied and dramatised in human experience represented in the text"* (van Manen, 2014, p.319). This contrasts with ethnography in which the goal of thematic analysis is to discover the categories that makes for the description of cultural groups and practices (Hammersley, and Atkinson, 2007). The unique style of thematic analysis in ethnography is also markedly different from that carried out in a grounded theory research which involves thematic coding, done by constantly comparing analysis to develop a theory (Glaser and Strauss 1967; Strauss and Corbin, 1998; Bryant and Charmaz, 2007).

Simple coding and conceptual abstraction would not provide phenomenological understandings into caregiving (van Manen, 2014). Therefore, my analysis of thematic meaning of caregiving amongst paid Nigerian migrant care workers caring for PLWD was a free but creative process of insightful invention, discovery and disclosure. Rather than being a fixed process with strict rules, the explication of meaning was guided by phenomenological reduction (see chapter 5) (van Manen, 2016). As van Manen (1997)

suggested, to gain insight into the lived experience of Nigerian migrant caregiving, texts were regarded as sources of meaning including single words, a phrase, an expression, a sentence, a paragraph or even at the level of the whole story (van Manen, 2014). This is what van Manen referred to as detailed, selective and '*wholistic*' reading.

I utilised the three processes of reading to generate details of the lived experience of paid Nigerian migrant care workers, through a description of their experience of caregiving (selective) and an overall understanding of their caregiving (holistic). Thus, from reading each transcript, I constantly questioned what the individual sentences uncovered about the lived experience of Nigerian migrant care workers for PLWD. Through this, I was able to identify thematic expressions, phrases and descriptive paragraphs that allowed the phenomenological meaning of my participant's experience to uncover itself in the text (van Manen, 2014). Beginning with a detailed reading and analysis of the transcripts, different meaningful units of paid migrant caregiving were identified giving rise to several subthemes (see Figure 6.1).

Using similar method of analysis as the detailed reading of sentences, I also read selective texts several times whilst posing the question, 'What does this expression or phrase reveal about migrant caregiving? During selective reading, the subthemes were categorised into main themes. Some of the phrases or expressions were very thought provoking, for instance, 'it is good for my CV'. Phrases like this were used to develop and write the phenomenological text (van Manen, 2014). Lastly, using the '*wholistic*' reading approach by van Manen (2014), the text from this study was read in whole to ascertain how the main importance of the text (as a whole) could be captured.

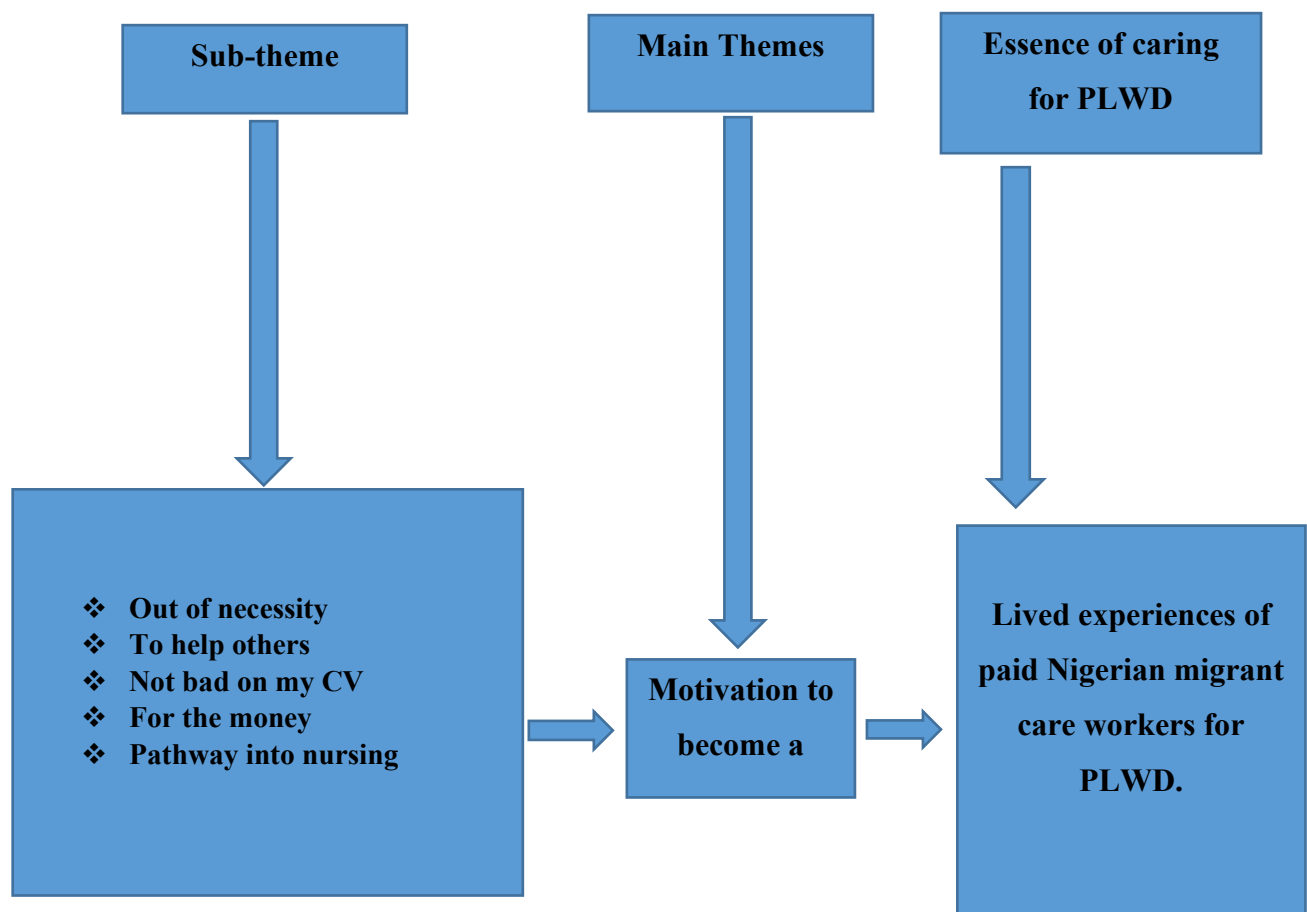


Figure 6.1: A working example of the data analysis process

These subthemes were identified, which led to emergence of the main theme of motivation to care and subsequently the discovery of the essences of caregiving in paid Nigerian migrant care workers for PLWD in the UK.

6.6.4. Phenomenological writing

The conceptual categories which emerged from the text and the entire data are abstract but are influenced by the researcher's theoretical, personal and professional characteristics. Since phenomenological writings is a representation of the researcher's interpretation and thoughts on the data (van Manen, 1997). I engaged in writing down my interpretation of the data using a pattern of the worked example of data analysis shown in Table 6.1 below. Phenomenological writing was essential to bringing the essence of the lived experience of Nigerian migrant care workers to life.

Worked Examples of data analysis

Journey into care

Main theme	Sub-theme	Example of extract	Explanation
Journey into care	Motivation for leaving Nigeria for the UK	<i>“...because there is need for career progression, I had to quit my job to further...”</i>	Lola considers her desire to further herself in her career as the primary reason for leaving her job as a nurse in Nigeria. She further added that completing her top-up course in nursing will make a whole lot of difference when she returns to Nigeria.

Table 6.1: Worked example of data analysis

6.7. Data storage and NVivo

Data coding was done manually. However, to effectively manage qualitative data, Gibbs, Friese and Manabeira (2002) advocated for a consistent, efficient and systematic storage of the data which can be facilitated using suitable software packages such as NVivo, or Atlas-ti. NVivo, like most qualitative data management packages, enabled the storage of all transcribed data in an organised fashion. Considering the number of

interviews (21) conducted in this study, with each averaging an hour, the large amount of transcribed materials that emerged were conveniently handled using NVivo software. Although, coding was done manually, the use of NVivo also aided the line-by-line process of coding adopted for the data analysis and ensured the data was better organised. It allowed me track codes as they developed and then to develop categories.

6.8. Assessing study trustworthiness

This study gained an increased understanding of the lived experiences of Nigerian migrant care workers of people living with dementia through an empirical approach, and it was essential to ensure a rigorous approach to legitimise the findings of the research (Armour, Rivaux and Bell, 2009). Morse *et al.* (2002, p. 14) described research void of rigour as, '*worthless*', stating that such research, '*becomes fiction, and loses its utility*'.

Hence, whilst conducting the study, I observed the four aspects of 'trustworthiness' relevant to qualitative research, namely, credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985; Rolfe, 2006). For example, during my transcription and analysis, my supervisor offered valuable guidance and helped check to ensure things were going as planned. They also looked at a copy of some anonymised transcripts. Throughout the process, the confidentiality of the participants was protected.

6.9. Summary

This chapter highlights the practical activities undertaken during the research and described the specific data collection methods, data coding and analysis. I discussed the ethics application process, noting the ethical issues that were significant to the study and how they were addressed. I also discussed how I gained access to my participants, recruiting them from two NHS wards using purposive sampling. Lastly, the processes of data generation and analysis were also discussed. In the next chapter, the study findings are presented, beginning with an introduction to the chapter followed by a consideration of the main themes that emerged from the data coding process.

CHAPTER SEVEN

BACKGROUND OF PAID NIGERIAN MIGRANT HEALTH CARE ASSISTANTS AND NURSES AND THEIR MOTIVATION TO MIGRATE TO THE UK

7.1. Introduction

This chapter presents the findings on paid Nigerian migrants' health care assistants (HCAs) and nurses working in the NHS and their experience of caring for people living with dementia (PLWD) in the UK. It is the first of four chapters that explores my participants' experiences using a qualitative approach (phenomenology) informed by the work of van Manen (1990; 2014) and Gadamer (1990). As noted in the last chapter, this research involved understanding the lived experience of my participants through phenomenological reflection and writing as captured in a face-to-face in-depth interview. This chapter presents the background of my participants, to provide a context for understanding their experience of migrating to the UK and their experience of caring for PLWD in the UK.

This chapter is in two key sections. The first section reports and discusses my participants' background characteristics, thus providing a profile for paid Nigerian registered mental health nurses (RMN or nurses) and healthcare assistants (HCAs). The second section captures my participants lived experiences of migrating from Nigeria to the UK.

7.2. Background of paid Nigerian migrant HCA and nurses caring for people with dementia in the NHS.

7.2.1. Introduction

In this section, I highlight the characteristics of the participants, including their place of origin and where they lived in Nigeria before migrating to the United Kingdom (UK). This provides some background to the participants' educational and professional backgrounds, as well as their motivation to migrate to the UK.

This foundational information was essential to understand the profile of the paid Nigerian migrant care workers, as previous studies on migrant care workers have not specifically considered the profile of Nigerian migrants working as nurses or HCAs (Aboderin, 2007). I also wanted to gain insight into why they began to work as paid carers and nurses for PLWD in the National Health Service (NHS) in the UK. Hence in this section, I discuss the characteristics of the participants, looking at their gender, age, and their educational and professional background prior to migrating to the UK. Extensive searches for literature on the profiles of Nigerian migrant health care workers and nurses caring for people with dementia failed to identify any relevant literature.

7.2.2. Participant characteristics

As noted in the last chapter, data collected from participants during the pilot study was not included in this analysis. Of the twenty-one care workers interviewed in this study, fifteen were currently working as HCAs and six were RMNs, all working in the NHS. As noted earlier (see section 3.2.6), HCAs and RMNs have different professional responsibilities with reference to the care they provide to the patients. However, despite their differences in terms of professional qualification and training, they essentially work together as the nursing team (Spilsbury and Meyer, 2004; Ball and Pike, 2009) to provide care for PLWD in most dementia care setting including the NHS hospital from where these twenty-one participants were recruited. One of the criteria therefore observed in recruiting participants to this study was that they have all worked as HCA at some point, whether currently or before training to become RMN in the UK. However, among those currently working as HCAs, some (n=5) originally trained as nurses in Nigeria while the others had varied background (and most of them not linked to healthcare). As it is the case throughout this study, pseudonyms were used to protect the identity of the participants. The six nurses in this study all trained in the UK and had previously worked as HCAs.

Other data collected from a participant at the beginning of an interview included their self-reported gender, age, educational qualification, and places of birth/origin in Nigeria. These data which were entered in a sample form (Appendix 7.1) are presented and discussed below.

7.2.3. Gender

Research suggests that the task of caring for older family relatives in most cultures has generally been delegated to women (Kim, 2001; Tsuji, Sauvaget and Hisamichi, 2002; Koh and Koh, 2008; Nishi *et al.*, 2010; Day, Anderson and Davis, 2014; Kuo, 2015). Hence, previous literature on caregiving has overly focused on the assumption that caring for older adults is the role reserved for female relatives (Trussell and Shaw, 2009; Rabins, Lyketsos and Steele, 2016). Consequently, many studies on the care for PLWD have recruited more women than men participants in their study sample, with women reported to experience more of caregiving burden than men (Kao and McHugh, 2004; Chiou, Chen and Wang, 2005; Pinquart and Sörensen, 2006).

With these assumptions and knowledge in mind, during sampling, the initial goal of the research was to ensure that an equal number of male and female participants were recruited. However, due to some practical limitations, this could not be achieved. In total, of the twenty-one participants who took part in the study, there were twelve males and nine females (see Table 7.1 below). Of the twelve males, nine were HCA and three were RMN while of the nine females, six HCAs and three RMNs and all of them were working in the NHS.

Table 7.1: Participants' gender, age and current role

S/No	Participants	Sex	Age	Current role
1.	Adams	Male	50	HCA
2.	Ademola	Male	51	RMN
3.	Benard	Male	55	RMN
4.	Bosede	Female	54	RMN
5.	Cynthia	Female	38	RMN
6.	Dankay	Male	50	RMN
7.	Doris	Female	28	HCA
8.	Folashade	Female	38	HCA
9.	Jackie	Female	39	HCA
10.	Jane	Female	35	HCA
11.	Jeff	Male	32	HCA
12.	John	Male	28	HCA
13.	Kate	Female	30	HCA
14.	Kemdo	Male	44	HCA
15.	Miriam	Female	30	HCA
16.	Morgan	Male	40	HCA
17.	Omolara	Female	46	RMN
18.	Oscar	Male	33	HCA
19.	Paul	Male	42	HCA
20.	Robert	Male	31	HCA
21.	Sharpiro	Male	47	HCA

HCA – Health Care Assistant; RMN – Registered Mental-health Nurse

Another element of the care worker's profile explored in this study was the age of the participants and this is outlined below.

7.2.4. Age

This study focused on the experience of adult care workers and the participants were aged between 28 years and 56 years, with a mean age of 40 years and a median of 41 years (see Table 7.1). All six RMNs were over 38 years old, whilst most of the HCAs were aged between 25 and 40 years. The reason the nurses were older in age than those who were HCA might be because most of the qualified nurses have stayed in the UK longer than most of the HCAs. Most of them came to the UK as young adults, and they worked as HCAs before training to be nurses. I thought that the age of the participants was important, because literature seems to suggest a relationship between age and coping with caregiving stress (Okoye and Asa, 2011). Hence one of the possible relationships considered in a later section of this chapter was how my younger participants coped with the challenges of caregiving identified in comparison to older participants. For instance, Van Wijk (1997) observed that younger military nurses experienced more stress than older counterparts. Although, the literature on the age of care workers and how they cope with work related stress does not provide a conclusive picture of the relationship between age and stress, because there may be other confounding factors. For example, Landa *et al.* (2008), whilst noting that younger nurses experienced more stress than their older counterpart, they also acknowledge that the effect of the age of the nurse might be influenced by their emotional intelligence and their length of service. There is nonetheless some evidence that age does play a role in how care workers handle stress (Saks and Ashforth, 2000; Purcell, Kutash and Cobb, 2011; Tomietto *et al.*, 2015; Tourigny, Baba and Lituchy, 2016).

Another aspect of the care worker's experience of living in Nigeria before migrating to the UK was their place of origin in Nigeria.

7.2.5. *Place of origin*

Nigeria has at least 374 ethnic groups, occupying 36 different states (Otite, 1990). The ethnic groups are spread across the country's six geopolitical zones, three each in the northern and southern parts of the country. The geopolitical zones includes; the South-East (consisting of mainly the Ibo ethnic group), South-South (consisting of diverse ethnic groups such as Edo, Urhobo, Ijaw, Eket, Oron, Itsekiri, Kalabari and other ethnic minority groups), South-West (consisting of mainly the Yoruba ethnic group), North-West (Hausa, Fulani, Nupe, etc), North-Central (consisting of Hausa, Fulani, Tiv, Idoma, Igala, Ebira and many other minority ethnic groups) and North-East (comprising Kanuri, Hausa, Fulani, and other smaller ethnic groups) (National Population Commission, NPC, and ICF Macro, 2009; NPC and ICF International, 2014; 2019). Of these ethnic groups, Hausa/Fulani, Yoruba and Ibo ethnic group constitute almost 70% of the total population (Otite, 1990; Vande, 2012; Amali and Jekayinfa, 2013).

In this study, 17 of my 21 participants were from the three geopolitical zones in the southern part of Nigeria, while the remaining four participants were from the North-Central geopolitical zone in the northern part of Nigeria (Table 7.2). Of the 17 participants who were from southern part of Nigeria, 9 were from South-West, 5 from the South-East and 4 from the South-South. This has implications because the different ethnic identities, may result in their cultural orientation being different and this may influence understandings and perceptions of dementia. Apart from these differences in ethnic identities, they had similar religious affiliations with the 21 participants in this study self-identified as Christian. Research suggests that Nigerians from the southern part of Nigeria are predominately Christian, while those who originate from the northern part of the country are predominantly Muslim (Paden, 2007, 2008).

Table 7.2: Table showing the participants place of origin, place of birth and place of residence before coming to the UK

S/No	Participants	State of origin	Geopolitical zone	Ethnic group	Place of birth	Place of residence/work	Place type
1.	Adams	Akwa-Ibom	South-South	Oron	Lagos	Lagos	Urban
2.	Ademola	Ekiti	South-West	Yoruba	Ekiti	Ibadan	Urban
3.	Benard	Edo	South-South	Edo	Ekpoma	Benin City; Germany	Urban
4.	Bosedede	Ekiti	South-West	Yoruba	Akure	Akure; Lagos	Urban
5.	Cynthia	Oyo	South-West	Yoruba	Lagos	Lagos; Ibadan	Urban
6.	Dankay	Imo	South-East	Igbo	Brazil*	Brazil; Owerri	Urban
7.	Doris	Kogi	North-Central	Igala	Warri	Warri; Asaba	Urban
8.	Jackie	Oyo	South-West	Yoruba	Ibadan	Ibadan	Urban
9.	Jane	Kogi	North-Central	Igala/Yoruba	Lokoja	Abuja	Urban
10	Jeff	Imo	South-East	Igbo	Owerri	Owerri; Elele (a town near PH); Ondo	Urban
11	John	Anambra	South-East	Igbo	Orlu	Orlu; Owerri	Urban
12	Kate	Lagos	South-West	Yoruba	Ado-Ekiti	Ado-Ekiti; Oshogbo; Lagos; Kano;	Urban
13	Kemdo	Anambra	South-East	Igbo	Enugu	Enugu; Onitsha,	Urban
14	Miriam	Kogi	North-Central	Igala	Kaduna	Kaduna	Urban
15	Morgan	Ondo	South-West	Yoruba	Ondo	Ondo; Benin	Urban
16	Omolara	Oyo	South-West	Yoruba	Ibadan	Ibadan	Urban
17	Oscar	Anambra	South-East	Igbo	Otukpo	Otukpo; Owerri; Lagos; PH	Urban
18	Paul	Oyo	South-West	Yoruba	Lagos	Aba; Ibadan	Urban
19	Robert	Benue	North-Central	Tiv	Kaduna	Kaduna; Ibadan,	Urban
20	Shade	Lagos	South-West	Yoruba	Lagos	Lagos; Aba; Ibadan	Urban
21	Sharpiro	Edo	South-South	Edo	Lagos	Lagos; Italy	Urban

* - Dankay was born in Brazil; PH - Port Harcourt (a city in Nigeria's Niger Delta)

Despite efforts made to recruit Nigerians of all ethnic groups, the main observable difference between my participants and the general Nigerian population was the absence of participants who self-identified as Muslims or were from the main ethnic groups in the north of Nigeria (the Hausa Fulani ethnic groups). As a result, I would suggest that the findings from this study do not specifically apply to any specific ethnic group. In other words, the concept of ‘being a Nigerian care worker’ was approached from the point of view of the participants originating from Nigeria as a country, however, it is important to also acknowledge the complex and heterogeneous nature of peoples ethnic and cultural identity (Amali and Jekayinfa, 2013). This was why other factors such as the place of birth of the participants and the nature of their place of main residence, was also taken into consideration, and are presented below.

7.2.6. Place of birth and place of residence

Place of birth and place of residence in Nigeria were classed into rural, sub-urban and urban living (with the latter referring to participants living in densely populated areas, or in the city centres). Most of the participants were born in urban cities across Nigeria, while some were born in semi-urban/urban towns/cities (see Table 7.2). Prior to migrating to the UK, all participants had spent the last few years of living in Nigeria in cities.

Research suggests that rural and urban dwellers usually differ in levels of education, and they are usually less exposed to people from other cultures (Gasparini, 2000). The essence of exploring the participant’s place of birth and residence was established to gain an insight into their lived experience in Nigeria, so that I could build a profile for my participants to better understand their migratory experience.

In the next subsection, I present and discuss the educational and professional background of my participant to complete their profile before exploring their motivation to leave Nigeria for the UK.

7.2.7. Educational and professional background

As part of my study, I wanted to know about the participants’ experiences in Nigeria, including their educational and professional background. Some studies on migrants

working in the UK and other European countries have sometimes presented the picture of some migrant being low-skilled and poorly educated (Facchini and Mayda, 2012; Helbling, 2011). However, Malhotra, Margalit and Mo (2013) have suggested that anti-immigration sentiments remain strong in many sections of society, regardless of whether migrants are well-educated and highly skilled, or less-educated and low-skilled and this was borne out in my own research.

All the participants had a post-secondary degree before leaving Nigeria for the UK (Table 7.3). Some of the participants had a diploma degree qualification in nursing, obtained from schools and colleges of nursing in Nigeria, while other care workers (who did not train as nurses in Nigeria) had their first degree in different fields of study.

Table 7.3: Table showing the academic qualifications and of the participants and their work experience prior to migrating.

S/No	Participants	Educational attainment before coming to the UK	Educational attainment at the time of the interview	Main job before coming to the UK	Total time spent on the main job before coming to the UK
1.	Doris	Diploma in Nursing; Post-basic programme in midwifery	BSc in Nursing MSc (in progress)	Worked as a general nurse	2 years
2.	Robert	Diploma	BSc; MSc (in progress)	Worked as a general/mental health nurse	2 years
3.	Kemdo	BSc in Accountancy	ACCA (in progress)	Worked with an accountancy firm.	3 years
4.	Adams	BA	Unchanged	Worked as a community liaison officer	5 years
5.	Sharpiro	BSc	Unchanged	Worked as a marketer	4 years
6.	Jane	Diploma	BSc in Nursing; MSc (in progress)	Worked as a general nurse	3 years
7.	Jackie	Diploma; BSc	BSc in Nursing (in progress)	Worked as a marketer	5 years
8.	Paul	Diploma; BSc	MBA; DProf (in progress)	Worked as a sale representative for a pharmaceutical and last	10 years and 6 months

9.	Morgan	BSc in Microbiology	MSc in Public Health MSc Nursing (in	Worked as a medical sales representative	4 years
10.	Jeff	BSc in Microbiology	MSc in Public Health	Worked as a microbiologist under training; also taught	1 year and 6 months
11.	Shade	BA in language studies	BSc in Nursing (in progress)	Worked with a fast-food company	4 years
12.	Kate	Diploma in Nursing	BSc in Nursing	Worked as a general nurse, orthopaedic nurse	2 years
13.	Oscar	BSc in Material and Metallurgical Engineering	Unchanged	Worked in a marketing and technological company as a marketer;	3 years and 4 months
14.	John	BSc in Urban planning	MSc in Construction management; BSc in Nursing (in progress)	Taught in a secondary school for one year and then worked in a clerical	3 years
15.	Miriam	Diploma in Nursing	BSc in Nursing; MSc in Public Health	Worked as a general nurse	2 years
16.	Benard	BSc Guidance and Counselling	Diploma in Nursing	Worked as a counsellor in Nigeria and worked in different industries upon	5 years
17.	Dankay	BSc in banking and finance (obtained in the UK)	MSc (banking related); BSc in Nursing	Worked in a managerial role in a bank	1 year and 8 months (in the managerial role in the UK)
18.	Bosede	BA in language studies, MA (human resource)	BSc in Nursing	Worked with an NGO	15 years

19.	Omolara	BSc in Physiotherapy	BSc in Nursing	Worked as a physiotherapist	4 years
20.	Ademola	BSc (Public health)	Diploma in Nursing	Worked as a public health office	8 years
21.	Cynthia	BA in Journalism	BSc in Nursing	Worked as a journalist	2 years

Key

BSc - Bachelor of Science Degree; MSc - Master of Science Degree; BA - Bachelor of Arts Degree; MA - Master of Arts Degree

MBA - Master of Business Administration; DProf – Doctor of Professional Studies; ACCA = Association of Chartered Certified Accountants

Unchanged – The participant had not undertaken further education in the UK at the time of the study. This specifically applies to gaining a further University diploma or degree-level education or more only and does not take into consideration courses that are lower than diploma/degree level.

In summary, of the seven participants with a diploma, five had diplomas in nursing. The other two participants with a non-nursing diploma certificate also had BSc degrees before coming to the UK. The remaining fourteen participants without diploma had at least a BSc degree level of education. In addition, most participants (n=18) were in relatively good employment before they made the decision to come to the UK. They fit well into the category of ‘well-educated highly-skilled migrants’, who for various reasons decided to leave Nigeria for the UK. Reflecting on the skills of migrant workers, De Haas (2005) argued that this idea of being unskilled is one of the myths held about migrant workers and as my findings show (Table 7.3), not only were my participants well educated but also, most of them went on to gain higher degrees in the UK. My findings also indicate that all my participants arrived the UK with significant professional experiences in their respective fields, with many having work experiences outside of the care sector. On average, the duration of their professional experience ranged from one year and six months to fifteen years, with a mean of four years, suggesting that they had considerable professional experience before migrating to the UK (see Table 7.3). This finding contradicts those of Parutis (2014), who considered the popular profile of an economic migrant to be one who has a low level of education and is relatively low skilled.

In the next section, I present findings on why my participants migrated to the UK from Nigeria despite being well educated and in many cases in relatively good employment in Nigeria.

7.3. Motivation for coming to the UK

7.3.1. Introduction

Considering their educational and professional experiences, I wanted to understand why my participants decided to come to the UK. As suggested in Chapter 2, the motivation of people to migrate to another country consists of a combination of factors, which are embedded in their individual experiences (Kline, 2003; Freeman *et al.*, 2012). Findings from my study shows that my participants were motivated for two main reasons: in search for better opportunities and for family reasons. These two reasons are discussed further in this section. However, because the reason for migration determines the type

of visa to be applied for by a non-EU national, this will be discussed first followed by the presentation and discussion of the motives for migration.

7.3.2. Participants' route of migrating to the UK

I collected some basic data regarding the visa status of my participants when they applied to enter the UK, as well as their current visa status and this information is presented in Table 7.4 below.

Table 7.4: Participants' route of migrating to the UK

* -

S/No	Participants	Migratory motives	Visa route to the UK	Current immigration status
1.	Doris	To study	Student*	Student
2.	Robert	To study	Student	Student
3.	Kemdo	To work	Student	Not stated
4.	Adams	To work	Student	British
5.	Sharpiro	To work	Student	British
6.	Jane	To study	Student	Student
7.	Jackie	To support a spouse	Freedom of movement as an EU migrant#	An EU migrant
8.	Paul	To study	Student	Student
9.	Morgan	To study	Student	Student
10.	Jeff	To study	Student	Student
11.	Shade	To support spouse	Dependant visa	Dependant visa
12.	Kate	To study	Student	Student
13.	Oscar	To study	Student	Student
14.	John	To study	Student	Student
15.	Miriam	To study	Student	Student
16.	Benard	To work	Freedom of movement as an EU migrant	An EU migrant
17.	Dankay	Family reasons – a child	Child dependant visa	British
18.	Bosede	To work	On the HSMP visa	British
19.	Omolara	To support spouse	Dependant visa	British
20.	Ademola	To support spouse	Dependant visa	British
21.	Cynthia	To support spouse	Dependant visa	British

Student visa is also referred to as the Tier 4 visa. # - Freedom of movement - EU migrant enjoyed this right at the time of the interview but with the UK set to leave the EU after the 31st of December 2020, this arrangement might change (Portes and Forte, 2017; Hepburn, 2020).

HSMP: The Highly Skilled Migrant Programme – Now defunct, the HSMP ran from 2002 to 2008 and offered a route for migrants to come, work and settle in the UK (UK Visas and Immigration, 2008; Kiwan, 2010).

Many of the participants (n=13) in this study migrated to the UK as students and many were still students at the time of the interview. Some participants (n=7) came to the UK as EU citizens or on other visa categories. Only one participant came as a child migrant. It is interesting to note that some participants whose motive for migration was to work used study as a strategy to migrate to the UK. This might be due to the increasing difficulty in securing a work permit that would give them the necessary legal grounds to work in the UK (Cangiano and Walsh, 2014; Gopal, 2016). In addition, the practice of using an educational course, as a mechanism to enter the UK is well documented in the literature (Baas, 2006; Verbik and Lasanowski, 2007; Geddie, 2015; Gewin, 2017; Tan and Hugo, 2017). For example, in a study of the motivation of Indian students to enrol in Australia as an international student, Baas (2006) observed that they were mainly motivated by their desire to gain permanent residence in Australia.

Although I did not specifically explore a detail record of my participants visa history, in the last ten years, when most of my participants migrated to the UK, the Home Office has adopted a policy which they have been termed as, “a hostile environment” (Webber, 2019). The policy is meant to make it easy for the Home Office to target and remove people who are in the UK illegally. However, it has also in part resulted in the deliberate closure of visa routes that hitherto made it easy for migrants to enter and work in the UK. For instance, Bosede, one of my participants, migrated into the UK via the HSMP visa (UK Visas and Immigration, 2008). The criteria organisation must meet to sponsor a non-British national has become more stringent (Shahvisi, 2019) as are the criteria the individual themselves must have to meet (Sumption and Vargas-Silva, 2019). Although migrants on student visas can work, they are often limited to work 20-hours per week aside the added constraint imposed on them by their studies. It is possible that migrants who come to study rather than work will do less to fill the shortage in the care work force within the NHS and other care settings (Anderson and Ruhs, 2010).

Another important event that reduces the prospect of meeting the shortage in the healthcare work force is the 2016 decision of the UK to leave the EU (Sumption, 2017). For example, since voting to leave the EU, there has been a fall in the number

of nurses and other health professionals seeking to migrate to the UK (Sumption, 2017; Wadsworth, 2018; Wells, 2020). This will no doubt negatively affect how the NHS and other care settings who rely on the free movement of labour cope with the reduction in the number of persons coming from the EU. In the next subsection, I discuss in detail my participants' migratory motives.

7.3.3. Migratory motives

Sixteen of the twenty-one participants in this study migrated to the UK in search of better opportunities and they used different strategies to achieve that goal. As stated in the previous sub-section (see also Table 7.4), many (n=10) migrated to the UK specifically to further their career while some (n=6) came specifically to work. Only five participants came to the UK for family-related reasons.

7.3.3.1. For better opportunity

Most of the participants (n=16) identified the search for better opportunities as their reason for migration and this took the form of undertaking to further their career by studying or to outrightly look for work. The participants (n=13) who identified career related motivation as their reason for migration came either to pursue further academic goals in their chosen career or to begin a different career.

For instance, Paul, who worked as a sales representative for a pharmaceutical firm for about 10 years and served as a sales manager before coming to the UK, noted that his decision to migrate to the UK to undertake further studies was inspired by his desire to give his career a boost. He noted:

“I decided to further my education because after working in the company... I discovered that the best way of getting quick or rapid promotion ...is that if you have your advanced diploma or post graduate courses, especially masters...”
(Paul, HCA)

Despite being in the top echelons of the company, Paul considered gaining a master's degree to enhance his career. At the time of the interview, he had already completed an MBA and was undertaking the study for his doctorate at the time of

the interview. For Paul, working in dementia care fitted into his current study schedules and he stated that he would leave care work once he completes his studies. Morgan, who like Paul, worked for a pharmaceutical company as a medical sale representative in Nigeria, also gave a similar reason for migration. He left his job because he wanted to have a career change, having grown disillusioned with the job, and describing it as hectic and too physically demanding. In addition, Morgan noted further that:

“I saw a lot of vacancies for public health jobs in the NGO, private sector, charity sector in Nigeria..., they were just requesting that I need to have a degree in public health. Master’s in public health was an added advantage, then I decided to come and study, to get that qualification” (Morgan, HCA)

Like other participants, Morgan, had more than one reason for coming to study for a Master’s in Public Health in the UK. He was confident completing the course would enhance his chances of securing a job with any reputable non-governmental organisation (NGO), which always features having a degree in public health as a key requirement to be considered for the job. This is interesting because as the findings show, some of my participants were motivated to study in the UK because of the allure of getting a good job after graduation and this could involve the individual making a career change. Maringe and Carter (2007) highlighted this in their description of a key “pull” factor in the “push-pull” framework. In this context, the “pull” factor presents the potential migrant with an outcome that is better than what they currently enjoy. Although Morgan’s main motivation for migrating to the UK was his desire to secure a better job in Nigeria, his description of the event that led to him deciding to leave appeared to have been far more complex, consisting of a personal sense of bereavement and deep frustration with the job he had at the time. He observed:

“I was ...getting fed up of the job and also one of my friends that was working for another company died while... was driving, was driving and he fell into a ditch. So, after the guy’s death I just decided... I need to do something else... and then I started looking for another job.” (Morgan, HCA)

Morgan's personal circumstances contributed to his decision to leave. This further highlight one of the major criticisms of the "push-pull" framework as being too simplistic to explain people's reason for migration. As O'Reilly (2012) suggested, the framework did not fully take account of other complexities and factors beyond economics.

Similarly, what resonates from the experience of the participants who migrated to the UK in search for better opportunities is that most of them (n=18) were in well-paid employment when they left. Morgan, Paul, John and some of the other participants who practiced as nurses in Nigeria (Doris, Miriam, Kate, Robert and Jane) were all in employment. However, unlike their counterparts who did not practice as nurses in Nigeria, those who worked as nurses in Nigeria wanted to migrate to the UK and continue to work as nurses, probably because of better working conditions. All the participants who decided to further their careers had chosen to come to the UK (as opposed to undertaking their studies in Nigeria or in other countries). They considered the UK's educational system better and more time efficient than the educational system in Nigeria, which is often bedevilled with industrial actions by university staff, such that it takes longer to finish an academic degree (Maringe and Carter, 2007). Although, I did not explore in detail why my participants chose to come and study in the UK as opposed to other developed countries, as it was not the focus of my interest, the reasons they cited fit within the pull-pull model for their decision to migrate (Rodríguez, Bustillo and Mariel, 2011).

Mazzarol and Soutar (2002) in a review of findings from four different studies from Indonesia, Taiwan, China and India, observed that majority of students considered an overseas degree better than the one obtained in their country because employers think it is of a better quality and this was one of the main factors that influenced their choice of going to study abroad. Mazzarol and Soutar therefore proposed a combination of push-pull factors that motivate students to study abroad, with the push factors being factors that made them leave their home country and pull factors being factors that attracted them to the country of their choice. As Paul and the other participants stated, the irregular academic calendar and the perceived low standard of higher education in Nigeria are some of the push factors that motivated them to

leave. Similarly, their perception of the high standard of higher education in the UK and the uninterrupted nature of their academic calendar was enough incentive to pull them to the UK (Herrero *et al.*, 2015).

Although some of the participants' (like Paul and Morgan) decision to leave a high paying job to come to study in the UK was necessitated only by a desire to advance their careers, another participant, Adam, did not have a job in Nigeria and he cited other career-related reasons for migrating to the UK. He noted:

"...a friend of mine who has been in the UK sold me an idea...when I lost my job, I started thinking what can I do? That idea I had years ago came back. So, that propelled me to come to the UK and ... I did a programme in health and social care" (Adams, HCA)

Unlike Paul and the other participants who left their jobs voluntarily, Adams was motivated to migrate to the UK when he lost his job as a community liaison officer for a non-governmental organisation (NGO). Having the ambition to own and run a business for a long time, the experience of losing his job spurred him to come to the UK as he considered the country to be a place where he could work towards executing his business plan. Although Adams might be considered an 'economic migrant' since he decided to come to the UK after he lost his job, his personal ambition to learn how to set up his own business played a big role in his decision to migrate. Nevertheless, he has a similar profile to the group of participants who came to the UK in search of better opportunity in terms of their education and professional background.

Some (n=5) of the participants who came to the UK to further their education were nurses who had diploma certificate in nursing and migrated to the UK to specifically undertake a top-up programme to obtain a BSc in nursing. Dolamo and Olubiyi (2013) suggests that this is a trend that has become popular since the Nursing and Midwifery Council (NMC) of Nigeria has continued to push for more nurses to upgrade their educational qualifications from diploma to Bachelor of Science degree (BSc). This is because of the increased expectations for nurses to be at par with other courses and profession where a university degree is a basic requirement.

However, my findings suggest that whilst completing a degree in nursing in Nigeria was considered, most of my participants also opted to come to the UK instead of completing it in Nigeria to save some time. As Jane noted,

“After acquiring five years of experience... it was a good idea for me to top it up, with a degree, than just remaining with a diploma, because time waits for no man. I just want to build my career.... the UK have got a lot of advantages compared to the Nigeria education system, where you can enter the uni and you graduate the exact time you should...” (Jane, HCA)

As suggested earlier, the Nigerian educational system is regularly beset with industrial strike actions due to a disagreement between trade union leaders and the government over pay, working conditions and other work-related issues (Maringe and Carter, 2007). The findings on the motivation for Nigerian nurses to migrate to the UK is contrary to findings by Aboderin (2007), who in a qualitative study of nurses found that financial gain was the motivating factor. However, the nurses interviewed by Aboderin (2007) were Nigerian nurses who already had their indefinite leave to remain in the UK and were registered to practice as nurses in the UK. In contrast, nurses interviewed in my research had all come to the UK mainly to study (on student visas). Although they harboured the ambition to practise as nurses in the UK, they were yet to start doing so. They would need to first finish their top-up nursing degree and undergo the adaptation process to enable them practice as registered nurses in the UK. Thus, the difference in motivation between participants in this study and those reported by Aboderin (2007) might be due to their individual needs and each attending to it according to their hierarchy of importance. My findings further highlight the hurdle overseas-trained nurses must overcome to work in the UK. Even though most of my participants had qualified and worked as nurses for many years in Nigeria, the UK Nursing and Midwifery Council (NMC) still considered them not fit to practise.

As I shall present shortly, most of the participants who came to the UK for better opportunities through career progression achieved their original goal of coming to the UK and they have since carried on with their lives and engaged in other things,

with an immediate return to Nigeria no longer urgent. Although the issues are beyond the scope of this research, this raises concern of the ‘brain drain’ and the resultant implication on their country of origin.

It is interesting to note that while most of my participants stated further career progression as a reason for migrating to the UK, many also inherently saw the study route to migrating as a means to getting better opportunities than the one they had in Nigeria.

7.3.3.2. To find work

One factor that makes the UK a significant migrant destination as reflected in the narratives of the lived experiences of my participants was the hope to find a job that offers better opportunity. Some participants (n=6), namely: Adams, Benard, Bosede, Jackie, Kemdo and Sharpiro relocated to live permanently in the UK. However, they migrated to the UK through different visa routes. Adams, Kemdo and Sharpiro migrated to look for work but came as students and as discussed in the last sub-section, many people use the student visa as a strategy for migration (Gewin, 2017; Tan and Hugo, 2017). Contrarily, Benard and Jackie both came to the UK as EU migrants, but while the former came to find a job, the latter came to support a spouse. Only Bosede came to the UK with a work-related visa, the HSMP visa, which is now defunct. Regardless of how they came, their main motivation was to find work.

Speaking of his decision to migrate, Kemdo reflected:

“Basically, it was to move away from...unemployment and lack of job satisfaction but the only choice available then was to come and further my studies. It was a means to come over to this place and study the environment and see what I can gain out of it...” (Kemdo, HCA)

Kemdo was very frustrated by his job. He stated that he made the decision to leave his last job in Nigeria (working as an internal control manager), after he was transferred to a city in Northern Nigeria. He decided against moving, citing incessant religious violence, the differences in religious beliefs and harsh weather

conditions as some of the reasons that made him leave the job. Instead, he decided to come to the UK to undertake a professional training in accounting. Kemdo was motivated by the prospect of finding better job opportunities but had to come as a student because of the limited migratory opportunities for people from another country to gain employment in the UK.

However, unlike Kemdo, many of the other participants who hoped for better opportunity and life in the UK did not all rely on studying to enter the country as they came to the UK through other migratory routes, for example, Bosede who now works as a nurse, migrated to the UK through the HSMP visa. Bosede stated that:

“I just felt I don’t want to come to UK because I knew no matter the qualification you are coming here with, you are starting from the beginning...actually it was the children...yes, because of the children...we were looking at giving them the best....”
(Bosede, RMN)

She noted that her decision to come to the UK was motivated by the desire to see her children have good education, as a demonstration of affection for them. In discussing her work experience and life in Nigeria, Bosede noted that she was a manager in a reputable international organisation. However, despite her personal fulfilment in Nigeria, Bosede had her family at the core of decision to come to the UK, where they can have access to a better overall quality of life. Her decision to migrate had the welfare of her children at the core but was primarily facilitated by the opportunity to come and work in the UK, which offered her children better life chances.

My study thus suggests that people do not only migrate because they seek better opportunities, but they also migrate because of other circumstances in their home countries which they consider could inhibit their future or their families’. Although Bosede and some of my other participants did not identify any specific factors in Nigeria that they considered inimical to their individual fulfilment, I can relate well with the challenges of living in Nigeria as a developing country. Some of the challenges include incessant cuts to power supplies and high levels of corruption. The lack of basic amenities in rural areas is almost non-existent and in cities/urban

centres unreliable. While Nigeria's educational sector is growing rapidly, inadequate government funding means industrial actions are rampant (Aidelunuoghene 2014; Odoziobodo, 2015). Therefore, although individuals may consider the allure of a better life in the UK as a motivation to leave Nigeria, similar to Bosede, better opportunities as well as family consideration and the desire to give one's family the best, might be an added motivation (Boyd, 1989; Ruhs, 2006).

7.3.3.3. Family reasons

Some participants (n=4) were motivated to come to the UK because of a commitment to support their spouse who was migrating or had migrated to the UK. For instance, Cynthia, who was working as a journalist in Nigeria noted:

"...what made me come to the UK, my husband was here at the time we were not married, ehm one thing led to another and he was quite serious and anyway he was here already and he just made it easy anyway" (Cynthia, RMN)

Other participants also shared a similar experience, for example, Ademola, Omolara, Oscar and Jackie all came to the UK to support their spouse. The majority of those who came to join their spouse in the UK were women and they were twice the number of men who joined their wives in the UK. Research suggests, that in the past, in most traditional African and Asian marriages it was often assumed that women would join their male spouse overseas (Gilmartin and Migge, 2015). Although Charsley and Shaw (2006) have challenged this assumption arguing that it is not an established fact that women joined their male spouses to sojourn abroad.

My findings suggest that my participants who migrated to the UK as spouse dependants did so solely for the purpose of supporting their partners and to build their lives in the UK. Relating this to the theories of migration reviewed in chapter 2, the finding reflects the decision-making process that is involved in a migrant's decision to migrate. It shows the role of family members in a migrant's decision to migrate as posited by the New Economics of Labour Migration theory.

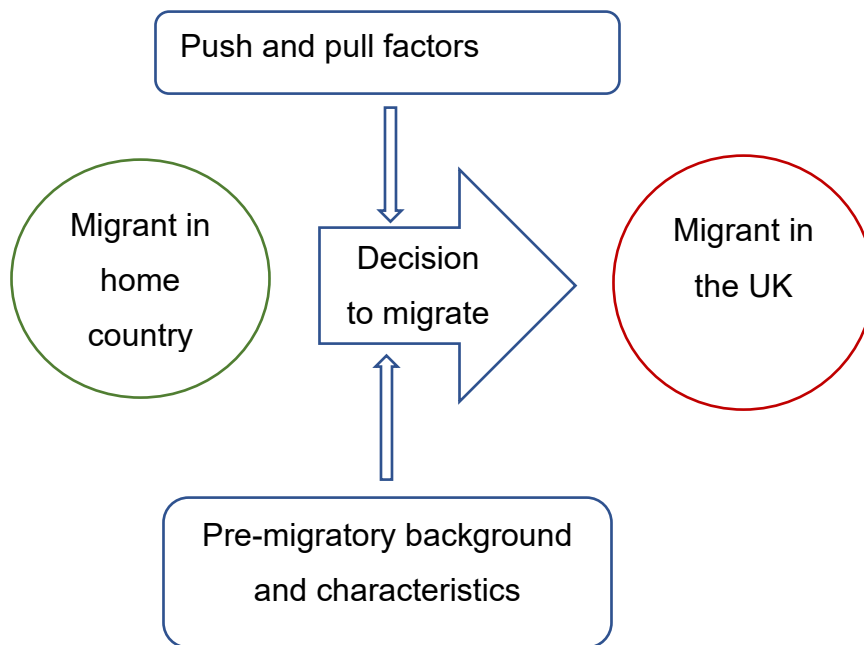
7.4. Discussion

In this study of paid Nigerian HCAs and nurses, I was particularly interested in their motivation to come to the UK to gain insight into their migratory journey and how they came to be caring for PLWD. I considered this important for several reasons. First, as I have discussed in the previous sections of this chapter, most of my participants were not only well educated but were also gainfully employed prior to migrating to the UK. Second, their motivation to leave Nigeria for the UK appears to be complex and does not seem to fit in completely into some of the basic migratory theories, such as the push-pull (Ackerman, 1976; Arango, 2004) and the push-pull-mooring frameworks (Moon, 1995; Bansal, Taylor and James, 2005) at the micro and individual level migration, as well as the neo-economic labour migration framework (Lee, 1966; Longino, 1992; Moon, 1995). Lastly, I was interested in their motivation to come to the UK to understand, from their perspective, whether their current role as care workers was influenced by their initial motivation to migrate and the impact it has on their lived experience caring for PLWD.

As I suggested in my literature review (see Chapter 2), research on voluntary or forced migration recognises the push-pull factors as the two broad factors that are generally inherent in the motives of people leaving their country of origin into another country (Lee, 1966; Kunz, 1973; Ward, Bochner and Furnham, 2001). The push-pull theory developed by Everett Lee (1966) and the push-pull-mooring (PPM) model of migration (Longino, 1992; Moon, 1995; Bansal, Taylor and James, 2005) are often considered as basic frameworks for understanding micro or individual level migration. The push-pull framework suggests that an individual's decision to migrate from one place to another is contingent on the negative (push) factors that compel them to leave their original place and the positive (pull) factors that attract them to their chosen destination. The PPM framework for micro-migration proposed by Moon (1995), incorporates 'mooring factors' (which includes personal and social factors that promote or inhibits an individual's decision to migrate). Although both frameworks could be used to explain to some extent the motivation of my participants to come to the UK, my study suggests that

participants' motivation for coming to the UK do not all fit into either the push-pull or PPM frameworks. This is because they do not account for why people chose to migrate even in favourable circumstances, and they do not account for all the reasons for migration (O'Reilly, 2012). The conceptual framework developed for this study (see chapter 4) offered some understanding for why my participants chose to migrate despite their educational and professional achievements.

Figure 7.1. Framework to understand my participants motivation to migrate



My study findings indicate that my participants' motivation to migrate was a close interaction between their pre-migratory background and the push/pull factors that were at play at the time of their migration. Even though their educational and professional background may be viewed as an asset, it was not necessarily a sufficient reason for migration. In addition, while the assertion that people migrate to the UK for economic reasons may be true for some of my participants (Winkelmann-Gleed, 2006), my findings suggest that the motivation of my participants to come to the UK were far more complex.

7.5. Summary

Despite their motivation to come to the UK, none of my participants referred to a specific job they were to undertake when they came to the UK. For the participants who were motivated for career-related reasons, their goal was first to study and to work while they studied. However, most participants did not plan to work in the care sector. Rather, most of them looked for any form of employment that might sustain them while they studied, and care work fitted in well into their busy study life (due to flexibility of shifts). The participants who had professional background in nursing in Nigeria, all stated that they had moved to secure jobs in care upon arrival in the UK. This is explored in more detail in the next section on the motivation for working as a care worker.

CHAPTER EIGHT

MOTIVATIONS AND REWARDS FOR CARING FOR PEOPLE LIVING WITH DEMENTIA IN THE UK NHS

8.1. Introduction

Findings presented in the previous chapter indicates that paid Nigerian migrant nurses and healthcare assistants (HCA) had different reasons for coming to the UK. None of my participants (except those who had previously worked as nurses) migrated to the UK with the sole intention of undertaking paid work as an HCA. In this chapter, I explored the reasons they gave for working as HCAs, and why those who currently work as nurses (having trained to be nurses in the UK) continue to provide care for people living with dementia (PLWD). In addition to examining the different intersecting motives for caring for PLWD and some of the complexities and interplay between the identified motives, this chapter also examines the rewards my participants derived from taking care of PLWD. The chapter is in three main sections; the next two sections present and discusses the findings on my participants' motivation to care for PLWD and the rewards they received from their roles. This is followed by a section discussing the findings in relation to the conceptual framework (see chapter 4) and concludes with a summary of the chapter.

8.2. Motivations for caring for PLWD

One of the characteristics common to my participants was their experience of working as HCAs, either in their current role or for those who are nurses, in their previous role working as HCAs prior to nurse training. Thus, this section centres on reasons for working as HCAs (whether presently or previously), or as nurses, caring for PLWD. It was notable that both those who currently work as nurses and HCAs presented similar reasons for first working as HCAs. The motivations can be grouped into three broad but intersecting categories; moral motivation, career-oriented motivation and needs-based (necessity-defined) motivation (summarised in Table 8.1)

Table 8.1: Table showing participants' motivation for caring, rewards they derive from caring and their previous care experiences

S/No	Participants	Motivations for doing care work			Previous experience of caring in Nigeria			Rewards of caring for people with dementia		
		Moral motivation	Career-oriented motivation	Needs-based & financial motivation	Worked as a nurse in Nigeria	Previous informal care	No paid or unpaid care	Emotional rewards	Financial & material rewards	Opportunity to socialise
1.	Adams	✓	-	✓	-	-	✓	✓	✓	-
2.	Ademola	-	✓	✓	-	-	✓	✓	-	-
3.	Bernard	✓	-	✓	-	-	✓	✓	-	-
4.	Bosede	✓	✓	-	-	-	✓	✓	-	✓
5.	Cynthia	✓	✓	-	-	✓	-	✓	-	-
6.	Dankay	✓	-	-	-	-	✓	✓	-	-
7.	Doris	✓	✓	✓	✓	-	-	✓	-	-
8.	Folashade	✓	-	✓	-	✓	-	✓	✓	-
9.	Jackie	✓	-	✓	-	-	✓	✓	✓	-
10.	Jane	✓	✓	-	✓	-	-	✓	-	-
11.	Jeff	-	✓	✓ *	-	-	✓	-	✓	-
12.	John	-	-	✓ *	-	-	✓	-	✓	-
13.	Kate	✓	✓	✓	✓	-	-	✓	✓	-
14.	Kemdo	-	-	✓ *	-	-	✓	-	✓	✓
15.	Miriam	✓	✓	-	✓	✓	-	✓	✓	-
16.	Morgan	✓	✓	✓	-	✓	-	✓	✓	✓
17.	Omolara	-	✓	✓	-	✓	-	✓	-	-
18.	Oscar	✓	✓	✓	-	✓	-	✓	✓	-
19.	Paul	✓	-	✓	-	-	✓	✓	✓	✓
20.	Robert	✓	✓	-	✓	✓	-	✓	-	-
21.	Sharpiro	✓	-	✓	-	✓	-	✓	✓	-

* - indicates participants who were solely motivated to care because of the monetary rewards accrued the role.

Moral (or emotional) motivation for caring refers to participants assuming the role because of their altruistic attachment to it, whereas career-oriented motivation for caring comprises of participants who consider their working as a HCA for PLWD as a means to an end, in furtherance of their long-term career goal. Lastly, needs-based (or necessity-defined) motivation covers motivations based on the extrinsic rewards attached to the role. This includes financial motivation which encompasses motivation based solely on monetary incentives or other material gains. As indicated in the literature review (see chapter 3), these three broad motives fall under the two main categories of motivation, viz: intrinsic and extrinsic motivation. In the following section, the findings are presented under these three broad categories.

8.2.1. Moral motivation

Most of my participants (n=16) considered ‘passion for the job’ as the key motivating factor for assuming and working in paid care in the UK. However, it is noteworthy that while some (n=5) of them described their passion for the job with particular reference to their experience of working as nurses in Nigeria, six of them related their passion for the job to their previous experience of providing unpaid care and ‘moral values’ consistent with their religious or cultural beliefs. Those who had previously worked as nurses expressed their love for caring for people.

For example, Robert, a 31-year-old HCA who worked as a qualified general and mental health nurse in Nigeria for at least two years, stated:

“I have just one word for you, it’s called passion.... So, it like, I’m attached to the field [health care], I have passion for it. So that’s... the reason I choose to do health duty”
(Robert, HCA)

Robert related his passion for working as HCA and his attachment to the healthcare profession to his previous job, working as a nurse in Nigeria. Although having passion for caring may not be solely attributed to my participants’ previous role as nurses, other authors such as Usher *et al.* (2013) and Marcinowicz *et al.* (2016) found that most people who chose nursing as a career did so because of their ‘desire to help others’.

Robert's passion to work as HCA derives from his professional calling as a nurse even though he was yet to complete the adaptation programme that would enable him work as a registered nurse in the UK.

Apart from Robert, other HCAs such as Doris, Jane, Miriam and Kate, who were also qualified general nurses in Nigeria, also described their main reasons for assuming the HCA role. For example, Doris noted that:

"...being passionate about it is rewarding in the sense that you will be able to, at least, sometimes you put smiles on their face and that is, that is rewarding" (Doris, HCA)

Like Robert, Doris, a 28-year-old HCA, had passion for the role due to her previous experience of working as a nurse in Nigeria. This is interesting because even though working as HCA is often construed as a low status and low paid job, my participants who previously had higher professional status, chose to work as HCAs because of their passion for the job. It is however also worth noting that like Robert, these Nigerian-trained nurses who were currently working as HCA were yet to complete their professional adaptation to enable them work as registered nurses in the UK. Moreover, Miriam (another Nigerian-trained nurse working as HCA), made it clear that if she did not have the opportunity to work in care as HCA, in a paid capacity, she would have volunteered to help in any capacity in the hospital because of her desire to care. She stated that:

"... [I] would have considered still working as a volunteer in a hospital or something because I'm more keen into the care, yes. ... my family members have been sick [.....], I ... helped them with... feeding,... standing up,... to toilet, to bath, personal care, everything. I have been doing that before I even got into nursing. So, it has been part of me." (Miriam, HCA)

For Miriam, her passion for nursing and caring for others predate her nurse training, which she attributed to a natural desire to care. Being compassionate is one of the criteria employers seek in individuals who want to work in care, which other authors have highlighted as people's attachment to the caring professions. For example, one

study by Lindquist *et al.* (2012) which sought to understand the motivation of paid carers of older adults surveyed 98 paid carers. They found that most of the carers surveyed (60.7%) chose the role because they love to be with older adults. Although, no participant in my study particularly cited ‘care for older people’ as the source of their passion, it is of interest that ‘passion to care for people’ was, for most (n=16) of the participants their main motivation for working as HCAs. Therefore, it might be inferred that working as a nurse in Nigeria helped some of my participants develop the passion to work as HCA in the UK.

Furthermore, another point to note is that some (n=6) of the participants developed the passion to care from their experience of working as informal carers in Nigeria or volunteers in a care setting in the UK, even though this was not necessarily their sole motivation for taking up care work. For example, further exploring the motivation of Dankay and Cynthia who are both UK-trained nurses (and has previously worked as HCAs), revealed that their passion to caring was not something they would regard as innate, rather, it was what they grew into. For Dankay, his love for caring for older adults became a motivation to continue to work in the healthcare profession in the long term only after he began to work as HCA. Now in his late 40s, he described how he started out as a 16-year-old, first as a volunteer and then as paid carer. He noted:

“I started [working] with [people with] dementia, so I grew in love with it because that was my mum’s area [of specialty], so I didn’t know anything in healthcare apart from dementia [.....] I just know I’m helping these older adults out. Then we started getting paid for it....” (Dankay, RMN)

Dankay developed passion for the job after he had worked as a volunteer in a care home managed by his mother at the time. Cynthia who cared for her grandmother with symptoms of dementia long before she came to understand what dementia was, also volunteered to work as HCA when she came into the UK, and she spoke of her volunteering experience as what made her passionate about care for older adults. She stated that:

“I was just a voluntary person coming to do a little bit of assistance here and there, so it was fun then, I got to understand so much about dementia and I think that was where the interest came from. Looking back at my grandmother who I was looking after [in Nigeria] [.....] I didn’t quite understand the gravity of what we took for granted” (Cynthia, RMN)

Apart from her volunteering experience, Cynthia related her interest and passion for care to the time she cared for her grandmother. Hence, the experience of working as HCA and the moral motivation to assume caring role shows a similar pattern, that is, people may be motivated to care for older adults from undertaking previous unpaid care work. For example, Adams, an HCA who worked as a sociologist in Nigeria, stated that he was drawn to work as HCA in the UK when he understood what dementia was:

“With the knowledge now and my previous knowledge then if they are match together, there is so much empathy in me, so much compassion in me. Because I had a first contact with them [people with dementia] back then I didn’t know what it was, now I’ve been educated, now I have knowledge, now I know what it is....” (Adam, HCA)

However, when ‘passion’ as a motivational factor was further explored with these participants, it quickly emerged that in most cases, it was not their sole motivator for undertaking the job. For instance, some of the participants who trained as nurses in Nigeria expressed their desire to leave their role of caring for people with dementia once they become qualified to practice as nurses in the UK. For example, speaking about her plans for work when she becomes a registered nurse, Doris reflected:

“Emm yeah because after the completion of my program two things are involved, it's either I get registered and start working as a nurse, and even though I am going to work as a nurse, to be sincere, am not gonna work in a care home, I will prefer working in a hospital” (Doris, HCA)

It follows that although Doris is passionate about her job as a carer for PLWD in the NHS now, when put into wider perspective of her career ambition and plans, it is not a

role she would consider doing on a long-term basis. She made it clear that she will rather not work in a care home. Kate, also echoed similar views:

“Ahh, I work to pay my bills (laughs), yea, and for the experience” (Kate, HCA)

This further highlights the complex nature of my participant’s motivation. The reason why they were motivated to assume work as HCA may be completely different from the reason they chose to remain in the role. Like Cynthia, Kate had also cared for her grandmother and became a carer because of her passion for the role but she appeared to have continued in the role because of her career related goals, which she alluded to working ‘for the experience’. In addition, she also highlighted that she worked to pay her bills, which is a monetary motivation for continuing in the role. However, to consider the financial gain she derives from the role in isolation could be misleading, as Kate’s motivation for assuming and continuing in her caring role is rather complex and intertwined.

The moral motivation for caring from the perspective of those whose previous professional experience was nursing are closely linked but different from those who chose to undertake care work mainly because of career-oriented motives and their differences is highlighted in the next subsection.

8.2.2. Career-oriented motivation

Some of my participants were motivated to assume or continue in care for career-oriented reasons, either singly or in combination with their passion for the job and/or other forms of motivation. The career motivations included: inability to find work in their chosen career; the view that working as a carer kept them in close touch to their profession; the belief that working as a care worker offered better prospects to their curriculum vitae (CV) than working in jobs outside of care, and the notion that care work provides a pathway to undertaking a career in nursing. These motives are presented and discussed in more detail below.

8.2.2.1. Unavailability of jobs in chosen career

As noted earlier, several of my participants (n=7), both those who had worked for many years as qualified nurses in Nigeria and those with other professional experiences, were working as HCAs in the UK because of the inability to find work in their chosen career. This was due to some reasons which are captured in the narration of their experiences of searching for jobs in the UK.

Firstly, their lack of work experience in the UK made it difficult for them to secure the job they wanted. Usually, most employers in the UK seek to employ people with work experience acquired in the UK and they consider it as a prerequisite to make an offer of employment (Mackenzie and Forde, 2009). Thus, migrants who are new to the country often have to take up jobs below their professional or academic qualifications just to get some experience of working in the UK and to cover for living expenses (Mackenzie and Forde, 2009).

They also take up a lower-skilled job so they can familiarise themselves with what is required to get a job in their chosen career. Oscar reflected on some of the frustrations of this situation, stating:

“Hmm, coupled with the experience I have had back home when I came into the country, I sort of looked for job even within a freight forwarding company as well I did some application even to some of the engineering companies” (Oscar, HCA)

With his experience of working in freight forwarding in Nigeria, Oscar was initially optimistic that he would get a job in the UK, but that optimism quickly turned into frustration when he could not get one, despite attending some interviews. He narrated why he felt he did not get a job in freight forwarding or as an engineer:

“[.....] They [the employers] needed an experience within the terrain of United Kingdom which I never had. The one for freight forwarding as well, ... they couldn't really employ me because um is a different terrain altogether [.....] Having experience

in Nigeria, coming over here, starting all over again, so it's more or less I don't have any experience working [.....] I didn't get the job.” (Oscar, HCA)

Oscar described his eventual sojourn into care as a reluctant move and a consequence of not been able to secure a job in his chosen career. Although he began to work as HCA because of the need to earn some money, he was also motivated by his previous experience of caring for his grandfather and observed that:

“So... that period, I actually couldn't get a job there and um, coupled with the fact that um I met some few friends that encourage me... to think of other things to do, that was when I, I actually remembered that I've done something in care back home and I've nursed the passion, ... in continuing in that particular direction” (Oscar, HCA)

Secondly, some of my participants could not find work in their chosen career because of the UK-specific requirements that had to be met before they could be allowed to practice in the UK. Some professions (like nursing and medicine) require overseas applicants to demonstrate that they meet the necessary professional proficiencies to practice in the UK (Miller, 2008; Shirmohammadi, Beigi and Stewart, 2019). This was one of the many reasons why highly qualified migrant workers often undergo the process of deskilling when they arrive in a foreign land. In my study, most of my participants especially those who practiced as nurses in Nigeria became HCA in a deliberate act of deskilling.

While care work was sometimes used by some of my participants as a strategic job to support their career progression, those who were trained nurses considered it as a job that keeps them within healthcare. Deskilling, the practice of taking on a role that is below an individual's training and educational expertise, may result in the individual losing previously acquired skills (O'Brien, 2007). In the literature, the form of deskilling among migrant nurses mostly discussed is the case of employed nurses working below their acquired skill set (Adhikari and Melia, 2015; Kurniati *et al.*, 2017). However, my findings suggest that overseas-trained nurses also take a step down to work as HCAs.

Doris (and the other overseas nurses who had the desire to work as nurses in the UK), would have to first complete her registration with the Nursing and Midwifery Council (NMC) as part of the adaptation programme (Taylor, 2005). It is also notable that deskilling was not only limited to nurses working as HCAs but also extended to highly qualified people (such as Oscar) working as HCAs. My findings are similar to those of Willott and Stephenson (2013) who conducted a study with refugees in the UK. The authors found that despite 44 of the 50 refugees identifying as professionals, most of them were not employed as professionals. Indeed, in that study, even though most of their participants were highly qualified professionals (doctors, dentists, teachers, accountants, engineers, nurses, solicitors and journalists), almost all were currently unemployed, as they were unable to secure similar jobs in the UK. Of those who were employed, many were in low-skilled and low-paid jobs with little or no connection to their previous profession. Although neither Oscar nor my other participants were refugees, Willott and Stephenson (2013) highlight the very essence that qualifications and degrees obtained abroad (particularly in developing countries) are not considered 'good enough' in Western countries like the UK. Amongst my participants, those who were professionals outside of healthcare and nursing embraced working as HCA partly because of their inability to find a job befitting their educational training, whereas those who were qualified nurses embraced it not only because of not being able to work as nurses in the UK but also because they considered it closely related to nursing.

8.2.2.2. *'Closest job to my health-related profession'*

My findings suggest that many of the participants (n=7), both the trained nurses and those who were not nurses, were also motivated to work as HCA because they felt that working as a care worker was close to their chosen career.

Speaking about his previous job as an industrial worker, Jeff pointed out the need to keep track with his career and continued to do something that is related. He stated that:

“...to be honest and considering my background [as a microbiologist] I wanted to maintain my medical background, health and care background, so that’s why I picked interest not in industrial but health [jobs]” (Jeff, HCA)

Jeff’s motivation is consistent with McGregor (2007) who suggests that migrant carers often considered care work as a useful steppingstone to higher career achievements. Although working as an HCA, which does not require an academic degree is a significant step-down to participants like Jeff, it was a job that he was willing to undertake in the interim (because of the connection to healthcare), rather than a future career. The nature of the job (being health care), also motivated Doris to continue in the role. Being a trained nurse, she considered working as HCA the closest job to working as a nurse. Doris concluded that:

“...if I am not working as a nurse then that is the only thing I can do, I can never do anything aside that... Because that’s just what I think, that’s the only job” (Doris, HCA)

8.2.2.3. “Not bad on my CV [curriculum vitae]”

The CV is an important piece of document that can determine an individual’s career path and suitability for employment (Dietz *et al.*, 2000; Dietz and Bozeman, 2005; Cañibano and Bozeman, 2009). Some of my participants (n=3) suggested that one of the rewarding things about working as a care worker is the effect it has on their CV. Because my participants are qualified individuals, who had engaged significant work experiences in and outside of the care sector in Nigeria, they valued their CV highly. Morgan whose encounter with an immigration officer whilst returning to the UK after a visit to Nigeria narrated his experience:

“[....] one of the ... immigration officer was trying to know the kind of job I have been doing in the UK and why I travelled back to Nigeria and [.....], he found that I have been doing industrial kind of jobs and ... working with healthcare [.....] and then he advice that I stop working [industrial jobs], that because my degree is health related, is not related to industrial...” (Morgan, HCA)

This encounter influenced Morgan's decision to do only care work and it further highlights the significant role an individual's perception of their CV plays in their choice of jobs. This is however not an isolated case because Jeff, who stated that he preferred working in the care industry rather than as an agency worker in an industrial site, also expressed similar views. Jeff who has an MSc in Public Health in the UK noted:

"... so my curriculum vitae [...], it won't make sense to put industrial experience in my CV, but care is quite fundamental. With that, you can decide to do nursing tomorrow. Like now I've got interest in doing mental health nursing." (Jeff, HCA)

In Jeff's case he considered working in care as a low-level job he could do outside working as a trained microbiologist because it is within the field of healthcare. His experience of working as an industrial worker (which he viewed as menial work), informed his desire to assume and continue as a carer for PLWD, which he sees as a job closely related to his professional training. He also considered continuing in industrial jobs as what can have a potentially damning impact on his CV and his quest to continue career progression.

Despite not been involved in industrial jobs, Kate, a Nigerian-trained qualified general and mental health nurse who now works in the UK as HCA stated that she was willing to continue in the role as long as possible. She considered the opportunity to engage in care work to far outweigh the financial incentives attached. She noted that:

"Well it's [motivations to care] not a big deal to me. If few were absent, I will still do because of the experience. There is no amount of money that can equal to an experience you have" (Kate, HCA)

Kate spoke of her desire to continue to work as an HCA in terms of the effect such type of work experience of professional caring will have on her CV rather than the impact on her clinical skills as a trained nurse. Both Jeff and Kate's made the decision to work as HCA because it was beneficial to their overall career prospects and considered the work experience good enough to be included in their CV. Hence, working as a HCA

not only addresses a gap they would have had to explain to potential employers but also provides them with the opportunity to point to that period of the working life as a time they spent doing what was technically within the sphere of their profession. This concept of considering what kind of work or personal experience should go into ones CV is not new. Scholars such as Watkins and Johnston (2000) have suggested that the quality of a resumé can have a positive impact on an individual's chances of being employed.

8.2.2.4. As a pathway to nursing

Some of my participants (n=5) who had the ambition to train as nurses believed that working as HCA would improve their chances of being admitted to study nursing when they eventually apply. Cynthia, one of the nurses spoke of her own journey to training as a nurse and noted that:

"... I had to do some hours [working as HCA] because that was also part of my requirement for my two years [nursing] programme. I think it was about 500 or 600 hours... just to make up for that and after that, I was doing my NVQ [National Vocational Qualification]." (Cynthia, RMN)

Cynthia stated that applicants into the 2-years master's in nursing course, an accelerated nursing degree, needed to show about 500-600 hours of working in a healthcare environment and other participants also cited similar reasons for first working as HCA before training as nurse. Bosede, a nurse, explained how she had longed dreamed of being a nurse when she was in Nigeria but ended up working as a public administrator. She described how she became a care worker in the UK and why she made the decision to be a nurse:

"I eventually started as a carer and somebody now counselled me...to go to care, because I wanted to do nursing and they told me it should be good I have a care experience and so I started caring[....]." (Bosede, RMN)

Bosede and the other participants who had the intention to train as a nurse considered doing care work as a good pathway to training as a nurse and as such saw it as '*a means to an end*', rather than an end itself. Similar findings were reported by Lepore (2008) in a study of care workers working in a long-term care setting. They observed that 18% of their participants were engaged in care work primarily because they considered it an important part of their professional training in view to fulfil their long-term goal. Two of my participants, Cynthia and Bosede, were particularly motivated to do care work because they felt it was a good way to have a grounded understanding of health care before the commencement of their nursing programme. However, their motivation also resonates with other participants, particularly those who had worked as nurses in Nigeria and considered working as an HCA as a necessary thing to do even it meant them having to deskill as discussed below.

8.2.3. Needs-based (necessity-defined) motivation

Most participants (n=15) cited needs-based reasons for working as a care worker, which included, not having enough shift in their former jobs and the financial incentives of working as a care worker.

8.2.3.1. Not enough shift in other jobs

One of needs-based extrinsic forms of motivation that spurred some participants (n=6) to assume the role of HCA was the lack of shift in their previous jobs. This was common with participants who had no prior nursing training in Nigeria. As noted earlier in this chapter, they were unable to find jobs that befits their professional expectation and therefore had to work to earn some money, and this was often only found in low-paying jobs. For example, Kemdo (who has a degree in accounting and worked as a resident control officer in a Nigerian bank) narrated how he became a porter in a care home after he migrated to the UK. He reflected:

“At the initial stage, because you are just coming in, you don’t have work experience in the United Kingdom, you cannot find bank job here so I started with, porter ehm,

they call it catering job. You work in the kitchen, you wash plates, you tidy the dining in the care home.” (Kemdo, HCA)

Working as a kitchen porter and washing-up dishes was not something Kemdo wanted to do but he did it all the same. Like Kemdo, nearly all my participants who were not nurses, took jobs that they considered menial and low paid. However, after working in these low paid jobs for some time, they changed jobs and began to work as HCAs because due to what they described as the ‘lack of shift’. The shortage of staff in the NHS and the availability of shifts also facilitated these choices. For instance, Morgan, who worked at an industrial site before becoming a care worker shared his experience:

“What motivated me [into caregiving] was that I wasn’t getting enough shift [.....]in the industrial sector, so I decided that, ‘no I can’t survive like this, I can’t keep on going like this, I need, I need an additional source of income’ [.....]” (Morgan, HCA)

Although Morgan had earlier cited the negative impact working in the industrial sector would have on his CV, (being a graduate with a health-related degree), he also stated that the lack of shift in that sector was another reason he chose to become a care worker. While the assumption might be that this was only related to income, other research (Alexander and Haley-Lock, 2013; Aaron-Mele, 2014; Alexander, Haley-Lock and Ruan, 2014) suggests that lack of regular work patterns and shifts have been implicated in high level of stress reported amongst people working as agency staff (e.g., temporary and casual workers on a zero-hours contract). My findings support Aarons-Mele (2014), as the participants identified stress (including the physical demands of working as a factory worker) in their previous role as one of the factors that made them take up a job in care. For example, Jeff, another participant, described his previous industrial work in the UK as tedious and more stressful than working as a care worker. He added:

“To be honest considering mm, that industrial job, has its own challenges as well as in it’s a bit stressful as well, so you have to stand too long ... , a lot of lifting, pushing, pulling, you know. Apart from that, they are not very well paid.” (Jeff, HCA)

Jeff and Morgan also found working as a care worker financially rewarding because they get more shifts than when in industrial jobs and they consider this an additional motivation. For example, Jeff noted that:

“Yes, the money, yes, so the pay [from care work] is better as well, so compared to industrial so why spending lot of time” (Jeff, HCA)

When asked specifically about caring for PLWD, Jeff admitted he only took the job as a care worker out of necessity. Whereas Morgan’s decision to remain in care work is because he considers it closely related to public health, having completed his master’s degree. Indeed, Morgan seemed to have come to like his role as a carer and he attributed this to his experience of caring for his adopted dad, an experience Jeff never forgets.

Although Jeff found care work less physically demanding than his previous industrial job, he also mentioned why he prefers to work in other mental health wards rather than a dementia ward. He stated:

“...if I have the opportunity not to work there [on a dementia ward] ..., I will not work there because their level of psychosis and cognitive fluctuations.” (Jeff, HCA)

Despite the stated desire to work as HCA, Jeff took an exception to working as a care worker for PLWD and noted that his key reason he would contemplate doing so was the monetary gains he would receive. Compared to not working at all, Jeff considers caring for PLWD as a job he does out of necessity, to get the money. This complete monetary motivation to care is explored further in the next sub-section.

8.2.3.2. Financial incentives:

Everyone needs to earn a living. It was therefore not surprising that financial remuneration is a motivating factor to engage in care work. However, three of my participants, Jeff, John and Kemdo, seemed to be expressly motivated by the financial reward they derived from working as a care worker. I explored this in further details later (see subsection 8.2.4).

8.2.3.3. Other needs-based motivations

Other material motives for caring included attending to childcare needs and suitable shift patterns Omolara who works as a nurse, stated she was first motivated to work as HCA out of necessity. She noted:

“... when I came here [to the UK], I practiced as a physio[therapist] but physio is a 9-5 job so it wasn't helpful with the kids and [...] with child care... So, I decided to step down and do night ... working as a health care assistant” (Omolara, RMN)

Listening to Omolara, it seems that she was pragmatic in her decision to deskill and her employment strategy took her child-care need into consideration. Although she expressed other career-oriented motives for engaging in care, she basically typifies nearly all my participants whose motivation to care were mostly more than a single reason. In the next section, I present and discuss the main rewards that my participants derived from working as a care worker and nurse for PLWD.

8.3. The rewarding aspects of caring for PLWD

8.3.1. Introduction

In the previous section, I presented and discussed my findings on the motivation of paid Nigerian migrant nurses and HCAs to care for PLWD in two NHS wards. However, this also raised questions about my participants motivation to remain in their caring role, which other authors have suggested is closely associated with the rewards that they derive from their role (Quinn, Clare and Woods, 2010). My findings indicate that whether care workers were motivated to assume care for intrinsic or extrinsic reasons, their motivation to remain in care was based on the benefit(s) they derived from the role, which in turn may or may not be related to what motivated them to assume the role in the first instance.

Previous research into care worker's experiences of caring for PLWD has mostly focused on the associated care burden or the challenges (Stacey, 2005; Bevans and Sternberg, 2012). Furthermore, most of the literature centred on informal carers, with

little attention given to paid carers' experience of caring. One of the objectives of my research was to fill this gap in the literature on which aspects my participants found rewarding, which motivated them to continue to care for PLWD. As highlighted in Table 8.1, my participants mentioned three main rewards they derived from caring for PLWD, namely, financial and emotional rewards and opportunity for social interactions. These rewards are presented and discussed under those headings in the subsections below.

8.3.2. Financial rewards

Although the latest NHS pay scale shows that a Band 5 nurse earns £22,000 – £28,700 per annum and an HCA earns £15,400 – £19,850 per annum depending on their experience, this puts them amongst the medium and low-paid jobs respectively (Royal College of Nursing, RCN, 2020). Other research suggests that working as a nurse and particularly as HCA is low-paying (Tarricone and Tsouros, 2008; Downs, 2015), and contributes to why UK-born individuals may not be attracted to take up the HCA role.

However, findings from this study indicate that the notion of care work being a low-paying job might be relative, as some of my participants (n=3) in the study particularly viewed the job as financially rewarding. For example, two of my participants, Jeff and Kemdo, who are both HCAs, specifically held the view that *'the pay is good'*. From their previous experience of working in other jobs (as an industrial casual worker and a porter respectively) in the UK, they emphasised that their previous jobs had paid less than what they were currently been paid in care work. Therefore, it was understandable why they both considered working in the NHS as financially rewarding. Moreover, Kemdo who was a student when he began to work as HCA had completed his studies but decided to continue work full-time as HCA. He spoke about the financial benefit he derived from working as a care worker, noting that:

"If I can be able to work as a carer and pay my school fees and pay the bills, and then sustain my family and at the same time study, I think is...is a good thing." (Kemdo, HCA)

Although HCA work is generally considered as a low paid job (Downs, 2015), both Kemdo and Jeff, had lived and worked in Nigeria before coming to the UK, and therefore viewed their pay relative to that received in Nigeria. As Kemdo suggested:

“If you look at what you will gain financially and translate it to naira [the Nigerian currency], it's rewarding. It's rewarding if you are looking at it from Nigerian perspective, but if you are looking at it as if you are living here, it's not so” (Kemdo, HCA)

Interestingly, Kemdo related the worth of the money he is been paid in care to its equivalent in Nigerian naira. This finding concurs with research by the World Bank Group (2016), which suggests that many migrant workers relate their earnings to the currency of the countries they originally emigrated from, although other research indicates that this might be because most migrant workers usually have to give back a part of their earning in the form of financial remittance to their family in their country of origin (Nititham, 2017).

However, Kemdo, also suggested that he recognised the reality that the true worth of what he is paid in comparison to the cost of living in the UK means that working as HCA was not completely financially rewarding, when he stated:

“[.....] if you are looking at it from the point of view that you are a Nigerian it's rewarding but if you are looking at it from the point of view that you are in UK, this is where your life is, this may not... I look at it from point of view that I am a Nigerian. You pay your bills but the little you can save is something...” (Kemdo, HCA)

This is similar to one of the reasons another participant, Jeff also gave as the rewarding aspect of caring for PLWD, when he declared that:

“I just have to do it, just to, to get the money.” (Jeff, HCA)

These finding concur with Chenoweth *et al.* (2010) who conducted a systematic review to understand what made care workers retain their work in caring for PLWD. Chenoweth *et al.* (2010) observed that both extrinsic and intrinsic rewards contribute

toward staff retention with improved pay being one of the extrinsic factors cited. However, while Chenoweth *et al.* (2010) emphasised the effect of improved pay as a way to retain nursing staff, my findings indicate that some care workers actually considered caring simply as a job that they require to do in order to meet their financial needs. Although there was no evidence to suggest that the carers who were in care work solely for the money provided poorer quality of care, although one participant (Jeff) stated that he was never motivated to go the extra mile in meeting the care recipient's needs. Jeff stated that:

"....some staff, they may say, "Okay, I want to give a bath or a shower to this patient" ... even if it is someone who will be going home, let's say in 20 minutes, some of them might decide to give a shower, give a bath before they go, but myself I might not take it upon me, I can just make the person comfortable, I might not really give that shower because I'm going home." (Jeff, HCA)

Jeff narrated his approach to care in circumstances when he is about to finish his a and a care recipient needs to be attended to. He noted that he would not be using any extra time to provide care if he will not be paid. Rather, he will 'just make the person comfortable'. In other words, he will provide a temporary fix to the need of the care recipient. While this may sound utilitarian, Jeff offered a deeper explanation as to why he would not go the extra mile to provide care.

"...that motivation when it's your father or mother...might not be there, you understand? To give that person shower. You might just clean the person, make sure the person is comfortable and leave the person... some people go extra mile, while even some Caucasians still do not do it but personally, I wouldn't bother." (Jeff, HCA)

Jeff alluded to the emotional detachment he feels when caring for people who are not his family members. Folbre and Nelson (2000) argued that people engaged in caring jobs can be both motivated altruistically and out of self-interest. However, from this study, those who were motivated by the self-interest of the financial gains they were to receive (Jeff, Kemdo and John) did not seem to exhibit the level of compassion 'to go

the extra mile' in providing care to the care recipient. They implied that they were only motivated to remain in the role solely because of the financial reward they received, which is contrary to the compassionate nature often associated with caring roles and entails some form of emotional labour (Simpson and Acton, 2013). The views of these three participants were different in some way from the experiences of the other participants who expressed passion for the job as their motivations for engaging in care for PLWD.

8.3.3. Emotional rewards

Whilst Kemdo, John and Jeff focused on the financial rewards, most of the other participants (n=18) talked about the positive emotions attached to caring for people with dementia. For example, many of them talked about '*putting smiles*' on the care recipient's face, implying that, for once, the older people became themselves again. Doris tried to make a link between passion for the job and what a carer might find rewarding.

"...being passionate about it is rewarding in the sense that you will be able to at least, sometimes you put smiles on their face and that is, that is rewarding..." (Doris, HCA)

Two of the participants suggested that the simple smile on the care recipient was the most rewarding part of their role. Like Doris, Jackie also identified the satisfaction she gets from the smile on the care recipient:

"There are some people that doesn't communicate, they have impairment with their hearing, possible they can't walk very well, [.....] at the end of the day they just give you that little smile, so it's not always about monetary [reward], [it] is good [.....] but the utmost rewarding thing is ...for them to give you a little smile." (Jackie, HCA)

Jackie, unlike Jeff, John and Kemdo, prized a smile from the care recipient more than the money she is paid to care. While she acknowledged the role of getting paid to care, in terms of paying bills and meeting personal needs, Jackie also emphasised the core purpose of her job, which was to care.

Another participant, Miriam also highlighted the pleasure at eliciting a positive emotion from the people she cared for, she noted that:

“The care I give and also the blessings I get, the smile I put on most of the persons I have taken care of, I think is one of the rewarding things at least I think I, I’ve gotten from the job so far” (Miriam, HCA)

It is notable from findings that the participants who stated that they were satisfied when the patients smiled, were mostly women which may be related to the gender roles, since care activities were traditionally deemed to be ‘women’s work’ (Damaske and Frech, 2016; Scrinzi, 2018). Previous studies (Fields *et al.*, 2011; Williams *et al.*, 2014) have shown that women in the caring profession demonstrate more empathy than their male counterparts. Although my study did not set out to explore my participants’ show of empathy, it is interesting to note that despite having fewer female participants, they were more likely than the male participants, to discuss the emotional rewards of caring. While this observation might be associated with gender, it is also possible that the male participants did not show the same level of empathy as the female participants (or they did not choose to tell me in the interview).

8.3.4. Opportunity to socialise

The opportunity to meet and interact with other people and particularly people of the same ethnic background was one of the things few of my participants (n=4) regarded as a reward of engaging in care work in the NHS. They expressed a feeling of isolation of being ‘a foreigner’ living in the UK which they attributed to not being around people of the same shared culture as themselves. They therefore saw their job as care workers, caring for PLWD as an opportunity to meet, socialise and interact with people of similar shared ethnic and cultural background, which helps them overcome the social isolation that they had become accustomed to. For instance, Kemdo conceptualised the rewarding nature of meeting people to overcome social isolation:

“Another way that it is rewarding is that ..., in terms of interacting with other people...with patient and family members [.....] you can't live in isolation, you have to

relate with people. So that is why it's rewarding for me, my meeting people" (Kemdo, HCA)

Kemdo alluded to feeling isolated after he relocated to the UK from Nigeria. This is consistent with the findings by Kim *et al.* (2003), who explored the immigration experiences of ten Asian Americans. They found that some reported missing the sense of community in their native countries. One participant in their study said, *"I cannot help but miss...my house...the entering and leaving friends, neighbors, and relatives who'd drop by at any time of the day"* (Kim *et al.*, 2003, p.162). The authors also found that to address feeling isolated, their participants interacted with people from a similar background and felt a sense of community. The findings from my study suggest that paid Nigerian migrants care workers also sometimes felt socially isolated and that care work offered them an opportunity to meet people of shared ethnic background. For example, Morgan noted that:

"... it provides an opportunity for me [.....] to develop relationship with other workers, ... meet other Africans, ... people from Nigeria [.....], with the patients as well [.....] I look forward to going to work to meet people I enjoy working with" (Morgan, HCA)

Morgan pointed that the social isolation he felt was due to the UK not having the kind of communal life he experienced back in Nigeria. He found working as HCA within the NHS as a way of maintaining social interactions. Although not every participant mentioned this as a rewarding aspect of caring for PLWD, it underscores the importance of the workplace in building social network amongst migrant care workers who feel disconnected from their home country. Migrant workers can sometimes feel socially excluded as they try to adjust to life in the destination country, which like most western countries, is mostly individualistic (Rozario and Rosetti, 2012; Lüdecke *et al.*, 2018). As highlighted in the literature review (see chapter 2), most family structures in African society are by nature collectivist, which might explain why some of my participants felt isolated when they were away from their family. However, this desire to socialise is not uniquely Nigerian as the same can be said of people of other ethnicities.

8.4. Discussion

The findings presented in this chapter suggest that Nigerian migrant HCAs and nurses were motivated to care for PLWD for intrinsic and extrinsic reasons consistent with the core principle of the self-determination theory (SDT) (Deci and Ryan, 2000). As reviewed in the literature (see chapter 3), applying the SDT to a care worker's motivation to care takes into consideration the “why” (motives) and “what” (goals) of individual care worker's behaviour (Sheldon *et al.*, 2004). My participants were motivated by a combination of motives and goals to engage in care. Hence, most of my participants' motivation to care was not a binary choice between intrinsic or extrinsic but an intersection of both motivations.

It is also interesting to note that those who were motivated only by the financial reward they derived from the role expressed little empathy to care and were only motivated to remain in care because of the money. However, this does not imply that the participants who expressed a lack of enthusiasm to care without the money were bad care workers (Luff, 2010; England, Folbre and Leana, 2012). It is possible that their utilitarian approach to the job is inspired by their own previous experience of working in non-care jobs in the UK. Since all three participants worked in jobs with limited human contact before working as HCA, it might explain why they had less enthusiastic view of remaining in the job. Another explanation for the lack of empathy might be the participant's sources of motivation which were completely extrinsic. This might occur when a person fails to fully identify with the behaviour or internalise it because they are extrinsically motivated outside of self (Gagne and Deci, 2005). The Figure 8.1 below shows the conceptual framework to understand my participant's motivation to engage in care as HCA and the rewards they derived from their role as care workers.

Figure 8.1. Framework for participants motivations and reward of caring for PLWD

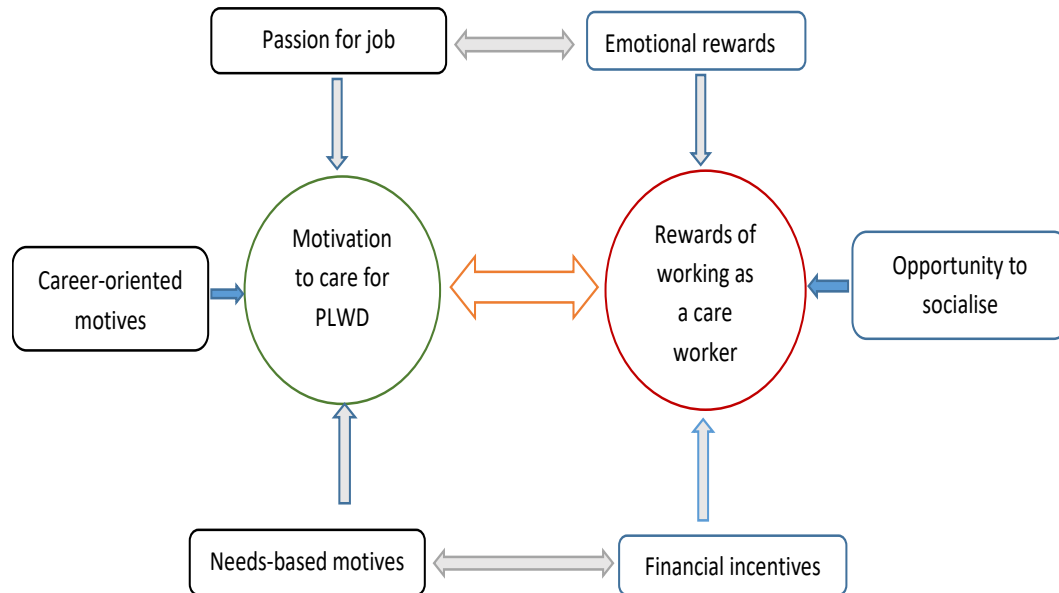


Figure 8.1. Framework for participants' motivations and reward of caring for PLWD

In addition, my participants found working as a care worker financially rewarding. Much of the literature and statistics on care workers' pay suggest that it is relatively low (Low Pay Commission, 2014; Skills for Care, 2018) and thus has little influence on why they would want to continue in the role (Rakovski and Price-Glynn, 2010; Morgan, Dill and Kalleberg, 2013). My findings however indicate that many of my participants also considered the pay to be 'okay' and some considered it the only thing keeping them in the job. It is worth noting that their description of the pay being 'okay' was in relation to their being able to pay bills and meet their financial needs. There were some participants who equally felt that what they were paid was not what was keeping them in the job. These were the participants whose main motivation to care was their love for the job and the passion to care for older adults (Brodaty and Donkin, 2009).

Consistent with Hussein (2017) findings on care workers' pay, my participants appear to have accepted the low pay they received as part of the job. England (2005) referred to this phenomenon as the 'prisoners of love' framework which might have a wider implication on care workers pay (England, Allison and Wu, 2007; Hirsch and Manzella, 2014).

Lastly, it is also interesting to note that many of the participants chose to 'voluntarily deskill', and it is clear that they did so because of the constraints imposed on them by their personal circumstances and the circumstances around them. In addition, my participants who were Nigerian-trained nurses continued in their role as care workers whilst they undertake the necessary adaptation programme that will enable them to practice as nurses in the UK. These findings concur with other studies (Rosser and King, 2003; O'Brien, 2007), which indicate that migrant nurses often felt deskilled when they continue to work as HCA for a long time without utilising their clinical skills. This could have a devastating effect on migrant nurses with a long-term plan to return to their home country to practice, which further aggravates the effect of brain drain (Kurniati *et al.*, 2017). It may also have implications for these nurses achieving their professional goal of coming to the UK to enhance their career, as they may never get an opportunity to practice as qualified nurses in the UK.

8.5. Summary

On the motivation to care, findings from this study on paid Nigerian care workers suggest that they are motivated to assume and remain as care workers because of both intrinsic and extrinsic reasons such as the passion to care for people, to advance their career and for monetary gain. In addition, care workers who had nursing qualification prior to migrating to the UK became care workers and continue to care as they want to maintain their nursing practice by doing a job that they believed was closest to working as a nurse. In contrast, my participants who had no prior training as nurses before coming to the UK took on different low paying jobs upon arrival in the UK. Subsequently they became HCAs due to inability to find job in the career they were qualified, but some of them also cited doing it out of necessity, monetary gain and

passion for the role as some of the added reasons they decided to become care workers. However, participants who were mainly motivated by passion to assume caregiving role developed their passion from previous unpaid experience of working with the older adults and others became passionate after undertaking some volunteering role caring for the elderly. In the next section, I present findings on the challenges of caring for PLWD and the coping strategies my participants employed to manage the identified challenges.

CHAPTER NINE

CHALLENGES AND COPING WITH CARING FOR PEOPLE LIVING WITH DEMENTIA IN THE NHS

9.1. Introduction

This is the third of three successive chapters which presents and discusses findings on the experience of Nigerian migrant health care assistants (HCA) and nurses caring for people living with dementia (PLWD) in the NHS. It explores the challenging aspects of caring for PLWD in the NHS and how my participants coped with the challenges they identified. It is divided into two main sections, viz: challenges of caring and coping with caring for PLWD, which is followed by a discussion of the main findings and a summary of the chapter.

9.2. Challenges of caring for PLWD

9.2.1. Introduction

Some of the challenges identified include physical/verbal abuse from patients, the physically demanding nature of caring, poor staffing levels, undesirable shift patterns and several instances of racial discrimination (see Table 9.1). This section discusses these challenges further.

Table 9.1. – The challenges faced by HCA and nurses caring for PLWD in the NHS

S/No	Participants	Challenges of caring for people with dementia									
		Communication difficulties	Physically demanding	Physical aggression	Inadequate staffing level	Racism and Discrimination	Uncooperative staff	Verbally abusive	Mentally and psychological draining	Personal care	Shift pattern
1.	Adams	-	✓	✓	✓	✓	✓	✓	-	-	-
2.	Ademola	-	✓	✓	✓	✓	✓	✓	-	✓	-
3.	Bernard	-	✓	✓	✓	✓	✓	✓	-	-	-
4.	Bosede	✓	✓	-	✓	✓	✓	-	✓	-	-
5.	Cynthia	-	✓	✓	✓	-	✓	-	✓	✓	-
6.	Dankay	-	✓	✓	✓	-	✓	-	✓	-	✓
7.	Doris	-	✓	-	✓	✓	✓	-	✓	-	✓
8.	Folashade	-	✓	✓	✓	✓	✓	-	-	-	-
9.	Jackie	-	✓	✓	-	-	-	✓	✓	-	-
10.	Jane	✓	✓	✓	✓	-	✓	-	-	-	-
11.	Jeff	✓	✓	✓	✓	✓	✓	✓	-	✓	-
12.	John	-	-	-	-	✓	-	-	-	✓	✓
13.	Kate	✓	-	-	-	✓	-	-	-	✓	-
14.	Kemdo	-	✓	-	-	✓	-	-	✓	✓	-
15.	Miriam	-	✓	✓	✓	✓	-	-	-	-	-
16.	Morgan	-	✓	✓	-	✓	-	✓	-	-	-
17.	Omolara	✓	✓	✓	-	✓	-	-	-	-	-
18.	Oscar	✓	✓	✓	-	-	-	-	✓	✓	-
19.	Paul	✓	-	✓	-	✓	-	✓	-	✓	-
20.	Robert	-	✓	✓	-	✓	-	✓	-	-	-

21.	Shapiro	✓	✓	-	-	✓	✓	✓	✓	-	-
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9.2.2. Physically demanding

Nearly all my participants (n=18) found caring for PLWD physically demanding, and they attributed it to the complex needs involved (McPherson, Hiskey and Alderson, 2016). For example, meeting a patient's care needs (such as bathing, toileting, grooming and feeding) was reported to be particularly challenging when the patient becomes resistive (Fauth, Femia and Zarit, 2016). This is discussed further in a later subsection (see subsection 9.2.6). However, what contributes to make giving personal care demanding is the adverse cumulative effect of the use of manual handling techniques and equipment on the care worker (Samaei *et al.*, 2017).

Aside the physical demands of giving personal care, PLWD can present with different behavioural disturbances which makes it difficult to manage or engage them in activities of daily living (ADL) (Desai, Grossberg and Sheth, 2004; Miyamoto, Tachimori and Ito, 2010). Dealing with the patients' behavioural presentations and the heavy workload had a negative toll on my participants. For instance, Robert itemised some of care activities he routinely carries out on the ward:

“From the workload, yes, you come in, you have to help them with their personal care, help them with their nutritional needs, help them with ... some engagement, try to relate... get to know what they want, take them for activities... Yes, there is so much to do, within the short time you have.” (Robert, HCA)

Robert's description of activities on the ward underscores the physically demanding nature of caring for PLWD, which both nurses and HCA discussed in terms of the heavy workload they had to complete within a limited time. Two factors that contribute to the heavy workload experienced by my participants are the deteriorative nature of dementia and the stage at which they are admitted into hospital (Zimmerman *et al.*, 2005). Firstly, the observable decline in PLWD as the condition advances makes them wholly dependent on care staff for their personal care needs (Fauth, Femia and Zarit, 2016; Bernstein, 2017; Batchelor-Murphy, Steinberg and Young, 2019). Secondly, as dementia advances to the stage when it becomes difficult for family carers to cope at

home, it becomes necessary for the individual to be placed in a residential home (Toot *et al.*, 2017; Harrison *et al.*, 2017), or as is the case in my study, admitted into a specialist dementia ward (Briggs *et al.*, 2017). In addition, because PLWD represent the older adult group with significant medical comorbidities (Timmons *et al.*, 2015; Clague *et al.*, 2017), care workers may have to facilitate frequent appointments to and from primary and secondary care centres (Mueller *et al.*, 2017). These physical demands of caring for PLWD sometimes resulted in adverse health effects on my participants. As Doris mentioned:

“... often times, I return back having headaches because [of] the whole stuff to be done at the same time, ... you’ve got their personal care, ... their feeding, ... you need to make the environment clean, conducive, you need to do your documentation, ... you are trying to manage so many things at the same time, so it really challenging.” (Doris, HCA)

When care workers become stressed, the impact can be far reaching, leading to absenteeism, increased sick leave, increased turnover of staff and the consequent effect on patients care (Pitfield, Shahriyarmolki and Livingston, 2011). Conversely, Morgan held a different view. Whilst he acknowledged that the job is indeed physically demanding, he noted that uses it to his advantage, stating that:

“It saves me money from registering at the gym.... because it’s very physically demanding working in this area, so I don’t need a gym.... when I go to work, I really exert myself physically, so I exhaust myself...” (Morgan, HCA)

Morgan takes a positive attitude despite the demands of the role, which suggests that care workers often employ different techniques to cope with the stress they experienced.

9.2.3. Psychologically/mentally stressful

In addition to the physical demand of caring for PLWD, many of my participants (n=8) found it to be psychologically and mentally draining. They attributed it to different forms of discordant noise (like screaming and shouting) and other behavioural

disturbances on the ward. The behavioural or psychological symptoms of dementia which manifests as screaming may be caused by the cognitive impairment resulting from the condition, or the response of the patient to unmet needs (Bourbonnais and Ducharme, 2008; Cohen-Mansfield *et al.*, 2015). Regardless of the cause of a patient screaming on the ward, one reason my participant found it distressing was because it could continue for a long time. For instance, Doris observed that:

“[.....] psychological [stress] is part of it, it comprises of everything. You are giving in your all to it [caring], ...some of them [PLWD], you have to be calming them down while they are shouting, ... and just when you stop, they are starting again.” (Doris, HCA)

My findings are consistent with those reported in previous studies (Edgberg *et al.*, 2008; Miyamoto, Tachimori and Ito, 2010). Another point worth mentioning is that the experience of screaming could have a long-term effect on care workers mental health. Although my participants did not raise this as a concern, it was evident from their emphatic description of their experience that they might still be suffering from their experience of patients screaming on the ward. For instance, Oscar spoke emotionally about the effect constant screaming had on him:

“I could remember when I first started, I worked with a lady that screams all the time, ... and even when I finished my job and got back home, even when am lying down, I still hear her screaming as if she is just behind me....” (Oscar, HCA)

This is a vivid example of the mental and psychological toll screaming had on my participants. My own personal experience was no different. I can still remember feeling mentally distressed when I worked in a nursing home some years ago where two patients screamed intensely throughout the shift. It was my first time in the home, and I never went back there again because of that. Although my employment status as an agency worker at the time afforded me the opportunity not to work there again, I could only imagine what the experiences of the full-time care workers in the home whose contract required them to be there regularly.

Another cause of psychological distress was the ripple effect of other challenges my participants experienced. As one participant commented:

“...we run on one nurse, which at the time you are finishing, you are both mentally and physically stressed....” (Bosede, RMN)

The causes of psychological stress to my participants were mostly a combination of many stressors that are not limited to the ones already highlighted. In the next subsection, I continue to discuss some of the challenges that contribute to my participants' experiences of psychological distress.

9.2.4. Physically aggression and verbal abuse

My participants faced several forms of physical aggression (n=15) and verbal abuse (n=9) whilst caring for PLWD in the NHS. Jointly, sixteen participants experienced verbal abuse and/or physical aggression (see Table 9.1). Verbal abuse includes swearing, use of derogatory words or racial abuse (see subsection 9.2.10). My participants' experience of physical aggression alone was the third most cited challenge that they faced, aside the physically demanding nature of their role and racism/discrimination. They noted that most times, physical aggression results when patients resist having personal care done.

“The physical aggression from patients, ehm, when you are trying to provide personal care for example you can get punched” (Morgan, HCA)

The intrusive nature of personal care, the cognitive impairment of PLWD and staffs' inability to understand patients' unmet needs probably contributed to the patients' resisting personal care. Care workers who are not regular on a ward will likely not be familiar with a patient's needs and care (Zahran *et al.*, 2016). The nature of employment contracts has changed over the years, with many care workers (such as bank or agency staff) on flexible contract (Ball *et al.*, 2017; Datta, Giupponi and Machin, 2019; Farina, Green and McVicar, 2020). In this study, about three quarter of my participants were on a temporary contract and did not work on the two NHS wards on a regular basis (in

comparison to staffs on permanent contract). This might have contributed to their experience of physical aggression and verbal abuse because they do not get to know the patients and neither do the patients know them well. From my own experience, I have been on a dementia ward where a patient had said to me, ‘who are all these strangers’, referring to members of staff who were not familiar with the ward. Although PLWD may have been greatly impacted by the disease, they are still human and, in many cases, have lucid moments (Baird, 2019). They had a life that was stolen from them by the disease but as humans, they also have needs that should be met. Understanding the patients could go a long way to reducing the incidence of physical and verbal aggression on an NHS ward. This approach continues to gain momentum and it is based on the needs-driven dementia-compromised behaviour (NDB) model (Cohen-Mansfield *et al.*, 2015; Davison *et al.*, 2016).

Care workers’ experiences of physical aggression sometimes resulted to assault and injuries. My participants who reported that they experienced physical aggression also stated that they have experience physical assault and injuries from PLWD. For example, one participant noted:

“...the patient requested for a hot drink, so I made a hot drink, brought it to the patient, offered it to the patient, the patient got it and just poured it on me like that” (Morgan)

Aside psychological distress and injury to the body, verbal abuse/physical aggression can also lead to absenteeism of injured staff and the spiral effect of increased physical demands on unaffected staff (Pitfield, Shahriyarmolki and Livingston, 2011). Other factors that might contribute to a patient’s aggressive behaviour include adverse effect of medications, institutional abuse, and other forms of abuse which were not explored in this study. However, one factor that might contribute to physical aggression is poor communication between the care worker and the patients, and this is discussed next.

9.2.5. Communication difficulties

A difficulty with communicating was highlighted by some of my participants (n=8) as one of the challenges associated with caring for PLWD. They discussed the difficulties

they experienced from two main perspectives. Firstly, their lack of understanding of what a patient is saying, which they attributed to the patient's deteriorating cognitive presentation that hinders effective communication. For instance, Sharpiro alluded to how stressful this could be, saying:

“Like someone living with dementia... is trying to communicate to you, and you are not able to understand, you cannot get what the person is saying” – (Sharpiro, HCA)

From my participants' descriptions of their communication difficulty, it appears that they mostly relied on verbal expression as a means of communicating with PLWD, hence, they experienced the challenge of understanding what PLWD are trying to communicate. This finding resonates with Stans *et al.* (2013) who observed that care workers lacked the skill and knowledge required to communicate effectively with PLWD.

Another issue worth pointing is that my participant did not mention using non-verbal expression in their communication with PLWD, suggesting that it may have been largely ignored. Working as a care worker can be daunting and it is not surprising why they relied on verbal rather than non-verbal skills to communicate with their patients. While verbal expression is essential to patient care, it is of less value in care for PLWD because of the cognitive impairment that characterise the condition.

Although it can be challenging, researchers (Brodaty, Draper and Low, 2003, Savundranayagam, Hummert and Montgomery, 2005, Wang, Hsieh and Wang, 2013) have stated the need for care workers to rely on non-verbal behavioural communication and impaired verbal expression to better understand and communicate with PLWD.

Secondly, few of my participants (n=3) believed that the reason PLWD or their families could not understand them was because of their accent. Kate observed that:

“It was challenging when I came in [to care work] because of my accent. All my life I was studying in English, even though our presentation of English back in Nigeria and the presentation of English here is different, but we speak English” (Kate, HCA)

A care worker's accent can be a barrier to communication (Burda *et al.*, 2004; Levy and Crowley, 2012). However, the three participants stated they only faced the challenge when they began to work as care workers, but they overcame it by learning to talk with a British accent. The overall effect of a difficult in communication was mostly felt during personal care and this is discussed next.

9.2.6. Challenges of giving personal care

As stated earlier, providing personal care is integral to caring for PLWD because the deteriorating nature of the illness makes PLWD dependent on their carers or care workers (Bernstein, 2017). Apart from the physically demanding nature of giving personal care (see subsection 9.2.2), some of my participants (n=8) cited two other reasons they found giving personal care challenging. Firstly, because they were mostly professionally qualified and had many years of experience working in their respective career pre-migration, they were frustrated that they had to 'condescend' to doing a job they considered to be below their professional qualification. Kemdo, who has a degree in accountancy and worked as a quality control officer in a bank reflected on how he felt having to work as a care worker in the UK:

"...you have to bear a lot of things, ... that ordinarily you will feel that you are above the level to do. For instance, packing shit... is one of the challenges that is part of the job but, you still feel like "no, I shouldn't be doing this"." (Kemdo, HCA)

Evidence from previous studies (McGregor, 2007) and the findings presented earlier (see chapter 8) indicates that migrant workers in the UK often had to settle for jobs below their professional qualification. However, it is interesting to note that despite choosing to work as care workers, Kemdo and other seven care workers found giving personal care which is an essential aspect of care work challenging. An understanding of their individual motivation to engage in care work provides better insight to why they found providing personal care challenging. For instance, Kemdo's motivation to care for PLWD was mostly needs-based (financial reward), just like other participants (Jeff and John) who also found giving personal care to PLWD challenging.

Secondly, they lacked any experience of paid or unpaid care work. For example, Jeff stated candidly that:

“...considering the fact that in Nigeria I don’t see poo, I don’t see faeces, you know, except my own faeces. But here, you have to clean people, pack their faeces you know, give have them a wash, you know. It’s not really that easy.” (Jeff, HCA)

It is notable that unlike Jeff, most of the participants who had worked as nurses in Nigeria (except for Kate) and some participants who had previously cared for a relative in Nigeria (e.g., Morgan) did not express displeasure at having to conduct personal care. These care workers generally perceived their overall role to be less stressful.

Thirdly, six out of eight participants who found giving personal care challenging were males, suggesting that there might be some gender/cultural perspective to the issue and this is discussed later (see section 10.5.4). In the next section, I discuss the challenges my participants experienced in relation to working with other care workers.

9.2.7. Inadequate staffing level

In my study, many of the participants (n=11) stated that they were mostly short of staff which this often left them feeling stressed and overwhelmed by workload. For instance, Doris alludes to this:

“I think ... having enough staff seems to be the best because it reduces the stress load [....]” (Doris, HCA)

Common reasons mentioned for the shortage of staff were mostly institutional and includes staff being on sick-leave and inability of the ward management to cover cancelled shifts. My participants suggested that the frequent shortage of staff might be part of the ward management’s and/or NHS Trust’s cost-cutting measures. Jackie noted:

“Yeah, there have been [concerns raised] but nothing has been done about it, probably they don’t have the funds for more staff, I don’t know” (Jackie, HCA)

Inadequate staffing levels have dire consequences on to the wellbeing of both patients and staff (Ball, 2006). For patients, it could result in an increase in physical aggression when their needs are not met (Houghton *et al.*, 2016, Spilsbury *et al.*, 2011). For example, Doris noted that inadequate staffing compromised the quality of care the patients received because care workers were unable to give their 100%, stating:

“... with the [low] staff strength, for instance, if you’ve got like sixteen (16) residents to look after, you can’t be giving them [the] 100% care that you really want to because, with that, it’s going to get to twelve [patients]” (Doris, HCA)

Inadequate staffing also had enormous impact on patient-staff relationship as staff concentrate on utilising the numbers of staff available to meet the need of the patients (Dinsdale, 2003; Ball, 2006). Doris continued her description of her experience of caring when there were not enough staff on the ward:

“for instance you get to work at 7:30am, you meant to ensure they are all up in the lounge for them to have their breakfast, if you really want to spend that time with them, to let them pour their heart to you, talk with them, give them time to talk you, respond to them you, you won’t be able to meet up” (Doris, HCA)

Doris’ description highlights the ill effect of inadequate staff numbers on the patients, as it essentially hinders the delivery of a person-centred care. With fixed task to be done on a shift, patients’ care was typically treated as part of the routine to be completed with little or no attention given to the patients’ emotional or individualised needs.

Inadequate staffing level was also detrimental to my participants’ wellbeing. For instance, it led to increased absenteeism, use of sick leave and turnover of staff (Johnson *et al.*, 2018) and the attendant effects on the care workers left to deal with the negative consequences on the ward. It also has a knock-on effect on all the challenges discussed so far.

Although a study by Schnelle *et al.* (2004) observed that there was no linear relationship between staffing levels and the quality of care, the authors acknowledged the existence

of a ‘staffing threshold’, which must be attained before the benefits of staffing levels can be seen on the ward (similar findings were reported by Zhang and Grabowski, 2004). Stress may be inevitable when inadequate staffing numbers persist (Schnelle *et al.*, 2004). My participants also had other institutional challenges, which are discussed below.

9.2.8. Undesirable length of shift

Few participants (n=4) identified the length of shift as a stressor. Shift in care/nursing work usually consist of working long 12-hours shift or shorter shifts (Royal College of Nursing, RCN, 2017; Harris *et al.*, 2015). Although all the participants in this study worked the same 12-hours shift, those who considered the length of shift as challenging stated that they were constrained to work because that was the only type of shifts available in the two NHS wards. One participant, John, cited the lack of choice as the reason he is compelled to do long-shift.

“I have to do them, I don’t have any choice, that’s the only challenge am facing now, I have to do the long days and the night shift.” (John, HCA)

They endured the long hours spent on the job because of the nature of caring for PLWD discussed earlier and they often stressed afterwards. Another participant, Doris gave some insight into doing a long day:

“... whenever am going for a long day, I just prepare myself like okay, am going there today and often times I return back having headaches...” (Doris, HCA)

It is important to point that despite these participants citing the longer hours as a challenge, a further look at their narratives indicates that their experience of stress was more to do with their apparent lack of choice, as no alternative was available. This is consistent with findings reported in previous literature (Bambra *et al.*, 2008; Rosa *et al.*, 2019). Although the other participants who did not cite shift pattern as a challenge did not mention their affinity for it, the literature suggests that some staff working in the NHS preferred the 12-hours shift despite it being linked to low job satisfaction and other

negative impact to their physical and psychological wellbeing (Stone *et al.*, 2006; Gander *et al.*, 2019).

It is possible that these four participants considered the shift pattern challenging because it did not fit into their work-life balance. However, their experience may have been further accentuated by the nature of the job, which usually involves dealing with patients' behavioural disturbances, their personal care needs, and the other challenges (such as staffing levels) already discussed. My participants also faced the challenge of working with 'difficult' members of staff and this is discussed in the next subsection.

9.2.9. Uncooperative staff

Narratives by my participants (n=11) indicates that they sometimes find it challenging to work with some members of staff citing reasons such as, the staff's inability to cope with work-related stress which affects their attitude to work and staff bringing their own personal/family problems to work. It was evident that my participants deemed this to be an additional burden to the already demanding job of caring for PLWD. Folashade summed it up, saying:

"I think the most important one is working with bad staff. Yea, because at the end of the day, working with a dementia patient... is challenging" (Folashade, HCA)

My participants considered staff who they perceived to be lazy and with a bad attitude difficult to work with. However, their challenging work relationship was often fallout from the challenges previously discussed, which Alexander and Hegarty (2000) noted leads to staff burnout and emotional exhaustion.

In addition, my participants also mentioned racial discrimination from staff as one reason they find it difficult to work with some staff and this is discussed next.

9.2.10. Discrimination and racism

Most of my participants (n=16) narrated different instances of workplace discrimination and/or what they perceived as outright racism towards them. This was the second most

mentioned challenge, and it was perpetuated by fellow staff and the patients/their families.

9.2.10.1. Staff on staff discrimination and racism

My participants agreed that the racial discriminations they experienced from their Caucasian counterparts was mostly covert and subtle. An instance of this subtle form of racial discrimination was being denied a career opportunity that was made available to Caucasian staffs. Adams commenting on a case he witnessed observed that:

“ you see someone [Caucasian] ... with GCSE, 6 months experience and the manager... is forwarding that individual to go and do associate practitioner training... but here you have someone [person of colour] ... whose got the skills and everything, ... goes to the same manager, he doesn't get the approval.” (Adams, HCA)

Adams could not understand why black care workers who had multiple degrees were not sponsored to pursue a career in nursing whereas their white colleagues with no degree were allowed. This experience resulted in self-doubt because my participants began to question themselves as to why they were overlooked. They also believed that they were often unfairly targeted by their White counterpart and assigned the most difficult patients or duties on the ward. One participant, Miriams noted:

“[....] they will just give you [the difficult allocation] because you are black..., to me that's how I feel it, I see it that it's been racist” (Miriam, HCA)

Despite their experience of workplace discrimination/racism, only few spoke out against it. For example, Adams shared his experience of confronting racism, although this was at his previous place of work. He stated that:

“I told her [the ward manager], I said, 'look, just tell me straight away if you don't want to sponsor me'. It was highly demoralising and that was the reason why I resigned from that job” (Adams, HCA)

In this instance, Adam was visibly disappointed that the manager did not support his career ambition to be an associate professional even though other white colleagues were sponsored. He felt he was refused sponsorship because of the colour of his skin. Although Adams spoke up and eventually had to quit the job, most of my participants did not bother to complain about this. They tried to rationalise the discriminatory or racist behaviour and simply carried on with their job. For example, both Kate and Doris showed indifference to racist behaviour targeted at them because they saw it as what they could endure.

“... the worst I can do is if I feel I cannot take it, I can no longer accommodate their attitude and I’m getting to my wits end, I might just quit and get a job somewhere else.”
(Doris, HCA)

“... what I feel I can accommodate there is no point talking about it and secondly, I just have it in my head that am not going to be here forever, am just going to be here for a short while” (Kate, HCA)

Both Kate and Doris appeared to have a threshold where they were willing to accept discriminatory behaviours before they will quit the job. One reason my participants did not bother to report their experiences of racism was lack of confidence in how their complaints would be handled. They believed that the forms of racism they experienced was entrenched within the NHS and there was no need complaining about it. Doris explained why this is the case:

“There is actually a ‘speak up, speak up’ thing but I don’t think people actually use it.... Because I just think, some people just have this idea that no matter what I say, in as much as I’m not one of them, then I can never be accepted.” (Doris, HCA)

Another reason for their inaction was the nature of their work contract. As stated previously, most of my participants (n=16) were on zero-hours contract which offered no guaranteed work hours. Hence, some of my participants did not want to complain about their experience of racial discrimination for fear they may not be considered for work again. This finding is not unique. Migrant care workers’ experiences of racism

have been reported in other studies (Mercer, Heacock and Beck, 1994; Stevens, Hussein and Manthorpe, 2012). For example, Mercer, Heacock and Beck (1994) found that the experience of racism was one of the stressors most cited by nursing aides. Listening to the participants, it seemed that although they detest the racist abuse, they experienced from some of their white counterparts they were unwilling to complain about it. However, they were more understanding of the abuse they received from their patients because they say it as a reflection of the illness.

9.2.10.2. Patients on staff racist behaviour

Most participants also reported facing most overt racist behaviour from patients. However, they did not feel offended and were quick to excuse the behaviour, explaining it away. Participants saw those sorts of behaviours from patients to be part of their presentation and one of the signs that comes with dementia. In addition, they also stated that they have faced discriminatory behaviours and racism at one point or another. Their reaction to this kind of behaviours varied from explaining it away, making excuses for it or simply disregarding it as something not worth worrying about. Doris, who mentioned discriminatory behaviours as being responsible for some of her colleagues leaving her workplace, spoke of the attitude of some white staff to black members of staff. She noted:

“... they’ll resist your honest intention to help, because you are dark in complexion, ... it has been challenging, but some people [patients] love you because you are black. It’s not usually 100% bad” (Doris, HCA)

However, my participants stated that the experience of racism from the patients contributes to the psychologically and physically demands of the job. Miriam shared her experience of caring for a patient who was racially abusive, commenting that:

“I assumed he was sick, I knew he was doing the wrong thing, but I just refused... to get angry with such people because when you start getting angry it affects the care I’m giving to the patient” (Miriam, HCA)

Miriam chose to ignore racial abuse from the patients because she rationalised their behaviour to be the result of dementia. Like many of my participants who had to endure racism, Miriam stated that she tried to digest it and let it go. This attitude towards racism and discrimination in the workplace might be due to the feeling of hopelessness that anything will ever change (Jönson, 2007; Shutes and Walsh, 2012).

9.2.11. The challenges of working as a nurse caring for PLWD

My findings suggest that the six practicing nurses experienced the added constraint of working as nurses in the NHS. Comparing her experiences of working as HCA and as a nurse, Omolara stated:

“The only difference now is that as a nurse, I give the medication. You know and, and the HCAs they are more on the floor, they know what happens more with the patient, so if you as a nurse, if you don’t have a relationship with the staff you’re working with, it becomes difficult to know what is going on with the patient”. (Omolara, RMN)

Omolara’s description of her role as a nurse and her perception of the role of an HCA in her nursing team is a view widely held by nurses (Alcorn and Topping, 2009; Hugh, McKenna and Keeney, 2013) and not typical of Nigerian migrant nurses. However, Omolara’s description raises issues relating to how the nursing team works, where the HCAs are often delegated to see to the direct care of the patients while nurses commit themselves to the bureaucratic aspects of nursing like completing paper works (Wheatley 2006). James et al. (2010) noted that this rising trend might have serious implication to patients care because the HCAs are not clinically trained to detect deterioration in patient’s care. Spending more time on documentation and paper works rather than the patients have been frequently cited as some of the common challenges that nurses face in the UK (Albaugh, 2003; Sellgren, Ekvall and Tomson, 2008; Duffield *et al.*, 2014).

9.2.12. Comparing paid and unpaid caregiving experiences

Although only some of my participants (n=8) had cared for relatives in Nigeria before becoming care workers in the UK, their experiences were similar and shared. One notable point made by Morgan and Oscar was that they found their previous unpaid caregiving roles (as family carers in Nigeria) less challenging when compared to the challenges they face as paid care workers. For example, Morgan noted that caring for his dad was less challenging because he had a relationship with the care recipient as opposed to caring for someone, ‘who do not know you from Adam’. Oscar, also echoed this point stating:

“Yea, it wasn’t really challenging per se because it’s just my granddad and again his, someone am already use to.... You understand he is someone I’m already...” (Oscar, HCA)

This finding contrasts with the notion that unpaid carers always find caring for PLWD challenging (Greenwood *et al.*, 2019), indeed Morgan and Oscar suggested that it was the exact opposite.

Oscar did not find caring for his grandfather challenging because of the quality of relationship and love he had for him. Morgan also shared a similar experience stating that care workers in care homes for PLWD, may find it more challenging because they do not have any filial relationship with their patients. It is possible that they considered caring for their relatives a way to show reciprocity. For instance, Morgan, stated that care workers are like stranger who are trying to help people they do not know. Although it has been widely speculated that unpaid carers suffer more because they provide round-the-clock care to their relatives, Morgan and Oscar who have lived in both worlds considered working as a care worker to be more challenging because nurses and HCAs had no filial relationship with the PLWD. However, although it was not discussed by the participants, it is also notable that most PLWD only go into institutional care when they are in the advanced stage of their illness and clearly this brings additional challenges to care work (Toot *et al.*, 2017; Harrison *et al.*, 2017).

9.3. Coping with the challenges of caring for PLWD

9.3.1. Introduction

In the following section, I present the findings on how my participants coped with the challenges they identified, and the different coping strategies (and sometimes multiple strategies) employed.

9.3.2. Types of coping strategies identified

Coping in this context can be described as what the care worker does to adapt or adjust to a situation of stress (Cooper *et al.*, 2008). This entails a care worker responding to caregiving stress by allocating cognitive and behavioural mechanism they have within them in response to internal and/or external demands placed on them, which currently surpasses their normal capacity to respond (Folkman and Lazarus, 1980; Endler and Parker, 1990; Austenfeld and Stanton, 2004). However, for this study, the coping strategies employed by my participants may be grouped under two broad categories (Cooper *et al.*, 2008), namely: problem-focused coping (n=13), emotion-focused coping (n=9) and both (n=2). A few of the participants (e.g., Jeff) also mentioned what could be described as dysfunctional or avoidance coping (non-coping) but they did not express it as their sole coping strategy.

The next section highlights the strategies that the care workers used to manage work stress.

9.3.3. Problem-focused strategies

Most of my participants (n=13) used problem or task-focused coping strategies by undertaking an action which directly removes, or reduces their caregiving stress (Austenfeld and Stanton, 2004) and the strategies as discussed below.

9.3.3.1. Knowing the patients

Instead of focusing on the physical and behavioural challenges posed by the care recipients on the ward, Ademola (an RMN) chose to address what he perceived to be

the source of such behaviours. He acknowledged the importance of knowing the patients by developing a relationship with them, so he could deal with some of the physical/behavioural challenges they posed on the ward. Ademola noted that he can better respond to their needs because he tries to understand his patients. This has helped him avoid chaos that could arise on the ward as a result of having to deal with restless patients.

“.... once you know the patient there is no amount of strains that they can put on you, because as I have said, there is a policy and procedure... you have your medication as backup, ... further therapy ... one to one ... a lot of things [.....]” (Ademola, RMN)

Ademola spoke in his professional capacity as a nurse and mentioned different measures he takes in advance to guide against physical aggression and other behavioural challenges on the ward and this includes knowing what works for the patient. Although, Ademola’s response might have been different if he had been working in the capacity of an HCA because the additional training he received as a qualified nurse enabled him to consider alternative behaviour management strategies. In comparison to taking rest breaks, a commonly used strategy by both HCAs and nurses, most nurses like Ademola tend to take a professional perspective to coping with caring for his care recipients. For instance, Ademola re-emphasized the importance of knowing the patient to understand them and to be able to respond appropriately. He noted:

“Because once you know the patient, you will know how to manage the patient, you will get yourself known, familiar with the care plan, familiar with the risk that the patient can possess, you know, with that, that is easy for you to manage.” (Ademola, RMN)

Similarities can be drawn between Ademola’s approach to getting to know the care recipient as a strategy to cope with challenges of caregiving and Morgan’s idea of why his experience of doing unpaid caregiving was not particularly challenging (discussed in section 9.2.12). These findings are supported by previous studies, for example, Ostaszkievicz *et al.* (2015) observed that nurses managed physical and behavioural

challenges from clients through a range of strategies, including understanding individual care recipients. Moreover, Cohen-Mansfield (2000) framework for managing challenging behaviour also provides an explanation for understanding care recipient's presentation from their care plan to better manage their care needs and cope with the challenges of their behaviours.

The Cohen-Mansfield (2000) behavioural/learning model theorizes that challenges manifested by care recipients can be due to unmet care needs and when these are addressed, the challenges are managed. It therefore follows that care workers who understand and anticipate what these unmet care needs are will be prepared to deal with them. Although Ademola used the strategy of knowing the patient as a form of problem-focused coping strategy, he and the other participants also used other coping strategies, and these are highlighted in the next sections.

9.3.3.2. Rest and recreation

Another important coping strategy used by my participants was to take rest/break. Morgan described how he handles a stressful shift whilst on the ward, stating that:

“.... the way you cope at work is to take a break, you can go out because sometimes it can be very stuffy within the setting, you go outside to get fresh air... deep breath in and out” (Morgan, HCA)

As discussed earlier, the physical demand of caring for PLWD can take a toll on care workers (Miyamoto, Tachimori and Ito, 2010). Morgan's reflection of how he coped with the demand of his job by taking time to rest and take fresh air before returning to work highlights the place of rest in the workplace. Rest is vital and the adverse effect of staff not having enough rest at work and off work can be damaging to their health and wellbeing (Dall'Ora *et al.*, 2018).

However, the nature of the workplace might present with constraints that makes it difficult for staff to take rest. For instance, Morgan admitted to not being able to rest at work because certain situations do not permit, commenting:

“I will take some rest [if I were home], in this case [at work] you can’t rest until you finish your shift, you just endure until you finish your shift. So, when you get home, ... how you feel within you will determine if you are going back to work the next day or not” (Morgan, HCA)

Taking rest at work can be met with practical constraints such as not being able, to do so when it is most needed. This might be due to the busy activity on the ward (Turner *et al.*, 2017) and my participant would often have to ‘endure’ not taking a break. It is noteworthy that Morgan specifically used the words ‘just endure’ when referring to being unable to take a rest/break. At one level, this could be something he had to accept, however, on the other hand, it might be something he feels he had to suffer because he had no choice. Having to cope with stress by postponing much needed rest can have dire consequences on the care worker (Johnson *et al.*, 2018). As Morgan rightly noted, it could result in sick leave or absenteeism. Thus, Morgan used physical activity to cope with the stress he experienced in his job. He observed that:

“[...] you know, at home, [it] is to sometimes exercise, that is, most of the times [I] go jogging in the park, come back have a good sleep, yea, sleeping is a very good eh, coping mechanism.... Yea, engaging in physical activity and having a good sleep definitely refreshes you” (Morgan, HCA)

It is interesting to note that Morgan’s apparent use of physical activity to cope with the stress of caring for PLWD might be unique to him. This is because although other participants also cited taking rest as their main strategy to cope with the challenges they faced, Morgan was the only participant who specifically stated that he did not need to register in a gym because caring for PLWD was like going to one. This suggests that care workers might rely on coping strategies they find helpful. In addition to the problem-focused strategies, my participants also utilised emotion-focused coping and this is discussed next.

9.3.4. Emotion-focused coping

Many of the care workers (n=9) used emotion-focused coping in which they sought to adjust their emotional responses to cope with the caregiving stress. This was often applied in situations where the stressor (source of stress) was beyond their immediate control. They employed emotion-focused coping using emotional expressions to reflect positively or negatively on the source of stress (McWilliams, Cox and Enns, 2003). An important response to stress is the use of strategies that can be described as avoidance coping, where the care workers sought to completely avoid the stress. However, this can lead to the dysfunctional consequences of a further increase in stress (McWilliams, Cox and Enns, 2003).

9.3.4.1. *I know that the job is temporary*

Jeff considered his current role as HCA to be a temporary job and stated that his main ambition is to become a nurse. He stated that it was this mind-set and ambition and the better days ahead that was keeping him going. He reflected:

“Anyway, I know that the job is temporary, um, I look forward to better days whereby, maybe I will do more training and become a nurse... I may [chose] not [to] be working on dementia ward...” (Jeff, HCA)

This is an emotion-focused coping strategy because Jeff tries to take his attention from the stressful situation by reflecting that the job was only temporary which therefore strengthens his resilience to go through the periods of work stress.

From the perspective of their gender, it is worth noting that there was no significant difference between male and female participants in terms of their reflections of working as HCA in a temporary capacity.

9.3.4.2. Predetermined coping

One care worker, Doris, reported having a predetermined focus, which seemed to help her face any potentially challenging situations at work. She described how she copes with doing a long day shift which often left her with headaches:

“Yeah, that’s like whenever am going for a long day, I just prepare myself like okay, am going there today and often times I return back having headaches because, the whole stuff to be done [....]” (Doris, HCA)

Therefore, Doris coped with the stress of the job by preparing her mind before work and reminding herself of the different tasks she will undertake at work. She cited this resolve and her predetermined beliefs as what helps her get through every long day shift. To put it clearly, she noted:

“I cope with it and having the mind, and already having the mind that okay, am going for a 12-hours shift, after 12 hours is over, I will come back home, just having that in mind that keeps me going” (Doris, HCA)

9.3.4.3. Once I step out of the ward, I start another life

One creative way that some care workers dealt with psychological challenges on the ward was to employ an avoidance coping style. This was candidly described in Ademola’s response as to why he never calls-in sick when he is required to work:

“But one thing I always do, the moment I stepped out of the ward, I don’t like doing, sort of carrying over. Once I step out of the ward, sign [out], that is it, I start another life. So, when I come back, then I pick it from where I stopped” (Ademola, RMN)

The very practice of living work at work is not new (Wattis, Standing and Yerkes, 2013). Ademola acknowledged the need to have a life outside of work and maintain a work-life balance. He was able to detach himself from work and he attributed this attitude to why he has not taken time off sick. This is interesting because care provision is done in continuum such that there will always be fellow professionals who take care

of PLWD at any given time. More importantly, it is essential that care workers maintain a work-life balance to ensure they don't suffer harsh consequences such as fatigue and burnout (Alexander and Hegarty, 2000; Johnson *et al.*, 2018).

9.3.5. Coping in the context of culture

My findings suggest that the care workers sometimes drew on their cultural beliefs and spirituality to help them cope with stressful situations. For instance, Morgan confessed to avoid showing signs of weakness or tiredness when he is at work, preferring instead to pretend to be strong, even when he is feeling weak. He stated:

“No, when I go in my closet, in my private I do what I need to, it's the coping mechanism... I can give a sigh of relieve, I can sleep...You know what I mean, yea I can do anything. Obviously, I can't sleep while am at work then, when I go back home, I can sleep, even I can't give a sigh of relieve in front of my patients” (Morgan, HCA)

Morgan attributed this coping strategy to his culture, stating that to show signs of weakness were not acceptable in his culture. This cultural perception of what is expected of him as a man influenced how he coped with the stress he faced at work. The next chapter discuss the overall influence of my participants cultural beliefs and values on their experience of caring for PLWD.

9.3.6. Availability of support for coping

Although most (n=13) participants were aware of the availability of some forms of formal support with coping, none of them reported using any workplace support or other formal support group or network, instead, they relied on using personal strategies that they had developed for themselves. Indeed, some participants (n=8) were unaware of the availability of formal support to assist with coping with the demands of caregiving. One participant (Cynthia) spoke about the availability of formal support to help her cope but admitted that she has not use it. She noted:

“Emm, yes, there is support in the NHS... but I haven't used it myself” (Cynthia, RMN)

It is possible that Cynthia, like all the other participants did not use any of the formal support available because they appear to be able to cope by using their own individual coping techniques. In addition, although none of the participants specifically mentioned the use of informal support groups to cope with the challenges they faced in their role. It might be argued that they may have considered such form of support as an integral part of their everyday life and hence does not warrant a special mention. The fact that they all self-identified as practicing Christian and are part of a church community suggest that it is possible that they used it as a support system. However, they made mention of some informal ways they coped with the emotional strain caring for PLWD placed on them and this is discussed further next.

9.4. Discussion

Although a further discussion of my findings in relation to the research objectives (see section 1.7) and existing literature is presented in a later chapter (see section 11.3b), here, an aspect of their experiences that I find particularly interesting are highlighted and then I relate their experience to the conceptual framework.

Firstly, the inability/difficulty in communicating with the patients had an overarching effect on the care worker's experiences of caring for PLWD. Although only a few of my participants specifically mentioned this as a challenge, it is evident from all my participants description of their experiences that a difficulty in communication was perhaps implicated in most of the challenges they faced with the patients. This might be because they overly relied on a patient's verbal expression rather than their non-verbal expressions. It is understandable that this is the case. A patient's non-verbal expressions require care workers to be patient, but the heavy workload they must complete within a limited time made communicating with PLWD of little priority (Buron, 2008, Stans *et al.*, 2013). One possible consequence of this approach is that it hinders the provision of person-centred care (Twigg, 2011). This easily occurs when care workers, due to workload, engage PLWD in only brief interaction that is usually based around personal care and mostly task-oriented (Wood *et al.*, 2005; Williams *et al.*, 2009; Beerens *et al.*, 2016), resulting in PLWD being inadvertently treated like

robots for all intent and purpose (Machiels *et al.*, 2017). The wider impact of this practice is the increase in unmet needs which can contribute to an increased physical aggression and psychological behaviours on the ward.

Secondly, in the conceptual framework (see Figure 4.1), I noted that care workers' experiences of caring for PLWD would depend on the challenges they face in their role and how they dealt with them. My findings however indicate that most of the challenges that they faced was from the patients and the added constraints imposed on them by organisational challenges (e.g., inadequate staffing), that was beyond their control. This is consistent with findings by (Rafferty *et al.*, 2007; Øye, Jacobsen and Mekki, 2017; Gwernan-Jones *et al.*, 2020). However, it is also interesting to note that despite using various strategies to cope with workplace stress, they did not make use of formal support services available to them in their workplace. One possible explanation for this is their cultural perception of the challenges they faced, and this is highlighted in the next chapter.

9.5. Summary

In this chapter, the challenging aspects of my participants' experiences of caring for PLWD and how they coped is discussed. My findings suggest that Nigerian care workers found their role as nurses and HCA caring for PLWD in an NHS ward to be challenging. They utilised different informal strategies to cope. In the next chapter, the study findings on the cultural beliefs and perception of paid Nigerian migrant care workers are presented.

CHAPTER TEN

CULTURE, DEMENTIA AND THE PRACTICE OF CAREGIVING

10.1. Introduction

This chapter explores my participants' experiences of dementia from a cultural perspective. It highlights the paid Nigerian migrant health care assistants' (HCAs) and nurses' cultural beliefs and perception of dementia before and after migrating to engage in care for people living with dementia (PLWD) in the UK. Divided into three main sections, it starts by examining the participants' past understanding, perceptions, and experiences of dementia in Nigeria, their care training in the UK and their overall lived experiences as care workers coming from a different culture. The second section discusses the shift in participants' beliefs about dementia once they began to work as care workers and nurses in the UK (although some of my participants [n=5] who worked as qualified nurses in Nigeria had already studied the biomedical constructs of dementia as part of their professional nursing training). Finally, section three of this chapter explores my participants' practices and experiences of caring as they worked in a dementia ward in the NHS.

10.2. Paid Nigerian migrant HCAs' and nurses' cultural beliefs about dementia

In this study, it was essential to explore my participant's journey into care work and to understand their beliefs about dementia. This is because the research literature suggests that there is a global multiplicity of cultural beliefs about dementia which might influence the practice of caregiving (Dilworth-Anderson and Gibson, 2002; Antelius and Kiwi, 2015; Nichols, Horner and Fyfe, 2015; Xiao, Habel and De Bellis, 2015; Brooke *et al.*, 2018). It was also pertinent because of the phenomenological study design employed in this research. Understanding my participants' cultural perspectives on dementia allowed me to gain better insight of some of the nuances that might arise from their description of their experience of caring for PLWD in the UK. Prior to coming to the UK, my participants held varying beliefs about dementia that were not consistent with the biomedical model of understanding dementia. This section examines

these different beliefs, which include the construction of dementia as an inevitable part of the normal ageing process, equating dementia to other mental illnesses, demonic influences on an individual, being possessed with witchcraft, as well as the notion of dementia being the negative reward of an individual's lived experiences. Such misconceptions about dementia generally highlights my participants' lack of awareness of the condition.

10.2.1. Dementia as a normal ageing

One of the beliefs commonly held by most participants (n=13) before they migrated to the UK and subsequently began to work as care workers was the belief that dementia is an inevitable part of the ageing process. They frequently described how what they now recognise as dementia was traditionally believed to be a part of the normal ageing process in many Nigerian cultures. Apart from three participants (Paul, Morgan and Miriam) who ascribed other causes to dementia, most of my participants (n=10) considered dementia as part of normal ageing. They admitted that the symptoms /behaviours which they now regard as dementia was what they had previously attributed to an individual who had simply 'grown old'. These participants noted that they held on to this belief until when they were training to be nurses (for those who worked as nurses in Nigeria), or until they began to work as care workers in the UK (for those participants who were not trained nurses before migrating to the UK). For instance, Morgan, who was a professional microbiologist before coming to the UK (with no prior nurse training), reflecting on comparing dementia occurring early or later in an older adult observed:

"Yea, because, we tend to say, dementia is normal for old people, not for anyone younger ... my father had it when he was ...76, but he died when he was 86, you know, but if you have it at 60, no, ...we don't consider it as normal" (Morgan, HCA)

In this assertion, Morgan appears to suggest that for people who were younger than 60 years and presenting with the symptoms of dementia would be abnormal. His choice of words, *"my father had it when he was76"* also indicates that Morgan saw his father's

presentation as expected for a man that age. Similarly, Oscar, an engineer by profession, stated that he cared for his grandfather who had dementia-like symptoms while in Nigeria. He noted that:

“...then, back home, it was mostly attributed to old age like someone living above certain age 85 and above and getting old you begin to lose memories” (Oscar, HCA)

It is notable that Oscar used the word, ‘begin’ to refer to the process the disease develops, implying that it is an inevitable aspect of ageing, and his views were shared by many of the participants (n=14) in this study. However, this belief associating dementia with normal ageing is not new and research suggests that many people in other cultures also hold this belief (Hinton *et al.*, 2000; Zhan, 2004; Sun, Ong and Burnette, 2012). For example, Lanting *et al.* (2011) conducted a qualitative study with participants from the Aboriginal community in Canada and observed that they perceived memory loss and behavioural changes in dementia as a usual expectation in the ageing process. Other authors (Zhan, 2004; Sun, Ong and Burnette, 2012) also reported similar findings among Chinese informal care workers living in the USA. Moreover, Suzuki *et al.* (2015) observed that although there are many multi-ethnic variations in the way that dementia is construed, the belief that ‘dementia is a part of normal ageing’ is reported in different ethnic-minority groups.

It might be suggested that Oscar’s (and other participants’) description of dementia as being a part of the normal ageing supports the continuum explanation for ageing. It holds that both dementia and normal ageing are two extremes in a continuum, whereas the dis-continuum explanation holds that dementia is a disease that is categorically distinct from normal ageing (Huppert, 1994; Huppert and Brayne, 1994; Buckner, 2004; McKhann *et al.*, 2011; Khachaturian, 2012). If normal ageing and the development of dementia exist in a continuum, it implies that every person will eventually grow old and develop dementia, as some of my participants seem to suggest.

Unlike Oscar, despite having a background in the life or medical sciences, Morgan appeared to be completely unaware of the true cause of his father’s presentation.

Moreover, Morgan's experience of dementia before coming to the UK and his previously held beliefs about dementia are not peculiar. I had a similar lived experience to Morgan in many ways. As I mentioned in section 1.2, despite holding a BSc degree in human physiology, I never related my grandmother's presentation to any illness. I considered it a natural part of the ageing process. What I knew about dementia at the time was purely theoretical as dementia remained an illness that was not common in our part of the world.

My findings indicate that the participants who had no nursing background considered dementia as a normal sign of ageing and only learnt to differentiate it from normal ageing once they undertook care training in the UK. However, it is interesting to note that those who had trained and worked as nurses in Nigeria also considered dementia as part of the ageing process before they trained as nurses, supporting the notion that this is a commonly held belief in Nigeria. Although some of them admitted to having only the basic knowledge of dementia even after their nursing training. For example, Jane (who had many years of experience working as a nurse in Nigeria) shed more light on what she thought dementia was prior to her nursing training.

"If I wasn't a nurse, I wouldn't really understand it because ..., the understanding I had coming into the country [the UK], was the pathophysiology of these old age conditions. But when I got to the care home, I was able to recognise the symptoms... this helped me to have a better understanding of what I have learnt in school" (Jane, HCA)

Although Jane had good theoretical knowledge of dementia, it remained academic until she began to work as HCA in the UK. Like Jane, other Nigerian-trained nurses also described their level of understanding of the disease as basic 'textbook knowledge' because they could not relate with the condition due to the different cultural perception and stigma associated with dementia in Nigeria. This is also because only very few cases of people with symptoms resembling dementia were actually coming to seek help in hospitals (Ochayi and Thacher, 2006; Adebisi *et al.*, 2016). Poor help-seeking behaviour from PLWD and their families has been reported in other studies (Zeng *et*

al., 2015; Zhao *et al.*, 2015) and it may be attributable to the perception of dementia as part of normal ageing. Consequently, the participants who worked as nurses in Nigeria were still not able to relate with the condition in practical sense until caring for PLWD in the UK, giving a new perspective to their understanding of the condition.

Another participant, Doris, also noted that the presentation of PLWD to healthcare centres in Nigeria is low, citing it as one of the reasons why she like other nurses, never really related her theoretical knowledge of dementia to a person with the condition. She stated:

“...back home we really don't come across most of the demented patients like in care home [in the UK]. I can't really say that in the course of two years and few months that I worked, if I came across any patients, I won't say it was up to two patients. So, we don't really have that experience of dementia.” (Doris, HCA)

In the above excerpts, Doris compared her experience of caring for PLWD in Nigeria and the UK and raised some critical issues that might have influenced her experience of caring in the two settings.

As Doris noted, in Nigeria, there were few cases of PLWD that she cared for. This is not entirely surprising because from the discussion of her work history before migrating to the UK, she worked in a general/non-psychiatric ward/hospital where most patients were admitted primarily because of their physical ailment rather than for a mental illness (Uwakwe, 2000; Bello *et al.*, 2017; Elugbadebo and Baiyewu, 2017). Although other authors, Nakasujja *et al.* (2007), have observed that the somatisation of psychological symptoms and/or the attribution of the symptoms to old age often resulted in many older adults being admitted to non-psychiatric wards. The implication is that healthcare professionals working in non-psychiatric settings are often ill-equipped to diagnose and properly care for patients with a mental condition, including dementia (Sokoya and Baiyewu, 2003; Mohammed *et al.*, 2014). Also, there are not as many care homes or other institutional settings of residential care for older adults in Nigeria as are in most western countries (Mokomane, 2011). This might be due to the

absence of a system of social support/security and the closely knit collectivist nature of most of the Nigeria society (Hofstede, 2011; Elegbe and Nwachukwu, 2017), which for cultural reasons, still favours children and younger family members (usually women) caring for their older parents and relatives (Idogo, 2015). Placing one's parents in a care home in Nigeria (as is in many African cultures), is discouraged and frowned at because it is considered as a practice alien to Africa (Mokomane, 2011).

In addition, the belief that dementia is a normal aspect of old age, an inevitable state of the human life cycle makes it less likely for carers of older relatives to seek appropriate medical help (Gureje, Kola and Afolabi, 2007). Doris also reflected on this in the language she used to describe the development of dementia:

“Yeah, so they really don't, we really don't give it that medical term that this person is demented, this patient is demented, or this individual has dementia. We just say that this woman is really showing signs of old age because of this thing she is doing” (Doris, HCA)

Doris admitted that she had not used the word, ‘*demented*’ or ‘*dementia*’ in Nigeria to describe signs she now considers to be linked to dementia. She stated that the widely held belief in Nigeria was that old age was characterised by a slow decline in physical and behavioural presentation in the older adult. However, in contrast, Doris appears not to consider the signs that she now recognises as dementia to be a definitive part of the ageing process. Referring to her experiences before working with PLWD in the UK, Doris noted that she used to refer to people who did not show signs of dementia as an ‘exception to the rule’ because of her belief that dementia was a normal part of normal ageing. The rule in this instance was that an older adult is bound to exhibit some signs consistent with old age and dementia is just one of such signs. She observed that:

“...there is always an exception to every rule. Just like every old person must not behave this way. Some of the old people are fine, they are old but, ... there is no brain degeneration ...while some... have brain degeneration. So, it's just like it does not really

necessarily need to affect all old people but these are just signs of old age.” (Doris, HCA)

Despite being a trained nurse in Nigeria, Doris appeared not to distinguish between healthy ageing and the signs of dementia. The apparent confusion of dementia with ageing even by health professionals has previously received some attention in the literature (see for example, Harding and Palfry, 1997; Ginesi, Jenkins and Keenan, 2016). This may be attributed to a lack of understanding of the process, onset and span of normal ageing (Jansen *et al.*, 2018), leading to the misconceptions of ageing shown by my participants’ other cultural beliefs about dementia. These beliefs are considered next.

10.2.2. Other cultural beliefs about dementia

In addition to considering dementia part of the ageing process, participants also expressed other previously held beliefs. As shown in Table 10.1 below, although two participants had no previous belief about the condition, many of the other participants (n=9) attributed dementia to insanity and imbecility, witchcraft, spiritual affliction, and punishment of PLWD for past misdeeds. These are presented and discussed further in the following subsection.

Table 10.1: Cultural beliefs concerning dementia held by the participants prior to training

S/No	Participants	Old age	Insanity and imbecility	Witchcraft/ Demonised	Punishment for wrongs	No specific beliefs
1.	Adams	-	✓	-	-	-
2.	Ademola	✓	-	-	-	-
3.	Bernard	✓	-	-	-	-
4.	Bosede	-	-	-	-	✓
5.	Cynthia	✓	-	-	-	-
6.	Dankay***	-	-	✓ (1)	✓ (2)	-
7.	Doris	✓	-		-	-

8.	Folashade	-	-	✓	-	-
9.	Jackie	✓	-	-	-	-
10.	Jane	✓	-	-	-	-
11.	Jeff	-	-	-	-	✓
12.	John	-	✓	-	-	-
13.	Kate	-	-	✓	-	-
14.	Kemdo***	-	✓ (2)	✓ (1)	✓ (3)	-
15.	Miriam***	✓ (1)	-	✓ (2)	-	-
16.	Morgan***	✓ (1)	✓ (2)	✓ (3)	✓ (4)	-
17.	Omolara	✓	-	-	-	-
18.	Oscar	✓	-	-	-	-
19.	Paul***	✓ (2)	-	✓ (1)	-	-
20.	Robert	✓	-	-	-	-
21.	Shapiro	✓	-	-	-	-

*** The participants, Dankay, Kemdo, Miriam, Morgan and Paul previously held multiple beliefs about dementia the numbers in brackets represent the order in which they held those beliefs.

10.2.2.1. Insanity and imbecility

Some of my participants (n=4) believed that dementia was a form of mental illness, and considered older adults living with the condition to be suffering from insanity or imbecility. For instance, John, who was an engineer in Nigeria before migrating to the UK noted:

“...yes of course even the old person, I just grouped everything as mad.... Then I use to class them as madness because if I see you are talking to yourself on the street and doing some things which are strange, to me, I will classify you as being mad. These are the way I see those people with dementia [in Nigeria].” (John, HCA)

In John’s description of his belief about dementia before working as HCA in the UK, he categorised the condition as madness. In addition, he simply deemed every older adult presenting with a sign of dementia as mad and labelled any behaviour that does

not concur with his perception of a normal behaviour as strange. Like John, another participant, Adams, used a different term depicting a mental illness/disability to describe PLWD. Adams referred to them as imbeciles, abandoned by their family members. He described the older adult presenting with behaviour he now associates with dementia as ‘*a neglect*’ and ‘*an imbecile*’ and observed:

“That would have been my best definition then, an imbecile. But with this knowledge of today I would say, he is not an imbecile he is struggling with dementia” (Adams, HCA)

These examples of Adams’ and John’s prior beliefs appears to have been shaped by their overall lack of understanding of the condition. Although the terms they employed are derogatory and are not commonly used in the UK, the views were held from the standpoint of unfamiliarity with the condition. The terms are also a reflection of foregrounding pathological/behavioural presentation of PLWD at the expense of their person (Gilmour and Brannelly, 2010), but so too is the term, ‘dementia’. Some scholars (Sachdev, 2000; Chiu, 2005) have argued that its place in the medical lexicon needs re-examining because the literal Latin meaning is ‘without mind’ (Chiu, 2005, p.S20). This is a direct contradiction of the European cultural construction of humanity which the philosopher Descartes summarised in the famous statement, “*Cogito, ergo sum*” (I am thinking, therefore I exist; Audi, 1995, p.195) (Audi, 2015). The fact that some of my participants (n=4) held these beliefs about dementia before coming to the UK, further highlights the wider issue of the level of awareness of mental illness and dementia in Nigeria and the way language is used to describe mental illness (Gendron *et al.*, 2016).

The last two decades has seen an increase in the awareness of dementia in Nigeria with more studies on the epidemiology and prevalence of the condition in the country (Ogunniyi *et al.*, 2000; Prince *et al.*, 2003; Olaniyi and Mbuyi, 2014; Adeloye *et al.*, 2019), but it is yet to gain much media attention like other more physically debilitating diseases (e.g., diabetes, stroke, and other cardiovascular diseases). This lack of media attention is not unconnected with the prevailing cultural perception of the illness. In comparison, it mirrors the UK’s context where mental illness is also a subject of less

attention than physical illness despite the increased awareness over the years (Rhydderch *et al.*, 2016; Chen. and Lawrie 2017; Carmichael *et al.*, 2019).

As my participants' description indicates, the use of derogatory terms to describe the condition attests to their lack of awareness of the condition. This may have dire consequences on the willingness for people to report symptoms or seek help due to the inherent stigma associated with mental illness (Benbow and Jolley, 2012; Schomerus *et al.*, 2015). The effects of the stigma on the nature of caregiving (which is mostly done by family members) is one reason for the general lack of awareness. The stigma and discrimination around mental illness in Nigeria contributes to family members' unwillingness to disclose the true state of health of their older adults to people outside the immediate family circle (Olagundoye, Akhuemokhan and Alugo, 2017). As Morgan and two other participants who were involved in the care of their older relative pointed out, family members were unwilling to do so because of the shame they may encounter if they did.

A second reason for the apparent lack of dementia awareness in Nigeria may be attributed to the low life expectancy from birth in the country, which still stands at 55 years for women and 53 years for men (World Bank, 2019). Apart from early onset dementia which occurs before 60 years old, the risk of most dementias increases with age over 60 years and with the current life expectancy in Nigeria fewer people live long enough to present with symptoms of the disease (Morris, 1999; World Bank, 2019). Those who live long enough to develop dementia symptoms might face not only the negative effects of stigma due to their mental illness and ageism but also stigma resulting from the misconception of dementia with witchcraft, and this is discussed below.

10.2.2.2. Witchcraft

Dementia was also associated with the belief that older adults showing signs of dementia were possessed with witchcraft. Witches (or those possessed with witchcraft), are often thought to possess supernatural powers, which they employ to negatively

affect or cause harm to others (Ashforth, 1998; 2005). Although only four participants in my study held this belief about dementia, their description appears to suggest that older adults who show signs of dementia were ‘perpetuators’ of some wicked acts of witchcraft and were therefore receiving a well-deserved punishment. They pointed out that the expression of bizarre behaviour by older adults was the consequences of the terrible things they had done and still do. For example, Kate observed that:

“Actually, the understanding I had of older people living in a bizarre manner is just because... they were all witches. They were trying to do something bad, and they got caught or something happened, and they started misbehaving. A lot of women, older women in the city, they stone them to death” (Kate, HCA)

Those participants who drew a link between dementia and witchcraft appeared to suggest that older adults behaving in a certain way and presenting with certain behaviours were possessed with witchcraft. This finding is consistent with other studies on the beliefs in witchcraft in relation to the perception of dementia and old age and is common in many cultures and countries across Africa (Hindley *et al.*, 2016; Mkhonto and Hanssen, 2018; Kehoua, 2019). One of my participants, Miriam, reflecting on the general belief about dementia and witchcraft while growing up in Nigeria noted that:

If you look at the cultural aspect, ...witchcraft make people confuse and all that, which, we are not looking at dementia this time, ... actually it's witchcraft.” (Miriam, HCA)

Hence, older adults accused of witchcraft are often stigmatised and maltreated. In addition, this was a gender issue with only older women labelled as “witches”. As my participant Kate noted, older women who were the accused of witchcraft could be stoned to death. This was reported by Samber, Avanger and Abanyam (2014) and Mouton and Southerland (2017) suggesting that these older women are not only shunned and stigmatised but are also bullied and beaten. In more extreme situations, they are stoned, burned, or even killed.

One of the implications of the stigma and ill-treatment of older adults accused of witchcraft is the influence on the family carers’ help-seeking behaviours, some of

whom turn to unorthodox sources. For example, Mushi *et al.* (2014) conducted qualitative interviews with carers for PLWD in Tanzania and observed that nearly half of those caring for their loved ones with dementia and who associated it with witchcraft also sought help from traditional healers (de Jager *et al.*, 2015).

However, there were three participants who considered dementia as a punishment to those living with the disease for wrong deeds done in the past, although they did not link this directly with witchcraft. This formed the basis for the two beliefs earlier examined, holding that people suffer the consequence of what they did earlier in their life's journey and that what they currently faced is a direct or indirect result of what they have done.

10.2.2.3. Spiritual affliction

Four of the participants believed that dementia was caused by a spiritual affliction, inflicted on the sufferer by a sinister force. They considered PLWD to be hapless victims to forces beyond their control. My participant's description of why people became victims to spiritual affliction seemed to apportion the blame on the individual themselves, depicting them as the cause of their affliction. One of the participants, Folashade noted:

"I believe is many bad habits people have picked up while growing up that led to... Yea, there were so many causes back home that people could relate but one of them that I believe and I still hold on to is the fact that many of them were demonised" (Folashade, HCA)

Relating dementia to affliction by demons, Folashade pointed to the role of the PLWD as being passive participants in their own predicament. The four participants' description of how they came to form this belief about dementia appears to suggest that it might be related to their spiritual beliefs. All my participants self-identified as practicing Christians, but only four attributed the belief that dementia is an affliction to their spiritual beliefs.

Some of the care workers expressed spiritual and religious beliefs about dementia, its causes and presentation. For example, Folashade and Paul who were a wife of a pastor and the pastor respectively both held beliefs linked to their spirituality and roles in the church. Paul talked about the complexity of his spiritual and other beliefs, and he also highlighted how different conditions (including dementia) could impact on family decision making when people are choosing to get married, Paul stated that:

“I think ... part of my understanding about dementia is that apart from being attributed to or linked with old age, there is also some spiritual undertone to it.” (Paul, HCA)

From Paul’s narrative, it is interesting how people’s construction of dementia as a spiritual condition relates to it being some form of insanity. The association of the disease with spiritual causes has existed for centuries across different cultures worldwide (Eisenberg *et al.*, 2009; Frith, 2016), and it is primarily due to the lack of understanding of disease causation (Rosato *et al.*, 2019). Paul’s description of people’s understanding of dementia and some other conditions that are hereditary further highlights the issue of mental health and stigma in Nigeria. As discussed in the literature review (see section 4.7.4.), stigmatising those with dementia or their families has also been reported in Asian cultures (Henderson and Traphagan, 2005; Woo and Mehta, 2017) and it extends to mental health illnesses in general (Jang, Chiriboga and Okazaki, 2009; Zheng and Woo, 2016).

10.2.2.4. No specific belief about dementia

Two participants in this study, Bosede and Jeff, did not hold any specific beliefs about dementia before migrating to the UK. They attributed it to not meeting any person with symptoms similar to dementia. For example, Bosede described her lack of awareness of dementia, stating that:

“I have never heard of that name [dementia] before... and when I came... I started as a carer, I was wondering could people [with dementia] be living like this because before I left Nigeria nobody ever thought of dementia” (Bosede, RMN)

These two participants, Jeff and Bosede had no characteristics that make them different from the other participants. Bosede only knew about the word ‘dementia’ and the associated symptoms when she began to work as a care worker in the UK. Like Jeff, she never met any person with the condition in Nigeria but unlike the other participants they both had no belief about the cause of the illness. Since they both had similar lived experiences to the other participants, it is likely that they had no beliefs about dementia because of the general lack of awareness of the disease in the country. The lack of adequate awareness on dementia and the inherent stigma attached to mental illness has contributed to entrenching misconceptions and lack of understanding of dementia in Nigeria (Shah *et al.*, 2016; WHO, 2017c; Chertkow, 2018).

Despite my participants’ varying past beliefs, there was a consistency in their current understanding of dementia, and this discussed below.

10.3. Current understanding of dementia

All my 21 participants stated that they had benefitted from the training they received before they began to work in care, with most of them (n=19) stating the training was helpful in changing their previously held beliefs about the condition. When asked to describe their current understanding of the condition, all the participants discussed dementia in terms of the biomedical model of dementia (WHO, 1992; Ostaszkievicz, Dunning and Streat, 2018) describing the decline in cognitive function, changes in memory as well as physical, behavioural and social changes in the person with dementia. Jackie, a participant, explained dementia thus:

“Dementia in my own understanding is the problem of the brain and when the brain is malfunctioning, and basically, they don’t know what causes it.” (Jackie, HCA)

Jackie understood dementia to be associated with a malfunction in the brain, alluding to the biomedical model. Although this model of dementia has been challenged (Engel, 1977; Wade and Halligan, 2017), it remains a dominant model in the understanding of dementia with an emphasis on the aetiology of the condition and its pathological and physical symptoms (White, 2013).

The biomedical model has been criticised for being deficit-centred with the condition only attributed to neurologic decline while ignoring the psychological and social worlds of PLWD (McGovern, 2011). But other approaches are starting to gain recognition. For example, Kitwood (1997) seminal work advocated for the person-centred model of dementia, which attempts to shift the focus of dementia from the disease model, that is how it can be managed and potentially cured, to the person-centred model that is concerned with how people can live better with the disease (Cuijpers and Van Lente, 2015; Vernooij-Dassen and Moniz-Cook, 2017). Five participants gave less clinical descriptions of dementia that seems to embody a combination of approaches. For example, Adams described it as:

“It’s an unfortunate illness that affects the human brain whereby you just simply forget who you are, you cannot remember anything, ... your ability to do certain things begin to fail, you lose sight of, you can’t even remember the people you loved [.....]” (Adams, HCA)

Adams’ understanding and description of dementia encompasses the biomedical and person-centred approaches to understanding the condition and highlighted the focus on the person with dementia by his repeated use of the pronoun ‘you’ to address the focus of the condition. Echoing Adam, other participants also combined the approaches to underpin their understanding of dementia. This was noted in care workers such as Morgan, who further explained the impact of the disease on personhood:

“... as a neurodegenerative disease... it has to do with the brain..., characterised by a lot of a combination of symptoms like memory loss... and forgetting the immediate events [.....] become incontinent, of urine, of faeces, ... they strip, they remove their clothes in public, they are not ashamed..., they are not aware of their surrounding” (Morgan, HCA)

Morgan described dementia as neurodegenerative with reference to his biomedical understanding of the condition (a decline in brain function, memory loss and behavioural changes). However, Morgan, Adam and many of the other participants also

recognised the loss of personhood associated with the different behaviours exhibited by PLWD (Higgs and Gilleard, 2015; 2016). Those participants who had worked as nurses in Nigeria also described dementia using similar biomedical terms used by those with no nurse training. For example, Jane, who is a Nigerian-trained nurse but works as HCA, compared her past and current understanding of dementia:

“... dementia is a progressive neurological disease which affects multiple brain functions including memory. But back at home [in Nigeria] when you talk of dementia, ... we’ll just be thinking, oh this old woman is running mad, this old man is becoming insane.” (Jane, HCA)

Care workers who were currently working as nurses in the UK also expressed a good knowledge of dementia, describing it in similar ways to Jane and the other nurses who trained in Nigeria. For instance, Bosede who only became a nurse in the UK described dementia as:

“Dementia is a sickness of the brain and it is progressive. There is no cure for it. The only medication available at the moment for dementia is to ehm reduce the progression rate” (Bosede, RMN)

As noted in the previous section, apart from care workers who had trained as nurses in Nigeria and had some theoretical knowledge of dementia in Nigeria, every other participant in this study experienced a shift in their pre-migratory beliefs about dementia, and this is explored further in the next section.

10.4. Shift in beliefs

As my findings suggest, the current knowledge my participants hold about dementia were mainly acquired in the UK and is largely different to the knowledge they previously held about dementia. The shift from the general Nigerian folk beliefs and knowledge about dementia to the accepted Western biomedical approach emerged as a major theme in this study of the lived experience of paid Nigerian migrant care workers.

All participants mainly attributed this change in beliefs to the training they received before they began to work as care workers.

In the following section, I present the findings on the importance of training in the shift in cultural beliefs about dementia and the role of the ageing simulation suit in the change of cultural beliefs about dementia.

10.4.1. The role of NHS training in changing beliefs

Training is an essential requirement to work with PLWD particularly for individuals new to care work (Gandesha *et al.*, 2012; Surr *et al.*, 2017). Most of my participants stated that they found the training offered by the NHS helpful and this may have been especially important as most of them came from employment outside of care work.

As was discussed in chapter 7, an exploration of their previous work background revealed that most of the participants, except for those who worked as nurses in Nigeria, had no experience working in health or social care environments. Hence, the decision to work in care presented a significant career shift for most participants whose previous profession include engineers, administrators, microbiologists, marketers, etc. Once they decided to become paid care workers, they undertook some days of training in the critical aspects of care, which include manual handling and other essential skills before they began to work in care. The essence of such training is to educate staff about dementia and how they should care for PLWD (Kaiser *et al.*, 2000; Royal College of Nursing, 2002; Jootun and Pryde, 2013; Sturman-Floyd, 2013).

My findings suggest that all my participants found the training effective in changing their perception of dementia and how to care for people with the condition, which is consistent with Burgio *et al.* (2002) who showed the effectiveness of training for care workers working with PLWD. For example, Jackie, explained why she found the training useful:

“The training really helped me because ... I did not really understand the mind of the person living with dementia. You can’t really care for them because they are so

vulnerable and in so many ways you have to understand some things about them, so it's until you get that understanding that is when you can really take care of them" (Jackie, HCA)

Both those who had no unpaid care experience (n=10) before coming to the UK (e.g., Jeff, see Table 8.1) and those who had unpaid care experience (n=8) (e.g. Morgan) found training helpful and considered it the main instrument that led to their change in previously held beliefs about the condition. Although Morgan had already expressed his lack of understanding of dementia when he was in Nigeria, he stated that:

"No, my knowledge of dementia now is just on the job training I had from the agency I worked for...Yea I did that training before I started working in care.... it was very helpful [.....] and it has informed my current knowledge of dementia and ... care for people with it" (Morgan, HCA)

Morgan also pointed to the role of training in helping to cope with the demands of the role. Despite having offered unpaid care previously, he found caring for people who were not members of his family to be particularly challenging, although he noted that the training has helped him to cope with the challenges. For instance, he stated that the training prepared and equipped him for the role, but he felt the training currently being provided does not encourage care workers to form an interpersonal relationship with their care recipients. Morgan, who was training to be a nurse at the time of the interview compared his previous experience of caring for his adopted father with his current experience of paid care work and offered some advice for better training. He observed that the challenging behaviours in PLWD was due to the lack of interpersonal relationship between care workers and care recipients. He therefore pointed to the need for additional training on how to improve interpersonal relationship between care workers and their care recipients.

However, while the training was beneficial to care workers with no previous care experience in Nigeria, it is notable that even the Nigerian-trained nurses also found it

helpful. Miriam describes her experience of the training in comparison to the training she received in Nigeria.

“When I started, I was new to everything so we had a training, [in] which they explained dementia, the types of dementia... they talked a lot about it and what you should be expecting [.....], in Nigeria [it] was just basic but here ... the training was very in-depth which really helped so”(Miriam, HCA)

This research therefore suggests that training is vital in dementia care regardless of professional background as it served to enlighten paid Nigerian migrant care workers about dementia. Each participant mentioned several types of training that they found helpful. The ones mostly identified includes manual handling (moving and handling), feeding, hoisting, infection control, effective communication, cardiopulmonary resuscitation (CPR), safeguarding of older adults and the mental health act (MHA) trainings. The effectiveness of these trainings has been reported in the literature (Somerville, 2006; Hughes *et al.*, 2008; Palesy and Billett, 2017). As the effectiveness of the specific types of training identified by my participants was not the focus of my study, it was not explored further. However, a point worth noting is their unanimous conclusion that the training they received was instrumental to changing their misconceptions about dementia.

10.4.2. Benefits of training with the age simulation suit

Apart from the benefits of training every participant received at the time of entering care work and the yearly refresher course, three participants found the use of age simulation suit beneficial. The suit allows individuals who use it (care workers or students) to experience some of the biological challenges of an ageing body by adding weights (to limit mobility), as well as the use of special gadgets to limit vision and sounds etc. (Kullman, 2016). Recent dementia training involves the use of the age simulation suit which aims to create an artificial sense of ageing and to show the physical limitations that many older adults face (Perot *et al.*, 2020). The aim of using the suit is to elicit empathy and better understanding of what it feels like to be old

(Eymard, Crawford and Keller, 2010) which is consistent with the person-centred model of dementia caregiving (Kitwood, 1997).

Although the age simulation suit does not simulate the experience of dementia, the technology was designed with the premise that old age is characterised by diminished vision (due to diseases such as glaucoma and diabetic retinopathy), cognitive impairment and problems with gait and posture (Chou *et al.*, 2013; Mitoku *et al.*, 2016). Hence, the suit tries to replicate the features of a decline in health. In my study, three participants shared their experiences of using the suit and stated that it changed their perception of PLWD, and it helped them develop empathy to become more sympathetic to the plight of people in their care. Two participants, Jackie and Sharpiro described what it felt like to use the suit: “[...] *it is then [after using the suit] you will have that understanding that sometimes when you give them something, they can’t grip it because their fingers are so heavy [...]*” (Jackie, HCA)

“... *there is a saying that, “He who wears the shoe knows where it pinches” [...] I had the experience of wearing a gadget [age simulation suit], [...] that is when it dawned on me how it was like, these people [PLWD] feel*” (Sharpiro, HCA)

Sharpiro (and Jackie) explained how the simulation suit felt, drawing a comparison between the world as he saw it and the world of older people and that seemed to help to gain more insight into PLWD experience with the limitations of ageing. These findings support the evidence from literature that suggests that the experience of wearing a simulation suit does help to change attitudes to older people (see for example, studies by Lauenroth *et al.*, 2017; Eymard, Crawford and Keller, 2010; Farmer and Bruce, 2010 and Lavallière *et al.* 2016).

In my study, only the three participants who have used the suit found it beneficial and the other participants did not mention using it. This is because it is not presently mandatory to use the suit as part of the dementia training, however, its growing use and the impact it has on empathy might see this changed (Henry, Douglass and Kostiwa,

2007; Tremayne, Burdett and Utecht, 2011; Ford, 2016). In the next section, I discuss the influence of cultural beliefs and values on caring.

10.5. Influence of cultural beliefs and values on care work

In the last two sections, I discussed the cultural beliefs held by my participants before and after they migrated to the UK to engage in care work. In this section, I examine the influences of their past and present understanding of dementia on their current experience of care work in the NHS.

10.5.1. Influence of previous beliefs and understanding of dementia on care work

When asked to discuss how their previous cultural beliefs and knowledge of dementia influenced how they cared for PLWD, all my participants stated that it had no influence on the way they cared because the training they received had given them a better understanding of dementia. Even two participants, Paul and Folashade, who admitted that they continue to hold their pre-training beliefs and perception of dementia also stated that holding those beliefs did not influence how they cared for PLWD. For example, Folashade's approach to caring for her care recipients was one which focused on what she was taught in training. She noted:

“My knowledge about dementia has been added to, not changed as it were. Yes, now I now see it more in an academic scientific point of view. I think what we had before was just a purely spiritual point of view, coupled with culture... as a Nigerian [...].”
(Folashade, HCA)

Folashade considered the views about dementia gained in training to be just one aspect of her view of dementia. Folashade explained that caring for PLWD went beyond her personal beliefs about dementia because her focus remains her patient who needs care.

It might be argued that the reason why my participants' cultural beliefs appeared to have no influence on how they cared for their care recipients, is a result of acculturation, as well as the influence of their organisational (workplace) policy that promotes treating care recipients with dignity and respect (Department of Health, 2009; Ho and Chiang,

2015; Yong and Manthorpe, 2016). This is consistent with Brooke *et al.* (2019) which showed that despite their cultural beliefs about dementia, migrant student nurses caring for PLWD care and support for their patients was informed by their clinical experiences and education.

Another point worth noting is that two of the participants' religious beliefs might have also played a role in them holding firmly to their beliefs about dementia. This is because although all my participants were Christians, Folashade and Paul were quick to state that they were ministers in the church which might suggest the reason for their strongly held views. Cook (1997) made a case for Christians holding views that would be considered contrary to the medical view about an illness, particularly mental illness. Despite holding different beliefs about dementia, both felt that it did not influence the way they cared. Folashade further noted that:

"[.....] I had to let this [own culture of caring] go ...and just learn how you do it [cultural adaptation]. And for me I think basically, that is, if you are coming to the United Kingdom to work ...with your Nigerian point of view, it's not going to work" (Folashade, HCA)

It is however surprising that Folashade believed that her multiple view about dementia had no influence on how she cared for her patients. Her comment about having to let go her 'Nigerian point of view' whilst working in the UK seem to suggest that she took a utilitarian strategy to working which helped her care for PLWD, despite holding beliefs contrary to the biomedical explanation for the causes of dementia. Thus, paid Nigerian care workers appeared to set aside their pre-training beliefs when they cared for PLWD because of the training they received.

10.5.2. Influence of current understanding of dementia on care work

The paid Nigerian care workers also spoke of the empathy they felt towards their care recipients after they had a better understanding of dementia. A typical example is Adams who had engaged in previous community work in Nigeria as a Community Liaison Officer and had some engagements with families of PLWD during the time as

part of his role. He stated that he previously referred to PLWD as ‘imbeciles’ because of his lack of understanding of the condition. However, he now felt that:

“With the knowledge now and my previous knowledge then, if they are matched together there is so much empathy in me, so much compassion in me... back then I didn’t know what it was, now I’ve been educated, now I have the knowledge, now I know what it is, you know, sometimes it just breaks my heart” (Adams, HCA)

Adams described how he developed the empathy to care, through his new understanding of dementia as opposed to the tendency of blaming the care recipient for their condition or treating them like ‘empty-shells’ of their former self, and devoid of any personality (Moore *et al.*, 2003, p.5). This phenomenon of the loss of personhood is a common perception of what remains of the person with dementia (Buron, 2008). The lack of understanding of dementia has often led to the unfortunate use of labels to describe PLWD to be existing as ‘fragments of humanity’ (Keane, 1994, p.151). This further entrenches the notion that they are incapable of forming relationship and should therefore be treated ‘as other’ rather than ‘as individual’ (Malloy and Hadjistavropoulos, 2004).

Griffiths *et al.* (2012) suggested that empathy is necessary for care workers to understand the patients they care for and the findings from this study supports this perspective with participants reporting they had become more empathetic when they understood the condition better. Empathy, which is often considered to be one of the key qualities required to deliver person-centred care entails understanding and sharing in an individual’s pain or circumstances (Cunico *et al.*, 2012). It is considered essential for a favourable caring relationship between a care worker and the care recipient (Mercer and Reynolds, 2002). It was clear from my findings that most of the Nigerian care workers felt that their understanding of dementia changed with the training, and for a few participants, the additional training using the age simulation suit made them feel more empathetic and this finding resonates with the work of Jütten, Mark and Sitskoorn (2018). However, although empathy was cited as one of the benefits of the

training in changing beliefs about dementia, some of my participants suggest that empathy was a result of the influence of their culture on their caregiving practices.

10.5.3. Influence of cultural values on care work

Nearly all my participants indicated that their cultural values influenced how they cared for PWLD noting that they drew on the cultural values of respect for older adults, reciprocity, familism, filial piety and their spirituality/religious values in their care for PLWD. For example, Folashade described what it meant to respect an older adult in her culture:

“... where I come from in Nigeria, parents are set to be gods. So, you more like, worship them..., you think of all they’ve done for you, you respect them... you adore them, yea, you don’t, you don’t trample on your parents. I think it applies to every parent (biological and non-biological) ... it’s more like a cultural thing [....]” (Folashade, HCA)

Folashade is from the Yoruba-speaking ethnic group in the south-western part of Nigeria (see Table 7.2), which is noted for their rich culture of respect for older adults and the public show of obeisance (Szilagyi, 2013; Olanipekun, 2017). It is therefore not surprising that she spoke of the culture of treating older adults with high regard as if they were semi-gods. Folashade, like all the other participants seemed to be of the view that these cultural values were ingrained in them through their early socialisation and therefore informed their attitudes towards those they cared for. Furthermore, the cultural value of reciprocity was also highlighted. Conceptualised within the context of informal caregiving, reciprocity of care is the practice of giving back to one’s parent or relatives for the previous act of affection shown (Jervis, Boland and Fickenscher, 2010; Peacock *et al.*, 2010). However, my findings suggest that even though they were not related to those they cared for in the NHS setting, my participants held the cultural value of reciprocity highly, attributing it to the cultural practices of treating every elderly person like their own parent. This is the concept referred to by Adams and Sharp (2013) as professional reciprocity. Beside seeing care work as a way of giving back and

reciprocating the ‘parental love’, my participants also appeared to consider care work and every act of care rendered as a form of ‘investment’ or ‘capital’ made in advance to be received in kind in the future when they become older and require care. This is captured in their description, for instance, Morgan observed that:

“It's what you're sowing, that you will reap, and I want to grow up to rightful old age and am looking at this [care work] as what am doing, am sowing for my future... what I'm doing to people now, when am old, people will do it to me. As am doing it well, people will do it well to me. If I do it badly, I will be badly treated when I am old”
(Morgan, HCA)

The value of reciprocity that Morgan and others showed as care workers was viewed as a strategy used as an intangible incentive to provide quality care, in anticipation that they would receive good care when they grow old as well. Although my participants attributed the idea of receiving the intangible rewards of long life and the hope to receive better care to their culture, it bears close semblance to the doctrine of sowing and reaping taught in the bible, implying that it might be due to the influence of their religious beliefs and practices. This is because they frequently drew on their spirituality in their narratives of their experience of caring for PLWD. In the next section, I consider some of the ways my participants negotiated their roles as care workers.

10.5.4. Cultural attitude to body work taboos

‘Body work’ in the form of personal care is an essential part of caring for PLWD and it entails the non-medical tasks (i.e., care activities) conducted by care workers (Twigg, 2000a; 2000b; Twigg *et al.*, 2011). Body work includes washing, bathing, personal grooming, and assistance with dressing (Campbell, 2012). Discussions with my participants reveal that five of them (all male HCAs) attempted to negotiate the concept of body work from their cultural standpoint of what care should entail, their ideal cultural expression of masculinity as well as the societal (Nigerian) expectations for what a man can or cannot do. They expressed their struggles with giving personal care

to PLWD, particularly female patients. For instance, John described his reluctance to assist a female patient with personal care:

“.... It’s not really proper, so what I do then is, if you [the care recipient] call me that you need help, what I will do, if you are a woman, I will say, ‘okay, just hold on let me get a female member of the staff to assist you with what you need.’” (John, HCA)

John attributed his reluctance to undertake personal care to his cultural beliefs and the Nigerian societal expectation of roles men can undertake. While he acknowledged that personal care was part of care work, John spoke about how difficult it was for him to give personal care to female patients. It is interesting to note that everyone who held this belief were men. This points to their unfamiliarity with the bodily work that goes with care (Cohen and Wolkowitz, 2017). However, about half of the male participants did not have any difficulty giving personal care to their patients, suggesting that there might be other reasons some participants found it challenging. A possible explanation might be the length of time they have spent working as care workers in the UK because the five participants admitted to gradually getting used to giving personal care to their patients after struggling for a long time. John and the others four participants communicated their experience of doing personal care with strong emotions. For example, Oscar spoke with heightened emotions about his initial distress in having to conduct personal bodily care for PLWD, he explained:

“...it was very challenging because of my background and where I am coming from as a Nigerian.... when it comes to our culture, ... it not actually what I was used to, from back home.... it was very, very difficult because I have this belief as an African..., we tend not to see older people, so, like [seeing] the nakedness of older people, it’s more like a sacrilege” (Oscar, HCA)

Oscar and John both described their struggles with caring for older naked bodies, a practice that was not only new to them but was also against their cultural beliefs and values based on their respect for older adults, although as HCAs, bodywork is integral to their role. Oscar also referred to the act of seeing the nakedness of an older person as

a taboo. The idea of bodies as a subject of taboo is found in the religious text. For example, in the Holy Bible (1983, Genesis 9:20-27), it is recorded that Noah cursed Ham, one of his three sons because Ham saw his nakedness when he was drunk (Bergsma and Hahn, 2005). Although this does not apply directly to the context of caregiving, it demonstrates a long-held taboo associated with nakedness.

Other researchers have also discussed the taboos surrounding bodily work in caregiving (Twigg, 2000b; Twigg *et al.*, 2011). For example, bodily care is often punctuated by a sense of taboo, particularly nakedness and contact with people's private parts and the concept of body taboo is observed to be much more common among male care workers and nurses (Malmsten, 1999; Andersson and Hansebo, 2009). Although some of my participants attributed their attitude towards giving personal care to their cultural beliefs, other studies on the perception of work done on the body's private parts indicates that the views are widely held (Holmes, Lauzon and Gagnon, 2010; Ward, Campbell and Keady, 2016). The implication of their attitude towards giving personal care to a female patient means the likelihood of not providing the needed care to PLWD because of their perceived cultural objection to doing so.

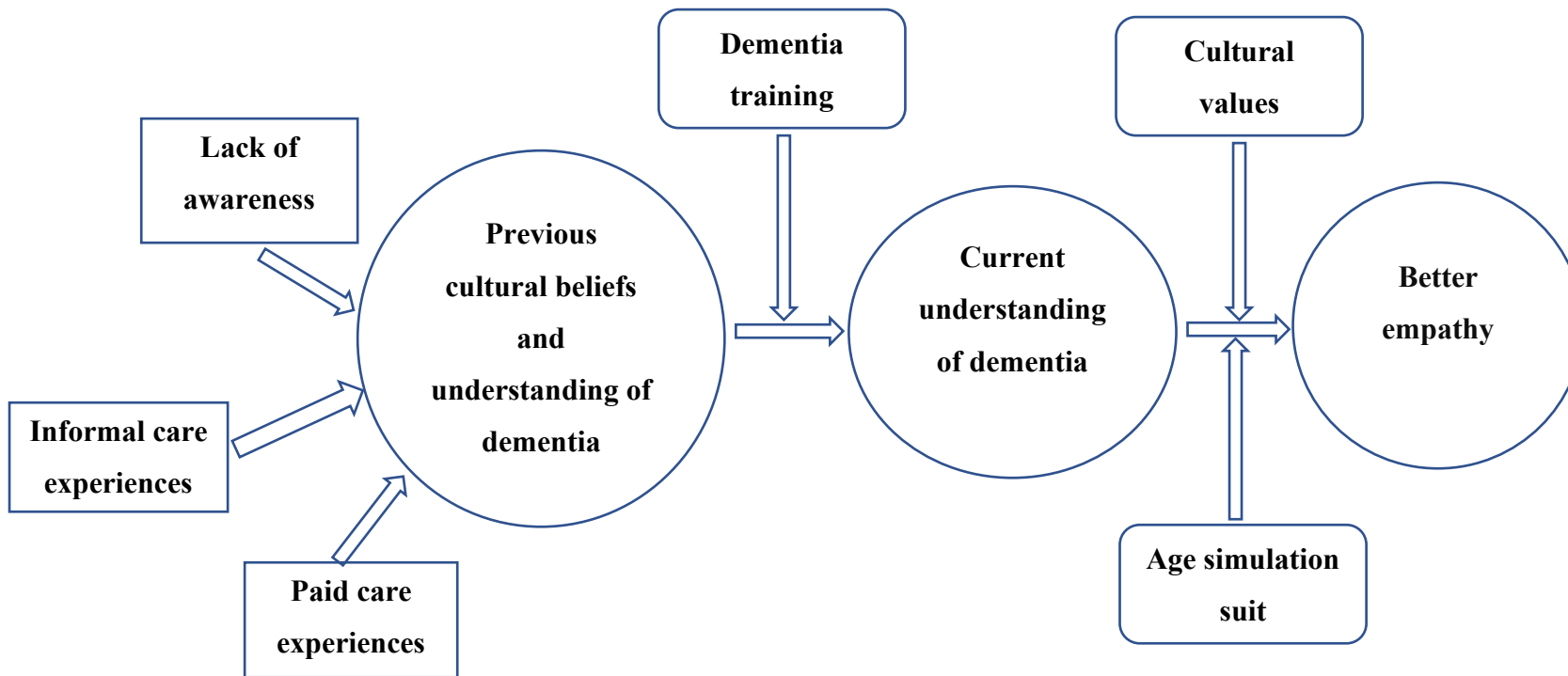
10.6. Discussion

As a public health issue, the influence of dementia on the 'global care chain' has seen increasing numbers of care workers and health care professionals recruited from around the world to meet the health care shortage in developed countries (Hussein, Stevens and Manthorpe, 2011; Aleshkovski, 2016). However, the literature suggests that globally, there are several cultural perspectives on dementia (Dilworth-Anderson and Gibson, 2002; Xiao, Habel and De Bellis, 2015; Brooke *et al.*, 2018) which has contributed to stigmatisation against PLWD. In the present study, my findings indicate that Nigerian migrant care workers also held a variety of cultural beliefs about dementia before migrating to the UK.

The cultural beliefs identified were consistent with the lay understanding of dementia and indicates the lack of awareness about dementia in Nigeria (Prince *et al.*, 2003;

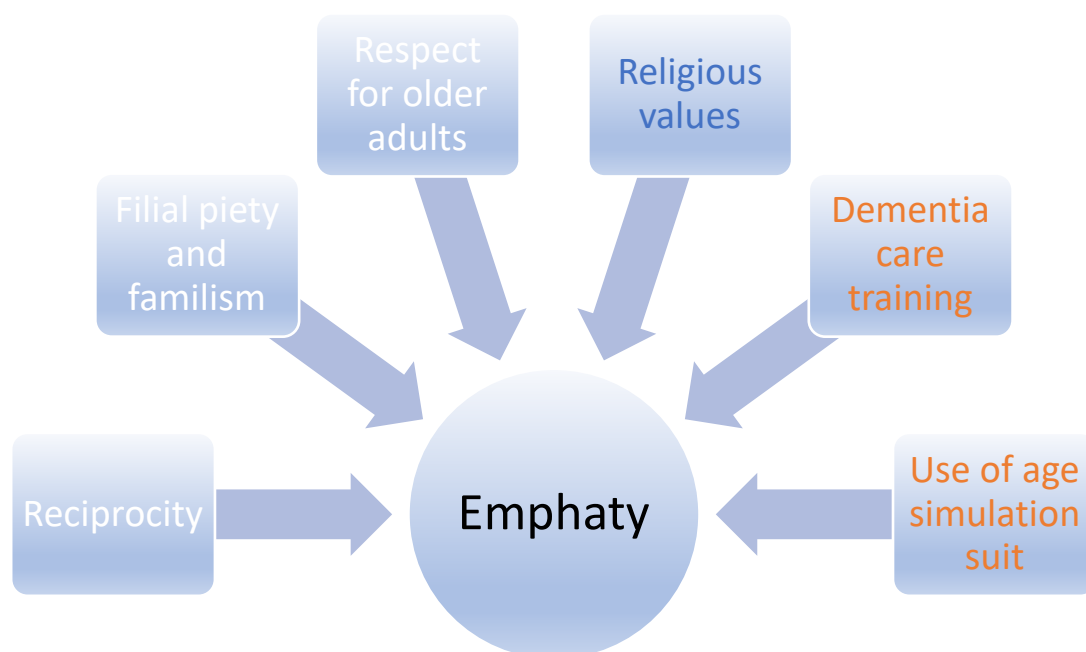
Adeloye *et al.*, 2019). As suggested in the conceptual framework for this study (see section 4.10), dementia training was instrumental to changing cultural beliefs about dementia (see Figure 10.1).

Figure 10.1: Framework showing the influence of training on cultural beliefs about dementia



My findings indicate that although my participants' current understanding of dementia was informed by the dementia care trainings they received and they found all components of the training helpful, the first dementia training they attended was key to educating them about dementia. My findings resonate with the literature in this field (Scerri, Innes and Scerri, 2017; Adebayo *et al.*, 2020; Schneider *et al.*, 2020). However, whilst my participants' current understanding of dementia is remarkably different from their previously held cultural beliefs about the condition, my findings further suggest that their cultural values continue to influence the way they care for PLWD and this is reflected in their show of empathy (see Figure 10.2).

Figure 10.2: Influence of cultural values on Nigerian migrant care workers



My findings highlight the influence of my participants' cultural values in the development of empathy. Unlike their cultural beliefs, Nigerian migrant care workers found their ingrained cultural values of respect, familism, filial piety, reciprocity, and their spiritual values relevant to their care of PLWD. The findings resonate with other studies (Tsai, Levenson and McCoy, 2006). The cultural values espoused by my participants stem from their lived experience of living in a largely collectivist society like Nigeria, which is characterised by close-knitted family ties and relationships. In

addition, their cultural values influenced how they perceived their relationship with PLWD. Despite being in paid care work, the empathy they felt towards their patients encouraged them to care for their patients as if they were caring for their relatives. Empathy is an important aspect of nursing and caring work (Chung and Bemak, 2002) and this is the reason it is focal in nursing education.

10.7. Summary

This chapter presented the findings on the cultural experiences of Nigerian migrant care workers for PLWD in the NHS. Cultural beliefs about dementia varied before they migrated to the UK and mostly consisted of folk beliefs as explanations of the possible cause of dementia. However, upon training, most of the participants changed their beliefs, and their current beliefs and understanding of dementia is consistent with the biomedical model taught in training, although, some of the participants still maintained some beliefs they held before training. Nevertheless, most of the paid Nigerian care workers found their cultural values helpful in caring for PLWD. In the following chapter, I shall discuss the contribution to literature made from my findings and relate them to my research objectives before providing a conclusion to the thesis.

CHAPTER ELEVEN

CONTRIBUTION TO KNOWLEDGE AND RECOMMENDATIONS

11.1. Introduction

In last four chapters, I presented and discussed the major findings of this study on the lived experiences of paid Nigerian migrant nurses and health care assistants (HCA) working in the NHS, who are caring for people living with dementia (PLWD). This chapter seeks to clarify how my research contributes to the empirical, conceptual understanding and knowledge concerning Nigerian migrant nurses and HCAs. It begins by reiterating the original aim of the study and discusses both my contribution to knowledge and the limitations of the study. It also includes a section on the implication of this study to the practice of caring for PLWD in the NHS and suggestions for further research. It ends with a conclusion of the chapter and thesis.

11.2. Aim of the research

The aim of this study was to explore and gain an understanding of the lived experiences of Nigerian migrant HCAs and nurses for PLWD in the UK. Twenty-one participants who were working as HCAs or nurses in two NHS inpatient wards for PLWD, described their experiences through in-depth narrative interviews. My study was largely informed by Gadamer's (1990) and van Manen's (1990; 2014) approaches to interpretive phenomenology. This approach provided a guide to my data collection, phenomenological reflection and writing which helped me to examine the life-worlds of the participants' caring for PLWD and reflect on the influence of culture in their role as care workers (nurses and HCAs).

11.3. Objectives of the research and key contributions to knowledge

In the following section, I discuss my study's findings and contributions to knowledge in relation to the research objectives (see section 1.7)

(a) Examine what motivates Nigerian migrant nurses and HCA to assume and remain in their role of caring for PLWD.

As suggested in earlier chapters (1 and 2), with the demographic changes that are prevalent in most western nations (Wu *et al.*, 2016; England and Azzopardi-Muscat, 2017), there has also been a rise in the number of PLWD (Niu *et al.*, 2017; Kosmidis *et al.*, 2018; Ferreira, Brandão and Cardoso, 2020) and this, combined with other local factors has created a demand for migrant care workers (Czaika and de Haas, 2013; Aleshkovski, 2016). Consequently, over the last decade, the global ‘care chain’ has increasingly prioritised the recruitment of migrant workers as a way of addressing the rising shortage of care workers and other healthcare professionals in the social care sector (Department of Health (DoH), 2009b; Hussein, Stevens and Manthorpe, 2011; Aleshkovski, 2016; Van Iersel *et al.*, 2016). However, employment as a care worker (particularly as HCA) for PLWD is often characterised as being low-skilled work and predominantly these jobs offer low pay (Devins *et al.*, 2014; Wright and Clibborn, 2019), even though dementia care work is especially demanding (Chenoweth *et al.*, 2014; Gao *et al.*, 2015). Although as several authors (Van Hooren, 2012; Duffy, Albelda and Hammonds, 2013; Oppert, O’Keeffe and Duong, 2018) have highlighted, caring for older adults living with dementia and other cognitive impairments also has its own challenges, which makes it a less attractive area of employment for many UK-born workers (Duffy, 2011; Van Hooren, 2012; Duffy, Albelda and Hammonds, 2013; Gospel, 2015).

As explored extensively in chapter 3, the existing literature on the motivation of migrant workers suggest that they do so for a variety of intrinsic (internal) and extrinsic (external) reasons (Brodaty and Donkin, 2009; Hussein and Christensen, 2017). My participants’ motivation to assume and remain in care was in some way influenced by their motivation to migrate and this is discussed next.

Motivation to migrate: My research evidenced the role of economic, professional (career) and family influences as part of the strategies employed by internationally trained nurses to attain better life opportunities. Furthermore, my research findings indicated that most of the research participants who were not trained nurses, did not migrate with a specific purpose of undertaking care work in the UK and these findings were consistent with earlier studies on migrant care workers (Awases *et al.*, 2004; Larsen *et al.*, 2005; Aboderin, 2007).

This research supports the findings of Larsen *et al.* (2005) and Aboderin (2007), who both observed that the primary migratory motives of Nigerian-trained nurses working in the UK were economic and professional, as part of an overarching strategy to seek better opportunities. However, in addition, this study provides a unique insight not only into the migratory motivation of care workers who were themselves trained nurses, but also individuals from other walks of life, with different professional/educational qualifications and experiences. Whereas Aboderin (2007) referred to economic motives as the decisive motivation without which Nigerian overseas nurses would not migrate, my findings suggest that, for my participants, this does not necessarily apply. Rather, the decisive motive for migration, if any, was a professional one which involved migrating for educational reasons. However, it is important to note that while Aboderin's (2007) participants were Nigerian-trained nurses actively working as UK-registered nurses, the Nigerian-trained nurses in my study were working as HCAs because they were yet to complete the registration process required for them to practice as nurses in the UK. The fact that the Nigeria-trained nurses in my study prioritised their professional advancement in their interviews might relate to meeting their immediate migratory desire to practice as nurses in the UK, compared to the Nigerian-trained nurses in Aboderin (2007) who considered their professional advancement as an 'added incentive'.

In addition, my study also highlights the migratory motives of the participant who were originally from educational and professional backgrounds outside of social care.

Choosing to work in the care sector in the UK: The findings from my study provide specific insights into the experiences of Nigerian migrant care workers, with different professional backgrounds who mostly did not anticipate working in the UK care sector. This notion of migrants of diverse professional backgrounds working in the care sector due to the lack of opportunity to work in their pre-migration professions, has also been highlighted by Willott and Stephenson (2013). They attributed the difficulties facing well-educated migrants finding a job in their chosen professions, to the perceived disparity between degrees obtained in the UK and those obtained elsewhere (particularly in the developing countries). However, my findings further suggest that while Nigerian migrants who had previously trained and worked as a nurse in Nigeria

did recognise the reality of not being able to continue to practice as a registered nurse immediately in the UK, they accepted working at a lower level in the care sector as a part of a longer-term strategy to work as a qualified nurse in the future.

Indeed, my research suggests that most of the participants were very strategic in their choice of employment. Moreover, my findings also suggest that they had a wide range of intersecting motives for working in the care sector, often comprising of moral, financial, career-oriented, and necessity-defined goals. These findings concur with other studies that suggest that migrant workers will often accept different forms of employment as, a means to an end, rather than an end itself (Gray and Johnson, 2009). My findings also echoed the work of McGregor (2007) who analysed data on Zimbabwean asylum seekers employed in care work. However, in contrast to McGregor who suggested that some Zimbabwean care workers felt trapped, my participants seem to indicate that Nigerian migrant care workers considered care work as just part of a longer-term employment strategy.

As part of my study, I profiled the different professional and care experiences of the participants before becoming care workers in the UK. Three sub-groups were identified regarding their prior experience of caregiving; namely, those with previous unpaid care experience, those without paid or unpaid care experience and those who had worked as nurses in Nigeria. The experiences of each sub-group of care workers were influenced by the nature or level of their previous caregiving experience prior to working in care in the UK. For instance, compared to participants who had no previous caregiving experience, those who had previous experience (whether working as an unpaid carer or as a nurse), expressed more desire to undertake care work in the UK because of their previous experiences of caregiving. However, regardless of the nature of their previous caregiving experiences, except for those who had worked as trained nurses in Nigeria most of the participants came from different professional backgrounds that did not reflect their eventual decision to become care workers in the UK. This finding provides an original contribution to the literature on Nigerian migrant care workers, and it is the first time that the profile of Nigerian migrant care workers in the UK has been explored in detail within the context of their professional background and previous caregiving experiences.

Motivation to take and remain in care work: I also consider that my study contributes to extending the understanding of the dynamics involved in Nigerian migrant male workers taking up a job as nurses and HCAs in a traditionally female-dominated sector. My findings resonate with those reported by Hussein and Christensen (2017) who suggested that the entrance of migrant men into the care sector could be theorised into different categories; those who stumbled upon and continued to work in care because of the lack of opportunities in other sectors (also referred to as ‘finders’ by Williams and Villemez, 1993) and those who for pragmatic reasons decide to remain as care workers (described by Simpson, 2005 described as ‘settlers’). Hussein and Christensen (2017) also noted a third category of migrant men in the care sector who faced an invisible ‘trapdoor’, where men engaged in care work often experienced barriers to their career progression because of their gender (although, this last category did not feature in my own study). I would suggest that majority of the participants in my own study could be identified as ‘finders’ or ‘settlers’, although over time, some of the male migrants who entered care as ‘finders’ may later become ‘settlers’. My findings indicate that this shift in strategies might be due to pragmatic decisions taken because of their migratory experiences. For instance, one of my participants (Oscar), described the care sector as the UK’s most popular sector to work in as a migrant, because of the relative ease to find a job in this sector. Evidence from the literature review shows that the assertion that it was easy to find work in the care sector maybe correct because of the shortage of workers in both health and social care due to the reasons previously explored (see chapter 2) (Buchan *et al.*, 2005; Cometto *et al.*, 2017; Jones-Berry, 2017).

Moreover, my study identified that care workers usually have multiple and intersecting reasons for assuming the role of caregiving. This aspect of my research concurs with the work of Sung, Chang and Tsai (2005) and further contributes to the growing literature on the motivation of migrant workers to assume and continue in the role of caregiving.

Echoing findings reported by Hussein, Manthorpe and Stevens (2011), my study also found that apart from altruistic and economic motives to undertake care work, not all the participants were willing to continue in the role. Whilst some nurses wanted to carry on with the role long term, others stated that they would consider working in other

mental health services due to the challenging nature of working with PLWD. My research found that the participants working as HCAs, reported that they were only in the role in a temporary capacity and used intersecting motivating reasons as the basis for continuing to work in care in the meantime. However, when you consider their current employment status, in relation to their educational status and previous professional experience, it is not difficult to see why the HCAs would consider this as temporary employment and did not envisage a long-term future or career in care work. Even those who aspired to work as mental health nurses were clear that they did not want to continue to work on a dementia ward, citing the challenging nature of the role amongst other personal reasons.

The research findings also indicated that although migrants working in the care sector are often assumed to be poorly educated and motivated to come to the UK for economic reasons, my participants were highly educated and were not always motivated by economic reasons. This finding is consistent with previous studies into migrant care workers, for example, Hussein, Stevens and Manthorpe (2010; 2013). However, my findings also suggested that the migrants mostly came to the UK to further their career, using the student visa as a mechanism for migration, while others came to support a spouse or family member.

My research also indicated that my participants derived personal satisfaction from their role, however, their stated motives for caring for PLWD did not appear to affect the care they believed they provided, and these findings resonate with those found in previous studies (Berg and Frost, 2005; Decker, Harris-Kojetin and Bercovitz, 2009; Rakovski and Price-Glynn, 2010). Although working with PLWD is generally construed as challenging, low-paid, and unattractive, majority of those interviewed in this study did not consider their jobs in these terms. Instead, they suggested that they were satisfied with the very notion of helping older adults, something they would willingly have done for family members living in Nigeria without being paid. These characteristics maybe due to being raised in a culture where the family structure acknowledges and values the role of the extended family (Rozario and Rosetti, 2012; Bień *et al.*, 2013). In contrast, it was notable that some of those interviewed suggested that they did not derive any personal satisfaction from the role. They took the role as

simply a task to be done for financial remuneration (see chapter 8). It could be argued that this approach to care work is ‘*mechanical*’ or ‘*business-like*’, contradicting the ideal model proposed by Twigg (2000) and McGreevy (2015) who advocated for a person-centred approach to caring for PLWD. However, my findings indicate that those care workers who identified the motivation for working with PWLD as being based on non-altruistic rewards (i.e., they were motivated by their earning capacity or other material gain) also suggested that they did derive satisfaction from caring and stated that it was this sort of reward (or the combined factors), that was keeping them in the role. This finding concurs with Folbre and Nelson (2000) who argued that people engaged in caring jobs could both be motivated altruistically and out of self-interest. Therefore, while some people may view care work as an avenue to make money and be motivated to remain in the role solely because of the financial reward they receive, much of the literature is based on the ‘compassionate nature discourse’ of caring and theories surrounding emotional labour of the work (Simpson and Acton, 2013). This aspect of care work leads to the next objective of the study, which is discussed next.

(b) Understand how Nigerian migrant HCAs and nurses embrace or adapt to the challenges associated with caring for PLWD and the coping strategies they employ.

The challenges of caring for PLWD have been well researched (Gospel, 2015; Kokkonen *et al.*, 2014) and this contributes to the unattractiveness of care work for UK born workers, giving rise to the increased need for migrant workers to fill the well documented gap in care workforce (Aleshkovski, 2016; Hassan *et al.*, 2017; Ferreira, Brandão and Cardoso, 2020). This study examined the challenges that my participants specifically faced in their role as nurses or HCAs and the findings provide some insight to how they coped with the challenges.

Challenges of caring for PLWD: There is a recognition of the need to tackle workforce shortages in the NHS and it has been suggested that this requires a holistic approach that acknowledges the factors exacerbating the growing shortage of workers and how best to address them (Sanford, 2013). In the literature, some of the factors implicated in the high turnover rates among professional care workers for PLWD in different care settings as well as the NHS, include low wages, availability of other job opportunities

and the demanding nature of the role (Bahareethan and Shah, 2000; Cocco *et al.*, 2003; McVicar, 2003; Glasberg, Eriksson and Norberg, 2008; Glasper, 2016).

However, caring for PLWD (as a family or a paid carer) is often characterised as being distinctive and one involving the potential for both positive and negative outcomes (Cohen, Colantonio and Vernich, 2002; Hatton and Emerson, 2003; Blacher, Neece and Paczkowski, 2005; Roth, Fredman and Haley, 2015). Furthermore, research suggests that care workers adopt different strategies to cope (Iavarone *et al.*, 2014; Kokkonen *et al.*, 2014) with the challenges (stress and strain) of their role, which may include problem-focused, emotional-focused and avoidance coping strategies depending on their appraisal of the role as difficult or rewarding (McWilliams, Cox and Enns, 2003; Cooper *et al.*, 2008; Li *et al.*, 2012).

Findings from my study support existing literature on professional care workers and indicated that the participants did indeed used a range of strategies to cope with the challenges they identified with caring for PLWD, and this thesis makes these following four contributions to extend knowledge:

Strategies to cope: Firstly, my findings suggest that the participants devised a range of strategies to cope with the demands of the role depending on the nature of the stressor. They utilised problem-focused strategies, emotional-focused strategies and avoidance strategies and these findings resonate with earlier research (Todd and Watts, 2005; Chien *et al.*, 2011; Gilhooly *et al.*, 2016). For instance, when dealing with problem of behaviour on the wards, interviewees prioritised the importance of knowing the patients, their presentations, and triggers, which they considered essential to managing challenging behaviours. This concept of knowing the patients has been reported in other studies (Rasin and Kautz, 2007; Tadd *et al.*, 2011; Dewing, 2014; Zahran *et al.*, 2016), with respect to providing person-centred care. My findings suggest that care workers considered knowing the patients as a way to cope with the behavioural presentations of PLWD, and this fits with the problem-focused approach of coping (Cooper *et al.*, 2008; Gray-Stanley and Muramatsu, 2011; Perkins and Hewitt, 2016). However, the dilemma of trying to know the patients as an NHS bank staff on a zero-hours contract raises further questions about the complex challenges of providing person-centred care

without adequate knowledge of the patients. The rate of turnover of patients in the NHS inpatient older adult unit in comparison to residential homes and other care settings, makes it difficult for staff on zero-hours contract to get to know the patients so they can better care for them.

Despite the challenges they faced, most of the participants also used emotional and avoidance/denial coping strategies to cope with the demands of their role. They ‘shrugged it off’ as not challenging enough while others chose to endure the challenges they face. They developed a pre-determined mind-set that the role is inherently difficult and had the belief that once they left their workplace, they left the stress behind. These findings are consistent with those reported in previous studies (Almberg, Grafstrom and Winblad, 1997; Quayhagen and Quayhagen 1996; Ingebretsen and Solem 2002; Stanton, Revenson and Tennen, 2007; Devereux *et al.*, 2009). Their use of these strategies to cope might be attributed to their appraisal of the difficulties they encountered in the role. For instance, most of my participants noted that the nature of the extended family structure in which they were raised in Nigeria made them want to care for older adults because back in Nigeria, it is what they would have done without expecting to be paid. This finding highlights the emotional and cultural connections that my participants drew upon and their normal traditional and communal expectation of care responsibility in Nigeria and this may have influenced their perceptions of their roles as nurses and HCAs, caring for PLWD in the NHS.

It is also worth noting that while this study did not set out to specifically examine the role of gender in the appraisal of caregiving challenges, my analysis suggests that female Nigerian migrant care workers were more open to speak about the physical and psychological challenges they faced in the role compared to their male counterparts. This is congruent with other research on traditional masculine norms in which men experience the cultural expectations placed on them as men (Revenson *et al.*, 2016b; Mincey *et al.*, 2015). As some of my participants noted, the belief commonly held in Nigeria that men should not show any sign of weakness might explain why most of my male participants appeared to not acknowledge the impact of caring for PLWD on them.

My findings also showed a further challenge because of the relationship between gender and caregiving, and it highlighted how the male care workers experienced ‘body work’ (i.e., personal care) involved in dementia caregiving. This is consistent with previous research, which attributes this to the challenge men face when they take jobs traditionally reserved for women in most cultures (Revenson *et al.*, 2016b). My findings also suggested that while both male and female care workers experience some form of challenges in their role, female care workers seemed to be more open to talk about their challenging experiences, whereas their male counterpart were more likely to downplay the severity of the challenges they face, and this is a unique contribution to knowledge as it points to intersection of gender expectations in care work as well as gender and culture.

Coping techniques: Secondly, my participants reported not using available formal support services but opted to deal with the challenges they encountered while working on the job, using self-help coping techniques. This might be due to the differences in care workers’ appraisal of the challenging nature of caregiving. Although, all the nurses and HCAs cited different challenges they faced in the role, many did not consider their role challenging enough to demand the use of formal support. This resonates with previous research on the appraisal of workplace stress (Abuatiq, 2015; Hazelhof *et al.*, 2016).

Racism in the workplace: While I did not set out to examine racism in the NHS, my study found that racism and workplace discrimination was the most common cited challenge that my participants faced despite legislation and NHS policy on equality and diversity (West, Dawson and Kaur, 2015).

There has been a concerted effort against all forms of racism/discrimination in the workplace and the NHS has been at the fore front of this campaign (NHS England, 2020). However, despite the remarkable progress that has been made over the years, more still needs to be done (McKay and Avery, 2015). As my findings highlight, workers still experience racism both overt and covert. In the context of my study, my participants experienced workplace racism and it was interesting to note that regardless

of the NHS drive to address this perennial issue, there were evidence that current approach to tackle it is ineffective.

In broad comparison, my participant reported more experiences of covert than overt forms of racism. Although all forms of racism are bad and illegal (Equality Act, 2010; DoH, 2012; Department of Health and Social Care, 2019), covert forms of racism are more difficult to prove and problematic to tackle (McKay and Avery, 2015). However, my participants experienced overt racism from some of their patients, which they attributed to the patient's mental state and illness presentation. However, my participants were much more concerned about the covert or subtle forms of racial discriminations that they experienced from fellow colleagues and the family members of care recipients.

In relation to their experience of racism, there are a few crucial points to note. First, the likelihood of my participants reporting an experience of racism against them appears to depend on the type of employment contract that they held. Staff on permanent contracts and therefore more secure were more likely to be vocal against perceived discrimination than those on temporary bank contract. Care workers hesitation to report or address racist abuse and discrimination against them might be due to the lack of guaranteed work hours which makes them unwilling to challenge those behaviour for fear of being seen as a troublemaker (Ravalier *et al.*, 2017).

Most of my participants narrated their experiences and how they handled it. Although previous studies have also reported this as a challenge (Stevens, Hussein and Manthorpe, 2012; Rimmer, 2019), this study makes an original contribution to knowledge as it highlights the attitude of my participants towards racist activities targeted at them. Besides ignoring it, 'shrugging it off', as something they have become used to, there was a general lack of willingness by the participants to report the incidence of racism or discrimination, which counters the NHS policy against discrimination. This is consistent with previous findings (Allan *et al.*, 2004; Allan, Cowie and Smith, 2009).

This study therefore makes a fresh contribution to the discussion around workplace racism and discrimination (Cangiano *et al.*, 2009; Sahraoui, 2011; Anderson and

Shutes, 2014), because it outlines how the Nigerian migrant care workers dealt with the racist and discriminatory behaviours they experienced. Apart from excusing the behaviour, they also expressed indifference and lack of enthusiasm towards addressing it. As the study suggests, they appeared unenthusiastic because they did not want to jeopardise their opportunity to continue to work on the ward, being bank staff and this might have contributed to entrenching this attitude (Stevens, Hussein and Manthorpe, 2012; Moore and Tailby, 2015; Tailby, 2015). This finding has implications for the nature of work employment contracts and the overall commitment of the NHS to tackling workplace racism and discrimination.

Another key point worth noting is the role of the participants' employment status. Most of the participants in this study were bank staff (not on a permanent work contract), this usually meant that the staff were working on a zero-hours contracts. Sixteen of the twenty-one participants interviewed were bank staff while the other eight were on a permanent contract. Care workers who were bank staff appeared to express unwillingness to report incidence of discrimination compared to those on permanent contract who were more willing to report incidences. This might be due to the unstable nature of zero-hours contracts, where getting a job is not guaranteed and if a member of staff is viewed by others as being problematic, they may not be booked to work on the ward again. The finding might also be related to the care workers' lack of a sense of belonging and a feeling of being excluded from the NHS ward.

In addition, my study suggests that one of the reasons for this may be because the participants saw themselves as '*visitors*' in the country and also because of their current visa status, they were unwilling to report incidences of perceived racism and discrimination against them. Nigerian migrant care workers may be unwilling to report incidences of racism because they feel like strangers in the UK and therefore chose to ignore such activities, as one of the participants (Kemdo) puts it, with reference to fellow workers and family members of care recipients showing racist attitude towards him, "*...it is their country...*" This also indicates the link between an individual and their migration status and how they dealt with the incidence of racism and discrimination targeted against them.

(c) Identify what common cultural beliefs about dementia are held by Nigerian migrant HCAs and nurses and examine how the identified cultural beliefs influence their care for PLWD.

The continuous entrance of migrant worker into care within the NHS and other care settings demands an examination of their cultural beliefs because of the potential influence it might have on care for PLWD (see chapter 4). This study examined the cultural views held by Nigerian migrant nurses and HCAs working in an NHS ward. The study findings contribute to extend the understanding of value of dementia training and age-simulation suit in changing beliefs and inspiring empathy in the care for people with dementia. They are examined further below.

The value of training in changing beliefs about dementia: Previous studies (Pinquart and Sörensen, 2005; Sun, Ong and Burnette, 2012) have highlighted the range of the ‘folk beliefs’ of dementia commonly held prior to the current biomedical model, which appears to be the dominant explanatory model in many Western countries. Folk beliefs, which pre-date more recent models for explaining dementia, are viewed as outdated and not helpful to understanding the condition because it is often suggested that they emerged from a lack of understanding of the condition (Livingston *et al.*, 2017) and my own findings also reiterate this perspective. My study provides an emic view of Nigerian migrants’ subjective view of the changes they had in their understanding of dementia upon working as care workers and nurses in the UK. However, this study contributes to knowledge because it highlights the usefulness of ‘dementia training’, in changing the cultural beliefs and perceptions/orientations about dementia originally held by the respondents (although some of the nurses had received training in Nigeria) and most of the participants considered it to be very useful in broadening their understanding of the condition. This finding is consistent with earlier research on the value of training in the understanding of dementia (Prince, Prina and Guerchet, 2013; Smythe *et al.*, 2017). Indeed, the National Dementia Strategy for England highlights the need for improved care for PLWD through staff education about the condition (DoH, 2009a; Livingston *et al.*, 2017). Although Smythe *et al.* (2017) considered the effectiveness of training in changing practices in the care for PLWD in a different setting (nursing home), my study underscores the importance of training in preparing

migrants from other cultures to the realities of working with older adults living with dementia in the NHS. Care within the NHS is mostly administered in a short-term basis, in comparison to other care settings for PLWD.

However, not every participant had abandoned their pre-migration beliefs about dementia. My findings suggest that although all the participants acknowledged the place of the biomedical model in understanding the aetiology of dementia, some participants remained -convinced that dementia was not purely a biomedical or pathological condition, maintaining that there is definitely a spiritual dimension to the condition. This points to possibility of my participants holding dual or multiple beliefs about dementia, one that supports the biomedical model and another that does not support it. This could be due to their strongly held religious views. However, the participants seemed to balance these beliefs in their working practices.

The training that incorporated the use of an age simulation suit was found to be most beneficial to training and attitudinal change in caregiving. My participants considered it very useful in their day-to-day care work because it inspired empathy in them, noting that after the training, they knew exactly what it felt like to be old and the physical limitations it puts on the body.

Implications for training in the NHS: Training and education have been identified as important variables in enhancing the psychological well-being of staff, and providing adequate training are likely to have broad-reaching benefits for staff and care recipients (Prince, Prina and Guerchet, 2013). This is significant for two reasons. Firstly, all the participants in this study started out in care in a different care setting to the NHS. Although they worked in the NHS at the time of the interview and spoke of regular training, it appears that with reference to changing their previously held beliefs about dementia, that change occurred before they began to work in the NHS.

Secondly, it appears current dementia training within the NHS does not necessarily involve the mandatory use of age-simulation suit. However, a scoping review by Coelho *et al.* (2017), suggested that age-simulation suits was beneficial to student nurses, a finding further validated by Rueffert and Bullinger (2020) who found that the use of

the age-simulation suit helped stimulate the sensitivity of student nurses to old-age related impairment when compared to student nurses who did not use the intervention.

(d) Explore how the participants' cultural beliefs and values shape their overall experience of dementia caregiving.

The experience of migrant care workers and nurses caring in different health and social care settings in the UK has previously been viewed from the standpoint of their working as migrant workers (Cangiano and Shutes, 2010; Shutes, 2012; Shutes and Chiatti, 2012). While most of those previous studies have provided valuable insight into how these migrant workers considered their role, there is little research on the cultural beliefs and values held by the migrant care workers and what influence it might have to the care they provide. In addition, studies that explored cultural beliefs within the context of care often focused on the provision of culturally sensitive care to the patients (Likupe, Baxter and Jogi, 2018; Singh, King-Shier and Sinclair, 2020) rather than from the perspective of the migrant care workers. The diversity of the workforce within the NHS makes this consideration paramount and there is currently little focus on the cultural perspective of the migrant worker.

In my research, as shown in last chapter, although most of the participants had abandoned or changed the beliefs they held about dementia pre-migration, for most of them care workers their cultural values continued to be relevant as they believed that those values made them unique as care workers for PLWD. My participants believed that they were able to navigate the workplace by always matching their cultural sensitivities and values despite or whilst complying with? the institutional/workplace policy and procedure. Despite acculturation and learning about the concept of dementia as a biomedical construct, most of my participants also readily employed their cultural values of respect and regard for the elderly in their day-to-day care for PLWD (Dilworth-Anderson and Gibson, 2002) and this is often an unrecognised and positive attribute in their provision of care. As Bhugra and Becker (2005) noted, in acculturation, both the dominant culture and the minority cultures interact in a dynamic and reciprocal way and most of my participants highlighted that they tried to maintain the cultural value of respect for older people in their everyday care work. This is significant because

in collectivist cultures, the concept of respect and reciprocity does not just apply to an individual's immediate parents or older relatives but also to whoever is considered as an older adult (Revenson *et al.*, 2016c). This does not imply that my participants were better carers but could suggest that they consider the care they provide for their patients as a continuation of the informal care they provide within the collectivist family circle back in their home country.

However, some of my participants also highlighted instances where they had to set aside what they considered to be their culturally appropriate values, to follow workplace policy. For example, while it is intuitive for an individual to come to the aid of an older adult in the process of falling, it was noted that they have had to learn not to intervene in a scenario of an older adult falling in the ward, so as not to counter work-place policy. In this example, the work-place policy was put in place to protect both the patient and the carer, who might come to harm while trying to prevent the patient from falling (Ang, O'Brien and Wilson, 2019).

This my research therefore is not claiming that being a Nigerian care worker influences the care given to PWLD but rather that the standard dementia training helped to counter previously held folk beliefs. Moreover, many of my participants perceived that their cultural values enabled them to provide better care than those who do not hold similar values.

However, the significance of these finding is the role migrant workers can play in the NHS drive to provide culturally sensitive care for older migrants. It is also essential to consider the notion of respect and that what my participants described in relation to this construct would largely apply to older adults of similar ethnic background, although cultural assimilation might help them apply specific values when caring for older adults from other ethnic groups. As one of the participants noted, the colour of the skin of the care recipient is immaterial when it comes to caring.

11.4. Summary contribution

This study makes a valuable contribution to the literature on migrant workers and their motivations for working in the UK and specifically of caring for people living with dementia in NHS settings.

My study found that contrary to expectations, the majority of the Nigerian care workers were highly educated when they migrated and moved into dementia care work as part of the longer-term personal or family strategy.

In this research, I also examined Nigerian migrant care workers' construction of dementia when living in Nigeria and the value of training to changes in attitudes. However, as suggested above, not all traditional beliefs were negative and some people believed that their cultural values and spiritual attitudes promoted a good quality of care.

My study also highlighted the motivating factors for caregiving and the continuation to stay in care work. Furthermore, it highlighted the influence of masculinity on care workers' coping strategies, the use of avoidance coping techniques and the general lack of use of formal support services.

One of the significant findings in my study was the common experience of racism and discrimination and while the participants 'accepted' this behaviour from clients because of their diminished capacity, racism was also ignored when it was generated from NHS staff and relatives of clients and my research indicated this was due concerns around the instability of work contracts (i.e., being a member of the bank staff on a zero-hour contract).

Instability of work contracts for those working with PWLD also has wider implications as has recently emerged during the Covid-19 pandemic. Not only has been a devastating impact on health there has also been direct consequences for people's jobs and livelihood (Anand, 2020). People with symptoms of coronavirus are required to self-isolate leading to loss income for those on zero-hours contracts (Douglas *et al.*, 2020). The UK government furlough scheme (Fisher and Harwood, 2020) followed by the job support scheme, has not offered protection for those on zero-hours contracts (Benzeval

et al., 2020). Low paid care workers may lose their income and often lack savings, a consequence of this is that they may choose not to self-isolate when they show symptoms because of the potential loss of income, risking their own health and that of others.

11.5. Limitations, implications for practice, recommendations, and conclusion

This section begins with a discussion of how the contribution from this study advances the understanding of Nigerian migrant care workers in the NHS. The study's limitations are discussed, and suggestions made for future research. Finally, the implications of the study for policy and the practice of caregiving for PLWD is highlighted.

11.5.1. Limitations

The central goal of this research was to explore, from the Nigerian migrant care workers' perspective and experiences, what their lives were like, caring for PLWD, coming from a culture different to the United Kingdom. Despite achieving this research aim, it remains that only those who have worked with PLWD will really understand what it is like in the context of their cultural perception of the condition. However, this study does not claim to advance a definitive explanation of the lived experience of every care worker for PLWD.

Familiarity with the participants in the caregiving role: The study has explored the experiences of Nigerian care workers through pre-reflective and reflective understanding of the phenomenological meaning of paid caregiving activities of Nigerian migrant care workers in the UK (described in Chapter 3). This study embodies the lived experience of Nigerian care workers in the NHS who were interviewed. However, I cannot claim that it represents the views and experiences of all Nigerian care workers. As with other studies, where the researcher and the research participants are known to each other previously, there were potential internal conflicts between my role as a researcher and my role as a care worker working in the same study location as my participants. In part, these tensions arise from the dominance of the positivist discourse that implies that research should be objective. However, within the phenomenological paradigms it is recognised that the researchers are situated within

the study especially as they are usually the main data collection tool (i.e., they collect the data in the context of personal relationship). As I suggested in my reflexive statements in Chapter 4, most of the participants I recruited for this study had prior familiarity with me, as a fellow HCA. Also, I had worked with most of the nurses on a shift in the past. To minimise this conflict, I stopped working on the wards in question during the time I was actively collecting data. However, because most of the participants were bank staff (and I was employed as a part-time, temporary HCA), on few occasions, I could not avoid working with some of my participants. Although I tried to avoid working with my participants during the time of the interviews, my familiarity with them in our previous working relationship raised two issues. One, it was important that participants did not feel obliged to participate in the research because they were being invited by a fellow HCA. Therefore, I emphasised on the participant information sheet and written consent form that their participation was completely voluntary, and they were free to withdraw from the study at any time.

The recruitment Christian participants: the religious background of my participants was homogeneous, with all of them self-identifying as Christians. This was not intended but excluded the spiritual experience of people of other faiths in the consideration of how their faith helped them cope with the role of caregiving. When most of my participants discussed their spirituality in the context of caring and how they coped, they spoke only from the viewpoint of being a Christian. Hence, the potential drawback is that the perspectives of the other faiths were not considered and a further study on the significance of different religious beliefs on dementia care would be useful.

The construct of 'Nigerian' care workers: The ethnic and cultural makeup of my participants (described in Chapter 5), is another potential limitation of this study. Nigeria is an ethnically and culturally diverse country and care workers of different ethnocultural groups participated in the study. This was necessitated by the limited pool of care workers from the different ethnic group available at the study site. As this study was not designed to consider the lived experience of any ethnic/cultural group in Nigeria, the findings cannot be applied to a particular group. Throughout the research, I considered Nigeria as a geographical entity, rather than as a culturally homogeneous country. However, I attempted to highlight the differences between the participants in

a discussion of their background in Chapter 5 and acknowledge their cultural similarities where they exist.

Timing of the study: A final limitation of the study, is that the data presented in this study was gathered in 2017/2018. Due to the fast-moving pace of research within the care literature, this may have implications for the relevance of findings to different audiences. However, at the time of submitting this thesis, no study has been identified that explores the experience of Nigerian care workers in the context and extent explored in this study.

11.5.2. Implications for practice

Several issues were highlighted in this research that are important for the recruitment and support of Nigerian migrant care workers for PLWD. Three suggestions are made that may enhance the experience of the care workers and help them provide better care and reduce their level of work-related stress, and potentially reduce high staff turnover in the care sector.

Incorporating a cultural understanding of dementia into training: It has been shown from the study that Nigerian migrant care workers have varying beliefs about dementia. While none of the participants who continued to hold on to their beliefs about dementia admitted that it interfered or affected their provision of care to PLWD, it will be beneficial if training sessions for migrant care workers are revised, to include the different range of cultural perceptions of dementia. Doing this will provide an opportunity for such beliefs to be discussed identifying an aspect of value (such as respect for older people) and addresses assumptions.

Increase support for migrant care workers: A common theme in the study was the challenging nature of care work. Nigerian migrant care workers can benefit from additional support to better cope with the challenges of the role. While NHS work settings do have policies in place to deal with incidents of workplace racism and discrimination (West, Dawson and Kaur, 2015), my research indicates that the policies are not necessarily resulting in behaviour change. In addition, care organisations such as the NHS, need to monitor discrimination in the workplace (rather than just depend

on staff report it) and migrant staff should be supported to report any abuse or discrimination regardless of their working contract.

Lived experience of care workers: This study showed that the lived experiences of Nigerian migrant nurses and HCAs in the UK's NHS is central to their experiences of caring for PLWD. These experiences should form part of the evaluation of the quality of services for PLWD, particularly with respect to the importance of training in changing previously held beliefs about dementia. Recognising and valuing cultural diversity in care work could have an attendant effect on stemming the tide of high turnover rate within the care sector. These recommendations offer a real prospect to enhancing the experience of Nigerian migrant care worker in the UK. However, further research is required to expand existing knowledge of these and other issues.

11.5.3. Recommendations for future research

Conducting this study has revealed new questions. I have identified the following future research areas from this study as having the potential to impact on the experience of Nigerian care workers for PLWD and add to the caregiving literature.

- a. A study to evaluate the effectiveness of the NHS policy on equality and diversity will provide insight to understanding why victims of discrimination and racism feel unable to report discrimination. and in particular, to address the reporting of racism in relation to the numbers of minority ethnic staff in the NHS on zero-contract hours.
- b. A study which explores the challenges bank staff face when working with PLWD.

11.5.4. Conclusion

The experience of Nigerian care workers for PLWD entails the journey of young Nigerians from Nigeria to the UK with the hope of a better life and career. But upon arrival, were drawn into working as care workers to deal with the reality, when they found that their educational qualification or professional experience could not secure them a choice job. Coming from a country with little awareness about dementia and culture with family structures which are still largely collective/compact, and the use of

institutional care is more or less non-existent, these care workers have over time learnt how to negotiate the world of caregiving. Their experiences are complex and vast; however, it is hoped that these findings will help to further develop the existing knowledge and understanding of the lived experience of care work.

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APPENDICES

APPENDIX 2.1: LITERATURE REVIEW PROCESS AND SCOPE

Literature search strategy: The literature review that was conducted for this study was a standard scoping review. The style was chosen because of the different concepts that were examined with the context of understanding the experience of paid Nigerian nurses and health care assistants (HCA) for people living with dementia (PLWD). A literature search method that involved the search of existing literature in some databases was done to aid the proper identification of relevant literature and studies. The following databases: Cochrane Library, PubMed, *Cumulative Index to Nursing and Allied Health Literature* (CINAHL), Medline (EBSCO), Social care online, Science Direct and Google Scholar; were searched at the outset of the preparation for the study. The search was conducted largely through the Anglia Ruskin University Digital Library. These databases were selected because they contain an array of primary research related to the research topic. No specific time frame was adopted in the literature search.

Key words or search terms

The search involved entering search term(s) into databases, with or without parentheses to ensure only studies relating to the search term(s) were retrieved. Examples of search terms used are, “dementia”, “carer” “carers”, “dementia carers”, “informal carers”, “formal carers”, “paid caregivers”, “Nigerian migrant caregivers”, “Alzheimer”, “caregiving”, “caregiver”, “ethnic minorities”, “family caregivers”, etc. Results obtained from the search formed the basis of this literature review.

Defining the scope of the review

Although this study is on paid Nigerian migrant, the literature reviewed attempts to understand the main concepts associated with their experiences of caregiving. However, the review was limited to studies largely on dementia caregiving.

Inclusion criteria: studies of all design

Exclusion criteria: studies not published in English

APPENDIX 6.1(A-D): LETTERS OF PERMISSION FROM CHURCHES

APPENDIX 6.1A: LETTER FROM RCCG HOPE HALL

[redacted in this version]

APPENDIX 6.1B: LETTER FROM RCCG POWER OF JEHOVAH

[redacted in this version]

APPENDIX 6.1C: LETTER FROM RCCG THANKSGIVING HOUSE

[redacted in this version]

APPENDIX 6.1D: LETTER FROM THE CHRIST ANOINTING ASSEMBLY

[redacted in this version]

APPENDIX 6.2(A-C): EVIDENCE OF HRA AND NHS R&D APPROVAL

APPENDIX 6.2A: HRA APPROVAL LETTER

[redacted in this version]

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Leaflet]	1	08 April 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity, Employers' Liability and Public/Products Liability]	1	20 July 2015
Interview schedules or topic guides for participants [Interview schedule]	1	20 March 2016
IRAS Application Form [IRAS_Form_17052016]		17 May 2016
Letters of invitation to participant [Letter of invitation]	1	08 April 2016
Participant consent form	3	26 May 2016
Participant information sheet (PIS) [Participant Information Sheet]	2	24 May 2016
Research protocol or project proposal [Research protocol]	2	24 May 2016
Summary CV for Chief Investigator (CI) [Curriculum Vitae (Ojeiu Ejere)]	1	20 March 2016
Summary CV for student [Curriculum Vitae (Ojeiu Ejere)]	1	20 March 2016
Summary CV for supervisor (student research) [Supervisor's CV]	1	27 April 2016

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study: Mr Ojeiu Ejere [REDACTED]

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments

IRAS project ID	204354
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Section	HRA Assessment Criteria	Compliant with Standards	Comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	An agreement is not being used as this is a student study, not requiring REC review, with a single NHS site. If further sites are added then the need for an agreement between the sponsor and participating organisations will be re-assessed.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding will be provided to the participating organisation.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals	Not Applicable	No comments

IRAS project ID	204354
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Section	HRA Assessment Criteria	Compliant with Standards	Comments
	and authorisations received		

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one-site type. Ward staff will be recruited by the student researcher to take part in an interview. The interview will take place outside of NHS premises.

Some participants may also be recruited outside the NHS. HRA approval does not cover activity outside the NHS. Before recruiting outside the NHS the research team must follow the procedures and governance arrangements of responsible organisations.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research**, because all study activity will be undertaken by the student researcher.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than **13th July 2016**):
 - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate

Page 7 of 9

- You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed..
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed.
- The document "[Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected](#)" provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expected, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator will need to be identified at the participating organisation to enable the researcher to access wards in order to recruit participants. A Local Collaborator will only be required where a Letter of Access is needed.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

A Letter of Access will only be required for the researcher to enter the NHS premises to recruit participants, if the recruitment activity will take place in patient-care areas of the participating organisation. No Disclosure and Barring Service and Occupational Health checks will be needed where a Letter of Access is required.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

IRAS project ID	204354
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APPENDIX 6.2B: HRA CONFIRMATION OF AMENDMENT

[redacted in this version]

APPENDIX 6.2C: NHS R&D APPROVAL

[redacted in this version]

APPENDIX 6.3: INSTITUTIONAL ETHICS APPROVAL LETTER



Ref: CS/jc/FMSFREP/15/16 055
Enquiries: Joanne Corney
Direct Line: 01245 684779
Date: 1st July 2016

Chelmsford Campus
Bishop Hall Lane
Chelmsford
CM1 1SQ

T: 0845 196 4779
Int: +44 (0)1245 493131
www.anglia.ac.uk

Ojeiu Ejere

Dear Ojeiu

Re: Application for Ethical Approval

Principal Investigator: Ojeiu Ejere

FREP number: 15/16 055

Project Title: The experiences of Black African caregivers of people with dementia-influence of cultural beliefs/values on perception, motivation and coping.

Thank you for your application for ethical approval which has now been considered by the Faculty (of Medical Science) Research Ethics Panel (FREP).

I am pleased to inform you that your application has been approved by the Vice Chair of the Faculty Research Ethics Panel under the terms of Anglia Ruskin University's Research Ethics Policy (Dated 23/6/14, Version 1).

Ethical approval is given for a period of 3 years from Friday 1st July 2016.

It is your responsibility to ensure that you comply with the Research Ethics Policy and Code of Practice for Applying for Ethical Approval at Anglia Ruskin University and specifically:

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these changes until you have received approval from FREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the FREP copies of this documentation if required, prior to starting your research.

- Any laws of the country where you are carrying the research and obtaining any other approvals or permissions that are required.
- Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a Project Risk Assessment must have been carried out prior to starting the research).
- Completing a Risk Assessment (Health and Safety) if required and updating this annually or if any aspects of your study change which affect this.
- Notifying the FREP Secretary when your study has ended.

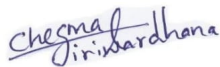
Information about the above can be obtained on our website at:

<http://web.anglia.ac.uk/onet/rdcs/ethics/index.phtml>

Please also note that your research may be subject to random monitoring by the Panel.

Should you have any queries, please do not hesitate to contact my office. May I wish you the best of luck with your research.

Yours sincerely,



Dr Chesmal Siriwardhana (Vice Chair)

For the Faculty (of Medical Science) Research Ethics Panel

APPENDIX 6.4: INVITATION LEAFLET

VOLUNTEERS NEEDED FOR RESEARCH ON THE EXPERIENCE OF NIGERIAN PAID CAREGIVERS OF PEOPLE WITH DEMENTIA

I am looking for volunteers to take part in the research on formal caregiving.

You will need to self-identify as a Nigerian, work as a paid/formal caregiver (nurse, carer, healthcare assistant or support worker) for people with dementia and be willing to discuss issues around it. As a participant, you will be asked your overall experience of caring for people with dementia as an African, a Nigerian. The interview will take approximately an hour.

Your participation will be a valuable addition to the study and the findings could lead to better understanding of the experience of paid caregivers and offer ways they can be supported in their role as caregivers.

If you are interested, please email at **X** or call me on **X**, so I can send you the participant information sheet and consent form. You can also email/call if you have any further questions or queries.

Thank you!

This study has been reviewed by and received ethics clearance through the Faculty Research Ethics Panel of the Faculty of Medical Science, Anglia Ruskin University.

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APPENDIX 6.5: FULL UNIVERSITY INDEMNITY LETTER

[redacted in this version]

APPENDIX 6.6: INTERVIEW GUIDE

Tell the respondent about the study again.

Start with a discussion about informed consent and ask if the respondent would be willing to sign the informed consent form

Themes

1. Introduction and preliminary interactions
2. Work experience before care work and journey into care work in the UK?
3. Meaning and perception of dementia and caregiving
4. Experiences of caring of people with dementia
5. Your future in care work

1. *Introduction and preliminary interactions*

Possible questions and prompts

- a) I am interested in your background. Please can you tell me where you were born in Nigeria?
- b) Please can you tell me a little about any work experiences in Nigeria and why you came to the UK (Prompt: can you tell me a little more about that?)

2. *Work experience before care work and journey into care work in the UK?*

Possible questions and prompts

- a) Can you tell me about any jobs you had in the UK before you became a carer?
- b) Can you tell me why you came into care work?
- c) How long have you worked as a paid carer?
- d) Is the job what you expected it to be?

3. *Meaning and perception of dementia and caregiving*

Possible questions and prompts

- a) Can you explain what dementia is?
- b) Before coming to work in the UK, had you cared for anyone else with dementia?
- c) When you started work here, were you offered any specific training in how to work with people with dementia?

Some people may look at the condition in different ways. Do you think our culture influences that way we care for people with dementia?

4. *Experiences of caring of people with dementia*

Possible questions and prompts

- a) How have you found the experience of working with people with dementia?
- b) Are there any particular aspects of the job you find difficult? (Prompt: Do you have any strategies or beliefs that help you to cope with these difficulties?)
- c) Are there any particular aspects of the job you find rewarding?

5. *Your future in care work*

Possible questions and prompts

- a) May I ask why you continue working as a caregiver?
- b) Finally I want to ask you, where do you see yourself working in the future?

End of interview.

I will ask the participant if they have any questions.

Thank the participant for their time and ask if they would like feedback on the findings of the study after project completion.

APPENDIX 6.7: IRAS APPLICATION FORM (FRONT PAGE)

IRAS Form

Reference:
16/HRA/1392

IRAS Version 5.3.0

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Experiences of paid Black African caregivers of people with dementia.

1. Is your project research?

☒ Yes ☐ No

2. Select one category from the list below:

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ☐ Basic science study involving procedures with human participants
- ☐ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☒ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ☐ Study limited to working with data (specific project only)
- ☐ Research tissue bank
- ☐ Research database

If your work does not fit any of these categories, select the option below:

☐ Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? ☐ Yes ☒ No
- b) Will you be taking new human tissue samples (or other human biological samples)? ☐ Yes ☒ No
- c) Will you be using existing human tissue samples (or other human biological samples)? ☐ Yes ☒ No

3. In which countries of the UK will the research sites be located? (Tick all that apply)

- ☒ England
- ☐ Scotland

Date: 17/05/2016

1

204354/970418/37/263

APPENDIX 6.8: LETTER OF INVITATION



LETTER OF INVITATION TO PARTICIPATE IN A RESEARCH PROJECT ON THE EXPERIENCE OF NIGERIAN CAREGIVERS OF PEOPLE WITH DEMENTIA

Dear _____,

Project Title: The experiences of Nigerian caregivers of people with dementia- influence of cultural beliefs/values on perception, motivation and coping.

My name is Ojeiu Ejere and I am a research student in the Postgraduate Medical Institute, Faculty of Medical Science at the Anglia Ruskin University.

I am conducting a research on the experience of Nigerian caregivers (healthcare assistants and nurses) of people living with dementia here in the UK and I would like to extend an invitation to you to participate in this research.

If you decide to participate, an interview would be arranged at a time and place that suits you. The interview would last about 1 hour. During this interview, I will ask you questions about your experience of caring for people with dementia being an African and a Nigerian. I would like to know more about your beliefs and perception of dementia and your role as a paid caregiver, what inspired or motivated you to take up your role as a caregiver and how you cope with the role.

I will also collect some personal data from you such as your age, gender and educational background. This information will be kept private and confidential. You will be given a pseudonym (false name) and identifiable information about you will never be used in a presentation or publication. I will not pass on your

details to any organisation or company. This research is purely for academic purposes and is not connected to the government.

This interview will take approximately 1 hour (but this depends on how much you have to say). There are no right or wrong answers. What is important is your opinion on any particular question, but you may choose not to answer any question(s) that you do not feel comfortable answering. There is no compensation for participating in this research. However, your participation will be a valuable addition to the study and the findings could lead to better understanding of the experience of paid caregivers and offer ways they can be supported in their role as caregivers.

Participation in this research is completely voluntary and you may choose to withdraw from the research at any time and you are not obliged to give any reason for your withdrawal and there are no consequences if you do so.

The participant information form and consent form have been attached for your information. If you have any further questions about the research, please do not hesitate to contact me via email at X or on my mobile on X

If you have any further questions regarding your rights as a research participant, you may contact any one of my supervisors

Thank you in advance for your consideration.

Yours sincerely,

Ojeiu Ejere

PhD Student,

Email:

Mobile no:

APPENDIX 6.9: PARTICIPANT CONSENT FORM



IRAS Project ID: 204354

PARTICIPANT CONSENT FORM

Name of participant: _____

Title of the project: The experience of paid Nigerian migrant caregivers of people with dementia.

Main investigator and contact details: Mr. Ojeiu Ejere

Department of Allied and Public Health,

Anglia Ruskin University, Chelmsford

CM1 1SQ

Email:

Mobile:

1. I agree to take part in the above research. I have read the Participant Information Sheet for the study. I understand what my role will be in

this research, and all my questions have been answered to my satisfaction. ☐

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice. ☐

3. I have been informed that the confidentiality of the information I provide will be safeguarded. ☐

4. I am free to ask any questions at any time before and during the study. ☐

5. I have been provided with a copy of this form and the Participant Information Sheet for the study. ☐

6. I agree to the use of an audio recording device to record the interview question. ☐

Data Protection: I agree to the Chief Investigator processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me. ☐

Name of participant

(print).....Signed.....Date.....

Name of Chief Investigator

(print).....Signed.....Date.....

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP AND A COPY WILL
BE KEPT IN THE INVESTIGATOR'S RESEARCH FILE

If you wish to withdraw from the research at any time, please complete the form below and return to the main investigator named above.

Title of Project: The experience of paid Nigerian migrant caregivers of people with dementia.

I WISH TO WITHDRAW FROM THIS STUDY

Name _____ Signed: _____ Date: _____

APPENDIX 6.10: PARTICIPANT INFORMATION SHEET



IRAS Project ID: 204354 PARTICIPANT INFORMATION SHEET

Section A: The Research Project

1. Title of project

The experience of paid Nigerian caregivers of people with dementia.

2. Purpose and value of study

The purpose of this research is to have a robust understanding of Nigerian caregivers' (healthcare assistant, support workers and nurses) experience of caregiving for people with dementia. It will also examine their beliefs and perception of dementia, what motivates them to turn to caregiving and how they cope with the demand of caregiving. An understanding of the experience of Nigerian caregivers of people with dementia will generate knowledge on the role cultural beliefs, perception of dementia/caregiving and motivation plays in shaping their caregiving experiences. It will also examine how they cope with the demand of caregiving.

3. Invitation to participate

I will like to invite you to participate in this study aimed at exploring the experience of paid Nigerian caregivers of people living with dementia. Before you decide whether or not to participate, you need to understand why the research is being done and what will be required of you. This information sheet was provided so you could make an informed decision as to whether or not to participate. Please take time to read the following information carefully. Do feel free to ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

You have been selected because you meet the inclusion criteria for this study and I am confident that the rich insight you will bring to this study will expand our understanding of the cultural uniqueness of the

experience of Nigerian caregivers. It will be interesting to know how your experience of caring for people with dementia is shaped by your cultural perception of the condition. It will also be interesting to have insight into what motivated you to take to paid caregiving and how you cope with the difficulties of the role.

4. Who is organising the research?

The main investigator for this research is Mr. Ojeiu Ejere. He is supervised by Dr Hilary Bungay and Dr Pauline Lane, of the Faculty of Medical Sciences and Faculty of Health, Social Care and Education of the Anglia Ruskin University.

5. What will happen to the results of the study

The results of the study will be analysed and the summary will be made available to any participant who register their willingness to get a copy. The results will also be published. However, be rest assured that confidentiality issues will be strictly applied and the principle of anonymity and use of pseudo names in the reporting will be held to its highest standard.

6. Research funding and compensation for the research

This research is funded by the main investigator and is completely for academic purposes. Hence, participants will not be paid for their participation.

7. Contact for further information

If you require any further information regarding this study or your participation, you may contact investigators Ojeiu Ejere, Dr Hilary Bungay and Dr Pauline Lane on the contact details provided at the end of this document.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Research Ethics and Governance Manager on X or email X

Section B: Your Participation in the Research Project

1. Why you have been invited to take part

You have been chosen to take part in this study because you meet all of the following inclusion and exclusion criteria;

Inclusion criteria

- a. Between 18 and 65 years of age,
- b. You have been in the caregiving role for at three (3) months,
- c. You self-identify as a Nigerian,
- d. You are fluent in the English language.

Exclusion criteria

- a. Caregivers who have not been in the role for up to 3 months.
- b. Caregivers are less than 18 years old.

2. Voluntary Participation

Participation in this study is voluntary. You may refuse to participate or refuse to answer any questions without providing any reason for doing so.

3. Withdrawal from the study

Participation in this study remains voluntary throughout the period of participation. That means you may decide to withdraw from the study at any time with no consequences. All you need to do to withdraw from the study is to complete the accompanying form indicating your desire not to participate.

4. Study Procedures

If you are eligible and willing to participate in the study, you will be required to sign the consent form attached to register your willingness to participate in the study. After this is done, you will be contacted so the date, time and place for your participation can be agreed. The interview may take place at your home if you so desire or we can have it conducted at a suitable room at the Anglia Ruskin University in Chelmsford.

The study is a face-to-face, in-depth interview session of about one hour long in duration, in which questions will centre on your experiences as a caregiver. The interview will be audio-recorded using an audio-recording device. The information you provide is purely for academic purposes and will be destroyed once the transcription has been done. Your identity will remain completely anonymous.

5. Possible risks and harms

Although no physical harm is involved, participants may sometimes become emotional when they speak of personal experience with the role of caregiving for people with the disease. In the event of this happening, the interview will be temporarily suspended until you regain composure. You will also be given information and contact to caregiver support groups who could help with emotional support. The interview may then be rescheduled if you are willing to participate further in the research. Agreement to participate in this research should not compromise your legal rights should something go wrong.

6. Risk assessment

Please be aware that risk assessment has been completed by the main investigator to identify any potential risk whilst undertaking the interview session. This is necessary to make sure all risk are eliminated or greatly minimised.

7. What will happen to any information/data that are collected from you

The information/data collected from the participants will be collated and analysed. The results will later be published and a summary of findings will be sent to the participants (if requested). Confidentiality and anonymity issues will be well respected.

8. Possible benefits from taking part

Although you will not specifically benefit from participating in this study, the study will generate knowledge that could help influence policy on support for Nigerian caregivers in particular and ethnic minority caregivers in general, as targeted coping support will be developed to suit them. It would also improve the understanding of how African cultural beliefs about dementia influences a caregiver's experience of caring for someone with dementia and consequently help improve services to caregivers of Nigerian origin.

9. How your participation in the project will be kept confidential

All data collected will remain confidential and accessible only to the investigators of this study, including personal information (full name, sex, year of birth, and email address). All personal data will be held for between 12-36 months, within which I will submit and defend my PhD thesis. Data collected from this study will be anonymised and stored in the University computer to which access is restricted only to the chief investigator. Audio record of interviews will be kept in securely locked cabinet. They will then be transcribed and destroyed after transcription. After transcription, generated data may be held for up to five years to allow me publish any finding that emerge from the analysis of data. When the results are published, your name will not be used because you will be assigned a pseudonym (false name). If you choose to withdraw

from this study, your data will be removed and destroyed from our records.

10. Publication

If the results of the study are published, your name will not be used. Pseudo names will be used instead. If you would like to receive a copy of the summary of any potential study findings, please contact Ojeiu Ejere.

	Contact details
Principal Investigator:	Mr. Ojeiu Ejere Department of Allied and Public Health, Postgraduate Medical Institute, Faculty of Medical Science, Anglia Ruskin University, Bishop Hall Lane CM1 1SQ Email: Mobile:

Project Supervisors

- (1):** Dr Hilary Bungay
Faculty of Medical Science,
Anglia Ruskin University,
Cambridge/Chelmsford
Email:
Tel:
- (2):** Dr Pauline Lane
Faculty of Health, Social Care and Education,
Anglia Ruskin University,
Cambridge/Chelmsford
Email:
Tel:

This letter is yours to keep for future reference.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

APPENDIX 6.11: RESEARCH PROTOCOL

1

RESEARCH TITLE:

Exploring the experiences of paid Nigerian caregivers of people with dementia:
influence on beliefs on perception, motivation and coping.

Research proposal

Ojeiu J. Ejere, B.Sc., MSc.
PhD Student
Faculty of Health, Social Care and Education,
Anglia Ruskin University,
Chelmsford, Essex, United Kingdom

Research Supervisors:

Dr Hilary Bungay and Dr Pauline Lane

Version No: 1

27/01/2017

BACKGROUND AND RATIONALE

Dementia is a significant health and social care problem which is a main cause of mental and cognitive impairment. It manifests in the form of Alzheimer's disease and other types of dementia (Brookmeyer, Johnson, Ziegler-Graham and Arrighi, 2007). There are about 35.6 million people living with a dementia worldwide (Prince et al., 2013) with approximately 700,000 of these people living in the United Kingdom. This estimate is expected to hit almost 1 million by 2021 (Knapp and Prince, 2007). Dementia affects people of all races and it is common among people who are over 65 years, although early onset dementia can present before this age (Harvey, Skelton-Robinson, Rossor, 2003; McMurtry et al, 2006; All Party Parliamentary Group, 2013). According to the UK Office of National Statistics (ONS), ethnic minorities makes up about 8% of the British population (ONS, 2001) with previous studies showing that the prevalence of dementia in this particular subset of the UK population was considerably higher compared to the indigenous White population (Knapp and Prince, 2007; Adelman et al., 2011).

Along with caregiving for a person with dementia comes the burden on both paid and unpaid caregivers, formal and informal. Although formal caregivers are paid to provide care, it does not in any way extricate the burden associated with caring for someone with dementia (Covinsky et al., 2003). In a care setting, the burden is even exacerbated by the number of people been cared for. Whilst family caregivers providing care for their loved ones suffer caregiving stress, formal caregivers working in for people with dementia have also been shown to suffer from burnout and caregiving stress, despite their care training (Schmidt *et al* 2012; Richardson et al., 2013; Li et al., 2014). Although the number of families affected by dementia is predicted to increase drastically over the next five decades and majority of people with dementia are cared for outside the conventional health care settings, there has been little attention given to paid caregivers who work in care settings and have to provide care to people with dementia, with whom they have no pre-existing filial relationship (Borbasi et al., 2006, Crombie, Boyd and Snell, 2008; Miyamoto, Tachimori and Ito, 2010; Schmidt et al., 2012). Miyamoto, Tachimori and Ito (2010)

Version No: 1

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showed disruptive and challenging behavior of people with dementia was closely linked to higher burden in formal caregivers.

Previous studies (Knight et al., 2000; Janevic and Connell, 2001) showed that both paid and unpaid Black African caregivers of persons with dementia had significantly lower levels of stress and burden in comparison with their white counterpart. Janevic and Connell (2001) observed that Caucasian caregivers tend to report greater depression and appraised caregiving as more stressful than African American caregivers. Although, this differences were described as racially related, the influence of cultural beliefs on a caregiver's overall experience of caregiving is unclear. Furthermore, most studies on caregiving have focused much on family caregivers rather than formal caregivers and very few have examined the influence of cultural beliefs and values on a formal caregiver's caregiving experiences. This study is aimed at understanding the experience of Nigerian migrant caregivers of people with dementia, exploring their beliefs and perception of dementia and dementia caregiving, motivation for caring and overall experience of caring for people living with dementia. The study is guided by the sociocultural stress and coping model (Knight et al., 2000; Knight and Sayegh, 2010) and the self-determination theory (Deci and Ryan, 1985, 2002). It will also generate knowledge on the motivation for caring and experience with coping with caregiving.

RESEARCH QUESTION

This study will attempt to answer the following research questions:

- ❖ What common cultural beliefs about dementia are held by Nigerian migrant caregivers?
- ❖ How do the identified cultural beliefs influence a caregiver's perception of dementia and dementia caregiving?
- ❖ What motivates Nigerian migrant caregivers to assume and remain in the role of being paid dementia caregivers?
- ❖ Does a caregivers' cultural beliefs and values shapes her/his overall experience of dementia caregiving?

- ❖ How well do Nigerian migrant caregivers embrace and adapt to the stress and strain associated with dementia caregiving and what coping strategies do they employ?
- ❖ Does the cultural belief of Nigerian migrant caregivers aid or inhibit their ability to cope with dementia caregiving?

AIM AND OBJECTIVES

The main aim of this study is to explore the lived experiences of paid Nigerian migrant caregivers of people with dementia in the UK.

To achieve this, other sub-objectives of the proposed study include to;

- ❖ Identify common cultural beliefs about dementia are held by Nigerian migrant caregivers?
- ❖ Examine how the identified cultural beliefs influence a caregiver's perception of dementia and dementia caregiving?
- ❖ Identify what motivates Nigerian migrant caregivers to assume and remain in the role of being paid dementia caregivers?
- ❖ Investigate how a caregivers' cultural beliefs and values shapes her/his overall experience of dementia caregiving.
- ❖ Understand how Nigerian migrant caregivers embrace and adapt to the stress and strain associated with dementia caregiving and what coping strategies do they employ.
- ❖ Identify how the cultural belief of Nigerian migrant caregivers aid or inhibit their ability to cope with dementia caregiving.

STUDY DESIGN AND METHODS

Research methodology and data collection

This is a qualitative study which informed by the use the phenomenological approach to explore the lived experience of Nigerian migrant caregivers of people with dementia (Dowling, 2007). Data will be collected through the use of face-to-face, in-depth interview (Dicicco-Bloom and Crabtree, 2006). The study consist of two phases, a pilot phase and the main study phase. Three (3) participants will be involved in the pilot study phase while ten (10) participants will be involved in the main study (Teijlingen van et al., 2001). Data collection for both the pilot and main study will be

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through the use of in-depth interviews. The average number of participant required for a phenomenological study of this nature is 25 and the minimum is between 6 and 10 (Mason, 2010).

The interviews will be conducted in a place agreed by a participant and the researcher such as their homes or a suitable room in Anglia Ruskin University for participants close to the University. Interview sessions will be recorded using an audio recording device and will be transcribed verbatim prior to analysis.

The Study Setting

Paid Nigerian migrant caregivers will be selected from two (2) wards in an NHS Trust in Essex and four (4) selected churches in Essex.

Participants

Paid caregivers (Registered Nurses, Health Care Assistant, Care Workers or Support Worker) who are currently into caregiving will be recruited for the study. They must also be able to provide a written informed consent to take part in the study. Eligible participants must meet all criteria for inclusion in the study. The criteria includes;

- ❖ Age: should be between the ages of 18 and 65
- ❖ Duration of caregiving: should have been in the caregiving role for at least 3 months.
- ❖ Ethnic group: Nigerian migrant caregivers of people with dementia in a formal care setting.
- ❖ Language proficiency: Participants must also fluent in the English language and be willing and able to provide a written informed consent to take part in the study.

Criteria for exclusion

- ❖ Young caregivers who are under 18 years old.
- ❖ Caregivers who have not spent up to three months in paid caregiving.

Sampling methods

Participants will be recruited using a combination of purposeful sampling and the snowballing technique. They will be recruited from these different settings;

- (a) Two wards (2) in an NHS Trust in Essex, who specialises in dementia care for the elderly
- (b) Four (4) local churches in Chelmsford, with a sizable number of Nigerians.
- (c) Snow-balling

Data Analysis

Transcripts of the interviews will be analysed using interpretative phenomenological analysis (Smith, 2004; Smith and Osborn, 2008). This present a structured guide to enable the researcher to analyse the data and interpret the participants' experience (Smith, Flowers and Larkin, 2009). Prior to data analysis, data will be initially processed using the software NVivo (Webb, 2003).

ETHICAL CONSIDERATION

Ethics Stage 1 and Ethics Stage 2 application for the proposed study has been obtained from the Faculty Research Ethics Panel (FREP) of the Faculty of Medical Science of Anglia Ruskin University. An amendment is in progress. Ethical approval has also been obtained from the Health Research Authority for the NHS R&D ethics approval for the two wards in the NHS Trust. An amendment to the approval by HRA is now in progress.

Letters of invitation to participate in the study will be sent out interested participants, along with the participant information sheet. Individual participants will be asked to sign the participant consent form before the commencement of the study. Leaflets explaining the study's aim and nature of the study will be made available to all potential participants for purposes of advertising the study.

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APPENDIX 6.12: RESEARCHER'S CURRICULUM VITAE

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APPENDIX 6.13: POSTER PRESENTATION AT THE 2016 FACULTY OF MEDICAL SCIENCE INTERDISCIPLINARY STUDENT CONFERENCE



FMS Interdisciplinary Student Conference 23rd May 2016

Title: Experiences of paid Black African caregivers of people with dementia

Name: Ojeiu Ejere (ojeiu.ejere@pgr.anglia.ac.uk)

Background/Aim

Working as a professional caregiver for people with dementia (PwD) can be demanding despite being paid to do so (Miyamoto, Tachimori and Ito, 2010). Although cultural difference in caregiving experiences has been shown among family caregivers who are mostly White, the influence of cultural beliefs on ethnic minority formal caregivers' experience is yet to be shown (Janevic and Connell, 2001; Knight ET AL., 2000; Miyamoto, Tachimori and Ito, 2010).

This study aims to explore the experience of paid Black African caregivers of people with dementia as well as understand their motivations and how they cope with caregiving demands.

Method

This qualitative study will adopt a phenomenological approach to study the experience of paid Black African caregivers of people with dementia (Dicicco-Bloom and Crabtree, 2006).

The study will be in two phases.

- ❖ Phase 1 - will be a pilot study of a semi-structured interview of 3-5 study participants to test the interview guide developed for the main study.
- ❖ Phase 2 - will involve a face-to-face, semi-structured interviews with 15-25 participants.

Data will be analysed using interpretative phenomenological analysis (IPA).

Results

This study will present rich qualitative data on the experience of paid Black African caregivers, providing insight into their beliefs and perception of dementia as well as what motivates them to assume and remain in their caregiving roles.

It is hoped that data on the common coping strategies employed by paid Black African will be generated in this study.



Proposed conceptual framework for understanding a Black caregiver's experience.

Conclusion

It is hoped that this study will add to the body of knowledge on dementia caregiving, particularly addressing the gap in literature on what motivates people to take up paid caregiving. It will also provide evidence on the effects cultural beliefs has on a Black African caregiver's caregiving experience.

Understanding this will offer a clear basis for the targeting of coping interventions that can help address any stress they may be experiencing in their role as caregivers.

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**APPENDIX 6.14: ABSTRACT AT THE 2017 ANGLIA RUSKIN ANNUAL
RESEARCH STUDENT CONFERENCE**

**ANGLIA RUSKIN UNIVERSITY
ABSTRACT
FACULTY OF MEDICAL SCIENCE
DOCTOR OF PHILOSOPHY**

**EXPERIENCES OF PAID NIGERIAN CAREGIVERS OF PEOPLE WITH
DEMENTIA**

**OJEIU EJERE
(Post Confirmation of Candidature)
July 2017**

Working as a professional caregiver for people with dementia (PWD) can be heavily demanding (emotionally, physically and psychologically) for some while others may find it rewarding. Although cultural difference in caregiving experiences has been shown among family caregivers who are mostly White, there is dearth in research on the experience of ethnic minority paid caregivers' experience and the potential influence of cultural beliefs. This study aims to explore the experience of paid Nigerian caregivers of PWD to understand their motivations and how they cope with caregiving demands.

Interpretive phenomenological analysis will be used to analyse data collected in a pilot interview of three (3) paid Nigerian caregivers currently working with PWD (Phase 1) followed by in-depth interview with another ten (10) paid Nigerian caregivers currently working with PWD (Phase 2).

This study will present rich qualitative data on the experience of paid Nigerian caregivers, providing insight into their journey into care, beliefs and perception of dementia as well as what motivates them to assume and remain in their caregiving roles. It is anticipated that data on the common coping strategies employed by paid Nigerian will be generated in this study. Understanding this will offer a clear basis for the use of targeted coping interventions that can help address any stress they may be experiencing in their role as caregivers.

Key words: paid caregiving, caregivers, dementia, Nigerian, cultural influence, phenomenology.

**APPENDIX 6.15: ORAL PRESENTATION ABSTRACT AT THE 2018 ANGLIA
RUSKIN UNIVERSITY ANNUAL RESEARCH STUDENT CONFERENCE**

**ANGLIA RUSKIN UNIVERSITY
ABSTRACT
FACULTY OF MEDICAL SCIENCE
DOCTOR OF PHILOSOPHY
MOTIVATION OF PAID NIGERIAN MIGRANT CAREGIVERS OF PEOPLE WITH
DEMENTIA**

**OJEIU EJERE
(Writing-Up Stage)
July 2018**

Previous studies on caregiving motivation for people with dementia focused largely on family caregivers, with scant literature on what motivates professional caregivers to care for people with dementia and even less on the motivation of paid migrant caregivers (care workers and nurses). Although they are paid to care, their experience of caregiving may be influenced by their motivation to assume or remain in the role. The aim of the study was to explore the motivation of paid Nigerian migrant caregivers to assume and remain in caring for people with dementia.

I collected data from 21 paid Nigerian migrant caregivers using in-depth interviews which were transcribed verbatim and analysed using interpretive phenomenology informed by Van Manen to explore the lived experience of the caregivers.

Findings indicate that paid Nigerian migrant caregivers are motivated by a combination of intrinsic and extrinsic factors. Participants who had a nursing qualification before migrating to the UK considered their caregiving roles as a way to keep in touch with nursing practices whilst studying. However, some of the participants who had no training as nurses are motivated to care out of the necessity to fulfil financial obligations, whilst others were motivated to care because of the passion they had for caregiving. Most participants found the caregiving role both challenging and altruistically rewarding regardless of their caregiving motivations but caregivers with extrinsic motivation had more negative perception of their caregiving experience.

Key words: paid caregiving, dementia, Nigerian caregivers, phenomenology, motivation.

**APPENDIX 7.1: SAMPLE FORM USED TO EXTRACT PARTICIPANT'S
SELF-REPORTED DATA AS OBTAINED FROM THE INTERVIEW**

Participant's Name	
Chosen pseudonym	
Gender	
Age	
Educational qualification prior to migration	
Educational qualification at the time of interview	
Place of birth	
Place of residence in Nigeria	
Place of origin in Nigeria	
Main motivation for coming to the UK	
Time spent in main job before coming to the UK	
Time spent working as a care worker in the UK	