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AN OVERVIEW OF CHALLENGES AND MIGRATION AMONG NURSING PROFESSIONALS

Abstract. *The paper intends to explore different aspects of a nurse's work life. The domination of women in the nursing profession and the numerous challenges faced by the workforce are major concerns. Being a woman, a nurse is responsible not only for her job but also for her family. Irrespective of the calls made for gender equality across the globe, today women still shoulder a greater share of household responsibility. A peculiarity of nursing work is the huge demands put on employees' physical and mental health. They are affected on both the occupational and personal fronts. The journey of a nursing professional is not easy and brings a range of challenges that need to be addressed urgently. This will help dissuade nurses from emigrating to foreign lands and save them from burnout and job turnover. Countries across the globe are reeling under the shortage of nurses and the situation will only worsen if action is not taken in time.*

Keywords: *nurses, occupational hazards, job stress, migration, burn out*

Introduction

Globalisation has brought rapid changes to our lives. The movement has shown an upward trend as far as work and technology are concerned. Still, women's progress remains questionable despite their success and achievements. The global outlook for women is still modest despite the education and advances accredited to them. A wide range of studies concerning women speaks volumes about what they have achieved to date, yet the perspective of a woman as a caregiver continues to be a priority. An employee's professional involvement in their work shows their level of efficiency, which is clearly an indicator of job success. However, some jobs are not only challenging but also take a heavy toll on both the body and mind of the employees. One such profession is nursing.

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Nursing is a very stressful and demanding job (Riahi, 2011; Verhaege et al., 2008). The number of people opting for the nursing profession is very low and it is among the last choices of professional occupations. The work time for nursing duties is 24 hours a day, 7 days a week, entailing rotating morning, evening and night shifts. These irregular hours simply add to nurses' working woes. It is hence a highly demanding job both physically and psychologically (Burke, 2013). Moreover, the work sees huge demands being made by both the top management and the patients within the hospital set up. On top of that, the profession has seen an immense shortage of staff that leads to the existing staff becoming overburdened. This contributes to the chaos and stigma as employees try to give the best services possible (Riahi, 2013). Fortunately, the very nature of the work is designed as care giving. It works as a platform for nurses to demonstrate their instinctive nature of care, love and attention while tending to patient needs. At the same time, the job brings several challenges that need to be addressed and require corrective measures to be introduced. Some issues are considered in this paper for detailed discussion so as to focus on their plight and find ways to overcome them. Nursing is undoubtedly a tough job containing many uncertainties that need to be examined (Benligiray and Sonmez, 2013). According to the International Labour Organisation (ILO, 2005), the biggest challenges in nursing are poor infrastructure, management issues, improper work conditions, high work demands, job overload, role conflict and shift work with irregular working hours. Such adverse working conditions with physical and musculoskeletal as well as injuries, burnout and low job satisfaction, make nursing an undesirable profession.

Occupational hazards

One of the most hazardous jobs in the health sector is nursing. It involves activities ranging from needle infections, overexposure to radiation, exposure to chemicals, the frequent use of chemicals and handling of heavy equipment (Chowdhury and Endres, 2010). According to Cheng C. Tan (1991), nurses' occupational health problems are mainly categorised as four types: biological, chemical, physical, and psychosocial. Nurses are the largest category of healthcare workers in every country and these deadly hazards can seriously impact their mind and body. Biological hazards include contracting infections at work, e.g. hepatitis B, tuberculosis, HIV etc. (McDiarmid, 2014). Chemical hazards include health problems resulting from the large numbers of chemicals used in the medical set up, e.g. certain drugs, anaesthetic agents or antibiotics (Ramsay et al., 2006). Physical hazards include the impact of the work that affects nurses physically, e.g. needle stick injuries, back pain or radiation (Akeau and Suchada, 2015; McDiarmid, 2014).

Psychosocial hazards are caused by the existing work conditions that entail a high level of work demands and low control and social support (Pal and Saksvik, 2008). The work atmosphere is affected by stress, shift work and challenging psychological conditions that make nurses vulnerable to mental health issues.

Of all the hazardous conditions, psychosocial hazards are a prime concern and need to be addressed in order to reduce the hazards from an emotional and mental perspective. It is one of the cardinal issues that forces nurses to leave their jobs, in turn possibly creating greater burdens for the existing nursing workforce and the overall work may become more difficult. Organisations across the globe are already reeling under the shortage of nurses, further exacerbated by some nurses who intend to leave their jobs at some stage (Tan, 1991). Nurses are also vulnerable to the varying physical and psychological conditions of patients, adding to the uncertainty and complexity of nursing work and making the significant job demands an occupational stressor (Chowdhury and Endres, 2010). This may adversely impact the safety of the work environment nurses must deal with. The presence of a safe environment is part of a shared employee perception of management practices that illustrate the commitment to safety. This situation is useful for controlling some stressors.

Occupational stress

Occupational stress is defined as the mental/physical arousal caused by external demands affecting workers' physical and emotional work demands. The outcome of the stressors may affect the functioning of the human autonomic nervous system (van der Colff and Rothmann, 2014). Therefore, occupational stress is associated with a higher turnover intention and a very poor mind–body alignment (Mosadeghrad, 2014). Another possible cause of the nurses' occupational stress is the rigid nature of the work.

Two major occupational stressors that have been identified are job pressure and lack of support at work (Spielberger et al., 2003). This is often visible in nursing work where the participation of management is poor, there is a less conducive work environment, little support comes from supervisors, there are multiple responsibilities, long work hours and work overload (Nabirye et al., 2011). Nurses are those who confront patients for most of their day-to-day work. The interaction is stressful because it may involve pain, anxiety, disgust, death and dying as well as emotional labour. Emotional labour is also a crucial factor that significantly impacts nurses' performance. This is related to their emotional involvement with people in the work environment, namely, patients, colleagues or relatives of the patient (Delgado et al., 2017). Hence, the level of stress nurses face is distinctly greater than for

physicians (Tan, 1991). Task overloads are associated with staff shortages, low salaries, limited career opportunities, and less time for direct patient care (van der Colff et al., 2014). One study reveals that occupational stress levels vary across different units of hospitals (Lyons et al., 1987). Nabirye et al., (2011) reported no significant differences in the stress levels of nurses from different wards or units. Hence, contradictory findings exist with regard to the units where nurses work (e.g. medicine, psychiatry, burn wards, emergency etc.). There is a lack of clarity about the occurrence of stress among nurses in various wards or work units in hospitals.

It has been found that the number of hours worked per day and occupational stress is positively correlated. As the working period increases, occupational stress rises (Nabirye et al., 2011). Moreover, according to Paul D. Tyson and Rana Pongruengphant (2004) (as cited in van der Colff et al., 2014) nurses in public-sector hospitals suffer from more stress than nurses in private hospitals. This might be related to the poor infrastructure and unavailability of resources in public hospitals. Rose Chalo Nabirye, Kathleen C. Brown, Erica R. Pryor and Elizabeth H. Maples (2011) reported that longer experience can also lead to high occupational stress compared to nurses with less than five years of work experience.

Nurses also perceive stress in their relationships with colleagues, managers and doctors that often entail disagreements. Stress is also perceived when the requisite resources are not made available to nurses, such as equipment, linen, staff, food etc., due to which the tasks at hand are not well managed (Maluwa et al., 2012). The job by nature is filled with perceived stress and emotionality. Occupational stress has negative effects on employees, including impaired performance, staff turnover, industrial accidents, frustration, burnout, low performance, reduced nurse-patient interaction, health problems, a rise in absenteeism, dissatisfaction, addiction to drugs and alcohol and misconduct like irregularities at work and antisocial activities etc. (Maluwa, et al., 2012; Nabirye et al., 2011). In the long run, such stress levels can ruin the ulterior purpose of an employee altogether. To sum up, work conditions include considerable variability that causes nurses to face the unpleasant circumstances in the workplace, creating further distress and emotional drain. Not only the work environment but also the organisational structures bring several predicaments that need to be addressed. Patient care and service quality are also impacted by the administrative authority that controls the nurse–patient relationship (Mosadeghrad, 2014; Nabirye et al., 2011).

Nurses are also likely to face the problem of having a range of different patients (Chowdhury and Endres, 2010) that depends on how nurses perceive the variability in the patients they interact with. As a result, a greater range of different patients may increase the complexity of performing

variable and routine tasks that, in turn, may increase the potential for errors and occupational injuries (Chowdhury and Endres, 2010). Thus, it may also add to nurses' existing stress levels. Handling the dynamics of patient behaviour can create workplace chaos, pushing nurses' ability to perform down to a miserable low point. Studies on occupational stress recommend that nursing employees who suffer from considerable job demands in the workplace along with poor support for their superiors should be provided with programmes for stress reduction (Riahi, 2011). Programmes for improving the proper recruitment and selection of management who can provide better output should be conducted to retain a quality workforce (Nabirye et al., 2011). Further, intervention schemes and social support systems using counselling and such training programmes can help nurses resolve their stress levels (van der Colff and Rothmann, 2014).

Poor salary structure is another cause of stress for nurses and should be handled effectively to ensure congruence between nurses' efforts and their rewards system (Nebirye et al., 2011). Large organisations already use workplace practices such as flexi-time, working from home, day care facilities and crèches etc. to allow their employees to more effectively deal with work pressure. Organisations should set up centres for women to teach self-management skills in order to handle stress, anxiety and emotional difficulties. They should learn to plan, solve problems, control emotion and develop a positive attitude and self-efficacy (Desai et al., 2011). Financial freedom for women may also bring along with it stress that affects their life and work satisfaction. In general, the key needs of working women are about the availability of social and organisational support with the possibility of providing a congenial workplace that includes part-time jobs, job sharing, paid leave, paid sick leave, affordable childcare and workplace flexibility. This will help firms' ability to hire and retain skilled employees. More precisely, there is a need for flexible work circumstances and a feminine attitude at work (Desai et al., 2011).

Shift work

The most pressing issue in the nursing profession is how to cope with their lives in the setting of shift rotation. This adversely impacts their physical and psychological health. The hospital is a service organisation which runs 24 hours a day, 7 days a week. Shift work causes sleep disturbances, fatigue and ineffective work performance. Studies show how sleep is upset by shift work, causing health issues and job strain (Karhula et al., 2013). It is especially jobs like nursing that are said to be high-demand and low-control by Karasek and Tores Teorell (1990) in his model depicting variables like job demands, control and support. Studies show that job strain affects sleep

patterns in the setting of shift work more than of non-shift work. The effects are particularly visible among females than males (Karhula et al., 2013). A systematic review of studies of shift-working nurses reveals the impact of shift work includes interference with their circadian rhythms, sleep deprivation, fatigue, lower attention levels, leading to a poor work performance and many critical problems (Niu et al., 2011; Wickwire et al., 2017). It has also been found that impaired sleep is strongly linked to shift work and strain due to the rotation of work hours (Wickwire et al., 2017).

Physical health conditions

A good share of nurse absenteeism is reported due to physical strain or musculoskeletal injuries. It was once believed to be caused by physical factors alone, but studies now also confirm a significant association between occupational stress and strain (Marras et al., 2000; Shamian et al., 2002).. Mass restructuring and job downsizing have led to job strain and intense physical activity on the part of nurses. Moreover, the work environment is constantly changed, adding to stress in one's job (Shamian et al., 2003). According to Mary Jane Feldman (1987; as cited by Tan, 1991), in fulfilling their duties nurses face hazardous physical challenges, like needle stick injuries, back injuries and sprain etc. Several studies indicate the high prevalence of needle stick injuries among nurses. The consequence of a needle stick injury might just be temporary, but it is also possible it may lead to a disability for life. Workers faced with tough physical work complain of back pain, seen particularly among nurses working in hospitals while handling patients. The act of lifting patients has been identified by nurses as the leading cause of back problems (Tan, 1991). A meta-analysis found that nurses working across a large number of hospitals reported that physical work conditions were some of the most prominent reasons for musculoskeletal injuries (Shamian et al., 2003). In short, the work circumstances associated with nurses' physical vulnerabilities include the unavailability of resources, untrained staff, a shortage of staff, and precarious work conditions. Apart from these, managerial problems that are authority-based or involve role conflict, job insecurity and poor support of supervisors result in a sub-optimal and hazardous work environment (Mosadeghrad, 2014).

Methods tailored to specific jobs can be prepared that consider a careful analysis of nurses' daily tasks with a focus on the most demanding tasks, followed by less demanding ones (Demerouti et al., 2000). The supervisory role is also a prime factor in the functioning of a healthy and effective organisation and ensuring employees' support in the form of conflict management, task execution, emotional support and skill development (Nebirye et al., 2011; Riahi, 2011). Most importantly, managers must create a safe work

environment that adds to a greater perception of safety. Managers' communication and behaviour help reinforce the employees' perception that safety is a primary goal that it is rewarded and should be carefully monitored. The need to deal with patient variability is another concern. It can be managed by creating a structured flow of nurse work, nurse assignments and patient–staff ratios can be effectively introduced since it is difficult to control the types of patients and their conditions (Chowdhury and Endreset al., 2010).

Burnout

Long-term exposure to the emotional and traumatic conditions at work makes burses become indifferent to their job, better known as burnout. It has three important facets: emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach et al., 2001). The significant association of burnout with the nursing profession is well cited in numerous studies (Cropanzano et al., 2003; Hobfoll and Shirom, 2000; Maslach et al., 2001). Some studies show that burnout is closely related to mental strain in one's job, especially when the job involves direct contact with clients, such as in nursing (Bakker and Schaufeli, 2000; Brenninkmeyer et al., 2001; Jennings, 2008). A recent study also indicates that job burnout has a strong correlation with nurses' subjective well-being. A high level of burnout may cause a decline in subjective well-being, leading to psychosomatic diseases (Qu and Wang, 2015), characterised by unhappiness with one's job and dissatisfaction with one's professional achievements (Vargas et al., 2014). Burnout at work is especially linked with stressors that remain in the work environment for a longer time (Maslach et al., 2001). Female workers in particular have been found to be victims of burnout more than their male counterparts (Maslach et al., 2001). It has been observed that women are more likely to respond to emotional exhaustion than men, who according to the gender role theory (Eagly, 1987; Portoghese et al., 2014) are more likely to relate to depersonalisation. Psychosocial factors such as exhaustion, burnout and frustration and the lack of social support from one's superiors and co-workers are stated to be the most important factors for nurses' poor health conditions (Shamian et al., 2003). One study established a high and significant correlation between burnout and job satisfaction, i.e. when workers are more satisfied with their jobs, they felt more professionally fulfilled (Vargas et al., 2014). The heavy workload of medical employees is a source of exhaustion. Exhaustion causes stress which lowers the individual's physical and mental abilities, ultimately leading to burnout. Burnout results in high turnover and work absences as well as low job satisfaction. Thus, the quality of the work environment plays an important role in betterment of the nursing workforce (Portoghese, et al., 2014). Important work

variables, like role ambiguity, a conflicting work structure, work–family conflict, job complexity, organisational politics, and the work environment itself are identified as the antecedents of emotional exhaustion that is linked to burnout (Kar and Suar, 2014).

Although the incidence of burnout cannot be eliminated altogether, greater participation in work-related decision-making can help nurses in dealing with their heavy job demands, suggest Suryatapa Kar and Damodar Suar (2014). Further, to control burnout, efforts should be made to formulate strategies aimed at reducing nursing workers' workload and enhancing their skills. In other words, considerable job autonomy can be option for managing occupational stress most effectively (Portoghese et al., 2014). The need to develop a healthy work environment that entails good social participation among the workforce requires a stronger emphasis on the safety and security of the workforce by providing opportunities to learn new techniques and skills, conducting workshops, integrating the diverse set of employees, honouring them with rewards and recognition. These approaches give a positive boost for the work performance of employees and their overall well-being (Mosadeghrad, 2014).

Feminisation of the nursing profession

Women are generally seen as natural care givers. The tendency to nurse and show care is an inherent quality women are endowed with. Nursing is a platform that enhances a woman's character, thereby further manifesting this quality. It is the reason nursing fits with the nature of women, allowing them to grow and generate a reputation. The feminine orientation of the job arises naturally in nursing (Adams, 2010).

While fewer males are involved in the profession, the number of male nurses is growing. Although the pace at which males are taking to nursing is slow, their participation remains undisputed (Evans, 1997). Women have always taken the backseat in the healthcare sector, especially in higher positions. Positions of authority are generally dominated by men, while supporting staff are typically female. Their job profile dominates in nursing-like positions or similar lower positions within the hospital set up (Adams, 2010). This shows the male domination of high work positions in hospitals, with female employees being seen in lower down positions like health workers or nurses. The subordination of females to male authority is quite evident in the healthcare industry.

The importance of gender difference has been boosted by the process of feminisation which is becoming ever more acknowledged (Adams, 2010). The female presence in nursing has been strong and continues; even if men are joining the profession it is at the level of a mere 7%, even in developed

countries like the USA and the UK. This movement is insignificant compared to the fact that women have been in nursing for a long time. This may reflect the fact that higher education and learning allow female nurses to more efficiently perform the work. The overall outcome is a rise of women's participation in advanced countries. The mix of professionalism along with the feminine attitude at work puts women in an optimal position in the nursing occupation. Other areas where women have been able to change the work landscape are law and management (Adams, 2010).

With a view to establishing greater gender diversity, men are encouraged to join the nursing profession. Studies refer to the perception and stereotype in Canada deterring men from entering nursing (Bartfay et al., 2010). The focus in nursing has been on the feminine way of handling patients. This has proven to be a major barrier in the promotion of male participation in the profession. There is a dearth of male role models in nursing, limiting active male participation in the area of patient care. The Canadian perception of male nurses is worse than for female nurses (Bartfay et al., 2010). In the nursing profession, the existence of males is regarded as tokenism and their number and role they play is minor. The very nature of the job has a nurturing and supporting style of work embedded in it. Hence, greater importance has always been placed on women more than men. Moreover, male nurses mostly stay away from basic care-giving jobs and prefer administrative or supervisory work. This is one way to keep themselves away from the lower work relations with female nurses. Having the advantage of being task-oriented in temperament, male nurses tend to adopt separate roles and responsibilities from their female counterparts (Evans, 1997).

Men choose to enter nursing on the basis of similar reasons as women, namely job security, career mobility, job opportunity and the desire to help others. There is always the social context attaching the feminine approach to nursing which dissuades men from entering the profession in greater numbers. The attrition rate of men in nursing education is quite high in developed countries due to the feminisation of the profession (Kellett et al., 2014).

Emigration of nurses

Nurses form an integral part of the medical service. Their contributions effectively support patient care. One of the most urgent areas of concern is the emigration of nurses. This issue of nurse emigration is faced by a large number of developing countries. The workforce serving as nurses in developing nations sees a significant number of such workers emigrate to a more developed country not only for the sake of a better salary but also for improved working conditions and possible growth as a professional (Bulletin of WHO, 2010). In addition, the regular emigration of qualified

doctors and nurses to other countries in the pursuit of better living conditions makes the scenario for nursing even murkier (Rao et al., 2011).

There are different versions of the emigration issue. The 'push and pull' factor is prominent and denotes two vital factors that lead to emigration (Alexis and Vydelingum, 2007; Dwyer, 2007). The push factors are found within the native country such as low pay, unemployment, modest benefits, and reduced scope for professional growth and career progress that forces nurses to leave their own country. In contrast, the pull factors lie within destination countries and may include lucrative aspects that entice nurses. They may be in the form of an attractive income, a better workplace, a rich learning experience and a possibility of career advancement. Countries like Asia, Africa and the Philippines are some of the main places nurses often emigrate from to economically stable countries like the USA, the UK and Europe generally (Alexis and Vydelingum, 2007; ILO, 1998; Nkemakonam et al., 2013). Another factor causing nurses to leave is the concept of 'care drain' (Kaelin, 2011). Source countries like sub-Saharan Africa which provide a large supply of nurses to developed countries suffer from a shortage of nurses for their own people. This imbalance in supply and demand for nurses across the globe is known as the care drain. It adds to the inequality in nurse–patient ratios in developed and developing nations. As per the WHO 2007 report, countries in Europe have 10 nurses per 1,000 patients whereas there are nearly 0.5 nurses per 1,000 patients in sub-Saharan Africa. Yet another element in nurses' emigration is socio-political, economic and personal factors. The huge migration from Africa to other countries is affected by political, social and economic instability. This results in nurses shifting from countries like Sierra Leone, Mozambique, Angola, Zimbabwe etc. to the USA and the UK and other European countries (Kaelin, 2011). The Philippines is a large exporter of nurses to developed nations since the country is suffering from mass unemployment (Hosein and Thomas, 2006), while economic stagnation in Zambia and Tanzania forces their nurses to relocate to other countries. Colonialism is one more factor that sees migrants moving to the country that once ruled over their place of origin. Examples include nurses emigrating from South Africa to the UK, Congo to Belgium etc. since nurses have developed a close association with them and share the language. Thus, the political situation facilitates easy movement and settlement in the destination. The geographical proximity of these countries also plays a vital role in nurses relocating from one country to another. Healthcare workers also often migrate to the closest country. The demand for more nurses in Western countries has prompted developing nations located nearby to seek to change this story (Kaelin, 2011). Lastly, globalisation also serves provides wide opportunities for migrants to relocate to the best possible location in terms of job security (Larsen et al., 2005; Sharma, 2011).

Thomas (2006) reported unhappiness concerning the prevalent social attitude to nurses in India as the major reason for nurses choosing to leave the country. One of the prime causes for nurses' emigration is the lack of proper training and the outcome is an acute shortage of nurses. This situation is growing steadily and rampant. Nursing is a predominantly female profession. Thus, the process of feminisation is also affected by migration (Kaelin, 2011). The changing work conditions in the world see a clear rise in female migration. Women migrating from their homeland to other developed countries account for nearly a significant portion of the total population of the world, states the United Nations, 2006. Specifically, there has been more female than male emigration from Asian countries and the African continent. The reason for this shift is need in other countries to meet the demand for highly skilled workers like nurses. This work is strongly feminised as females are the leading workers in such jobs. Indian women have been increasingly emigrating to Western countries, the Gulf countries, Australia and other Asian countries (Sharma, 2011). Female emigration from Kerala is quite high, specifically to the Gulf States. The causes for theme migrating are low pay, unemployment and poor living conditions compared with other developing countries. Developed nations look to Asia and Africa as places where they can find nurses to address their healthcare employment shortfalls (Humphries et al., 2008; Sharma, 2011). Indian nurses form a big share of overall nurse migration to those countries. The majority of nurses come from southern India. The degree of relocation of Indian nurses to the USA, Ireland, Australia and the Middle East has been considerable. According to Niamh Humphries, Ruairi Fionnbarra Brugha and Hannah McGee (2008), of the 10,000 nurses in Ireland, around 2,000 nurses come from India and the Philippines. This is a good example of the large-scale migration from developing countries to developed countries in the hope of a better livelihood, something that may greatly threaten the global healthcare system. Research not only shows the migration of qualified nurses but also those seeking an improved work status. Nursing is also considered as a job with good future prospects and international mobility (Johnson et al., 2014). Similarly, a large proportion of emigrants have gone from the African continent to Western countries. Ghana is another country on the African continent that is witness to bigger outflows of nurses to developed nations compared to their male counterparts (Nowak, 2009). While the movement of female nurses from Ghana is underpinned by the same factor of earn a better living, they also have a strong interest in growing professionally (Nowak, 2009). South Africa is also another example where nurses are moving to the UK in order to stabilise their economic situation and secure their future (Hull, 2010). Developing countries are severely affected by shortages of healthcare workers too. This is largely due to the unchecked migration of qualified nurses

from rural to urban areas and from poor to wealthy countries, leading to grave and uncertain health conditions for the locals (Hosein and Thomas, 2006; Kaelin, 2011; Nkemakonam et al., 2013; Pruitt and Epping-Jordan, 2005). Controls in this regard are therefore strongly required. It is also suggested that the migration process is not all bad because it generates remittances for the source nation and the migrant workers return home eventually with a great deal of knowledge to benefit their country (Lewis, 2011).

Therefore, countries like India encounter issues of nursing retention, job insecurity and low pay in both the private and public sectors, issues that remain to be tackled. Moreover, health worker migration also points to the need at ground level to enhance the work environment and professional growth in the source country. Both sides of the migration process also have something good to offer in terms of benefits. Hence, it is very urgent that source and destination countries establish a feasible agreement on the serious issue of migration and maintain good control to ensure a balance of and justice for those migrating.

India is said to be the home of the largest female population of professionals employed in the areas of information technology, finance and healthcare, after the USA (Desai et al., 2011). Employees' participation in the two key domains of work and the family remains in a critical balance, especially for women handling the dual responsibility of family and work, as opposed to men (Lingard et al., 2007). Nursing is regarded as a highly respectable profession in India. A large share of the nursing profession is female in India, like it is across the globe. In general, paid work has always been considered a man's job and females are supposed to take greater responsibility for the family alongside their work (Sahoo and Rath, 2003). The result is it is more difficult for a female nurse to be simultaneously involved with their work and their domestic work.

There is a poor output management and employee-oriented work environment as well as insufficient infrastructure in India (Bulletin of the WHO, 2010). This makes it difficult to manage work and family domains and strike a reasonable balance between the two. Nursing employees find it tough to manage the workplace crisis and face difficulty in handling complex situations effectively due to poor training and knowledge. This difficulty in balancing family life and work not only impacts women in India but also women across the globe (Desai et al., 2011). About 40% of Indian women are supported by their spouses in the sharing of household work and about 45% have help from their spouse in childcare too (Rout et al., 1999). According to a study by Mahadevan Sundarraj (2006; as cited in Desai et al., 2011), of the total population 17% of Indian working women are living in an urban arrangement. About 90% of urban Indian working women have full-time jobs, of which 80% work six days a week and 60% live in nuclear

families. Only 21% of urban Indian working women manage to have paid domestic help. This indicates the call for the nursing workforce to be better taken care of to prevent the scenario becoming irreparable.

In developing countries like India, the healthcare system is clearly seen to be in a dismal state (Ramani and Mavalankar, 2006). Although a major concern for the nation, the implementation of health provision is still in poor shape. The necessity of having healthcare workers is on the rise, but it remains hard to fill positions. Public healthcare is only available to 45% of the total Indian population in terms of inpatient care. In such a scenario, private healthcare facilities are taking advantage and seeking higher fees for providing basic healthcare.

A number of circumstances make the 'push and pull' factors the dominant features of the movement of nurses around the world (Garner et al., 2015; Kline, 2003). Low salaries, poor working conditions, low self-esteem and a perceived lack of career opportunities at home serve as the contextual factors that push Indian nurses to seek employment in foreign hospitals (Johnson et al., 2014; Nair, 2012). The profession has seen over time an improved picture for employability and the chance to earn an income overseas. The pull factors are the better job prospects and ever-growing demand for work outside the country (Johnson et al., 2014).

India suffers from a shortage of nurses in the healthcare sector. In addition, the workforce is in dire need of trained and skilled nurses. A big chunk of this workforce is concentrated in urban places, making it difficult to obtain good nurses in rural and remote India. There are widely unrealistic nurse-to-patient ratios, the unavailability of support staff and poor healthcare facilities. Interestingly, the nurse-to-patient ratio in India is 0.7 doctors and 1.5 nurses per 1,000 people, well below the WHO average of 2.5 doctors and nurses per 1,000 people (WHO, 2010). Despite the support provided by the government, it is a great challenge to bring in trained nurses to the remote areas of the country. Moreover, the regular emigration of qualified doctors and nurses from India to other countries for the sake of better living conditions exacerbate the existing nursing scenario (Rao et al., 2011). Therefore, the large share of vacancies (around 18%) for nursing staff seems to be on the rise in primary and community health centres. India urgently needs to develop policies that examine ways to expand and develop trained health professionals who can give leadership and direction to the health sector nationally (WHO, 2010). This also indicates that India is still dealing with a crisis of job insecurity, low pay in the public and private sectors, a non-conducive work environment and improper work conditions. These problems are tough and need to be addressed urgently in order to mitigate the nurse work crisis within the nation and ensure quality hospital services for patients.

Conclusion

Empirical studies on the nursing profession show how difficult the hospital set up can be and how nurses manage to work and survive. The nursing workforce is primarily female. Therefore, it is becoming important to assess the adversities they face. The irregular hours involved in shift work and overtime have been shown to cause high work stress and physical strain. The unpredictability of the work situation creates a tough environment for nurses. Moreover, the possible work hazards take a heavy toll on the health of the nursing workforce. Physical strains like lifting and shifting patients without much instrumental support are a big challenge for nurses. It would make a considerable impact if the crisis of shift and overtime work could be handled more effectively. Very importantly, skilled and qualified nurses do not see a future in underdeveloped and developing countries like India and Africa, resulting in a situation where nurses prefer to migrate to developed nations. This hint at the problem of a nursing job being low paid and limited in growth opportunities. This must be worked out as pay is a very crucial factor in nurses' emigration. Amending the relevant policies and regulations will help curtail the huge levels of emigration from the country. Further, the social attitude to such jobs is poor and this mindset needs to be changed. Indian society, for example, does not see nursing as a better job in comparison to other jobs. In order to improve their lives and living conditions, the nursing workforce prefers to leave. This is leading to a severe staff crunch in the homeland and poor-quality services for patients. It remains critical to find ways to elevate nurses to better social positions and ensure they enjoy good pay levels, enticing them to remain rooted in their place of work and perform their job effectively. Hospitals should find programmes to equip nurses in the performance of a number of training activities by adopting new technology and using inexpensive strategies to increase nursing effectiveness. The nursing workforce must also be provided with quality time to rest and relax in order to ensure they are more productive at work.

In the end, steps must be taken by government agencies and their policies to bring a change to the overall landscape facing nurses. A good level of coordination is sought from both nurses and management to deal with occupational stress and job strain. Further, there is a need to find strategies to improve salaries in the public health sector that provide certain benefits and privileges to the children of the nurses as well as a stringent condition to deter migration. An affirmative and growth-oriented work environment is required for nurses' intellectual improvement and professional growth. These are some of the possible ways of improving the likelihood of containing the nursing workforce in the country and dissuading its emigration.

We hope that the challenges can be mitigated in due course by such

steps and they provide a possibility for dealing with the shortage of nurses in the country. The developed nations that benefit from Indian healthcare workers relocating there can also contribute to India by providing opportunities for nursing students to be trained and educated.

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