Introduction

Since the late 1960s, there has been a significant increase in migration of skilled healthcare professionals from African countries, with the United States (U.S.) being a primary destination for these migrants. African immigrants were able to start coming to the U.S. in significant numbers largely because of two pieces of legislation: the 1965 Immigration Act and the 1990 Immigration Act. The 1965 Act ended the system of national origins quotas, which only allowed a very small number of Africans to migrate to the U.S. At the same time, it introduced occupational preferences, which enabled highly skilled Africans, such as physicians, to immigrate to the U.S. for educational opportunities. The 1990 Act created a Diversity Visa Program, which allowed an additional 50,000 Africans per year to migrate to the U.S. During the 1990s, in the face of a worsening European economy and increasingly stringent immigration policies in European countries, the U.S. became a more attractive destination for African immigrants.

Because the U.S. is a primary destination, African healthcare professionals in the U.S. are a source from which to learn about the experiences of the professionals, who are at the core of the "brain drain" policy issue. The brain drain is defined as the emigration of skilled laborers, such as healthcare professionals, from poorer, less developed to wealthier, more developed countries and regions. Motivations for migration among African healthcare professionals have been identified by several sources and include aspirations for better wages, working conditions, and career development opportunities. However, finer-grained analysis of the distinct experiences of sub-populations, such as females and males, within this group of professionals, has not been deeply explored.

Thus, the topic of this senior thesis is the gendered experiences of African healthcare professional immigrants in the U.S.

This project asks three main questions, namely, whether there are gendered differences among African healthcare professional immigrants in the U.S. in: (1) their motivations and decisions to migrate to the U.S.; (2) their experiences in the U.S. healthcare labor market after their arrival; and (3) their views of their long-term career paths and humanitarian aspirations, whether they be centered in the U.S. and/or their country of origin. In the process of researching these three questions, I will obtain rich data about professionalism in the medical field, differences and interactions between gender norms in the U.S. versus African contexts, and conceptions of national identity and responsibility. The questions to be examined in this research topic lie at the intersection of three literatures concerning: (1) African immigration to the U.S., (2) the brain drain of skilled African healthcare professionals to the U.S., and (3) gender in the process of migration and the U.S. labor market experience.

Literature Review

African Immigration

The dramatic increase in skilled healthcare professionals who have migrated from Africa to the U.S. reflects the overall increase in African immigrants to the U.S. since the 1960s. Joseph Takougang (2003) cites a statistic from the Immigration and Naturalization Service (INS), which estimates that "the number of African immigrants to the United States more than quadrupled in the last two decades; from 109,733 between 1961 and 1980 to 531,832 between 1981 and 2000" (1). Though most African immigrants come from former English-speaking colonies such as Nigeria, South Africa,

Kenya, and Ghana, there have recently been an increasing number of African immigrants from former Portuguese-, Spanish-, and French-speaking colonies. Most of these immigrants arrive in their twenties and thirties. While some settle in small towns in states such as Idaho, Iowa, Maine, and North and South Dakota, major cities such as New York, Chicago, Los Angeles, Houston, Atlanta, Boston, and Washington D.C. still attract the largest number of African immigrants. New York City and Atlanta, in particular, continue to be magnets for these immigrants because these immigrants often already have relatives or friends in these cities who can give them advice and a temporary residence. Takougang (2003) explains that African immigrants earned a median income of over $40,000 in 2003, and that they come to the U.S. eager to work to achieve a better life for themselves and their families.

The Brain Drain

Much of the literature on the brain drain from African countries has had a policy focus, identifying its magnitude, causes, consequences, and possible solutions. Connell, et al., (2007) identify South Africa and Nigeria as the major sources of skilled health workers emigrating from sub-Saharan Africa. Migrants from these two countries comprise 75 percent of the 5,500 African trained doctors in the U.S. Though this number might seem small in comparison to the number of non-African immigrants in the U.S., it represents a large proportion of the healthcare workforce in African countries. For example, about thirty percent of the doctors in South Africa now emigrate. This migration contributes to healthcare worker shortages, reducing the number of patients who can receive care, the quality of healthcare they receive, and the broader organizational strength of entire healthcare infrastructures in African countries.

In addition to research establishing the magnitude of the brain drain, other research more closely analyzes the subjective feelings of healthcare professionals in African countries. Eric Friedman of Physicians for Human Rights (2004) describes how demoralizing it is for African doctors, who have been trained to heal people, to lack the medicines, technologies, and logistical support to enable them to do this. Similarly, African doctors who believe that part of being a doctor is contributing to and staying current with research developments face great disappointment when they live in an environment where they can do neither. The relative lack of research and training opportunities is described by Hagopian et al. (2005:1755), who note that fewer than half the West African medical school graduates complete post-graduate training in their home countries. In contrast, in the U.S., there are generally more post-graduate training opportunities, such as residency positions for training in a clinical specialty, relative to the number of medical school graduates each year. The U.S. also boasts high-tech facilities, job security, and high salaries. Because of push and pull factors such as these, young medical professionals in African countries often feel that, "If you're ambitious, you'll migrate."

Based on interviews with medical students and faculty in Nigeria and Ghana, Hagopian et al. (2005:1750) even extended this sentiment about ambition and migration to assert that a veritable "culture of medical migration" exists in which peers and faculty encourage migration of medical school students, and feel proud of students who successfully emigrate. This culture is based on the fact that, for at least 20 years, medical schools in Nigeria and Ghana officially included a study abroad component in the United Kingdom (U.K.), to which both countries had colonial ties. Because migration to

countries such as the U.S. and the U.K. has so greatly increased in recent years, it is now commonplace for young Nigerian and South African medical doctors to have friends and family who are, or who have been, abroad, and who can provide migration advice and support.

During the 1960s and 1970s, African immigrants to the U.S. often came just long enough to obtain an education before returning to contribute to their home country. In contrast, Takougang (2003) asserts that the vast majority of recent African immigrants to the U.S. now seek to establish permanent residence. These immigrants often continue to contribute to their home countries by sending remittances. However, Hagopian et al. (2005) argue that these funds often go to private citizens, and thus do not directly benefit the public health and education systems, which provided émigré doctors with free or heavily subsidized medical school educations. At the same time, Hagopian et al. (2005:1758) refer to recent literature about "brain circulation" in which alumni return to their home country, on a rotating basis, to provide teaching and equipment to their alma maters. While such brain circulation would not likely recoup the cost of their medical education, which they received from their country of origin and now use abroad, this could provide a viable means for African trained healthcare professionals to live in the U.S., while still making tangible contributions to their home countries.

Gendered Migration

Despite the contributions made by social scientists in analyzing the brain drain, some scholars would critique such analyses of the brain drain for not considering the impact of gender. These scholars understand gender as a fluid process in which humans act in ways which reproduce or renegotiate gender identities and norms in human

relationships. However, Patricia Pessar (2007:259) notes that "gender becomes embedded in institutions," such as the family, and that these institutions shape people's actions. Thus, migration can be seen as a social phenomenon in which gendered institutions cause women to have different migration experiences than men, and in which women and men can renegotiate gender norms and identities. Furthermore, issues of gender have been found to play a role in each stage of the migration process, from deciding to leave and traveling to the U.S., to finding work and adjusting to life once they arrive (Pessar 2007).

One of the very few works that has as its main focus the intersection of gender and the brain drain in Africa analyzes one of the earliest stages in the migration process – namely, making the initial decision to migrate. This work, "Gender and the Brain Drain from South Africa," by Belinda Dodson (2002), concludes that among people in skilled professions such as medicine, teaching, and engineering, women have a "significantly lower emigration potential than men" (1). This is because, despite the fact that men and women have very similar levels of satisfaction or dissatisfaction with many quality of life indicators in South Africa, women had thought less about emigrating and were more likely to want to live abroad temporarily rather than permanently, as preferred by men. However, Dodson admits that women in her sample were generally younger, less likely to be married, and poorer than the men. Additionally, the female sub-sample was comprised of a higher percentage of blacks and a lower percentage of whites than the male sub-sample. Thus, her findings are likely due to the interaction between gender and these other socioeconomic and racial variables, rather than to gender alone. Furthermore, Dodson's work is based on a fixed-answer questionnaire, and thus does not capture the

subjective perspectives of male and female migrants, as they negotiate the process of leaving.

Other qualitative research has deeply probed the gendered experiences of non-African healthcare professional migrants. Such research shows that even after deciding to leave their home country, Latino women in the U.S., for example, often have different experiences than men. For example, Pessar (2007) explains how some Dominican parents are less supportive of the migration of their unmarried daughters, because the migration of these women elicits concerns of possible sexual freedom and promiscuity, which can harm the reputation of the family. In addition, Pierrette Hondagneu-Sotelo (1994) found that married Mexican women, whose husbands do not support their migration, often rely on female rather than male social networks to aid their migration to the U.S. Differences in level of familial support and types of social networks utilized potentially vary among male and female African healthcare professionals, as they do among Latino immigrant groups.

Finally, upon arrival in the U.S., both female Mexican migrants studied by Hondagneu-Sotelo (1994) and female African migrants studied by John Arthur (2000) renegotiated gender norms in their families, establishing more egalitarian relationships with their husbands. Women obtained more decision-making authority as they began to engage in paid employment, to forge linkages with schools, medical offices, co-ethnic immigrant organizations, and new family friends, and to gain power through increasing their socioeconomic contributions to the family relative to their husbands. Thus, many immigrant women pursue the dual tasks of safeguarding family interests and raising children according to values of their home country, while simultaneously creating more

autonomous roles for themselves. Furthermore, among Latino groups in the U.S., such as Mexican immigrants, women often experience a rise in status due to factors such as increased economic autonomy, while men often experience a loss in status due to racism, job insecurity, and often illegal status. Thus, among Mexican immigrants, Hondagneu-Sotelo (1994) found that men were often more eager to return to Mexico than women.

In addition to taking into account different norms about gender and different expectations about family responsibilities among female African healthcare professionals, one must also take into account the gender hierarchies which exist in the medical field. In the field of academic medicine in particular, Yedidia and Bickel (2001) found that women with childrearing responsibilities often faced difficulties meeting research and clinical demands. Furthermore, most women surveyed in a study by Levinson and Weiner (1991) report that their career has "been slowed or markedly slowed by childbearing" (64). Ochberg, Barton, and West (1989) have found that senior-level faculty members are almost all men, who have the power to provide strong career sponsorship, but are often less likely to understand and support a female academic clinician with more substantial family responsibilities. Junior-level faculty members, who might be more understanding, are unable to provide career sponsorship. Thus, Ochberg, Barton, and West (1989) concluded that women have great difficulties finding mentors, who provide both career sponsorship and a collegial, personally supportive relationship. This lack of effective mentorship is compounded by continued gender discrimination, and by what Fox (2001) describes as subjective, informal criteria for advancement that can "advantage those who 'look like' those currently in power" (662). The combination of these factors often prevents women from being promoted to

leadership positions in academic medicine. African healthcare professionals are potentially subject to these unequal conditions for advancement especially since many of them come to the U. S. for advanced training, which will involve academic research in a particular medical specialty.

Summary

In summary, this research project aims to provide a unique contribution to the research literature on immigration by combining the topics of African immigration, the brain drain of skilled healthcare professionals, and gendered migration experiences. Though there has been scholarship on each of these three individual topics, there has been very little analysis of the African brain drain from a gendered perspective. Such analysis will bring a more nuanced perspective not only to the research literature, but also to the policy debate about causes of and solutions for the brain drain from African countries. The methodology of this project is especially suited to obtaining personal insights from African healthcare professional immigrants which will help answer the three abovementioned research questions concerning this topic.

Methods

Sample

The sample for this study includes four women and four men, who are healthcare professionals working in the U.S., and who have grown up in, have been trained in, and have then emigrated from an African country to the U.S. In general, these men and women all have similar healthcare jobs, and most are, or have been, involved in some kind of residency or fellowship in a medical specialty. This helps prevent the detection of differences that are due to job rather than gender distinctions. However, there are

racial distinctions in the sample, since a few women and a few men are white and from Southern Africa. The fact that there are white migrants in both the male and the female sub-samples, however, means that the sub-samples are less biased than they would be if only one of them included white migrants.

The number of African healthcare professionals in the U.S. is small in absolute numbers. Moreover, the fact that these professionals are somewhat geographically dispersed rather than being in an easily identifiable enclave creates challenges in finding study participants. Thus, my theoretical sample of African immigrants, which includes an equal number of female and male subjects, had to be obtained through targeted snow-ball sampling. This sampling began by pursuing contacts via email among my friends and in the Harvard Medical School (HMS) community. The sample then expanded via the social and professional networks of these people to include professionals in medical centers in the northeastern and midwestern United States. I am conducting semi-structured in-depth interviews with these professionals to illuminate their gendered experiences and aspirations.

Furthermore, I am taking several steps to protect the identity of these professionals. As soon as the interviews are transcribed, the names of participants are removed from them and replaced with pseudonyms. After this de-identification, all remaining interview tapes and fieldnotes that had personal identifiers on them are destroyed. Finally, the identity of study participants remains protected in this research paper as their pseudonyms are used and places of employment and countries of origin are not mentioned.

Interviews

Semi-structured in-depth interviews consist of about forty questions structured around the three main abovementioned research questions of this project: (1) experiences in Africa and reasons for migrating; (2) experiences in the U.S. medical profession; and (3) future aspirations. A semi-structured in-depth interview methodology presents both difficulties and benefits. It is fruitful for establishing trust, comfort, and rapport with participants so that they feel more comfortable to share their subjective perspectives and emotions. It also allows for an understanding of how and why participants make certain assertions and statements about situations in their life, thereby illuminating the processes and significance behind events in their life. However, this methodology does not produce directly comparable data between all interview subjects, and it is influenced by the context in which interviews are collected, such as a subject's time constraints. These challenges are inherent in doing interview-based qualitative research. Nonetheless, it is the most appropriate method for answering the research questions.

Chapter Outline

My thesis will begin with an introduction, which will serve as an epilogue or abstract instead of a full chapter. The first chapter will consist of the literature review. The second chapter will discuss methodology. The next three chapters will present my main results, with each chapter presenting results for one of my three main research questions. One chapter will address reasons for migration, and the similarities and differences between reasons given by women and men in my sample. The next chapter will analyze barriers to advancement due to gender in the healthcare profession. The final chapter will explore differences among men and women in their kinds and specificity of their future career and humanitarian goals. Each of these results chapters

will include a few sections, structured around main points related to the research question addressed in that particular chapter. My last chapter will consist of a discussion of the results and their implications for future research and policy.

Progress to Date

I completed a smaller-scale version of this thesis project for my spring 2008 Junior Tutorial in Sociology (Sociology 98m) on immigration in contemporary America. In conjunction with my Sociology 98m professor, I decided to use semi-structured in-depth interview methodology. In addition, I developed a research proposal, human subjects research application, informed consent form, literature review, and interview guide, which my Sociology 98m professor approved. I used the guide to interview eight people for a research paper that I submitted for Sociology 98m.

I completed three major interview-related tasks from June through September, to advance my research. First, I streamlined my interview guide from my Junior Tutorial project. Though my guide now has fewer questions, these questions are less repetitive and more related to the personal experience of the interviewee. Second, I completed four interviews over the summer. During these interviews, the revised guide proved to be more conducive to drawing as much information as possible within the allotted hour for each interview. Third, I sent hundreds of emails to people, associated with the healthcare professions, trying to find more study participants. After sending these emails, and continuing to cultivate more potential interview contacts, I am confident that I will be able to reach my goal of having twenty to thirty interviewees.

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