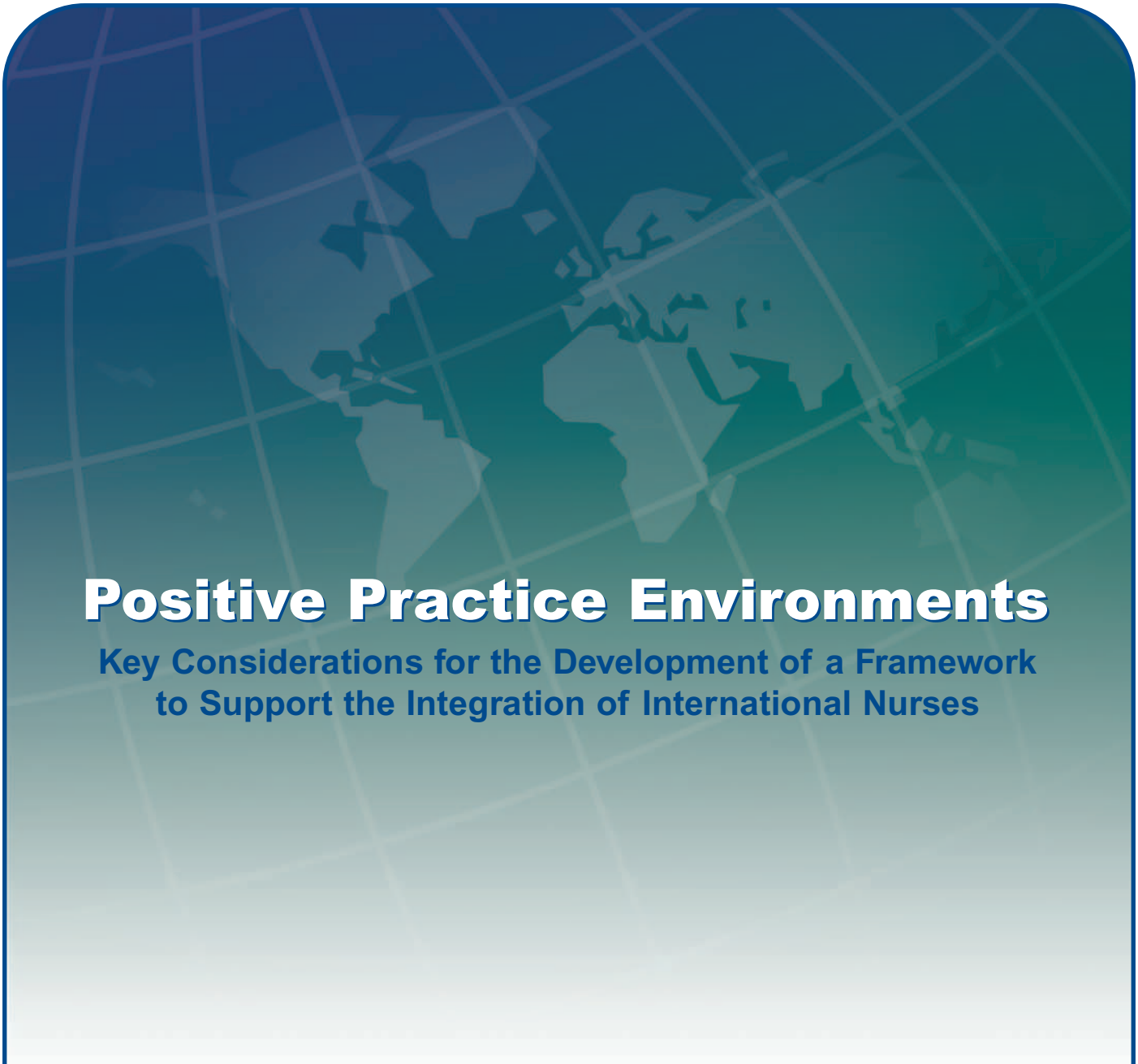

Positive Practice Environments

Key Considerations for the Development of a Framework to Support the Integration of International Nurses

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Commissioned by:

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COMMISSION ON GRADUATES OF FOREIGN NURSING SCHOOLS

International Council of Nurses

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Elizabeth Adams is currently on leave from her position as Principal Nursing Officer with the Office of the Chief Nursing Officer, Department of Health, Western Australia. In her time at the Department, she helped drive the strategic direction of nursing and midwifery during a significant health reform period. With the Chief Nursing Officer, she was instrumental in establishing the nurse practitioner role in Western Australia. She was the first student awarded a Master's degree in Science through Research from the School of Nursing and Midwifery, University of Dublin Trinity College. Previously she worked in the Department of Health and Children in Ireland as a Nurse Research Officer on a national *Study of Nursing and Midwifery Resource*. Prior to this, she gained extensive clinical and management experience over a 17-year period in the Mater Misericordiae University Hospital, Dublin, Ireland.

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In Ireland, Annette works with a variety of national organisations, including the Department of Health and Children, Nursing Policy Divisions, Irish Nursing Regulatory Body and a host of other voluntary and statutory bodies in relation to nursing and midwifery policy.

Annette is continually involved in workforce planning at National, European and International levels aimed at addressing the continent-wide shortage of nurses. She is an active participant in International Council of Nurses (ICN) programmes and a member of the ICN Credentialing Forum, ANCC International Advisory Committee, European Forum of Nursing Midwifery Associations and the World Health Organization (WHO), as well as the Workgroup of European Nurse Researchers. In 2004, she was selected as a member of Rho Chi Chapter, Sigma Theta Tau International, Honor Society of Nursing.

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The authors alone are responsible for the contents of the report and conclusions.

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Executive Summary

This paper focuses on nurses who have migrated and are registered/licensed/authorised to practice, post-adaptation/orientation, and are working as a nurse in a given country. The term international nurse is used for nurses who have been educated abroad and have either been recruited or have chosen to migrate. This paper aims to provide an overview of the influences of international policies and agreements, the social and personal benefits and costs of migration for international nurses based on their experiences, and to outline a possible framework to develop positive practice environments to support long-term integration and the retention of this valuable resource.

Over the past decades, multifaceted demographic, economic, political and social transformations have had a significant impact on the patterns and dynamics of migration and the movement of international nurses across the globe. Health systems throughout the world have been under mounting pressure to balance increasing service demands within the resources available while ensuring patient safety and quality of care. Governments and health services have developed policies, made structural and resource adjustments, and actively recruited from other countries to meet the workforce shortage. Migration is a transnational process, and inter-State cooperation is essential. In varying degrees, many sending and receiving countries are developing their regulatory capacities to manage international nurse mobility by taking into consideration the interests of respective governments, societies and the individual nurse.

The impact of migration on health systems, and quality and safety for patients and the nursing profession, has both positive and negative consequences and therefore cannot be underestimated. International nurses are now a feature in every country in the world, creating profound ethical, social, economic and health implications. Nurse migration is a multifaceted and intricate social phenomenon (Kingma 2006), which can have both positive and negative benefits for international nurses. There are many reasons why nurses migrate: to achieve a better quality of life, engage in professional development, attain additional skills and education, secure a better income, meet family responsibilities such as providing for children, or to enjoy the enrichment of becoming a member of a transnational community. However, numerous sacrifices have to be made, including moving from family, friends and community and often having to leave children and partners behind to become a stranger in a new country. Governments and employers are criticised for actively recruiting international nurses before addressing the underlying problems of recruitment and retention amongst their existing pool of nurses. It has been suggested that all countries should endeavour to attain self-sufficiency in producing their workforce and strive to retain the current workforce to reduce chronic dependency on international recruitment (International Council of Nurses 2001; Global Equity Initiative, Harvard University 2004).

Experiences of international nurses are explored in this paper. It is apparent that many international nurses, even those who migrate to a country with a similar culture and language, face many challenges, such as adapting to a new environment and dealing with a sense of belonging and strangeness. However, there is a significant amount of evidence demonstrating that international nurses are exposed to abuse, exploitation, discrimination and marginalisation from their colleagues, patients, the wider community and other

international nurses. The body of primarily qualitative research identifies numerous barriers that influence the integration of international nurses, including: language and communication difficulties; lack of access to appropriate information; lack of value and issues with de-skilling; lack of education and professional development opportunities; lack of promotional opportunities; lack of culturally sensitive services in relation to religious and cultural needs; institutional racism; different health belief systems and procedures; negative attitudes of some health staff and patients; fears about entitlements and security of employment contracts; social cost; and lack of family and community support.

There are two distinct concepts that need to be addressed to ensure the development of positive practice environments. First, there are many individual challenges that need to be identified in order to support the international nurse through the diverse range of difficulties including psychological, social, environmental, professional and personal issues that change over time. Secondly, the unacceptable and illegal abuse, exploitation, discrimination and marginalisation of international nurses must be proactively addressed and eradicated. In a profession that advocates equality, fairness, tolerance and respect for individual rights, it is inconceivable that prejudice and discrimination is tolerated in the caring environment. The fundamental framework required to ensure positive practice environments is based upon treating everyone fairly with respect and dignity.

The literature clearly identifies that integration is a process that spans over many years. Some international nurses have reported it taking up to 10 years in order to feel fully integrated into their host country and working environment. The success of integrating international nurses will depend partly on their capacity to face challenges in their social and work environment. However, the many achievements of international nurses will depend on the approaches taken by employers to manage the process of integration over time.

There are many positive practice initiatives developed for the integration of international nurses globally. Many of these practices have been influenced by equality legislation, mutual agreements, ethical recruitment practices, educational standards and the proactive work of numerous national nursing associations. Employers have also developed good employment practices with comprehensive orientation programmes, language preparation, mentoring, educational support and career progression. Cultural awareness programmes both for the “home nurses” and the international nurses are the norm; however, these initiatives in some instances appear to take place ad hoc and in isolation with little reference to national standards. The information regarding these initiatives is mostly anecdotal and documented evidence with which to detail examples or evaluate their outcome is minimal.

Building positive practice environments will assist the integration of international nurses, support nurses in the host environments and contribute to creating a dynamic team by valuing and using the skills and abilities of all nurses. The enriched cultural backgrounds of nurses will help in providing culturally competent care for diverse patient groups and delivering safe, effective and efficient nursing care to ensure optimal outcomes for patients.

This paper is divided into two parts. **Part One** outlines key considerations to developing positive practice environments that influence long-term integration of international nurses. The focus is on issues such as: globalisation and international influences; migration; labour market and nursing shortages; immigration and society; diversity; cultural

competency; and the experiences of international nurses. The main considerations for each topic are summarised at the end of each section and are intended to assist key stakeholders.

Section One: Globalisation and International Influences
Human rights standards, legislation, regulation and national and international agreements must underpin all policies and practice in the working environment. In addition, they must be implemented to the highest possible standard and evaluated to ensure compliance and effectiveness.

Section Two: Migration
Migration patterns are liable to change, therefore, positive practice environments need to be continually assessed and evaluated to ensure they achieve and maintain the objectives and targets. Identifying motivations for migration will inform and highlight issues that need to be addressed to ensure long-term integration.

Section Three: Labour Market and Nursing Shortages
Proactively addressing the underlying problems of recruitment and retention amongst existing staff will ensure a more stable workforce for the future. Managing retention to assist long-term integration of international nurses will reduce turnover and ensure high quality nursing care. Observing the demographic changes and long-term trends for the future planning of services and developing the workforce to meet patient needs and service demands is essential.

Section Four: Immigration and Society
International nurses not only need to be incorporated into the workforce and health care environment, they must be integrated into society. Developing partnerships with consumer groups, professional organisations, special interest groups, communities and local services to build relationships and social structures in order to integrate international nurses is suggested. A zero tolerance to racism from colleagues, patients and society is required.

Section Five: Characteristics of Diversity
There is a legal and moral responsibility to implement, monitor and evaluate diversity legislation. Leadership in accommodating and valuing diversity is required throughout the environment and at all levels within the organisational structure. It is essential to promote awareness of all employees in regard to their individual responsibility to ensure diversity legislation and policies are adhered to.

Section Six: Patient Care and Cultural Competency
Human rights legislation must be incorporated into the organisational philosophy, policies, strategies and procedures. Ensuring competencies and skills of international nurses are valued and maintained will benefit health care delivery and long-term retention. Adapting to culturally diverse patients requires education and training for all health professionals. Working toward mainstreaming health services in order to ensure physical, mental and social well-being of all individuals from minority groups is recommended.

Section Seven: Experiences of International Nurses in Employment
Adapting to cultural values is a dynamic process that is part of the experience of the individual, and those values change over time. Ensuring ethical employment policies are in use and continue to be administered fairly to all nurses is a priority. Providing support in

adjusting to variations in care systems, language competency, knowledge of medications and proficiency in technology will support integration. Policies to manage integration should take into consideration the social costs of migration.

Part Two focuses on supporting and developing positive practice environments for international nurses, including strategic approaches to long-term integration and retention.

Section One: Strategic Approaches to Long-Term Integration and Retention
The empirical evidence identifies areas that need to be considered at international, national, regional and local levels to support the retention and long-term integration of all nurses, including policy development and implementation, effective management approaches, professional practice investment, adequate staffing and organisational support. As outlined, there are many examples of progressive employment policies, such as the Magnet hospitals, equality legislation, collective bargaining agreements and partnership approaches to human resources management, which improve retention and recruitment.

Section Two: Key Challenges and Success Factors
Equality of opportunity goes beyond a focus on legislation compliance to a focus on difference and the accommodation of difference to achieve equality outcomes. A positive practice environment with an equality agenda covering both human resources and patient service functions poses real challenges and opportunities for employers. Education and training should only be one initiative in a multi-faceted strategy of an overall equal opportunities and diversity programme. Equality and diversity education and training, combined with equality policies, are the foundation on which to build workplaces characterised by equality. Policies establish strategy, infrastructure, organisational climate, sanctions/rewards and commitment. Education and training establish capacity to implement the policies.

Section Three: Developing Intercultural Workplaces and Best Practice
International nurses make a considerable contribution through their commitment and enthusiasm to working within health systems and providing high quality care to patients throughout the world. Therefore, governments, key stakeholders and employers must commit to supporting health services that are investing in education and training development, developing positive practice environments and effective human resources management, tackling discrimination and harassment, improving diversity, and enhancing the working lives of health care professionals in a way that directly contributes to better patient care.

The development of positive practice environments will deliver benefits to patients, individual nurses, health care teams and health services and, ultimately, the delivery of quality health care.

Introduction

Health systems throughout the world have been under significant pressure in recent years to balance increasing service demands within the resources available. While aspiring to deliver high performing health systems, most Western democracies are confronted by an ageing and growing population, widening gaps in health status, escalating demands on hospital care, increasing cost of technology and projected workforce shortages (OECD 2004).

In response to such increased demands and workforce shortages, many countries have resorted to international recruitment of health care professionals. International migration of health care professionals is a significant component of globalised labour markets. The impact is multifaceted and the issues for both the health care professionals and the countries involved are complex. The International Labour Office (ILO) highlights the fact that governments and employers rely heavily on international recruitment, rather than addressing the underlying problems of recruitment and retention amongst the existing health sector workforce, and are failing to sufficiently address issues with workforce planning (ILO 2003). A report by the Global Equity Initiative, Harvard University (2004) emphasises that all countries should endeavour to attain self-sufficiency in producing their workforce and strive to retain the current workforce to reduce chronic dependency on international recruitment.

This paper focuses on nurses who have migrated and are registered/licensed/authorised to practice as a nurse, post-adaptation/orientation, and are working in a given country. The term international nurse is used for nurses who have been educated abroad and have either been recruited or have chosen to migrate. This paper aims to provide an overview of international policies and agreements, and the social and personal benefits and costs of migration for international nurses based on their experiences. It also outlines a possible framework to develop positive practice environments to support long-term integration and the retention of this valuable resource.

International recruitment of health professionals has been associated with the term “brain drain”, which is the exodus of health care workers from developing nations to wealthier countries. A report by Physicians for Human Rights (2004) states that brain drain is largely a symptom of other health system deficits. The causes of brain drain are complex and interrelated, involving political, economic and social factors. While promoting the right of free movement, policies must protect the health of vulnerable populations (Global Equity Initiative, Harvard University 2004). According to Kingma (2001), there is a fine balance between the right of nurses to migrate and a collective concern for the health of a population. National and international nursing bodies over the years, working in partnership with governments, have strived to develop and implement ethical recruitment strategies. However, the motivation, benefits and human cost of international nursing recruitment continue to be widely debated. The International Organization for Migration (2005) recommends approaches such as a new transnational model of skills sharing and an emphasis by both sending and receiving countries on return and circulation of skills.

Internationally, cultural diversity is a major issue in health care. Because of demographic changes, health care employers can no longer cater to a single homogenous workforce or

service user. This presents a major challenge for the nursing profession working in culturally diverse teams to provide culturally congruent care for all patients (Wilson 2004). There is considerable discordance between nursing as a caring profession and inconsistencies in acknowledging and managing issues to promote cultural diversity in the profession. The review of the literature reveals that the nursing profession is struggling with how best to provide culturally competent care to diverse populations, increase representation and accept nurses from culturally diverse backgrounds, and educate nurses in the skills required for culturally competent practice (Gonzales et al. 2000). In a profession that advocates equality, fairness, tolerance and respect for individual rights, it can be difficult to acknowledge that prejudice and discrimination exist and, therefore, addressing the issues is often difficult. Crafting equitable policies and practices, including implementation of long-term integration approaches with evaluation, is a shared responsibility of all individuals.

This paper is divided into two parts. Part One outlines key considerations to developing positive practice environments that influence long-term integration of international nurses. The focus is on issues such as: globalisation and international influences; migration; labour market and nursing shortages; immigration and society; diversity; cultural competency; and the experiences of international nurses. The main considerations for each topic are summarised at the end of each section.

Part Two focuses on supporting and developing positive practice environments for international nurses, including strategic approaches to long-term integration and retention, key challenges and success factors, and developing intercultural workplaces and best practice.

Part One:

Key Considerations for Developing Positive Practice Environments for International Nurses

Section One: Globalisation and International Influences

Globalisation has led to increasing mobility of the workforce and greater interdependency of the labour markets throughout the world. The labour market for nurses consists of local nursing markets within countries, regional markets consisting of countries within geographical regions, and the world market. A number of significant trade agreements have impacted on the globalisation of the labour market:

- Asia-Pacific Economic Cooperation (APEC), comprises 21 countries;
- European Union (EU), comprises 25 countries;
- North America Free Trade Agreement (NAFTA) includes Canada, Mexico and the United States of America (USA).

Trade agreements encourage free movement of professionals such as nurses; however, barriers are formed by various educational and licensing systems in individual countries. These systems are generally in existence to regulate the nursing profession in order to protect the public against unsafe nursing practices. There are a number of models of regulation throughout the world. One approach is a body with statutory responsibilities that may incorporate competencies for nursing roles with education and regulation in order to register, license or authorise a nurse to practise and deliver safe and competent nursing care (Bryant 2005). In addition, trade agreements in recent years have included professional regulation known as “mutual recognition agreements”. One example of this is the Trans-Tasman Mutual Recognition Agreement between the Government of Australia and the Government of New Zealand.

International human rights conventions, other international human rights standards, legislation and regulation provide an important benchmark from which to inform existing standards of policy and create new policy related to safeguarding migrant workers and their families. Industrial countries have a relatively comprehensive range of laws and regulations governing all aspects of working life. These are being developed in parallel with minimum standards emanating from the European Union and the ILO. Equality legislation prohibits discrimination by employers against workers on a number of grounds including race. The International Confederation of Free Trade Unions (ICFTU) identifies three international instruments that specifically protect international nurses. These instruments are outlined in Table 1. While critical, they should not be considered a “magic formula” as the largest labour-receiving countries have not ratified the convention and cannot be forced to do so. Furthermore, some of the countries supplying the labour have also been reluctant to sign these conventions, failing to agree on the labour rights they would want upheld, and reluctant to become less competitive in the international labour market (Kingma 2006).

Table 1 – Instruments for the protection of international nurses

International Labour Office – Convention 97 on migrant workers (revised) of 1949	• International nurses legally residing in a country must receive equal treatment to nationals of the country. • Aims to eliminate any inequalities that might arise from government measures. • Advocates cooperation between that country of origin and the destination country.
International Labour Office – Convention 143 – The Migrant Workers (Supplementary Provision) convention of 1995	• Advocates equal treatment and equal opportunities for international nurses. • Extends provisions to cover migrant workers residing in illegal circumstances and those who have suffered abuse. • Respect for fundamental rights. • Sanctions against unscrupulous employers.
The United Nations Convention on protection of the rights of migrant workers and the members of their families (1990)	• Respect for fundamental rights for all. • Regardless of legal status, migrants to receive equal treatment to nationals in destination country. • Legal residents are ensured freedom of movement and equal treatment regarding access to education, training facilities and social services. • Measures to combat illegal migration and sanctions against unscrupulous employers.

Source: Renaut A (2004). Trade union support on arrival and departure*. Trade Union World – Briefing*. No 3. International Confederation of Free Trade Unions.

The General Agreement on Trade in Services (GATS) has a fundamental role for the trade of services. The multilateral system has a number of objectives including liberalising trade in services, encouraging economic growth and development, and increasing the participation of developing countries in world trade. For nursing, one of the concerns relating to GATS is the potential restriction or replacement of government and regulatory nursing structures that ensure quality health care. One example of the possible outcome of GATS on nursing is the standardisation of nursing qualifications throughout the world. It is conceivable that a standardised approach may lead to lowering nursing competency levels to meet the minimum standards to incorporate the widest possible range of countries (Kingma 2006).

Bilateral and multilateral agreements are a common approach used to regulate labour migration between countries. The agreements formalise each country's commitment to ensure migration occurs in line with agreed principles and procedures. However, the International Organisation for Migration (2004) states those agreements are difficult to complete due to "lack of interest of some receiving countries and fear of sending countries that by setting too high a standard of protection, their nationals will be less competitive on the international labour market".

There are numerous European Directives, Regulations and Recommendations that regulate employment across member states. European employment legislation falls under three broad headings: equality, health and safety, and working conditions. International

nurses are protected by both European and an individual country's employment law. The European Directives set minimum standards for the recruitment and employment of individuals, which must be incorporated into the domestic legislation of each individual member country. Therefore, domestic legislation across countries can vary from minimum to maximum standards. The Directives most relevant to the recruitment and employment of nurses are outlined in Table 2.

Table 2 – European Directives relevant to nursing recruitment and employment

- Directive No. 75/117/EEC applying the principle of equal pay between men and women.
- Directive No. 76/207/EEC implementing the principle of equal treatment for men and women in regards to access to employment, vocational training and promotion and working conditions.
- Directive No. 92/131/EEC encouraging improvements in the health and safety at work of pregnant workers and workers who have recently given birth or are breastfeeding.
- Directive No. 93/104/EEC on working time.
- Directive No. 96/34/EC on parental leave.
- Directive No. 97/81/EC regulating the employment conditions of part-time workers by preventing discrimination and improving the quality of part-time work.
- Directive No. 99/70/EC improving the quality of fixed-term work by forbidding discrimination and the abuse of successive fixed-term contracts.
- Directive No. 2000/43/EC laying down a framework for combating discrimination on the grounds of racial or ethnic origin.
- Directive No. 2000/78/EC establishing a general framework for equal treatment in employment and occupation to combat discrimination on grounds of religion or belief, disability, age or sexual orientation.

Source: Standing Committee of Nurses of the European Union (PCN). *PCN Good Practice Guidance for International Nurse Recruitment* [Online]. Available from: www.rcn.org.uk/downloads/press/PCN.doc [Accessed 8 December 2005] (additional information europa.eu.int/eur-lex).

Although all European Union citizens have free mobility, individual countries may require nurses to undertake tests to bridge national differences in laws, ethics and language, and embark on adaptation programmes prior to employment (Buchan 2002). Countries vary in their compliance to European Commission Directives and there is limited information on cross-border transferability of professional credentials (PCN 2005). The Organisation for Economic Co-operation and Development (2002) has identified that there is very little mobility in the European Union due to language being a major barrier between countries.

The European Commission has established an Anti-Discrimination Unit of the Directorate-General Employment and Social Affairs that focuses on all aspects to combat discrimination including legislation. The Unit publishes numerous resources including national information flyers for each of the 25 EU member states (see Appendix One). Legislation, such as the *Racial Equality Directive* and the *Employment Equality Directive,* introduced by the European Community in 2000 has afforded European Union citizens a common minimum level of protection against discrimination. The legislation represents Europe's response to combating the threat that discrimination poses to the economic and social cohesion of the Union, and has its basis in Article 13 of the 1997 Treaty of Amsterdam. This Article finally conferred to the European Community the powers to take measures to fight discrimination on grounds of sex, race/ethnic origin, religion/belief, disability, age and sexual orientation. A strategy framework, *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions Non-discrimination and Equal Opportunities*

for All - a Framework Strategy (2005), has been developed in consultation with member states to tackle discrimination and promote equality beyond the legal protection of people's rights to equal treatment.

The key considerations outlined in the each summary box in Part One, Sections One to Seven, are intended to assist key stakeholders such as policy makers, international and national organisations, employers, managers and employees to deliberate and incorporate the elements identified in relation to globalisation and international influences into their context and environment as appropriate. It is recommended that the key considerations are employed to support the development of positive practice environments at international, national, organisational and local level.

Summary: Globalisation and International Influences **Key considerations for developing positive practice environments for international nurses**
• Assess the impact of various national and international agreements on international nurses in your employment.
• Agreements generally establish minimum standards. To achieve successful outcomes, aim for the optimal standards.
• Know the responsibilities and honour obligations toward international nurses under the agreements.
• Ensure all employees and international nurses know the compliance requirements under the agreements.
• In the absence of agreements, adopt best practice and innovative approaches as benchmarks to develop positive practice environments.
• Incorporate national and international human rights standards, legislation and regulation into existing and future policies.
• Proactively assess national and international developments and build strategies to adapt for future changes.
• Consider how globalisation may continue to develop and influence the nursing profession.

Section Two: Migration

Migration is the "movement of a person or group of persons from one geographical unit to another, across an administrative or political border, to settle definitively or temporarily in a place…. Migration often does not occur directly between these two places but involves one or several places of transit. Various types and practices of migration include orderly migration, return migration, forced migration, irregular migration, smuggling, and trafficking" (adapted from *IOM World Migration Report*, IOM, Geneva 2003).

Labour migration systems developed by countries can be broadly categorised as demand or supply driven. In demand-driven systems, employers actively seek to recruit international nurses. In supply-driven systems, the individual nurse seeks to migrate (IOM 2005b). Opportunities for health care professionals to migrate are being facilitated by the growth of free trade blocks supported by the General Agreement on Trade in Services (OECD 2002). An international migrant worker is defined by the *United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* as "a person who is to be engaged, is engaged or has been engaged in remunerated activity in a State of which he or she is not a national" (United Nations 1990).

Some of the forces that influence migration are political, social, economic, legal, historical, cultural and educational (Kline 2003). The literature refers to these forces as "push" and "pull" factors. Push factors pertain to the donor countries and pull factors are generally associated with the receiving countries. To sustain migration, both the push and pull factors and the absence of restrictions such as legal constraints must be apparent (Buchan et al. 2005). According to Kingma (2006), the push factors are generally more likely to motivate international nurses to migrate as the majority of individuals find it difficult to leave families, friends and communities.

An international migration and mobility study by the International Council of Nurses (ICN), the Royal College of Nursing United Kingdom (RCN) and the World Health Organization (WHO), entitled the *International Nurse Mobility: Trends and Policy Implications,* provides empirical evidence of migration from an international perspective. The study reveals that, although there are push and pull factors stimulating mobility, the fundamental issues motivating nurses to migrate have not been addressed including poor pay, excessive workloads and violence in the workplace. In addition, developing countries have failed to build up their own workforce in sufficient numbers. In addition, "cyclical shortages and occasional surpluses tend to provoke short-term reactions" and often lead to driving the dynamics of aggressive and sometimes exploitive, international recruitment (The European Observatory on Health System and Policies 2006: 236). The globalisation of health labour markets in recent years has seen a shift from migration due to historical links and cultural ties to migration based on economic requirements. The ILO (2003) identified that migrants without historical links to the destination country may be more vulnerable to employment abuse and xenophobic attitudes.

Countries that in the past were fairly immune to the migration of nurses are being drawn into an increasingly integrated global labour market in which nurse migration is a significant component of human resource planning. In many developed countries,

addressing the demographic dilemmas of nursing and an ageing population and workforce has led to two broad strategies: improving retention and broadening the recruitment base through international recruitment. While ICN supports the rights of nurses to migrate, it clearly articulates that the active, aggressive recruitment of nurses may harm both donor and recipient countries (ICN 2002).

ICN (2002) outlines advantages and disadvantages to migration and making a career move. Migration can enable a nurse to achieve personal career goals, contribute to the nursing profession and raise competency standards. Career moves also provide opportunities for:

- "professional development;
- career development and advancement;
- improved quality of life;
- greater job satisfaction;
- recognition of professional expertise;
- higher self-esteem;
- wider sphere of influence;
- relevant learning opportunities; and/or
- multidisciplinary approaches".

These positive experiences can increase job satisfaction, foster commitment, improve confidence, and promote pride – all of which influence retention and excellence in nursing practice. However, there are a number of disadvantages that can occur due to recruitment abuses leading to a decreased income, lower professional status and threatened personal safety (ICN 2002).

The Public Services International (PSI) research on health care workers found that the vast majority of nurses would prefer to work in their home countries if they could earn a living wage. In addition, poor conditions of work, increased activity of international private recruitment agencies, ineffective health sector reforms and staff shortages all influenced the decision to migrate. The research also highlighted that international health workers frequently encountered racial and gender discrimination in host countries, found significant differences between expectations and actual experiences, and that migration had a high social cost for women in particular (Van Eyck 2005).

Nurses exemplify the increasing participation of women in skilled migration, as the profile of international nurses is predominately female (Hawthorne 2001). It is recognised that experiences of international health care professionals is influenced by gender. Women are more vulnerable to physical, sexual and verbal abuse (ICN 2002). Additionally, racism and discrimination is a component of international nurses' experiences. These experiences have been identified in relatively small-scale ethnographic studies.

Summary: Migration Key considerations for developing positive practice environments for international nurses
• Be aware of the reasons for migration of the international nurse to assist in understanding their motivations, expectations and what they wish to achieve.
• Ascertain whether there are historical links or cultural ties to the receiving country, which will indicate some of the social and personal support structures required by an individual international nurse.
• Recognise that international nurses without historical links or cultural ties may be more vulnerable to abuse and xenophobic attitudes.
• Understand the circumstances of migration, such as leaving family, to assist in identifying challenges to be overcome, such as loneliness and isolation.
• Employ international nurses into positions that will provide professional and career development, job satisfaction, recognition of experience and learning opportunities.
• Protect against recruitment abuses, which lead to low self-esteem, decreased income, lower professional status and threatened personal safety.
• Factor in that there is a high social cost for women migrants and that they are more vulnerable to physical, sexual and verbal abuse.

Section Three: Labour Market and Nursing Shortages

Many countries are searching for new and innovative ways of providing safe, effective, efficient and financially viable health care. Governments throughout the world have undertaken health system reform in response to economic, political, ideological or epidemiological processes (Collins et al. 1999). Three broad categories of change interact to influence labour markets. They are:

- long-term trends including ageing populations, technological advances and globalisation;
- cyclic changes such as market cycles;
- contingent change including natural disasters and political and economic crises (Baumann et al. 2004).

In recent years, with the advancements in technology and an ageing population, demand for health services has increased. To this end, the health reform agenda in many countries has evolved in response to escalating costs and a vision to improve and protect health by providing a safe, high-quality, accountable and sustainable health care system (Department of Health Western Australia 2004). Demographic changes have influenced the nature and development of nursing services in response to meeting population needs. According to Baumann et al. (2004), demographic changes affect the nursing labour market in two areas: the patient population, including the degree and sort of care required; and numbers and specialties of workers in the labour force. In addition, the nursing workforce has also undergone demographic changes with the average age of the nurse increasing significantly over the last decade in industrialised countries.

The contemporary nursing labour market, while striving to ensure high performing health systems, is burdened by nursing shortages in all but a few countries. The inability of health systems to retain nurses has been researched and debated for many years. Although there is an abundance of empirical evidence that clearly identifies the issues related to turnover, many governments and employers choose to actively recruit rather than address the underlying retention problems. International recruitment is only a short-term fix if the fundamental causes of turnover are not adequately addressed. Aiken et al. (2001) stated that nurses in distinctly different health care systems reported similar shortcomings in their work environments and in quality of care. The Magnet approach, developed in the mid-1980s in the USA, gained worldwide attention for its framework for attracting and retaining nurses. The elements of Magnet include leadership attributes of the nursing administrators, professional attributes of nursing staff and the environment that supports professional practice (Aiken et al. 2001; American Nurses Credentialing Center 1999). Demand for nursing services has been increasing due to ageing populations, greater consumer activism and increasing reliance on medical technologies (OECD 2004). The supply of nurses has failed to keep up with demand due to a combination of factors including health care reform, and restructuring and downsizing of the profession. In addition, with fewer people entering the profession, a greater range of other professional opportunities, negative perceptions of working conditions and the view that nursing is undervalued, are all contributory factors that have added to the complex phenomenon of nursing shortages (OECD 2004). Some developing countries' experiences of shortages are exacerbated by local nurses' migration to more affluent countries (Baumann et al.

2004) and increasing mortality rates due to HIV/AIDS. The reliance of governments and employers on international recruitment, rather than addressing the underlying problems of recruitment and retention amongst the existing health sector workforce, is evident. The ILO identifies that governments and employers are failing to sufficiently address issues with workforce planning (Bach 2003). The Joint Learning Initiative states that, as a priority, all countries should endeavour to attain self-sufficiency in producing their workforce and strive to retain the current workforce to reduce chronic dependency on international recruitment (Global Equity Initiative, Harvard University 2004).

In many Western democracies, nursing consumes a comparatively large proportion of the health service budget and delivers the highest proportion of direct patient care (Hewison 1999). Studies have found an association between higher nurse staffing ratios and reduced patient mortality, lower risk of medical complications and other desired outcomes including improved nurse retention (Aiken et al. 2003). Nursing shortages are a significant policy concern for many governments. It is reported that the most rapid growth area for nursing care will be services for the elderly. According to the OECD (2004), nursing shortages are expected to worsen as the current workforce ages. Failure to effectively address nursing shortages is "likely to lead to failure to maintain or improve health care" (Buchan and Calman 2004).

Summary: Labour Market and Nursing Shortages **Key considerations for developing positive practice environments for international nurses**
• Review employment and human resource practices and analyse the reason for the need to recruit international nurses.
• Identify the issues causing turnover and actively address issues and develop strategies to retain nurses currently in employment.
• Ensure competencies are current and responsive to patient needs by incorporating them into professional development plans and goals.
• Understand the demographic changes and long-term trends for the future planning of services and developing the workforce to meet patient needs and service demands in the future.
• Address negative perceptions such as the value of nursing and working conditions to improve circumstances for all nurses, which will assist in retaining this valuable resource.
• Manage retention to assist long-term integration of international nurses to reduce turnover and ensure high quality nursing care.

Section Four: Immigration and Society

Immigration is one of the most important challenges currently facing many countries. In society, it is imperative that the issues posed by immigration are dealt with in a positive, coherent and humane way. International human rights law and policy developments at national and regional levels increasingly provide safeguards for migrant workers and important benchmarks to which governments and employers should have regard when formulating policies.

A great deal of misinformation, misconception and exaggeration can often enter into a discourse about minority ethnic groups. In some receiving countries, negative perceptions of the effects of immigration have been reported from large sections of the public. Three inter-related concerns that have been identified in regard to immigration:

- Jobs are taken away from the local population.
- Wages are being driven down.
- There is a burden on the country's social welfare system (IOM 2005).

Internationally, the role of trade unions has moved from a protectionist stance, as outlined above, to an inclusive approach to migration. Trade unions have played a significant part in the protection of international nurses' conditions and rights (Bach 2003) and they have an important role in supporting them. Organisations with a strong union membership tend to have good working conditions where minimum labour standards are respected. Many unions have developed and supported migrant organisations, which provide support, advocacy, impartial advice and information. In addition, unions have had a significant influence through lobbying and advocacy for international nurses to be afforded fair and equitable treatment in the workplace and society in general (Pillinger 2005).

Taran and Gächter (2003:25) state that the "experience in many countries demonstrates that social inclusion and harmony degenerate in a context of discrimination". There is extensive evidence of physical and verbal abuse of minority ethnic groups, violence that is racially motivated and growth of anti-immigration organisations (Taran and Gächter 2003). In light of a growing resistance to migration in some receiving countries, the *World Migration Report 2005* emphasises the need for effective policies of socio-economic inclusion of migrants into host communities. Although these measures have a cost, they can ensure social cohesion in the face of cultural diversity and can generate immediate and longer-term benefits for all involved (IOM 2005).

The management of international nurses into new environments is extremely important for health care delivery, as it offers an opportunity to go beyond set legal requirements and strive for an acceptance and nurturing of cultural differences. A variety of good practice guidelines and examples of best practice exist. These include; structured induction and orientation programmes, effective mentoring systems and other support mechanisms, identifying clear pathways to integration such as via personal development plans, enforcing zero tolerance of racism, and taking active steps to ensure workers' rights are respected (Bach 2003).

Summary: Immigration and Society Key considerations for developing positive practice environments for international nurses
• Investigate and identify the attitudes and opinions of society in regard to migration and specific ethnic minority groups through national and local media, community representatives, patients and other employees.
• Market and promote the benefits of international nurses within the health care system, to patients, multidisciplinary teams and society in general.
• Ensure that the reasons for employing international nurses are clearly articulated to minimise misconceptions or negative perceptions.
• Recognise that international nurses not only need to be integrated into the work environment but also into society in general.
• Develop effective policies of socio-economic inclusion of international nurses with the multidisciplinary team.
• Develop partnerships with consumer groups, professional organisations, special interest groups, communities and local services to build relationships and social structures for international nurses.
• Support the development of cross-cultural groups and the establishment of kinship relationships.
• Strive for an acceptance and nurturing of cultural differences through the introduction of international nurses into the community, groups and consumer organisations.
• Continually review and evaluate society's attitudes and opinions towards international nurses and proactively address issues as they arise.
• Enforce a zero tolerance to racism from colleagues, society and patients.
• Provide a forum and process for international nurses and the multidisciplinary team to raise issues relating to social inclusion or exclusion.

Section Five: Characteristics of Diversity

Globalisation and international mobility are the future of nursing. The migration of nurses across international borders and their assimilation enables nursing to broaden its perspectives and increase diversity (Davis 2004). Most sociologists have argued that the presence of racial and cultural diversity is a sign of a healthy society (Obrey 2005). Employers in health care can no longer cater to a single homogenous workforce or service user. The challenge both to employers and health care professionals is to provide culturally competent care to diverse populations, increase representation and accept nurses from culturally diverse backgrounds, and to educate nurses in the skills required for culturally competent practice (Gonzales et al. 2000).

Wilson (2004) suggests that despite nursing claiming to value diversity, the profession is either unable or unwilling to fully embrace and respond adequately to the challenges of cultural diversity. A nurse's identity is linked with being caring, including caring about equity and fairness in society; the fact that racism occurs is often denied. Frequently, an individual's participation in racism is difficult to observe. Although diversity and cultural issues in health care can be addressed without paying attention to employment inequities and racism, multiculturalism, diversity and transcultural nursing cannot afford to ignore racism (Turrittin et al. 2002).

Primary characteristics of diversity and culture can encompass traditional categories such as age, gender, race, ethnicity and religion amongst others. Although valuable, traditional categories do not capture the extensive differences and similarities that exist within and between groups and individuals. A broader definition to encompass diversity and culture is paramount to promote and support a culturally diverse workforce. Secondary characteristics include socio-economic status, educational status, political beliefs, urban versus rural residence, martial status, parental status, physical characteristics, sexual orientation and gender issues (Purnell and Paulanka 2004). Table 3 outlines some of the general cultural and diversity categories.

Table 3 – Characteristics of culture and diversity categories

Ability	Ethnicity	Race
Actions	Experience level	Religion & spirituality
Age	Gender	Sexual orientation
Beliefs	Language	Societal & personal experiences
Class	Personality & unique style	Socioeconomic status
Customs	Place of birth & current residence	Values
Educational level	Political affiliation	Workplace position

Source: SenGupta I, SenGupta D. Cultural Competency in Healthcare: A Manual for Trainers. Seattle, Washington: The Cross Cultural Healthcare Program 2002.

Diversity focuses on the individual and this accommodation of difference across gender, marital status, family status, sexual orientation, religious belief, age, disability and race. It is about valuing and harnessing the potential of all individuals for productivity, as well as social and moral reasons. The recognition of diversity stimulates associated benefits of

improved efficiency, productivity, innovation and creativity that contribute to improved growth and competitiveness if managed successfully.

Accepting and accommodating diversity in the workplace is about providing equality of opportunity in terms of access and participation and realising equality outcomes for all employees. Equality is about preventing and eliminating workplace discrimination and accommodating difference.

Many countries have legislation relating to race relations that makes it unlawful to victimise or discriminate and treat a person less favourably on the grounds of race, colour, nationality or ethnic origin. Various studies demonstrate that despite the presence of equal opportunities and anti-racist legislation, international nurses, in particular black and minority ethnic nurses, experience racism from patients and staff. Therefore, it is argued that legislation and policies are not sufficient to address racism and discrimination in order to bring about equality in the workplace (Allan et al. 2004).

Summary: Diversity **Key considerations for developing positive practice environments for international nurses**
• Employers and managers have a legal and moral responsibility to implement, monitor and evaluate diversity legislative requirements.
• Promote awareness of diversity legislation and policies while ensuring every individual is cognisant of their obligations and responsibility throughout the organisation.
• Provide leadership in accommodating and valuing diversity in all aspects of the environment and at all levels.
• Develop a standardised approach throughout the organisation to include all categories of diversity to provide a clear coherent policy that applies to and is understood by all.
• Develop strategies to promote awareness of diversity among patients and the wider community.
• Develop an awareness that individuals from ethnic minority groups not only have to deal with racism but may also be exposed to discrimination on the grounds of gender or sexual orientation.
• Provide a forum and process for international nurses and the multidisciplinary team to raise issues relating to diversity and develop solutions to continually improve working environments.

Section Six: Patient Care and Cultural Competency

The United Nations (UN) and the majority of the world's states have recognised that health care is a universal human right. Article 12 of the *1966 UN International Covenant on Economic, Social and Cultural Rights* recognises "the right of everyone to have the enjoyment of the highest attainable standard of physical and mental health" (United Nations 1966). The right to health care flows from the "recognition of the inherent dignity and of equal and inalienable rights of all members of the human family" (United Nations 1948).

Health systems throughout the world strive to provide optimal safe care to achieve the best possible outcome for all patients. Migration has a significant impact on the delivery of health care in both sending and receiving countries. Sending countries often experience severe shortages with a loss of their most experienced staff. Receiving countries have to ensure that international nurses have the competencies and skill to deliver nursing care at a safe and acceptable standard. The primary function of most regulatory bodies is to protect the public by ensuring international nurses are screened to ensure they meet the competencies and the minimum standards required to deliver safe nursing care. The Nursing Board of Ireland (An Bord Altranais) identifies competencies required in order to register as a nurse. The competencies, which are similar to other frameworks worldwide, encompass five domains:

- professional/ethical practice;
- holistic approaches to care and the integration of knowledge;
- interpersonal relationships;
- organisation and management of care;
- personal and professional development.

The domains of competence represent a broad enabling framework to facilitate the assessment and ensure that the skills for critical analysis, problem solving, decision-making, reflective skills and abilities essential to the art and science of nursing meet the standard required to register as a nurse (ABA 2000). In light of the mobile global nursing profession, ICN has developed competencies in order to move towards an international standard in nursing regulation (ICN 2002). The need for the continued competency for those permitted to practice is well recognised. With increased consumer expectations, demographic and social changes, advancing practice, new technology and the requirement to use the most up-to-date evidence-based practice, nurses are obliged to demonstrate and maintain their competency through their professional life. However, a standardised process to address on-going professional competency is not well identified or articulated (Bryant 2005). Maintaining competencies is an issue for all nurses once they have been permitted to practice by a regulatory authority. On-going maintenance of competencies is the responsibility of the nurse and employer to ensure that they are able to provide safe quality care for patients. For international nurses who eventually wish to return home, they need to maintain their skills and competencies for practicing in their own country. Therefore, employers of international nurses have an obligation to ensure that de-skilling does not occur and that opportunities are provided for further development of skills and competencies.

Health and social care involves basic principles that apply to all patients irrespective of cultural or linguistic background. However, any health care system is necessarily based on the predominant culture and medical system. Nurses and health professionals often make assumptions based on their own culture. These assumptions influence practice and interactions with patients. When a nurse is caring for someone from an ethnic minority background, it is important that they are aware of their own values, beliefs, expectations and cultural practices, and consider how these impact on the care given to patients from different cultures. Factors that influence interactions include socio-economic status, politics, urban/rural origin, educational level, language proficiency, age, gender and personality.

A long-term aim of many health service providers is to mainstream multicultural health services in order to ensure physical, mental and social well-being of individuals from minority groups. A major requirement to meet the challenge of cultural competency is the development of an appropriate data and research base built in partnership with minority groups. This would:

- establish the health needs of diverse groups;
- monitor uptake of services and effectiveness of the response to needs;
- monitor outcomes and health status;
- examine the impact of policies on minority groups.

Cultural competency has been defined as the ability to function effectively in the context of cultural difference, or diversity (French 2003). Awareness and sensitivity education and training for all health care employees is a key requirement for adapting to culturally diverse patients and staff (Omeri and Atkins 2002). The focus of numerous education programmes is the development of knowledge and skills to provide services sensitive to cultural diversity, often delivered in partnership with minority groups. It has been identified in countries such as Australia that responding to the health care needs of individuals lacking fluency in English can lead to misunderstandings and result in poor outcomes (Omeri and Atkins 2002). International nurses clearly articulate that their expertise and skills in this area are often undervalued and ignored. International nurses often have a wealth of knowledge and skills that should be harnessed to provide appropriate care or advise their colleagues on culturally competent care to ethnic minorities. Many international nurses are multilingual and have a vast knowledge of social, psychological and cultural norms for specific ethnic minorities. Health care professionals need to be flexible in order to accommodate different cultural needs and value the obvious resource and expertise that international nurses can bring to diverse environments. Managers need to be more resourceful and creative in the way they use available expertise and resources.

Throughout the world there has been a significant increase in the demand for intercultural awareness and anti-racism programmes. An industry has developed and flourished to meet this demand through providing education and training programmes. A number of national organisations provide advice to support employers, trade unions and others in the provision, or for those commissioning, designing or delivering programmes. One example is the *Guidelines on Equality and Diversity Training in Enterprises,* which provides guidance and best practice on the value, delivery, content and certification of education and training programmes (National Framework Committee for the Development of Equal Opportunities Policies at the Level of the Enterprise 2005).

The success of a cultural competency initiative cannot depend solely on an education programme. The development of cultural competence, intercultural and anti-racism awareness is an important component of an overall whole organisation approach. Cultural competence, cultural awareness and embracing diversity must be part of a larger plan that includes the organisational philosophy, strategic direction initiatives, policies and practices, employee and patient resources, multi-disciplinary approach, monitoring and evaluation, ongoing staff development programmes and an infrastructure of accountability. There must be a "top-down" and "bottom-up" visible commitment to culture and diversity among employees and patients. Additionally, organisational efforts must be given time to succeed, grow and develop, and to benefit from the nurturance of staff and the leadership committed to achieving the goal of cultural diversity. Whether or not an organisation embraces cultural competency, change must begin with each individual by engaging with others to challenge and question behaviours of institutional practices. As nurses work with many other health professionals and provide the majority of direct care, they are in a unique position to influence change (National Framework Committee for the Development of Equal Opportunities Policies at the Level of the Enterprise 2005).

Summary: Patient Care and Cultural Competency **Key considerations for developing positive practice environments for international nurses**
• Employers and managers have a legal and moral responsibility to implement, monitor and evaluate human rights legislative requirements.
• Promote awareness of human rights legislation and policies while ensuring every individual is cognisant of their obligations and responsibility throughout the organisation.
• Provide leadership in incorporating human rights and dignity in all aspects of the environment and at all levels.
• Ensure that the health system incorporates human rights into policies and procedures throughout the organisation.
• Maintain a standardised human rights approach throughout the organisation to provide a clear coherent policy that applies to and is understood by all.
• Provide a forum and process for international nurses and the multidisciplinary team to raise issues relating to human rights and develop solutions to continually improve working environments.
• Ensure that the competencies and skills of international nurses are maintained and developed to facilitate their possible return home.
• Be aware of the experience, expertise, abilities and attributes that international nurses have to offer and ensure de-skilling does not occur.

• Regularly review competencies with the most recent evidence-based research in order to protect the patient and provide safe quality care that achieves optimal standards.
• Provide opportunities to maintain and enhance competencies in order to deliver safe quality care through evidence-based practice.
• Ensure thorough performance management to assess the areas and competencies that need to be developed and create a programme or opportunities to achieve the goals.
• Build a partnership between the international nurse and other nurses to develop competencies and skills and exchange knowledge and experience.
• Work towards mainstreaming health services in order to ensure physical, mental and social well-being of all individuals from minority groups.
• Support an open and transparent environment in order that individuals can securely question their own assumptions, values, expectations and beliefs and how they may impact on patients.
• Establish health needs of diverse groups and monitor uptake and effectiveness of response to needs.
• Examine and evaluate the impact of policies and procedures on minority groups.
• Adapting to culturally diverse patients requires education and training for all health care professionals.
• Employers and managers should recognise as a valuable resource the expertise and experience international nurses have in providing culturally competent care to minority patients.
• Patients lacking fluency of language require support to guard against poor outcomes due to misunderstandings.
• International nurses can contribute to linguistic and other cultural specific skills that should be valued and used to provide appropriate responses and excellence in care for diverse patient groups.
• Research the resources available nationally to guide and support the delivery of culturally competent care.
• Cultural competence, intercultural care and embracing patient diversity must be a systematic approach to incorporating concepts into the organisational philosophy, strategic direction, policies and practices with a “top-down” “bottom-up” visible commitment.

Section Seven: Experiences of International Nurses in Employment

While empirical studies on experiences of international nurses are reported in the literature, they have generally been designed as micro-projects confined to specific groups, areas, countries and time periods. The research on international nurses' experiences clearly identified as post-adaptation period is limited. Many studies that report on the experiences of international nurses do not correlate the length of time working in the environment with experiences and expectations reported. Initially, international nurses experience culture shock, cultural stress and cultural imposition (Leininger 1993). Adapting to different cultural values is a dynamic process that is part of the experience of an individual and those values change over time (Withers and Snowball 2003). Pilette (1989) describes a sequenced adjustment process that involves a number of phases. The phases of adjustment and time period include: acquaintance (0–3 months), indignation (3–6 months), conflict resolution (6–9 months) and integration (9–12 months). The experiences of international nurses captured by research are real and valuable and provide empirical data and contribute to understanding how international nurses from various ethnic backgrounds experience working in health systems throughout the world.

There is a significant social cost for international nurses who have left family, community and country. The experience can be extremely stressful even for those international nurses who choose to migrate to gain new experiences. However, the social cost can be more difficult to bear for those who are either forced to leave due to persecution, life-threatening situations or obliged in order to support their families. International nurses often have to leave their children behind in order to provide a better future for them. Leaving children behind is difficult as the parent–child bond is significantly weakened. According to Kingma (2006:68), "asking women to place the economic survival of the family ahead of the bond with their children is a significant social demand". Additionally, society endures the negative impact of dislocated family structures. On the other hand, bringing children to another country places additional challenges on top of the issues to be faced by an international nurse in a foreign country. Often international nurses accept the burdens of migration in order to give their families a better quality of life and greater opportunities for their future (Kingma 2006).

United Kingdom

The Royal College of Nursing in the United Kingdom (UK) (2003) researched the experiences of international nurses and demonstrated the concept of institutional racism in practice. The research identified that for those who fit into the dominant culture because they were not noticeably different, integration was less problematic. However, once differences became apparent, such as an accent or visibly different ethnic origin, discrimination was experienced. Black nurses in the same study encountered direct racism (Allan et al. 2004). International nurses experienced discrimination and racism motivated by racist beliefs about skin colour, ethnicity and nationality. However, there were differences between international nurses' interpretations of shared experiences of discrimination, which suggests that racism is not easily defined. The study concluded that racism and institutional racism are reproduced through personal, interpersonal and structured social relationships and that legislation and policies fail to address the fundamental values and racist attitudes that persist (Allan et al. 2003). According to Kingma (2006:210), the media often sensationalise migrant exploitation; however, this

often hides the reality that this "experience is frequently an exaggerated form of what many local nurses, particularly those from ethnic minorities, encounter on a daily basis".

Alexis and Vydelingum (2005a) studied the experiences of overseas black and minority ethnic registered nurses in an English hospital. The findings revealed a number of themes including feeling unappreciated, inadequate and unwelcome; lack of opportunity for skill development and training; unfairness in nursing practice and performance review; lack of support from overseas black and minority ethnic colleagues; and an increased need to prove themselves. The study outlined that feeling valued in the workforce is one of the most important factors to support integration. Walker (1994) outlined the "valuing difference model", which is underpinned by four key principles:

- People work best when they feel valued.
- They feel most valued when their group and individual differences have been taken into account.
- The ability to learn from people regarded as being different is the key to becoming fully empowered.
- When people feel valued and empowered they are able to build relationships in which they work together synergistically and on an interdisciplinary basis.

Buchan (2003) examined the employment policy and practice implications of the rapid growth in the numbers of international nurses working in the UK. The findings suggested that international nurses were subjected to poor working conditions and unfair treatment. Nurse managers reported the main challenges for international nurses to be language problems, differences in clinical and technical skills, and racism in the workplace. The findings reflect similar issues identified in the Market and Opinion Research International poll that revealed a lack of support, poor working conditions, lack of recognition and unfriendly and unaccommodating staff (RCN 2002). Other studies describe positive experiences and reported supportive relationships in the working environment, while also identifying that there were a number of unmet expectations. However, racism and discrimination from patients and staff was still reported (Allan et al. 2003; Daniel et al. 2001; Withers and Snowball 2003). Buchan (2003) concluded that there was a need for sound and legitimate ethical employment policies that would address issues such as poor working conditions and unfair treatment.

Iceland

Kingma (2006) identified that it is often assumed that racism and discrimination occur primarily in situations where wide cultural or race differences exist. However, the reality is that racism, bullying and discrimination occur between similar cultures. Additionally, there is evidence of similar discriminatory behaviour between international nurses of different cultures working in a host country (Kingma 2006). In a study exploring the experience of international nurses working in Iceland, Magnusdottir (2005) identified that migration places individuals in culturally different and unfamiliar environments and can result in a struggle to overcome strangeness and the communication barrier. The findings revealed that nurses from neighbouring countries that were linguistically and culturally close had similar experiences to other international nurses. Language problems existed even for those who were fluent, and difficulties in comprehension and writing were encountered due to local accents and colloquialisms. Experiences of international nurses in the study ranged from initially feeling like an outsider to developing personal and professional strength from overcoming challenges (Magnusdottir 2005). Recently, a group of Finnish nurses working in Norway filed claims of harassment. While Finnish and Norwegian

cultures have differences, there are similarities, such as structures and procedures, including mutual recognition of nursing qualifications. Accent and less fluency of language were identified as reasons for harassment and discrimination of Finnish nurses in Norway. However, once these issues of injustice were identified, proactive strategies were implemented to eliminate the harassment (Kingma 2006).

United States of America

The USA has been actively recruiting international nurses for decades (Davis and Nichols 2002). American nurses have reported issues working with international nurses, including poor communication skills and differences in decision making, behavioural norms and role expectations. On the other hand, international nurses identify a number of factors affecting adjustment in the USA, such as variations in health care systems, language competency, knowledge of medications and pharmacology, and proficiency in technology (Davis 2004). In a study of how Korean nurses adjust to American hospital settings, five categories were used to capture the essential aspects of the adjustment process:

- relieving psychological stress (confusion, anger, fear, frustration, self-depreciation, rejection, alienation and depression);
- overcoming language barrier (written, verbal and non-verbal communication);
- accepting US nursing practice (role of family, nurse aides and focus of nursing);
- adopting the styles of US problem-solving strategies;
- adopting the styles of US interpersonal relationships (nurses and patients, superiors and subordinates).

The study identified that the first three categories of the adjustment process to American hospitals took about two to three years, while the last two categories took an additional five to 10 years. Those nurses who had stayed for more than 10 years had adjusted successfully; however, the road to adjustment had been difficult. In addition, the process of adjustment was dynamic, categories were not mutually exclusive and it was not necessarily linear. According to Myungsum and Jezewski (2000) “the adjustment of immigrants occurs cumulatively and progressively”; therefore, the process of adjustment evolves in stages and may take a lengthy period of time.

The Commission on Graduates of Foreign Nursing Schools (CGFNS) conducted focus groups in eight cities in the USA and Canada to identify the major challenges facing international nurses practising outside their own country. The key themes that emerged were differences in language, culture and the practice of nursing. The focus groups identified that they felt inadequate and embarrassed when colloquial expressions or abbreviated terms were used. Due to lack of conversational English prior to migration, difficulties with telephone interactions and engaging with health care professionals, patients and their families were common (Davis and Nichols 2002). Fluency of language has a significant influence on communication by telephone, as there is no opportunity to support the dialogue by body language or to verify comprehension in writing. Often international nurses with language fluency issues may avoid using the telephone, or rely on colleagues to answer it. In turn, this may cause resentment or additional pressure on already overburdened nurses. It is widely reported that errors in relation to telephone orders occur between fluent speaking health care professionals. Therefore, the margin of error will increase with language fluency difficulties (Kingma 2006). CGFNS additionally found the multicultural nature of the population was a major issue, particularly for those from more homogeneous populations. In relation to nursing practice, pharmacology and

medical terminology caused significant issues for international nurses (Davis and Nichols 2002).

Canada

A report by the Canadian Nurses Association (2005) highlights the importance of international nurses understanding the health care system and the practice of nursing in the host country in order to become fully integrated. Employers identified the key requirements for understanding the system as knowledge of roles and scopes of practice of other health professionals, community health and social programmes, and health technology. They also noted that internationally recruited nurses from certain geographic regions were unfamiliar and uncomfortable with the autonomy expected of nurses in the Canadian system. The report identified that internationally recruited nurses with fluency of language and coming from similar professional environments still needed to learn subtle differences of language and the health care system. Employers acknowledged language and communication as the greatest challenges. The complexity of medical and nursing terminology, abbreviations, jargon, medication names, suffixes and prefixes also posed serious limitations. In addition, the report outlined that non-verbal communication was often culturally specific and might take years to learn. Difficulty with communication led to frustration and confusion for all professionals as well as patients. Concerns in regard to patient safety in an emergency situation were raised, as it was considered that sufficient time for mental translation might not be available. In addition, improperly written communication was outlined as a liability for the nurse and the employing organisation. Issues with communication might result in confusion or a negative experience for the internationally recruited nurses and the patient and/or co-worker. According to Turrittin et al. (2002), work in Canada has commenced to address issues of multiculturalism and transcultural nursing; however, little has been undertaken in regard to racism in the nursing profession. They argue that "intercultural matters cannot be dealt with fairly if racism and equity in employment are neglected in the process".

Australia

Over the past 200 years, approximately six million people have migrated to Australia. Consequently, Australia has a reputation of being a culturally diverse nation with a significant commitment by government to value and cultivate a multicultural society. However, in a study by Omeri and Atkins (2002) to understand international nurses' experiences, the existence of a social and cultural distance between nurses of the dominant culture and nurses from culturally and linguistically diverse backgrounds was evident. Western-born nurses had a number of issues in regard to the employment of international nurses, including envy due to financial incentives offered and liability for mistakes made by international nurses. Three main themes emerged from the study:

- "professional negation _ experienced as lack of support and direction;
- otherness _ experienced in cultural separateness and loneliness;
- silencing _ experienced in language and communication difficulties."

In summary, nurses in the study experienced marginalisation and felt they had been denied participation beyond the lower employment ranks, undermined in their professional roles and that their contribution was undervalued. Omeri and Atkins (2002) conclude international nurses need to be recognised as a valuable resource to delivering care and identify the "need for an evolution in attitude and policy beyond rhetoric".

Hawthorne (2001) examined the barriers confronting overseas qualified nurses and found that sustained migration of international nurses has resulted "in a dramatic ethnic diversification of the Australian nursing profession". The continuous migration of Australian-born nurses to other countries had resulted in an increasing reliance on international nurses, with a growing proportion of non-English speaking international nurses compared to those from English speaking countries. The study identified that non-English speaking international nurses had to overcome numerous barriers prior to employment including qualification recognition and language assessment. International nurses from Eastern Europe and non-Commonwealth Asia were identified as being among the most disadvantaged and least likely to be promoted. While English speaking international nurses were instantly accepted into the profession, non-English speaking international nurses were confronted with feelings of disadvantage, rejection by peers, and exposure to degrading comments, including experiences of racism and discrimination. They were also disproportionately concentrated in the stigmatised aged care sector. Despite the significant impact of these issues on international nurses, both personally and professionally, and the influence on integration, cohesion and supply, Hawthorne (2001) concluded that there has been "insufficient policy attention to date".

Zimbabwe

A survey of 1,000 Zimbabwean nationals living in the UK and South Africa from a number of professions, including nursing, examined skills base, transnational links and interest to contributing to development/return migration. The survey found that a large portion of emigration in Zimbabwe was among health care professionals, a significant number of whom were nurses. Brain drain was evident by the fact that the majority of participants had years of professional experience prior to migration. Also, an increasing number of females were migrating. All were multilingual, with English being the official language of Zimbabwe. The main reason for emigration was economy and employment. Bloch (2005) identified that being fluent in the language of the country of migration had a significant impact on social, professional and economic integration and opportunities for continued personal and professional development. While the majority of migrants had professional qualifications, they were not necessarily working in jobs equivalent with their skills and experience. Thirty-eight percent responded they had educational and professional experience that was not being utilised. Other findings of the study include:

- More than half of the migrants in the UK gained an additional qualification compared with a quarter of respondents in South Africa.
- Nearly all maintained regular social contact with family in Zimbabwe, with nearly half being in touch with their families once a week.
- Three-quarters sent remittances to support family members.
- Eighty-one percent reported being involved with activities with other Zimbabweans, including informal social activities, church and religious activities, clubs and groups.
- Nearly half participated with people or organisations in Zimbabwe through internet discussions, political activities and contributions to charities.
- Fifty-one percent communicated with Zimbabweans in other countries.
- The majority wanted to participate in a skills transfer programme and two-thirds wanted to return to Zimbabwe in the future.

It was reported that nurses and other migrants gaining additional skills and education could contribute on their return to Zimbabwe. However, a common feature of overseas employment is "occupational downgrading and an inability to use skills and qualifications commensurate with pre-migration experience" (Bloch 2005). Dumper (2002) identified that

23 per cent of nurses from another country of origin were not working as nurses in the UK. According to Kingma (2006), not using the full potential of international nurses' skills and expertise is widespread. With a global shortage of nursing, allowing de-skilling deteriorates a precious resource. For the international nurse, the negative impact on confidence and professional worth is significant. Although there is evidence that international nurses would eventually like to return home, it is often difficult to readjust on their return. International nurses from less-developed countries often establish additional independence that they would not experience in their home country. Furthermore, some employers – in particular the more rigid civil services – make it difficult for nurses to re-enter the health systems of their home countries, particularly at a level commensurate with the individual's qualifications and newly acquired competencies (Kingma 2006).

Ireland

The active recruitment of international nurses to Ireland is a relatively recent development. In a case study of internationally recruited nurses in Ireland, the most prevalent themes related to competency, education, and racial and social integration issues. It emerged that the level of competency for the provision of quality care was not standard and scope of practice varied across nationalities. Irish nurses in specialist areas found major blocks to the integration of international nurses due to varying levels of expertise, competence and language fluency. Better screening methods in the recruitment process, longer induction programmes and additional education for Irish nurses are suggested. It was reported that nurses had resigned as a consequence of being worried and frustrated about having to monitor their foreign colleagues' caring practices (McAdam et al. 2004). A study exploring the experiences of international nurses in Ireland had similar findings to much of the international research. The study indicated that the experiences of international nurses were shaped by their motivations and expectations and that recruitment and induction stages were crucial to their adaptation. Treatment by their colleagues, other professionals and their patients in general was acceptable; however, indifference, resentment, bullying and discrimination were not unusual. Family reunification was a major issue and had a significant influence on their decision to stay in Ireland (Taguinod 2005).

It is not only employers and individuals working in health care that discriminate against international nurses; often patients are the source of the abuse within the health care environment. Kingma (2006) reports on Swiss patients who refused nursing care from a German nurse due to the memories of World War II. Research on the experiences of black nurses have identified that they encounter racism and abuse from patients (Allan et al. 2003; Alexis and Vydelingum 2005b).

Buchan (2003) stated that it was vital to have a better understanding of the international nurses' motivations for migration in order to retain this valuable resource. Exploration of the experiences of host nurses in clinical areas could enhance future relations between host and international nurses. In addition, research is also needed to determine the impact of international nurses on patients and the multi-disciplinary team.

Summary: Experiences of International Nurses Key considerations for developing positive practice environments for international nurses
• Adapting to cultural values is a dynamic process that is part of the experience of the individual and those values change over time.
• Provide a forum to listen to the experiences of all nurses in relation to the integration of international nurses in order to identify the specific issues in the organisation that need to be addressed.
• Policies to manage integration should take into consideration the social cost for international nurses who have left family, community and country.
• Develop policies to address social issues such as flexibility with annual leave in order to facilitate visits to family.
• International nurses from different ethic minorities may have diverse experiences in the same working environment.
• Enforce zero tolerance to bullying and racism throughout the work environment.
• Take group and individual differences into account and ensure that international nurses are aware that they are valued.
• Empower international nurses by building relationships and fully incorporating them into the team.
• Encourage supportive relationships within the working environment.
• Ensure ethical employment policies are in use and continue to be administered fairly to all nurses.
• Address verbal and written communication within a supportive environment.
• Provide support in adjusting to variations in care systems, language competency, knowledge of medications and pharmacology, and proficiency in technology.

Part Two:

Supporting the Development of Positive Practice Environments for International Nurses

Section One: Strategic Approaches to Long-Term Integration and Retention

In order to support long-term integration and retention of nurses, it is necessary to have a modern and robust human resource management system that is capable of adapting to change. Human resource management in the health sector has a unique set of circumstances and characteristics. In comparison to most other sectors of society, health care is a highly labour-intensive enterprise (The European Observatory on Health System and Policies 2006). There are many challenges that influence health care delivery such as salary, staff motivation, unequal and inequitable distribution of the health workforce, poor staff performance, accountability and migration. Human resource management in health care is under-researched with most studies occurring in North America (Buchan 2004). Effective human resource management can be linked to both staff and care outcomes and influences employee health and well-being, as well as team and organisational performance (Michie and West 2004). A successful organisation is characterised by "excellence, innovation, resilience and optimism, with leaders intent on listening and committed to ethical values and open discussion, and where the labour-management relations are marked by mutual responsibility, flexibility and the belief in doing meaningful work" (The European Observatory on Health System and Policies 2006:157). In the USA, studies have identified that Magnet hospitals are recognised for implementing progressive employment policies and therefore attract and retain nursing staff. Studies highlighted how patient outcomes are mediated by key attributes of professional nursing practices, including nurse staffing, nurse–physician relations and nurse autonomy. The Magnet approach, developed in the mid-1980s in the USA, gained worldwide attention for its framework in attracting and retaining nurses. Such hospitals demonstrate superior patient outcomes, better patient satisfaction and higher levels of workplace safety, as well as greater job satisfaction for nurses (Aiken et al. 2001). The elements of Magnet include leadership attributes of the nursing administrators, professional attributes of nursing staff and the environment that supports professional practice (Aiken et al. 2001; American Nurses Credentialing Center 1999). Rafferty et al. (2005) state it is well acknowledged that human resource management is key to providing more effective, efficient and quality health services. However, availability of adequate resources and a commitment to human resource management at the highest level is essential.

Traditionally, the health care workforce has ranked low on the policy agenda. Human resources are often seen as a "recurring burden rather than capital assets that represent an investment for the future" (The European Observatory on Health System and Policies 2006). Literature indicates that some employers rely heavily on international recruitment, rather than addressing the underlying problems of recruitment and retention amongst the existing health sector workforce, and are failing to sufficiently address issues with workforce planning (ILO 2003). In a study of international nurses in London, 43 percent of all nurses reported that they were considering a move to another country. Sixty-three percent of nurses from the Philippines were considering moving to the USA. Nurses from Australia, New Zealand, South Africa and USA who were considering a move were most likely to return home (Buchan et al. 2005). Internationally, the turnover rate in nursing has historically been high. Turnover at high levels "has been demonstrated to have a destabilising effect on the working environment, in terms of the ability to care for patients, the quality of care provided, loss of continuity of care, loss of skills and local knowledge,

increased workload, and the pattern of communication" (Department of Health and Children 2002:155). In addition to threatening the quality and continuity of patient care and contributing to lower morale, the cost of turnover is likely to be high due to loss of productivity and the initial reduction in efficiency of new staff (Zurn et al. 2005). Determining what motivates nurses to leave is complex. Areas associated with turnover include organisational direction, environmental factors, internal and external labour.

It is apparent from the literature that a multitude of personal and organisational factors influence turnover. Turnover behaviour has been reported as a culmination of attitudinal, decisional and behavioural components (McCarthy et al. 2002). Research of non-practicing qualified nurses in Ireland examined their intention and willingness to return to practice. The findings highlighted a number of elements that needed to be in place for nurses to consider returning to practice and also provided information on their reason for leaving the profession in the first place. Table 4 outlines the main findings in relation to working hours, salary, working environment, promotional opportunities, family commitments and professional accountability.

Table 4 – Reasons that affected non-practicing qualified nurses' decision to leave nursing

Working hours
- During their nursing careers 74 percent were required at some stage to work more than their contracted hours, with 67 percent doing so at least once per week.
- Of those who worked more than their contracted hours, 73 percent were unpaid for overtime.

Salary
- Thirty-seven percent indicated that salary affected their decision to leave the profession and 56 percent suggested that increased pay levels would encourage their return.

Working environment
- Thirty-nine percent indicated their decision to leave was influenced by understaffing, poor resources, management problems, heavy workload and working hours.
- Twenty-seven percent stated that workload affected their decision to leave.
- Just under half responded that bullying in the workplace was an issue.
- Twenty-four percent had an accident in the workplace that affected their decision to leave.

Promotional opportunities
- Only eight percent agreed that there were sufficient opportunities for promotion in nursing.
- Forty percent indicated that additional qualifications were not recognised in relation to promotional opportunities.
- Thirty-two percent would return to nursing if there was a structured career path.

Family commitments
- Sixty-one percent of respondents identified that their decision to leave was influenced by family commitments.

Professional accountability
- Nearly all respondents agreed that nurses should be accountable for their work.
- Fifty-seven percent felt nurses were not given enough autonomy to make decisions.
- Sixty-four percent considered nurses did not have enough authority to make decisions.
- Fifty-six percent indicated that increased professional accountability affected their decision to leave with particular reference made to the number of nurses they were accountable for including international nurses, agency nurses and student nurses.

Source: Egan M, McAreavey D and Moynihan M (2003). *An Examination of Non-practising Qualified Nurses and Midwives in the Republic of Ireland and an Assessment of their Intentions and Willingness to Return to Practice.* Dublin, Irish Nurses Organisation and the Michael Smurfit Graduate School of Business.

The majority of non-practicing qualified nurses found working as a nurse highly satisfying and personally rewarding. The research concluded that flexibility of working hours and increased salary and bonuses are rated as the most important factors that would influence non-practicing qualified nurses to return to the profession (Egan et al. 2003).

In a national study of turnover in Ireland, two major reasons for leaving a current position were reported: other employment in nursing and foreign travel. In the study, nurse leavers identified a number of negative work issues including increased workload, perceived deteriorating standards of care, bullying, lack of managerial support, lack of promotional opportunities, poor job satisfaction and lack of autonomy. Issues, which pertained to work contracts, included the temporary nature of employment and lack of access to job-sharing (McCarthy et al. 2002). Buchan and Sochalski (2004) suggest that the dominant mechanism to shore up the nursing workforce has been international recruitment rather than exploiting the opportunities of effective retention strategies. There are examples of governments and organisations recognising the potential of developing a multifaceted policy approach to retention strategies. One example is a five-point action plan identified on the basis of research findings by an experienced group of senior nurse managers, recruitment specialists, personnel officers and human resource personnel, which provides a generic template for considering issues affecting retention of nurses (Department of Health and Children 2002). Table 5 outlines the five-point action plan.

Table 5 – Generic template for considering issues affecting retention

National, regional and local policy
- Strategy for recruitment and retention
- Nurse education
- Salary
- Marketing of nursing
- Workforce planning
- Targeted incentives

Management
- Management role, style and development
- Communication
- Value, respect and acknowledgement of staff
- Team building
- Information data systems

Professional nursing practice
- Induction and orientation
- Support for quality professional nursing practice
- Involvement in decision-making, autonomy and empowerment

Staffing
- Staffing ratio, skill mix and workload measurement
- Support staff
- Flexibility in rostering

Organisational support
- Career pathway and professional development

- Quality of working life and environment
- Fringe benefits

Source: Nursing Policy Division, Department of Health and Children (2002). *The Nursing and Midwifery Resource Final Report of the Steering Group: Towards Workforce Planning.* Dublin, Department of Health and Children.

Employers often use incentives to influence determinants of performance and motivation in order to retain nurses. An incentive can be implicit such as trust, duty and professional self-regulation, or explicit, such as financial or non-financial reward for performance (Saltman 2002). Monetary incentives may include direct or indirect payment such as salary bonuses, pensions, insurance, allowances, housing, scholarships, fellowships and loans. However, motivation is not always about financial incentives (Rafferty et al. 2005). Non-monetary incentives include autonomy, career development, flexible working and safe, well-resourced working environments and organisational infrastructures. However, there is minimal information on either the effectiveness or costs of incentives. In addition, there may be significant motivational differences between nurses from developed and developing countries (Zurn et al 2005). Therefore, it is a complex challenge for employers to identify and implement a standardised package of incentives that will effectively address the long-term integration and retention of all nurses. In designing policies and strategies to improve recruitment and retention of nurses, Zurn et al. (2005:26) highlight the importance of considering "organisational policies and provisions, economic constraints, cultural and social differences and regulatory and legal frameworks" in developing effective policy options.

The Institute of Employment Studies tested a series of attitudinal statements on the theme of employee engagement. Engagement appears to have a positive influence on integration and retention of employees. The study identified the importance of feeling valued and involved, and reported that there is highly significant correlation between feeling valued and involved and training and career development, immediate management, performance and appraisal, communication, equal opportunities and fair treatment, pay and benefits, trust, co-operation, job satisfaction, and relationship with colleagues (Robinson 2004).

Trade unions and professional organisations play an important role in supporting the retention and integration of nurses by providing impartial advice, information, advocacy and negotiating with employers on behalf of their members. Unions and their affiliates actively work towards bridging the disparities between the political strategic direction, employment procedures and actual practice. In addition to the employment standards established by legislation, collective bargaining agreements are used by unions and nursing organisations to address specific issues to improve the terms and conditions of employment. Therefore, a collective agreement is generally a written contract negotiated between the union or professional organisation and the employer. Although usually negotiated, they can be imposed by binding arbitration or by legislation. Collective agreements describe the terms and conditions of employment for their members addressing rights, privileges or duties of the employer and the represented employees. In recent years, a partnership approach has been used by key stakeholders including governments, employers, organisations and unions to address issues and reach collaborative consensus on collective bargaining agreements. In Ireland, the partnership approach that evolved provides "new and active relationships in managing change characterised by employee participation and consultation, the development of joint objectives, co-operation and trust and the delivery of patient-focused quality health

services" (Health Services National Partnership Forum 2003:2). Through partnership, patients have benefited by the introduction of service reorganisation and improvement, new and more flexible work practices, extended hours of service, infrastructure improvements and consultation and involvement in change. In addition, employees have benefited through increased levels of involvement and quality of work life through flexible working hours, childcare facilities, stress reduction programmes, anti-bullying programmes and staff representative facilities (Health Services National Partnership Forum 2003). There are many other examples of partnership such as the Labor-Management Project of New York, Allina Health System in Minnesota and the American Indian National Union Management Partnership Council to name but a few (Figueroa and Lazes 2002). A partnership approach assists all stakeholders to collaborate and strive to create patient care environments in which nurses can practice safely and professionally as they deliver high quality care (Fitzpatrick 2001).

In recent years, research has identified that it is important for many nurses to have a balance between their professional and home life. In response to this, employers are introducing incentives, for example, flexible work arrangements, childcare, time-off policies, elderly care, health care and counselling programmes (Egan et al. 2003). The Department of Health introduced a series of performance standards for National Health Service employers entitled *Improving Working Lives* (Department of Health 2000). The performance standards relate to practices such as flexible working hours, career breaks, childcare support schemes and recognising carers' needs. Rafferty et al. (2005) identified that employees may remain with an organisation because there are economic barriers against leaving. It is suggested that while additional benefits provide an incentive for employees to stay with the employer, organisations should structure the economics of the relationship in a way that does not obstruct commitment.

In summary, there are challenges with the retention and long-term integration of international nurses. The way in which the health care workforce is recruited, educated, rewarded, regulated and managed has often struggled to keep pace with the changing demands facing health care systems. Many countries have experienced a considerable transformation, requiring their workforce to develop new skills and adopt new behaviours in the market economy that has established new relationships with employers and patients. Therefore, all nurses need to have access to continuous professional development that includes skills for performance management, management of contracts and other new ways of operating in changing health care systems. There is a growing body of evidence on the potential benefits of more effective human resource management, in terms of both organisational and patient outcomes. Human resource practices that incorporate commitment to ensure adequate staffing, investment in education, teamwork, employee autonomy and empowerment are associated with high levels of retention and enhanced organisational outcomes and performance (The European Observatory on Health System and Policies 2006). The empirical evidence identifies areas that need to be considered at international, national, regional and local levels to support the retention and long-term integration of all nurses, including policy development and implementation, effective management approaches, professional practice investment, adequate staffing and organisational support. As outlined, there are many examples of progressive employment policies such as the Magnet hospitals, equality legislation, collective bargaining agreements and partnership approaches to human resources management, which improve retention and recruitment. However, due to disparities, for example, in legislation, policy direction, infrastructure, funding of health care delivery, group and individual differences, service requirements, organisational structures, ethos and

philosophical approaches to management across and within countries, no one standardised approach to human resource management has been identified.

Section Two: Key Challenges and Success Factors

Migration patterns have changed both the workplace and the wider society in many countries. International recruitment of nurses is an increasingly permanent part of employers' recruitment and retention strategies. With continued globalisation, integration is a key challenge for many countries, professions and individuals in terms of building supportive workplaces and environments to enhance health care delivery. Strategies to meet this challenge include:

- building a cultural diversity dimension into key health care policy strategies to support integration;
- developing policies that are specific to the needs of minority ethnic groups;
- developing good practice and policy guidelines within health care organisations.

Not all employers exercise ethical or good employment practices. Recruitment abuses are evident with nurses being employed under false pretences or misled as to the conditions of work and possible remuneration and benefits (ICN 2002). Buchan et al. (2005) reports that bad practice is still evident in some organisations and overseas nurses continue to experience mistreatment. Exploitation does not only occur in the initial stages of the recruitment process, but can continue into the employment phase, albeit in a different format such as lack of professional development or promotional opportunities. Therefore, it is essential to develop effective approaches to building intercultural workplaces at an early stage. Good practice must be a source of leadership and an example for the future. Change is required at every level of the workplace in order to achieve integration. Policies and procedures to eliminate abuse and poor treatment and to promote equality need to be in place. Education is necessary to ensure an awareness of cultural diversity and a competency to address these issues (Alexis 2005).

In response to abuse and exploitation, good practice guidelines for health care employers undertaking recruitment have been developed, such as those developed by the Royal College of Nursing in the UK. These guidelines cover employers considering international recruitment, ethical recruitment, working with commercial agencies, immigration and work permits, registration, supervised practice, adaptation, general induction, good employment practice, health screening, professional development, and trade union and professional organisations (RCN 2002). The innovative approach to outlining best practice for employers has led to similar publications in other countries and encouraged ethical recruitment and fair treatment of international nurses. However, best guidance for employers to ensure long-term integration of international nurses is less abundant.

Ryan (2003) identifies the difficulty in retaining and educating international nurses after their arrival and suggests that there are four major and often overlapping areas that must be addressed:

- "socialisation to the professional nursing role;
- acquisition of language and other communication skills;
- development of workplace competence, both clinical and organisational;
- availability of support systems and resources within the organisation".

Supportive strategies are required within each area to promote adjustment and long-term integration into the organisation. Organisational strategies include an appropriate orientation programme that is dynamic and flexible to meet the needs of the individual international nurse; support groups, such as a "buddy programme", within the organisation to ease the anxiety, isolation, or other psychological discomfort and distress of international nurses throughout the adjustment period; and a forum for conflict resolution and support for ongoing evaluation of professional growth and development (Ryan 2003).

The Royal College of Nursing publication, *Success with internationally recruited nurses – RCN good practice guidance for employers in recruiting and retaining* (2005), recognises the value of internationally recruited nurses and identifies the many problems they face. The publication identifies three broad approaches to recruiting and retaining nursing staff:

1. Preparing internationally recruited nurses prior to employment:
    - understanding and matching motives to migrate;
    - providing advanced and realistic information on social and employment issues to ensure realistic expectations;
    - addressing personal and professional adaptation on arrival.
2. Preparing existing staff:
    - inducting existing staff to assist in acceptance of professional and cultural differences;
    - providing information on the internationally recruited nurses;
    - involving managers to ensure support;
    - tackling racism through good management by acknowledging, challenging and dealing with it. The RCN states that racism "is not only bad for the working environment, it is also unlawful".
3. Ongoing support:
    - supportive management to ensure professional satisfaction and respect on an ongoing basis. Employers can "defuse feelings of frustration and continuing disorientation if they are clearly seen to value experience, skills and qualifications";
    - promoting public respect and appreciation;
    - avoiding de-skilling and recognising professional skills;
    - providing and supporting career progression, clinical practice development and career pathways;
    - promoting fair treatment of pay and grading, avoiding shift exploitation and developing family-friendly working practices.

It is considered best practice and recommended that employers fully prepare internationally recruited nurses, plan for their arrival with existing staff and encourage the development of their professional roles in order to retain and reap the benefits of this valuable resource (RCN 2005).

Developing a strategy to integrate international nurses should be underpinned by core principles such as ensuring a fully accessible and responsive service to meet the diverse needs of patients and communities. Prior to developing an integration strategy at the organisational level, each employer, in consultation with nurse spokespersons, should:

- Identify the key issues and challenges facing international nurses in their organisation.
- Ensure that the issues and challenges are communicated and understood throughout the organisation.
- Establish how the issues and challenges might be overcome.

- Devise approaches on how to continually improve equity and diversity based on good practice.
- Review and recommend policy changes on an ongoing basis that will address inequalities and discrimination.
- Develop partnerships with key stakeholders in order to identify actions and activities that will initiate change.
- Create the necessary consultation and grievance procedures so that issues are addressed in a timely and effective manner.

Managers must lead and address a number of issues in order to support positive practice environments for the nursing profession, including international nurses, thereby contributing to integration and quality patient care. These issues include:

- improving opportunities of education for all nurses;
- opening up employment opportunities and removing barriers;
- ensuring and fair, open and equitable system for all.

Opening up career opportunities for nurses and a professional development pathway will not only attract and retain nurses, but will ensure that their career progression and recognition is fair and open. In addition, educating the public and patients in their attitudes towards international nurses is another important aspect of the challenge.

A wide range of challenges in respect to integration in health care systems has been identified in the literature regarding international nurses. The Department of Health, UK (2003) identified a number of key challenges in their strategy for employers who are initiating equality and diversity in order to achieve integration. These challenges include leadership and cultural change, sharing and cultivating good practice, and building capacity to deliver a workforce reflective of the community.

The National Health Service (NHS) Employers are driving the concept of positive action that promotes equality of opportunity and diversity, which subsequently enables organisations to attract, recruit and retain and successfully achieve long-term integration of employees (NHS Employers 2005). NHS Employers work with organisations to establish a sound framework for developing and implementing positive action initiatives. In recent research, participating organisations identified the five key success factors and best practice, which are outlined in Table 6.

Table 6 - Positive action: key success factors and best practice

"Organisational culture
- Support for diverse workforce at all levels
- Celebrating success
- Thinking outside the box and taking calculated risks
- Being flexible and adaptable

Leadership
- Passion and drive
- Commitment from the top and across the organisation
- Team working
- Perseverance

Communication
- Knowing the local communities (consultation and engagement)
- Sharing good practice
- Marketing within the organisation

Strategic management approach
- Strategic framework
- Sound planning
- Managing expectations
- Local partnerships
- Monitoring

Resources
- Long-term funding
- Dedicated posts
- Targeted resources
- Project management"

Source: National Health System Employers in association with the University of Bradford (2005). *Positive action in the NHS*. United Kingdom: National Health Service Employers. (www.nhsemployers.org).

In summary, positive practice initiatives developed for the integration of international nurses have been influenced by equality legislation, mutual agreements, ethical recruitment practices, educational standards and the proactive work of numerous national nursing associations. Many employers have developed good employment practices with comprehensive orientation programmes, language preparation, mentoring, educational support and career progression. Continued work by professional nursing organisations, governments, policy makers, employers, consumers, health professionals, individual nurses, unions and their affiliates to promote intercultural workplace strategies is required to support integration. Practical support to ensure good practice in the recruitment and employment of international nurses is key to facilitating the change required to develop positive practice environments and support long-term integration of international nurses.

Section Three: Developing Intercultural Workplaces and Best Practice

As most countries predict that the employment of international nurses will continue for the foreseeable future, cultural diversity will be a permanent feature in many workplaces. Increased diversity has resulted in a range of challenges for employers and employees such as ensuring that services are accessible, user friendly and equitable to people from minority ethnic backgrounds and that staff from minority ethnic backgrounds are fully integrated into the workplace in a way that respects diversity.

Developing a proactive policy towards managing diversity and fostering the development of intercultural workplaces can have significant benefits for the employer, the employees and the patients. The European Commission's 2003 report, *The Costs and Benefits of Diversity,* highlights the benefits gained by employers who have invested in resources for developing active workplace diversity policies. These benefits are outlined in Table 7.

Table 7 – Benefits of diversity and building intercultural workplaces for employers

- Helped to attract and retain highly talented people.
- Improved motivation and efficiency of existing staff.
- Strengthened cultural values within the organisation.
- Enhanced corporate reputation.
- Improved innovation and creativity among employees.
- Enhanced service levels and customer satisfaction.
- Helped to overcome labour shortages.
- Reduced labour turnover.
- Lowered absenteeism rates.
- Improved access to new market segments.
- Avoided litigation costs.
- Improved global management capacity.

Source: European Commission (2003). *The Costs and Benefits of Diversity.* EU: European Commission.

Legislation is the main driver for employers to develop awareness and competence at the organisational and individual level. This, in turn, drives the development of appropriate policies, practices and procedures to ensure employees and the various structures within the organisation are complying with the legislation. Discrimination is unlawful on the grounds of sex, race, ethnic origin, religion, belief, disability, age and sexual orientation in relation to a number of areas including:

- access to employment;
- conditions of employment;
- education, training or experience in relation to employment;
- promotion or re-grading;
- classification of posts.

An intercultural workplace is primarily about creating a culture that seeks, respects, values and harnesses difference. The employers of international nurses have a responsibility, amongst others, to:

- Implement their statutory duty and monitor effectiveness
- Ensure policies and procedures are in line with legislation
- Establish equality of treatment with nationals of the host country in relation to employment rights
- Provide accessible information on employment rights
- Allow membership of a trade union
- Ensure effective complaint and redress mechanisms against exploitation and discrimination in the workplace
- Drive the elimination of discrimination
- Ascertain equality of treatment in relation to access to important services, including education and health care
- Support equality of opportunity and encourage good practice
- Promote positive affirmative action
- Harness good relationships between people of different racial groups

Across Western Europe, North America and elsewhere there is a spectrum of insights and initiatives that reflect common patterns of understanding of responses to ethnic diversity in the workplace. The nine elements in the spectrum include:

Stage Zero – doing nothing, being aware: relying on ad hoc measures to respond to problems as they manifest, which is identified as a risky approach.

Stage One – adapting the minority: providing orientation training. However, the impact of training is limited, as adaptation will not solve the external and visible characteristics that trigger discrimination.

Stage Two – making cultural allowances: job accommodation measures that address the practical implications of cultural diversity.

Stage Three – changing majority attitudes: developing an attitude change among the majority in the workforce.

Stage Four – changing majority behaviour: addressing behaviour that causes barriers for minority workers.

Stage Five – changing rules and procedures: targeting systematic discrimination that goes beyond individuals' bias or actions.

Stage Six – active recruiting and promotion: establishing positive action in achieving equality in the workplace.

Stage Seven – relying on diversity: actively moving from coping with diversity to being consciously diverse.

Stage Eight – mainstreaming equality: establishing equality as an integral part of all decision making within the organisation.

Taran and Gächter (2003) state that the nine elements can be grouped into three categories. Stages One and Two are identified as "noticing minorities", stages Three to Five are "making room for minorities" and stages Six to Eight are "equality for minorities".

Alexis and Chambers (2003a, 2003b) suggest that patients or health care professionals are not encouraged to benefit from the cultural diversity that international nurses bring to health care teams. Alexis' model identifies the five main components to provide the best environment for recruiting and retaining international nurses, which include:

- valuing overseas nurses;
- diversity and equality;
- the environment;
- induction programmes;
- education and training.

While numerous successful adaptation programmes incorporate these components, the research into international nurses' experiences still raises concerns in regard to short-term and long-term integration. Buchan et al. (2005) reports that international nurses are aware of opportunities elsewhere and more than four in 10 international nurses reported that they were considering moving to another country.

A national programme, *Positively Diverse,* provides a framework for the National Health Services in the UK to manage equality and diversity through organisational cultural change. The programme, which promotes a culture of inclusion and valuing the richness and diversity of individuals, also recognises the importance of equality and diversity in delivering high quality health service. *Positively Diverse* is designed to encourage innovation and build on best practice, enabling organisations to embrace equality and diversity in strategic plans and day-to-day practice (Department of Health 2001; NHS 2005).

Diversity at Work Network (DAWN) is a multi-organisational national project in Ireland that is funded by the European Union Community Equal Initiative. DAWN creates a range of supports for employers of migrant workers to create an intercultural environment within their organisation (DAWN 2004). Similar organisations throughout the world are established and provide evidence-base advice and guidelines to deal with diversity in the workplace. Appendix One provides links to national information flyers that detail the various bodies and contact details for organisations across Europe. The Equality Authority, Ireland has developed a succinct 10-step guide for employers on employment equality and is outlined in Table 8.

Table 8 – Ten-step guide to employment equality

- Agree upon and support an equality committee and equality officer.
- Communicate on employment equality with employees, clients, business contacts and service providers.
- Develop equality of opportunity in recruitment and selection processes, including advertising.
- Include positive actions, which are now allowed under all the grounds of the equality legislation, including race and membership of the marginalised communities.
- Accommodate diversity across gender, martial status, family status, sexual orientation, religious belief, age, disability, race and community membership and develop necessary workplace flexibilities.
- Build equality into job orientation in the workplace.
- Integrate the equality dimension into training, work experience and employment counselling opportunities.
- Develop equality of opportunity in promotions and progression including job re-grading or reclassification.

- Develop a network with other enterprises and public bodies to ensure best practice on equality of opportunity in the organisation.
- Evaluate, monitor and review your equality policies and practices.

Source: National Framework Committee for the Development of Equal Opportunities Policies at the Level of Enterprise. *Guidelines for Employment Equality Policies in Enterprises.* Dublin: National Framework Committee for the Development of Equal Opportunities Policies at the Level of Enterprise. Available online from: The Equality Authority, Ireland, www.equality.ie/index.asp?locID=109&docID=98

An intercultural workplace is one where the employer takes account of diversity and plans for increased cultural and ethnic diversity. The development of an intercultural workplace policy should be seen as integral to meeting the wider goals of the organisation. A whole organisation approach is considered to be best practice in order to address racism and support inclusive intercultural strategies within an organisation, with reference to equality policies and equality action plans.

Education and training can reinforce a culture where discrimination is not tolerated and diversity is welcomed and embraced. One primary objective of equality and diversity training is to change the behaviour of the employees participating. Behavioural change starts with people becoming aware of the need to change and is a gradual process. Change in behaviour will only be sustained if the organisation and its employees reinforce it generally. Organisations need to develop and introduce relevant professional and financial incentives that reward equality and diversity competence, which will include:

- understanding the dimensions of diversity and equality;
- managing diversity as a vital resource;
- developing inclusive leadership skills;
- career development/efficacy training and education for diverse employees.

Education and training is a resource-intensive initiative, which is critical to achieving change and therefore should be evaluated. Evaluating ensures investment achieves maximum impact. The key focus of evaluation should be on the extent to which participants effectively apply knowledge, skill and attitudes from theory into practice. Education and training should positively impact on the organisational culture as well as the individual's performance.

Table 9 outlines examples of equality and diversity performance, knowledge and skill indicators based on best practice which have been developed by the National Framework Committee for the Development of Equal Opportunities Policies at the Level of Enterprise in Ireland.

Table 9 - Equality and diversity performance, knowledge and skill indicators

Performance Indicators

- Greater openness to, and valuing of, diverse views, opinions and experiences of colleagues and patients
- Objectivity in decision making
- Increased diversity among selected new recruits and teams
- Increased diversity among those being promoted
- More open discussion on equality and diversity issues
- Extent to which strategies and action plans developed have been implemented
- Increased interaction by participant with different groups

- Increased confidence in dealing with equality and diversity issues in the workplace
- Experience of successfully managed complaints/conflict management skills.

Knowledge Indicators
- Knowledge of the law – discrimination (direct and indirect)
- Knowledge of equality issues
- Ability to identify discriminatory mechanisms and barriers
- Ability to identify problems in accommodating differences
- Ability to identify objective processes and eliminate negative effects
- Ability to identify and develop solutions to under-achievement in recruitment, selection, training and development
- Interpretation of data and use for monitoring and evaluation of equality and diversity performance
- Ability to identify appropriate facilities and work patterns for improved access and outcomes.

Skill Indicators
- Managing diversity – strengthening performance through diversity by accommodating and valuing employee differences and building diverse teams
- Planning diversity and equality through policy making, procedure development and action programme implementation
- Applying good communication skills and interacting with diverse employees
- Appraisal – overcomes behavioural differences and utilises appropriate information for decisions.

Source: Adapted from - National Framework Committee for the Development of Equal Opportunities Policies at the Level of Enterprise. *Guidelines on Equality and Diversity Training in Enterprise*. Dublin: National Framework Committee for the Development of Equal Opportunities Policies at the Level of Enterprise. Available online from: The Equality Authority, Ireland, www.equality.ie/index.asp?locID=109&docID=101.

In summary, employers, employees, education providers, professional associations, trade unions and employer organisations all have an obligation to ensure compliance with legislation and implement policies effectively. All stakeholders have a key contribution to building and developing the infrastructure for positive practice environments that incorporate equality and diversity in the workplace. Equality of opportunity goes beyond a focus on legislation compliance to a focus on difference and the accommodation of difference to achieve equality outcomes. A positive practice environment with an equality agenda covering both human resources and patient service functions poses real challenges and opportunities for employers. Education and training should only be one initiative in a multi-faceted strategy of an overall equal opportunities and diversity programme. Equality and diversity education and training, combined with equality policies, are the foundation on which to build workplaces characterised by equality. Policies establish strategy, infrastructure, organisational climate, sanctions/rewards and commitment; education and training establish capacity to implement the policies.

Conclusion

International nursing employment patterns have undergone dramatic change in past years as the cost and demand for health care continues to escalate. The delivery of quality health care is directly related to an adequate supply of nurses who comprise the majority of health care personnel employed in health care systems.

International nurses make a considerable contribution through their commitment and enthusiasm to working within health systems and providing high quality care to patients throughout the world. Therefore, governments must commit to supporting health services that are investing in education and training development, developing positive practice environments and effective human resources management, tackling discrimination and harassment, improving diversity, and enhancing the working lives of health care professionals in a way that directly contributes to better patient care. There are many positive practice initiatives developed for the integration of international nurses globally. Many of these practices have been influenced by equality legislation, mutual agreements, ethical recruitment practices, educational standards, collective bargaining and the proactive work of numerous national nursing associations. Many employers have proactively developed good employment practices with comprehensive orientation programmes, language preparation, mentoring, educational support and career progression.

Immigration requires adjustment to differences in nursing practices and education, and interaction with health care professionals and patients from a range of cultural backgrounds. The nursing profession must acknowledge two aspects of multicultural policies: diversity among health care professionals, as well as among the recipients of care. Cultural awareness programmes for both “home nurses” and international nurses should be the norm, however, these initiatives, in some instances, appear to take place ad hoc and in isolation with little reference to national standards. There is a need for the development of conceptual and practical guidance for the health care system in meeting the challenge of responding to cultural diversity. It is clear that unacceptable behaviour such as abuse, exploitation, discrimination and marginalisation is a reality for international nurses. The fundamental framework required to ensure international nurses have a positive experience is based upon treating them fairly with respect and dignity.

Governments, employers and key stakeholders involved in employing international nurses have a responsibility for ensuring that employment practices comply with ethical codes, human resources management principles and legislative requirements. Not only will this result in the humane treatment of the international nurse, but it will directly affect the quality, effectiveness and cost of health care. The development of positive practice environments will deliver benefits to patients, individual nurses, health care teams and health services.

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Appendix One – European Anti-Discrimination Resources

The Anti-Discrimination Unit of the Directorate-General Employment and Social Affairs, established by the European Commission, focuses on all aspects of the European Community Action Programme to combat discrimination and Community legislation related to fighting discrimination. It also provides links to, and information on, agencies and bodies across the EU that can help both employers and employees to learn more about their rights and obligations in obtaining and ensuring equal treatment under European law. Further information is available at:
www.europa.eu.int/comm/dgs/employment_social/index_en.htm

EU Information Campaigns website "Stop-discrimination", which is presented in all the EU languages and provides a wealth of practical information and advice on discrimination and how to fight it, is available at: www.stop-discrimination.info/index.php?english

National information flyers titled, *Our Differences Make the Difference,* produced for each of the twenty-five EU member states, inform individuals about anti-discrimination issues in their country. Together with the national working groups, information is compiled on national anti-discrimination legislation for that specific country, examples of discrimination and useful information on how to contact organisations offering support to victims of discrimination in their country.

European Union national information flyers links

Austria	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Austria/Documents/050527_screen_flyerAT.pdf
Belgium	web20.s112.typo3server.com/fileadmin/pdfs/Nationale_Inhalte/Belgium/documents/040629_Flyer_Belgien_fr.pdf www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Belgium/documents/040629_Flyer_Belgien_nl.pdf
Cyprus	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Cyprus/NIF/screen_NIF_CY.pdf
Czech Republic	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Czech_Republic/documents/screen_NIF_cz.pdf
Denmark	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Denmark/Dokumente/050527_screen_flyerDA.pdf
Germany	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Germany/documents/screen_NIF_de.pdf
Spain	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Spain/NIF/screen_NIF_ES.pdf
Estonia	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Estonia/Documents/050603_Infoflyer_est.pdf
Finland	web20.s112.typo3server.com/fileadmin/pdfs/Nationale_Inhalte/Finland/Dokumente/screen_NIF_fin.pdf www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Finland/Dokumente/screen_NIF_fin-sw.pdf
France	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/France/Documents/050630_screen_PDF_Flyer_franz.pdf
Greece	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Greece/Documents/screen_Infoflyer_gr_online.pdf
Hungary	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Hungary/Documents/screen_Infoflyer_hu.pdf
Ireland	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Ireland/Documents/screen_NIF_IE.pdf
Italy	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Italy/Documents/screen_NIF_it.pdf
Latvia	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Latvia/Documents/screen_NIF_lat.pdf

Lithuania	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Lithuania/Documents/050527_screen_flyerLIT.pdf
Luxemburg	web20.s112.typo3server.com/fileadmin/pdfs/Nationale_Inhalte/Luxembourg/Documents/050527_screen_flyerLUXde.pdf www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Luxembourg/Documents/050527_screen_flyer_LUX_fr.pdf
Malta	web20.s112.typo3server.com/fileadmin/pdfs/Nationale_Inhalte/Malta/Documents/screen_NIF_Malta_engl.pdf www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Malta/Documents/screen_NIF_Malta_mal.pdf
Netherlands	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Netherlands/National_Flyer/050530_screen_Infoflyer_nl.pdf
Poland	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Poland/Documents/050531_screen_Flyer_POL_1_SP.pdf
Portugal	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Poland/Documents/050531_screen_Flyer_POL_1_SP.pdf
Slovenia	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Slovakia/Documents/050531_screenFlyerSK_1_SP.pdf
Slovakia	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Slovenia/Documents/050527_screen_flyerSLOV.pdf
Sweden	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/Sweden/Dokument/nationalerFlyer_SWE_01.pdf
United Kingdom	www.stop-discrimination.info/fileadmin/pdfs/Nationale_Inhalte/UK/documents/screen_NIF_uk.pdf

Source: European Union. *Our Differences Make the Difference.* For Diversity Against Discrimination website: www.stop-discrimination.info/99.0.html