

BRAIN GAIN

MAKING HEALTH WORKER MIGRATION
WORK FOR RICH AND POOR COUNTRIES

VSO briefing: the perspective from Africa



CONTENTS

FOREWORD	3
EXECUTIVE SUMMARY	4
1. Introduction	6
2. Why migration isn't working for Africa's health services	8
3. Why migration isn't working for Africa's health workers	13
4. Why the UK needs to address this now	16
5. Making migration work for all	18
6. Conclusion and summary of recommendations to the UK Government	28
Appendix	30

FOREWORD

The global circulation of skills is at the heart of VSO's approach to development. For over 50 years we have been bringing people together from different parts of the world to tackle poverty by sharing ideas, knowledge and expertise. Our experience shows us that this exchange is vital for building people's capabilities, fostering innovation and bringing about lasting change.

We are passionate about the benefits of global skill sharing – not just for the poor and disadvantaged people where we have our programmes, but also for our volunteers who return home with enhanced skill sets and increased cultural understanding.

We know that migration can have significant benefits for individuals, their families and their communities. The impact of remittances has been well covered by others, but we believe that the exposure to new ideas, skills and networks that diaspora communities and returning migrants bring with them has even greater potential to help bring about sustainable development. Our wealth of experience has demonstrated the difference that small numbers of skilled professionals can make, but it has also shown us just how devastating the effects can be when key personnel are lost.

VSO has been sending British health professionals as volunteers since the sixties. As a result, our volunteers and staff have been at the frontline of the health workforce crisis. Nowhere more have we seen the devastating impact of under-investment in health systems and the health workforce than in Africa.

In recent years, we have responded by partnering with the UK's Department for International Development and African health ministries to send more volunteers to train local health workers and provide vital hands-on care. Since 2005 we have also supported members of diaspora communities in the UK to volunteer in their country of origin. However, we remain conscious that filling gaps through volunteers can only ever be a short-term solution, particularly when many African-trained health workers continue to migrate to meet labour shortages elsewhere. The OECD, and particularly the UK, is a preferred destination for many African health workers.

Our volunteers, staff and partners have seen the impact that this migration has had for health systems already struggling with severe staff shortages. They have also seen the consequences for the health workers who migrate and those left behind. We have become increasingly concerned that the current situation is no longer sustainable and are convinced that a new approach to tackling the brain drain of health workers is urgently needed.

We undertook to produce this briefing paper because we believe that the sustainability of Africa's health systems, and the long-term effectiveness of international aid efforts to strengthen them, rests on finding a solution to the global mobility of Africa's health workforce. We also felt the time was right to bring a human face to the immigration and 'brain drain' debates. VSO's unique contribution is our ability to bring people together to tackle poverty, and so this report aims to let policy makers hear themselves the voices of those who choose to migrate from poor countries and those who see the impact this has on the health systems they leave behind.



Brian Rockliffe, Director, VSO UK

EXECUTIVE SUMMARY

Many African countries are suffering from severe health worker shortages. Aid efforts to address these shortages are currently being undermined by the permanent migration overseas of health workers trained in Africa. A new way of managing migration is needed to ensure that efforts to scale up the training of Africa's health workforce can be sustained and progress made towards achieving the health Millennium Development Goals. The UK Government should work with developing countries to address the underlying causes of migration and implement policies that make it easier for migrant health workers who want to return home.

BACKGROUND

Fifty-seven countries worldwide suffer from a severe shortage of health workers. Thirty-six of these are in Africa, which has just three per cent of global health workers but bears 24 per cent of the global burden of disease.¹ In Malawi, for example, it is estimated that there are just two doctors for every 100,000 people.²

These shortages have been exacerbated by tens of thousands of health workers leaving Africa to find employment in the world's rich countries. It is estimated that 23 per cent of doctors trained in sub-Saharan Africa are now working in OECD countries.³ The UK has historically been an important destination country for migrant health workers from all over the world. In 2007, an estimated 31 per cent of NHS medical staff had qualified outside the European Economic Area,⁴ while migrants were estimated to make up 35 per cent of the nursing workforce in older adult care in 2008.⁵

The migration of health workers also has considerable implications for international aid efforts, particularly those focused on scaling up the recruitment and training of health workers in developing countries. According to WHO estimates, in 2002 Ghana had already lost around \$60 million in investment and training of health workers.⁶ Other estimates suggest that each emigrating professional represents a loss of \$184,000 for an African source country.⁷ Reducing the permanent loss of trained health workers is therefore critical to building confidence of donors and governments at a time when investing in scaling up the recruitment and training of Africa's health workforce is urgently needed.

VSO's role

VSO's volunteers, staff and partners have seen first hand how migration is damaging Africa's already struggling health systems. We have also experienced the conditions that force people to leave behind family and friends, and worked closely with members of the diaspora here in the UK.

Our experience indicates that to fight poverty effectively, it is vital that the voices on the frontline are heard. Their insights enable us to look beyond the statistics, comprehend what is really happening and find innovative solutions appropriate to the local context.

This paper is the outcome of a series of in-depth interviews and group discussions with over 100 African health workers and others at the grassroots to understand their experiences of migration and their ideas for solutions to it. We hope that the testimonies of those most closely involved with migration will provide an important addition to the wealth of academic literature on this issue.

THE PROBLEM

In Africa

The people we spoke to gave many reasons for their decisions to migrate, but one was mentioned time and time again: the pressure of working on crowded wards with few drugs and little essential equipment. Meagre salaries, limited opportunities for promotion or development and a general feeling of being undervalued were also recurring themes.

Perhaps not surprisingly, the research also revealed that once health workers have migrated, relatively few ever return to their country of origin to work in the public health service that originally trained them. Those health workers left behind suffer from declining motivation and morale as well as a lack of experienced role models. As a result, there are too few health workers with the skills and motivation needed to treat the queues of patients who arrive every day at Africa's hospitals and clinics. Patients receive inadequate attention and thousands of people die unnecessarily.

In the UK

The overall picture for the health workers who successfully found jobs in the UK was surprisingly mixed. Many of the nurses we interviewed had at some point had to work considerably below their skill level, including by taking jobs in private care homes. Typically, this was because of the difficulty they experienced in finding hospital posts due to the lack of recognition for their qualifications gained at home. Diaspora organisations and professional associations all voiced strong concerns about the potential deskilling of the migrant health workforce and the negative impact that would have for developing countries seeking to encourage health workers to return.

The pull of home

Our research critically found that many African health workers did not conceive of their move to the UK as permanent. They expressed a desire to go home, either permanently or temporarily, but felt constrained by legal, financial and regulatory barriers both in the UK and their country of origin.

Some, particularly those who ended up initially taking lower skilled and lower paying jobs, were staying longer in the UK than they wanted to because it took more time than expected to acquire the professional skills they desired or money to return home. Others had already started on their citizenship journey and didn't want to compromise this to return home.

THE SOLUTION

To manage migration more effectively, policy makers in both the developed and developing world will have to rethink their perception of migration flows as being permanent and one-way (from poor to rich countries). This does not accurately account for the aspirations and plans of many migrant health workers, who overwhelmingly aspire to return home.

Instead, policy makers should implement measures that will promote circular migration, the legal and recurring movement of people between countries. Circular migration should facilitate the mutual gain of skills and knowledge, at the same time ensuring migrants are not exploited. Barriers to returning home, such as rigid citizenship pathways, should also be reduced for those migrants choosing to go back to their country of origin temporarily or permanently.

Outlined below is a summary of the policy framework the UK Government should employ to make the circular migration of health workers a reality.

1. Get migration working outwards as well as in

Make it easier for skilled migrants who have contributed to our public services and economy to return home and help their country of origin, either temporarily, permanently, or on a recurring basis, according to individual choice. We should support those who want to go back by making provisions for a 'pause' in the citizenship journey, encouraging diaspora volunteering, and increasing the advice available to help them return. It will save lives in Africa and reduce permanent brain drain to the UK.

2. Build up African health systems and workforces

Many health workers who come to the UK want to take back new skills to their countries of origin, but are frustrated by the poor working conditions, inadequate staffing and lack of career prospects in their home countries. At least half of the UK's existing aid to global health should go towards tackling the underlying causes of migration and barriers to return by helping poor countries to strengthen their health infrastructure and build up their workforces. Returning migrants should play a vital role in helping to train and build the skills of health workers.

3. Support the professional development of migrant health workers in the UK

Supporting migrant health workers in the UK to share their skills back at home will be important for efforts to reduce the number of maternal and child deaths in poor countries. The UK should ensure that it supports migrant health workers to develop professionally by expanding training opportunities through schemes such as the Medical Training Initiative and ensuring migrants take jobs appropriate to their skills and qualifications. This will also enable the UK to continue to attract the brightest and best health workers to help meet our labour needs. Working with developing countries to ensure recognition of any skills gained by migrant health workers in the UK will support them to deploy those who return most effectively.

¹ World Health Organisation (WHO), 2006, Working Together for Health, p.xix

² WHO, 2006, Working Together for Health, p.194

³ WHO, 2006, Working Together for Health, p.99

⁴ NHS Information Centre, NHS staff 1997-2007, quoted in Slowther et al, 2009, Non UK qualified doctors and Good Medical Practice, Report for the General Medical Council, p.9

⁵ COMPAS, 2009, Migrant Care Workers in Ageing Societies, p.58

⁶ WHO, 2002, quoted in IPPR, 2005, Migration and Health in the UK, p.12

⁷ Pang, Langsang and Haines, 2002, quoted in IOM, 2006, Migration and Development: Opportunities and Challenges for Policy Makers, p.10

1. INTRODUCTION

VSO, like other international development agencies, is operating in an increasingly interconnected and globalised world. Since the nineties, a key feature of this world has been the growing migration of people from poor to rich countries.

It is in the health sector, and particularly in Africa, that VSO has felt the effect of international migration on our development programmes most strongly. Over the past two decades, thousands of health workers have left Africa to find employment in the world's rich countries. Although estimated figures vary, the trend has long been clear: Africa has lost, and continues to lose, some of its most qualified and highly-skilled workers to countries such as the UK, US, Australia and Canada.

The World Health Organisation states that just under a quarter of doctors and five per cent of nurses trained in Africa are now working in OECD countries.⁸ For some countries, however, the rates are even higher: 29 per cent of Ghana's physicians work outside the country, as do 34 per cent of Zimbabwean nurses.⁹

Although there is no systematic collection of data on the total number of foreign workers in the UK health service, according to NHS estimates, 31 per cent of the 90,698 medical and dental staff in hospital and community health services¹⁰ in 2008 qualified in countries outside the European Economic Area.¹¹ The UK's 2000 census, meanwhile, recorded 15,258 physicians and 20,647 nurses born in Africa.¹²

Much attention has understandably focused on the negative consequences of brain drain for Africa. However, a more nuanced picture is now beginning to emerge as the potential development benefits from migration become better understood.¹³ As research by the Institute for Public Policy Research (IPPR) has recently shown, migrants are likely to benefit economically; helping to lift themselves, friends and family, out of poverty. Moreover, in some contexts, the prospect of migration may act as an incentive for increasing educational achievement. In other situations, returning migrants can bring new skills, while diasporas offer 'social transfers' in the form of economic opportunities, knowledge and attitudes.¹⁴

As an organisation that brings people together to fight poverty, we understand the value of listening to those on the frontline. Their knowledge enables us to look beyond the statistics to comprehend what is really happening and find innovative solutions appropriate to the local context. We commissioned this research to enable policy makers to hear the voices of people involved in migration and those trying to deal with its consequences. Our aim was to consult African health workers and others at the grassroots to find out how they felt migration could be more effectively managed to achieve development gains.

OUR APPROACH

Our approach centred on in-depth interviews and focus group discussions with African-trained migrant health workers in the UK, as well as aspiring migrants and returned migrants in Malawi, Uganda and South Africa. In addition, we conducted semi-structured interviews with a wide variety of organisations supporting migrant health workers in the UK and Africa, including union representatives, diaspora organisations, academics, NGO staff and government officials. This paper also draws on interviews and reports from numerous VSO health volunteers and programme staff across Africa between 2008-10.

The focus of this report is the excerpts from our group discussions and interviews - they illustrate the experiences and recommendations of those most closely involved with migration. By drawing from their personal stories, we have deliberately tried to paint a broad picture of views from across Africa. We hope these testimonies will provide an important addition to the wealth of academic literature on this issue, and encourage others to undertake more detailed and context-specific research of their own.

⁸ WHO, 2006, Working Together for Health, p.99

⁹ WHO, 2006, Working Together for Health, p.100

¹⁰ This includes the posts of consultant, associate specialist, staff grade, registrar group, senior house officer, foundation year 2, house officer and foundation year 1, hospital practitioner/clinical assistant, other staff

¹¹ NHS Information Centre, NHS staff 1997-2007, quoted in Slowther et al, 2009, Non UK qualified doctors and Good Medical Practice, Report for the General Medical Council

¹² Clemens & Pettersson, 2007, New data on African health professionals abroad, Working Paper No 95, Centre for Global Development, p.22-23

¹³ IPPR, 2010, Development: Do points mean prizes; UNDP, 2009, Overcoming Barriers: human mobility and development

¹⁴ IPPR, 2010, Development: Do points mean prizes?, pp.10-12

"A lot of the problem is that people are migrating out into other parts of Africa and Europe, where they can earn a better living and can work in a service that they feel appreciates them better. We have a number of medical schools, at least four, and they probably churn out around 200 medical doctors a year, who tend to work on average around 2 years in the country, and then they move on. They do public health degrees and go to South Sudan, where there's more money, or they move on to South Africa, where they can earn a better living, and they're in services that are better run. Or they go on to the West - where there are shortages of health workers too. People leave the country, because they feel happier, or more fulfilled in other places."

Sarah Kyobe, VSO Health Programme Manager, Uganda

STRUCTURE

This research found that the global migration of health workers is currently generating only limited development benefits while potentially undermining efforts to strengthen Africa's health workforces. Our briefing paper covers this as follows:

- **Section 2** outlines why migration is having a negative impact for Africa's health systems
- **Section 3** explores why the potential benefits for individual migrants are not being fully realised
- **Section 4** provides an overview of why the UK Government should address this issue
- **Section 5** presents recommendations to get migration working for everyone
- **Section 6** offers a conclusion and summary of the recommendations.

Because the UK is currently at the forefront of efforts to strengthen health systems in developing countries, while at the same time remaining an important destination for migrant health workers, our recommendations focus on what the UK Government can do through its international development, health and immigration policies. Many of these policy recommendations, however, may also be relevant to other key destination countries for migrants, including the US, Canada and Australia as well as those within the EU.



2. WHY MIGRATION ISN'T WORKING FOR AFRICA'S HEALTH SERVICES



2.1 LOW PAY AND DIFFICULT WORKING CONDITIONS CAUSED BY CHRONIC SHORTAGES OF STAFF, DRUGS AND EQUIPMENT ARE IMPORTANT FACTORS IN DRIVING AFRICAN HEALTH WORKERS TO MIGRATE

Health workers in Africa are under immense pressure. Crowded wards, few drugs, shortages of essential equipment and high numbers of unfilled staff vacancies are taking their toll on all types of health workers.

“Being a health worker in Masindi needs a lot of commitment. It’s so demanding, there is a lot of workload, we have too many patients to take care of and our numbers are so low.”

Chris Joseph, Clinical Officer working in Masindi Hospital, Uganda

The majority of health workers considering migration spoke of their frustration at the lack of resources that prevented them from providing the care and treatment patients needed. In Malawi, for example, it is estimated that staff are struggling to treat up to 200 patients each a day.¹⁵ Many health workers also told us how they struggled to support their families on salaries of as little as £50 a month, and frequently needed to take second jobs to make ends meet. Others highlighted the lack of support and recognition they received, including the absence of opportunities to develop their professional skills and experience. All these factors contributed to health workers not feeling valued and looking to migrate elsewhere for work.

“Our annual survey shows that health workers are generally dissatisfied with their work and are not motivated because of the pressure of long hours and poor resources, because they carry the burden of care for many people without the assistance that they need.”

Martha Kwataine, National Coordinator, Malawi Health Equity Network

¹⁵ Medecins Sans Frontieres, 2007, Help Wanted: Confronting the health worker crisis to expand access to HIV/AIDS treatment, p.2

2.2 MIGRATION IS EXACERBATING THE SHORTAGES OF HEALTH WORKERS AND CONTRIBUTING TO THE DECLINE IN MOTIVATION AND MORALE AMONG THOSE WHO REMAIN

Respondents to our research highlighted the vicious spiral of difficult working conditions pushing many highly skilled health workers to migrate elsewhere while leaving behind those with less experience and declining morale and motivation.

“The whole healthcare system in Malawi is very understaffed, with few nurses, few clinicians, few of everything in general. Until we came to this district, there were no doctors here.”

Katrien Deschamps, VSO volunteer, Rumphi, Malawi

“We lost the majority of registered nurses at their prime. In a country with about 1000 registered nurses, we lost about 600 of them. I believe those who left were the most assertive ones, the ambitious ones, those who would have made really good mentors and strong leaders... that just weakened our system and our profession very much and I would say we have not recovered from that. It’s not just the numbers – it removed a whole

strong group of professional capable people. If you find them [health workers] now, you will find that they are very young, very junior, they are alone, confused, they haven’t had strong mentors. They are not as good as those who left, because there haven’t been strong people to lead them and support them.”

Dorothy Ngoma, Executive Director, National Organisation of Nurses and Midwives of Malawi

“Nurses frequently report late for duty, fail to turn up for duty at all or will bring their own sick child with them. They sleep on duty, do washing on duty and leave before the next shift arrives and often do not wear a uniform.”

Pamela Llewellyn, VSO volunteer, Uganda

2.3 FEW MIGRANT HEALTH WORKERS RETURN TO THE PUBLIC HEALTH SERVICE AFTER WORKING ABROAD

Our research showed that relatively few migrant health workers return to the public health service in the country of origin that trained them. Some choose to return and work for the private sector or NGOs where wages and working conditions are better. But many leave the health system altogether or come back only to retire.

“The average salary for a young doctor in Uganda is about £300 a month, perhaps a bit more. But they can earn between three and ten times that working for a NGO or working abroad. Doctors in Uganda are respected and well treated; other health workers are not. There are not enough nurses, for instance, although there are plenty of jobs. They only earn about £50 a month so many have to have two or three jobs. If they do come to the UK and then go back home, they go back to the private sector or are gobbled up by NGOs who pay them European salaries. But these doctors and nurses have the right to choose a job that pays well.”

Dr Richard Feinmann, VSO volunteer, Uganda

“When health workers do come back from working overseas, most do not go to the bedside. Our low level system with its inadequate resources and lack of equipment makes meeting the needs of intensive care very hard work. It’s traumatic psychologically when there is nothing you can do for people dying of things that they shouldn’t. If you’ve been away for perhaps 10 years, you’ve got used to a system where you have too much. Will it be easy for you to go to this system that is inadequately resourced? No. Most people will either go into the private system or to NGOs, international organizations, where they remain comfortable. They can come back physically, but not to where they were. If they do, they will not last because they can’t cope. You can’t blame them. It is an impossible task – we are asking them to do something none of us can.”

Dorothy Ngoma, National Organisation of Nurses and Midwives of Malawi

This reluctance to return to the public health sector was shared by a large number of the African health workers we spoke to in the UK, even though many did want to make a contribution to improving health in their country of origin.

“If I go back to South Africa it will be impossible for me to drop down to the public service - I won’t survive.”

Male health worker from Africa, currently working in the UK

2.4 HEALTH WORKER SHORTAGES AND LOW MORALE ARE UNDERMINING PROGRESS TOWARDS THE HEALTH MILLENNIUM DEVELOPMENT GOALS

The first-hand experience of VSO’s volunteers over many years has highlighted just how devastating low morale and health worker shortages can be on patients. Left insufficiently attended, women, children and men die unnecessarily every day. Their testimonies are supported by the statistics showing that a woman’s risk of dying in childbirth is one in 16 in sub-Saharan Africa, compared with one in 2,800 in the world’s richest countries.¹⁶ Every day in Malawi, 16 women die in childbirth or from related complications.¹⁷ The vast majority could have been saved if they had been able to give birth with the help of trained health personnel. In countries like Malawi, however, it is estimated there are now just two doctors and 26 nurses for every 100,000 people.¹⁸

“Entirely preventable deaths were reported daily. I was often not called until it was too late. Deaths due to inadequate staffing that would make headlines in Canada were so routine they went almost unnoticed: Miriam, the 19 year old mother who quietly bled to death in her hospital bed cradling her newly born baby - there was no one to check on her and perhaps she was too afraid to complain. Precious, the little boy who came in with an infection on his leg that worsened from neglect during his stay in the ward to the point

where he eventually needed an amputation. Madalitso, the young man who died from an abscess in his neck that slowly closed off his airway.

After a short while the patients suffering these tragedies became nameless, their stories too familiar to me. The many babies stillborn because of inadequate midwifery staff to check their heartbeats during the critical last stages of labour. The malnourished children who, after being correctly identified in the community and sent in for the standard refeeding program died anyway because there were not enough staff to monitor and administer the feeds and educate the caregivers.”

Dr Ilona Hale, VSO volunteer, Malawi

“A patient had fallen out of a palm tree and sustained a spinal injury, his position needed to be changed every two hours, aiming to prevent pressure sores from developing. Due to the lack of time of the nurses and perhaps lack of knowledge this did not happen and the patient ended up dying from an infection in a pressure sore.”

Susie Knox, VSO volunteer, Sierra Leone

¹⁶ WHO, 2005, Facts and Figures from the World Health Report 2005, p.1

¹⁷ <http://news.bbc.co.uk/1/hi/world/africa/8320781.stm>

¹⁸ WHO, 2006, Working Together for Health, p.194

3. WHY MIGRATION ISN'T WORKING FOR AFRICA'S HEALTH WORKERS

PAMELA LLEWELLYN, A VSO VOLUNTEER WHO SPENT TWO YEARS WORKING AS A COMMUNITY NURSE IN RURAL NORTH-EASTERN UGANDA, TALKS ABOUT THE IMPACT SEVERE STAFF SHORTAGES HAVE ON PATIENT CARE, AND EXPLAINS WHY SO MANY HEALTH WORKERS ARE DESPERATE TO WORK ABROAD.



"Although I was working as a community nurse I was based at a hospital, which gave me the opportunity to see nursing in two settings. They both suffer from a shortage of nurses and doctors, which present real problems for standards of patient care.

Generally holistic care did not happen: patients were mostly looked after by their families. In the hospital nurses did not have time for bathing and turning patients. On one occasion I challenged the sole nurse on duty about a patient who was lying in a bed of urine, faeces and maggots. She said she had her paper work to complete before she went off duty. This is an extreme case but demonstrates how patients can be neglected.

Recruitment for the hospital and the health units was an ongoing problem. There were a number of reasons for this, including: little or no on the job training; the district's failure to pay salaries on time; low standards of leadership; poor or no housing offered; and lack of equipment and drugs. For the most part nurses and doctors work in rural areas because they are transferred against their wishes or because they are local and are living with their families.

Many health workers have an additional job outside of the public sector. Doctors run private clinics, nurses run chemists and clinical officers work wherever someone is willing to pay them. This means that they are often absent from their government jobs and as a result patients and colleagues suffer and become further demotivated. Even the best nurse can feel defeated.

Clearly there are good nurses and doctors in Uganda but they are 'swimming against the tide' and feel a great deal of frustration, disappointment and even anger. Some opt to work for NGOs: they are better paid and have attractive packages, including housing, education, vehicles, training and health insurance. They also carry the dream of working abroad. Without exception, every

colleague I spoke to said they would work abroad given the chance. Most are seeking better pay so as to be able to support their families through education and general living, but they also want to become better professional people in their own right. Education is valuable here but for some there are few opportunities to implement their training and their knowledge.

I met a few people who had worked abroad and had returned to Uganda. Nobody came back to the public sector, but instead opted to work in the private or independent sector. All had returned for private reasons and acknowledged that working abroad whilst more lucrative brought its own problems, mostly social and working below one's qualifications."

"Many nurses are leaving Malawi, going overseas looking for greener pastures... Fellow Malawians are suffering a lot. With few nurses, it means that patients even die in the queue waiting to be attended."

Vester Chisale, Trainee Nurse, Malawi

3.1 SOME HEALTH WORKERS TAKE JOBS SIGNIFICANTLY BELOW THEIR SKILL LEVEL TO SURVIVE, LEADING TO THE DESKILLING OF AFRICA'S MIGRANT HEALTH WORKFORCE

We were surprised by the number of African nurses we interviewed who at some point had worked in a private care home, frequently as their first job in the UK. Some did this while waiting to do adaptation courses to enable them to work subsequently as nurses in the NHS, or while funding themselves through other forms of education. Others, however, spent the entirety of their time in the UK working in care or nursing homes because of the difficulties they had faced in finding hospital posts. Prejudice, limited networks and language difficulties may all be factors but many of our interviewees cited the fact that their qualifications weren't recognised in the UK as being the most significant obstacle. Representatives from professional associations and diaspora organisations voiced strong concerns about the deskilling of migrant nurse populations working in residential homes due to the more limited range of skills needed by care workers.

"There is no proper arrangement between the Malawi government and the countries where these people migrate, that is why people well qualified end up doing menial jobs abroad parallel to their fields or working in adult homes."

Blair Malini Sibale, Nursing Officer, Rumphi District Hospital, Malawi

Respondents also highlighted that migrant doctors working in the NHS were increasingly finding fewer opportunities available to them. As a result, some were taking lower-skilled locum posts, giving up medicine completely or migrating elsewhere.

"The restrictions on employment of non-EU people have turfed out a lot of people, particularly doctors, who have been on the margins of the health profession. In other words, doctors who have finished their training or who are coming to the end of their training. In the past they would have had various non-consultant jobs in the NHS, either so that they could continue to stay or so that they can complete some part of the regulatory requirement, so that they can move onto the next level. All of that has been stopped, more or less, which means that when they finish their training they can only get temporary jobs, like locum jobs, which is creating a kind of floating mass of people. And with temporary jobs your employment, your tenure, is very precarious. You have no security. That category of people is growing, but it's not making people go back. It's just making people struggle at the margin there, or, they go to some other country, or they leave medicine altogether and go do something else. We have met a number of Zimbabweans who have left medicine altogether, and are therefore trying their hands at other things."

Farai Madzimbamuto, Co-Chair, Zimbabwe Health Training Support and Consultant Anaesthetist in the NHS

3.2 MANY AFRICAN HEALTH WORKERS FIND THEMSELVES STAYING IN THE UK LONGER THAN PLANNED

The overwhelming majority of health workers that we interviewed did not want to migrate to the UK or elsewhere on a permanent basis. For almost all, the intent to migrate was for a short period of time to improve education or experience, achieve promotion, have a better standard of living and increase their income. Many health workers considering migration, and particularly nurses, told us that they would prefer not to migrate, and would not do so if the conditions were better in their country of origin.

“Maybe I would go for three years, enough time for getting more experience, but I don’t want to stay away from Malawi forever.”

Female nurse considering migrating, Malawi

However, our research found that many African health workers had ended up staying longer in the UK than they had originally envisaged. The research provided a rare opportunity to look beyond the ‘myth of return’¹⁹ and discover why this happens. Nurses in particular spoke of their initial struggle to find a job when their qualifications weren’t recognised, and the hurdles of taking adaptation courses. Health workers of all types told us they intended to return as soon as they had built up sufficient financial resources, but that the high cost of living and having to take jobs significantly below their skill level meant it took much longer to save money than they had expected.

“I always thought that it would not be a permanent move but I did stay longer than I intended. It was a good job and the money was obviously better than here but it was still difficult to save.”

Female nurse, Malawi, worked in the UK for six years

Despite this, many health workers did tell us about the improvements that their remittances had bought their families. The ability to send family members to school or build better houses were two of the achievements most frequently mentioned.

“The only financial benefit that has accrued from working in the UK has been for my family. Because I wouldn’t have been able to pay the school fees for my children if I had remained in Uganda. So my being here has helped quite a lot in the sense that my children have gone to some of the best schools at home and I have been able to have a roof over my head.”

Peter from Uganda, currently working in the UK

A small number of health workers reported that concerns about their citizenship status and their ability to return legally to the UK at a later stage were important factors in their decision to stay longer than planned. Respondents from trade unions, professional associations and academia also highlighted the potential impact of inflexible citizenship policies on driving migrants into staying longer than necessary.

“Sometimes people are forced to stay longer in the UK than they would have liked. In my case I was thinking, let me stay for at least five years and then I can process for an indefinite stay... At the moment, if you go back before the required time expires [on the citizenship pathway] you can’t easily go back and forth.”

Annie, Unit Matron in Malawi, worked in a private care home in the UK for five years before returning to Malawi

¹⁹ Anwar, 1979, The Myth of Return; Safran, 1991, Diasporas in modern societies: myths of homeland and return, *Diaspora* 1(1): 83-93

ZENAH*, A QUALIFIED NURSE WHO IS NOW WORKING IN SALES AND MARKETING, TALKED ABOUT HER EXPERIENCE OF TRYING TO WORK IN THE UK AND THE CHALLENGES SHE FACED WHEN SHE RETURNED TO UGANDA.



Zenah went to the UK after she had completed her nurse training in Uganda. She did not realise that her nursing qualification would be unacceptable in the UK and that she would have to repeat her nursing training. The application was fraught with difficulties because she was not a UK citizen and therefore not eligible for funding.

She took work as a carer in a residential home to save the money. When she had enough she reapplied only to be turned down again - the goal posts had changed and self-funding students were no longer eligible.

Zenah felt rejected and confused. This had changed her plans for her career and her life and she was no longer eligible for a student visa to stay in the UK as she had hoped. After three years working as a nursing assistant, Zenah decided to return to Uganda so that she could work as a professional nurse again. She was offered a job within a month of her return, but things did not go as she had hoped and expected.

During her time abroad she had been exposed to a different way of living and working; she had gained independence, confidence and self-belief. She found her Ugandan nursing colleagues timid, poor communicators and unable to answer patients’ questions. She believed they had the knowledge but lacked the conviction. She felt that Ugandan nursing was in denial about real patient needs.

Going abroad had helped Zenah to trust and believe in herself. When she came back to Uganda she wanted to challenge issues that she thought were wrong. Her nursing colleagues were not receptive or co-operative with her. Her colleagues saw her as superior and suspected her of spying on them.

After 18 months of nursing she was offered a job in medical sales and marketing and she accepted. The pay was higher and the hours more social - Monday to Friday, nine to five. She enjoys her new job and is rewarded by incentives. She says she fears nobody and is proud of her achievements. Although there is respect for professional hierarchy she says her colleagues work well with one another, unlike nurses who are subservient to doctors.

“Most of the nurses came here through some agencies that connected them to a nursing home. And there isn’t really much in the nursing home that people really do. There’s not so much challenge there, other than just giving tablets and care – that’s it. So if you’ve been there for quite a long time the chances are that you lose a lot of your skills.”

Patricia Malikebu, Malawian Initiative for National Development and former midwife in Malawi and the UK

* Surname withheld

4. WHY THE UK NEEDS TO ADDRESS THIS NOW

4.1 THE UK'S CURRENT APPROACH ISN'T STOPPING THE BRAIN DRAIN FROM AFRICA

Many of those interviewed in this research highlighted the increasingly competitive and global nature of the market for health professionals. As a result, they felt that the UK's efforts to restrict the recruitment of migrant health workers²⁰ actually had little impact on stemming brain drain from Africa's health services overall. Respondents from professional associations and diaspora organisations told us that African health workers who found it increasingly difficult to work in the UK were not choosing to remain in their country of origin but moving instead to the US, Canada and Australia.

"If they won't go to the UK, they will go to Australia. If they won't go to Australia, they will go to the US. While the UK has stopped recruiting directly, the US is recruiting and advertising openly."

Dorothy Ngoma, National Organisation of Nurses and Midwives of Malawi

This is reflected in statistics from the OECD, which shows that while the number of registrations of foreign-trained doctors to the UK has been declining since 2003, the number of overseas-educated doctors passing the USMLE exam to work as a doctor in the US increased 70 per cent between 2001-2008. Meanwhile countries that have relaxed their immigration restrictions for doctors have seen significant inflows. In Australia, for example, the immigration of doctors has increased two-fold, and by 40 per cent in Canada.²¹

²⁰ Including the introduction of the points based immigration system and the Department of Health's 2004 Code of Practice on the International Recruitment of Healthcare Professionals http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730

²¹ OECD, 2010, International Migration of Health Workers, Policy Brief, p.2

"Recruitment has diminished because the job opportunities in the NHS go in cycles. And at the moment, because more [British] people have been trained and because of the immigration changes that have been implemented, there is a tightening on jobs... But as far as African doctors are concerned, when they can't get jobs here they move to Australia or to the US. Both those countries are still recruiting."

Farai Madzimbamuto, Consultant Anaesthetist (NHS), Co-Chair of Zimbabwe Health Training Support

4.2 WITHOUT MANAGING MIGRATION MORE EFFECTIVELY, DONOR AID FOR AFRICA'S HEALTH SYSTEMS AND WORKFORCES WILL NOT DELIVER MAXIMUM VALUE FOR MONEY

Over the last few years there has been increasing recognition from the international community that meeting the health Millennium Development Goals will need a considerable expansion in the recruitment and training of Africa's health workers.

The experience of VSO's field staff and health volunteers, however, suggests that increasing the training of health workers is not enough to provide a lasting solution to Africa's workforce crisis alone. These initiatives must go hand-in-hand with broader efforts to tackle the underlying causes of health worker migration and barriers to return. Without this, international aid may indirectly end up subsidising Britain's NHS as well as the health services of countries like the US and Canada.

"When I was speaking to the doctor heading up the Faculty of Nursing at the Connaught Hospital in Freetown, he felt that over 50 per cent of his intake of student nurses – those that were going to have the full degree for full registration – were doing so to get out of Sierra Leone. And it was about families paying for that to happen. All sorts of networks coming together to give one person the opportunity to do the training and then scarper."

Laura Moffatt, former MP for Crawley and VSO 'PolVol' volunteer, Sierra Leone

"I think in a place like Uganda, the human resources for health issue has not been taken seriously enough. They talk about it, there's a lot of rhetoric, but the solution that I always hear coming out is: produce more doctors. So, make the medical schools larger, or build more medical schools – that kind of thing. But actually people are leaving, they're quite well trained and they move on. So that's not the solution. I think they need to deal with some of the issues locally that make people not want to stay."

Sarah Kyobe, VSO Health Programme Manager, Uganda

From the perspective of donor and African governments, the financial implications of simply increasing training without finding more effective solutions to migration are stark. According to WHO estimates, in 2002 Ghana had already lost around \$60 million in investment and training of health workers.²² Other estimates suggest that each emigrating professional represents a loss of \$184,000 for an African source country.²³

Finding ways to reduce the permanent loss of trained health workers is therefore critical to building confidence in the value for money of aid efforts to scale up the training of Africa's health workforce.

²² WHO, 2002, quoted in IPPR, 2005, Migration and Health in the UK, p.12

²³ Pang, Langsang and Haines, 2002, quoted in IOM, 2006, Migration and Development: Opportunities and Challenges for Policy Makers, p.10

5. MAKING MIGRATION WORK FOR ALL

As part of our research, we asked respondents to tell us how they believed governments could better manage the international migration of health workers. From the academics to the migrant health workers, what we heard was remarkably consistent. Everyone we spoke to emphasised the importance of tackling the underlying causes of migration, including the overwhelming workload and dangerous working conditions. The need to make it easier for migrant health workers wanting to return to Africa either temporarily or permanently also resonated strongly, as did the importance of ensuring that migrant health workers were supported to develop their professional skills during their periods of residence in the UK.

5.1 GET MIGRATION WORKING OUTWARDS AS WELL AS IN

5.1.1. Recognise that migrants don't want migration to be a one-way journey

During the course of this research, we were surprised by the strong desire among African health workers in the UK to return to their countries of origin. A majority stated that they would like to return at least temporarily, with many of them expressing an aspiration to return permanently.

“I want to take back what I've learnt here, take it back home. If possible establish something that will be beneficial to people back home. So hopefully whatever I do as a nurse here now, they'll ask me to do when I get back.”

Female health worker from Africa, currently working in the UK

“I have been considering [going back home]. I have made contacts and applied for jobs back home. But the conditions and pay are not favourable and this worried me... I will definitely go back in the long run.”

Male health worker from Africa, currently working in the UK

The high interest in returning is broadly reflective of previous surveys of international nurses in London carried out by the Kings Fund, which found that 60 per cent planned to stay for at least five years, 25 per cent of them for two to five years. Of almost 400 nurses who responded, 43 per cent reported considering moving on from the UK, either to return home or go somewhere new.²⁴

Our research suggests that there is a need for policy makers to change their perception of immigration. The idea of one-way flows from poor countries does not mirror migrants' own plans or aspirations. Those interviewed explained that they would much rather not settle in the UK permanently. This suggests considerable potential interest in initiatives that facilitate temporary migration or opportunities for recurring (circular) migration. It must, however, be recognised that decisions about return will always be complex and also subject to current political and economic conditions in migrants' countries of origin.

Respondents also highlighted the importance of ensuring that the option to return for those already settled in the UK should be a free choice for the individual and should not be forced.

“Malawians in the UK should not be forced to come back. The one doctor you don't want is one that doesn't want to be here.”

Dr Peter Kazembe, Executive Director, Bayler College of Medicine, Malawi

5.1.2 Provide information and advice to help migrant health workers return to Africa

Many health workers we interviewed spoke of wanting to go back to work in their home country's health system but felt anxious about taking such a big step after building up their lives in the UK. Some health workers suggested that they had been more likely to choose to return if they could do so through official programmes or organisations that helped them with the process and logistics of re-establishing themselves.

“I would go back if there were programmes and schemes to help people. Some of us have been away for many years. For example, a place to make contacts, get help with accommodation, children's education...”

Female health worker from Africa, currently working in the UK

“I think it will help if the return is facilitated. I have my home and family here but I may need help getting a job. Not just any job, but one that is right for my level and experience. So if my time in the UK is somehow officially recognised and the ministry here knows what is the best place for me then that will help.”

Female nurse considering migration, Malawi

5.1.3 Increase flexibility in the citizenship pathway and visas to make it easier for migrants to return

Facilitating the return or circular migration of health workers is a key recommendation in both the WHO and Commonwealth Codes of Practice on the International Recruitment of Health Personnel.²⁵ Our research respondents highlighted the importance of legal paths back to the UK for migrants considering temporary return, and for governments looking to facilitate this. Some drew attention to the need for visas that allowed movement back and forth between the UK and country of origin. For health workers already on the citizenship pathway, respondents felt that providing the option to temporarily 'pause' the journey would increase the likelihood of return.

“Getting visas that are secure is very important for circular migration. And then also your registration to practice. If you stay [in country of origin] for more than three or four months and do not practice for all that time you will have to go through the registration procedure [in the UK] all over again. So mostly it's about getting that security to start practising again.”

Health worker from Africa, currently in the UK

²⁴ King's Fund (Buchan James et al), 2005, Internationally Recruited Nurses in London, www.kingsfund.org.uk/resources/publications/internationally.html

²⁵ WHO, 2010, Global Code of Practice on the International Recruitment of Health Personnel, http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf, Commonwealth Secretariat, 2003, Commonwealth Code of Practice on the International Recruitment of Health Workers, http://www.latitudesgroup.com/Documents/Commonwealth_Code_of_Practice.pdf

“The whole issue of citizenship is important, because a lot of migrants won’t go back home because they’re fearful they might not agree with their own government. If they have a British passport it means that they have consular protection. And that’s quite important for returning migrants. And I think when you’re talking about circulation, a skilled migrant is probably more likely to circulate if he or she is a British citizen, because they have that extra security.”

Professor Ronald Skeldon, Senior Research Fellow in the Department for International Development, and Professorial Fellow in Geography at the University of Sussex

5.1.4 Promote volunteering and other initiatives to migrant health workers in the UK

Opportunities to return to Africa to work for short periods of time were extremely popular with the health workers who took part in our research, while those who had already undertaken such voluntary work were passionate about the contribution they felt they had made. Our research clearly indicated that there could be considerable demand among African health workers in the UK for volunteer opportunities in their country of origin, particularly if it did not affect their job security in the UK.

“People want to go back but they need to have the security of coming back to a job here. And so it’s a matter of working with the NHS here to allow them time off, such as a sabbatical where they have a sustained amount of time off and can go contribute to the health system in Sierra Leone but come back knowing that they have something here. So it’s about working a deal with the NHS where they could do that.”

Georgina Awoonor-Gordon, Programmes Manager, Sierra Leone Diaspora Network

“A lot of people really want to go and help the system back home but it’s just the constraints. So if there was an assurance that you can go and maybe work in a country for three months, or whatever period, and you would still maintain your holidays and everything else, then I think that would be helpful for the human resources back home.”

Patricia Malikebu, Malawian Initiative for National Development and former midwife in Malawi and the UK

A number of health workers and other respondents also suggested that such volunteering opportunities, as well as other types of involvement in diaspora organisations (such as linking with institutions or communities back home to provide technical support from a distance), may help migrants decide to eventually return permanently by providing up-to-date information and a chance to ‘test the waters’ themselves.

“Ever since I got involved with the diaspora here I am more enlightened about what’s happening in Sierra Leone about health – even before most of the people in my country know about it. We have sat with the President of Sierra Leone in this country and getting this audience has given me courage that I should be able to go back and fit in.”

Male health worker from Africa, currently working in the UK

“We need to encourage the health workers of the diaspora to be a bit more keen in coming back. Maybe we need to be able to show that we’re open to them and help them come back. Diaspora volunteering could enable people to find their way slowly back home, get a feel for what’s happening and what they could do to help.”

Sarah Kyobe, VSO Health Programme Manager, Uganda

VSO’s experience of supporting diaspora volunteering programmes has also found that diaspora volunteers can be particularly effective. Their existing understanding of the local culture enables them to build relationships and trust with colleagues more quickly.

“The diaspora volunteers tend to identify with people. They have a two-way effect and local Ghanaians feel very comfortable with the diaspora because of cultural similarities.”

Dr Wilfred Labi Abbo, Regional Director, Eastern Regional Hospital, Ghana

5.2 BUILD UP AFRICAN HEALTH SYSTEMS AND WORKFORCES

5.2.1 Address the critical shortages of health workers and improve their working conditions and pay

When we asked health workers about the things that would give them confidence to return to the public health systems in their countries of origin permanently, they were unanimous about the need to pay health workers a fair wage. They also emphasised the importance of investing in health infrastructure to build functioning hospitals and clinics where health workers had the equipment and medicine to save lives. While some development assistance is already directed towards these aims, the testimony of our respondents reinforces the importance of achieving them.

“For the Ugandan government to tempt people to come back and work in their country, they would need to improve on the health services, equip the hospitals, improve infrastructure and ensure good drug supply. And they would have to improve on the payment of health workers. Currently payment for health workers is so low, yet they have a lot of responsibilities. So if the health service is ok, the hospitals are good, health workers earn enough, then they won’t want to migrate to the UK for greener pastures.”

Chris Joseph, clinical officer working in Masindi Hospital, Uganda

ELIZABETH CONTEH HAS BEEN IN THE UK FOR OVER TWENTY YEARS NOW. HERE SHE REFLECTS ON THE CHALLENGES SHE FACED WHEN SHE FIRST ARRIVED AND TALKS ABOUT THE NEED FOR PEOPLE TO VOLUNTEER IN THEIR HOME COUNTRY.



Elizabeth Conteh is from Sierra Leone. She trained as a nurse, and in the mid 1980s she was made co-ordinator of the primary healthcare programme in a chiefdom in the east of the country. Here she worked alongside VSO volunteers in the hospital she was based in – doctors, nurses, a matron and an administrator. “There was a terrible shortage of staff,” she says. “Without the volunteers the hospital couldn’t have functioned as it did.”

Due to Elizabeth and the volunteers’ hard work, child and maternal mortality rates were dramatically reduced. Hospital standards improved with the matron’s introduction of staff accountability and standards of cleanliness, and child inoculations became normal practice on the advice of the doctors. “Lives were saved,” she says.

In 1988 Elizabeth migrated to the UK, where her husband had come to study. She has been living here ever since, now working as a discharge co-ordinator and general surgery nurse but settling in was not without its challenges.

“When I left Sierra Leone I had been the co-ordinator of primary healthcare across a chiefdom and was the equivalent of a band 8. When I arrived in the UK I could only get work as a health care assistant in a nursing home, which is the equivalent of a band 2 – a huge step down. We don’t even have nursing homes in Sierra Leone! Nurses from overseas have to do an adaptation course to be registered with the Nursing and Midwifery Council in the UK. I had to move from Bristol to London to get onto a course. Once I was on it, it was supposed to last for three months, but they kept our group on it for a whole year to work as full time staff even though we were students. I was working 37.5 hours a week and being paid 200 pounds a month. I worked through the nursing rank up to band 7, and am now working at band 6 level, as a discharge co-ordinator in the NHS and a surgical nurse in a private hospital. I am doing two jobs to make ends meet and to send money to Sierra Leone.”

Despite the challenges Elizabeth says health professionals continue to leave her home country: “People are not paid according to the cost of living, meaning that once they have paid for their rent they have no money for food or their own healthcare. Inevitably this leads to low morale and low standards of patient care. Nurses are well trained, but there is a lack of equipment and no technical repair for the equipment they do have. In the UK there are technicians who repair equipment and carry out quality checks, in Sierra Leone when something is faulty, they are pushed round the corner out of sight and not replaced. There is also a lack of medicines and pain relief, which is demoralising for workers – they feel they cannot help enough and cannot do their jobs properly. People leave in search of a better life.”

Elizabeth is now chair for the Organisation of the Sierra Leone Healthcare Professionals Abroad UK, which is a group of diaspora volunteers committed to improving health standards in their home country. Here Elizabeth has become involved with VSO again, as the organisation is an associate member of the Diaspora Volunteering Programme, a programme run by VSO and the Diaspora Volunteering Alliance:

“We want to give technical assistance, training, and equipment. I feel it’s my duty. I’m very passionate about Sierra Leone – I owe a lot to my country. It is a shame to the government and citizens that our country is at the bottom of the WHO health index. People die prematurely, I hear about deaths from Sierra Leone all the time – deaths for no good reason. Hospitals and equipment were destroyed during the war and have not been replaced across the country, and the patient to doctor ratio is unacceptable. There is a great need for capacity building and for skills in specialist areas. I’ll do whatever I can to contribute and to motivate others to do so as well.”

“If we want to get nurses to come back here we must build them houses so that they are comfortable. We need to train 16,000 new nurses so each doesn’t have to look after 100 patients alone. That is what they are running away from. They need that meal when they are on duty. Let’s attend to their health care needs, let’s give them insurance, let’s treat them, let’s prevent those diseases, let’s do something about the care environment, those congested wards, the equipment and resources for care so that patients get well instead of dying in masses... Who wants to be wrapping dead bodies their whole day?”

Dorothy Ngoma, National Organisation of Nurses and Midwives of Malawi

5.2.2 Improve opportunities for training and professional development

Other critical factors ‘pushing’ African health workers to migrate were the limited opportunities for education, professional training and career progression. These were frequently cited by respondents as factors motivating their move overseas, and as needing to be addressed by any government wanting to retain both newly qualified and returning health workers.

“A lot of the reasons why people leave are not all money, certainly for people like doctors a lot of it is to do with higher professional training.”

Farai Madzimbamuto, Co-Chair, Zimbabwe Health Training Support and Consultant Anaesthetist

“It’s the lack of training opportunities, quite apart from the poor working conditions, low pay and various other push factors, that pushes African doctors out of Africa. We should be spending more on education in Africa. More aid money should be going towards training staff.”

Lord Nigel Crisp, former Chief Executive of the NHS

5.2.3 Support British health workers to share their skills through volunteering

VSO has long understood the critical importance of skilled trainers and mentors to support health workers to develop their professional skills and apply best practice. The role of British health workers in providing this support was particularly welcomed and appreciated by those we spoke to.

“We’ve had VSO volunteers come out, we’ve had a nurse tutor who helped us start a nursing school and the crop of nurses that has come out of two years of work is just amazing. The nurses are great, they are critical thinkers, they solve problems better, they are a lot more enthusiastic and they are curious about what they can learn and what they can do.”

Hannah Magoola, HR Manager, International Hospital Kampala

“Since the VSO doctors came we are not referring many patients to the central hospitals. We are now able to manage these patients here because of the expertise of the VSO doctors. This has reduced transport costs to the central hospitals. It has made a big difference to us here.”

Bernard Chavinda, District Health Officer Rumphi, Malawi

Despite the high esteem in which British health workers are held by their African colleagues, UK professional associations highlighted the increasing difficulties facing those wanting to take time out from the UK health service to volunteer overseas.

“I think trusts and deaneries need to be more supportive of doctors who want to take time out [to volunteer in Africa]. We’ve heard from a number of our members that they’re not supported or they have to use their holidays and their own funding. It’s an untapped resource on the UK side.”

Spokesperson, British Medical Association

We wanted to find out what the government could do to encourage more British health workers to volunteer overseas, so we sent a survey to a representative sample of health workers who had previously volunteered with VSO in Africa. Over 100 responded. More than three quarters (77 per cent) stated that they would like to volunteer again, and that being able to continue their professional development (66 per cent) or take extended leave of absence (55 per cent) would support them do so.

5.2.4 Effectively utilise and deploy returning migrant health workers to strengthen Africa’s health systems

In the same way that British health workers have played an important role in helping to train and supervise African colleagues, many of the people we interviewed highlighted the potential impact that returning migrant workers could have in carrying out similar tasks. This could in turn help address some of the factors that lead to migration, by increasing opportunities for health workers to develop new professional skills and sharing knowledge or best practice to drive change within Africa’s health systems and workforce management.

“I think they [returning migrant health workers] would be useful in training institutions. Train our young doctors, that’s where we need their expertise. They will see 60 students a year, we will fill the huge vacancies we have in this country, rather than being deployed at a hospital level, or being in the Ministry. I want them to impart their expertise to so many others who will benefit from their skills. So that is what I would do – increase the capacity of our training institutions.”

Mr Kondwane, Assistant Registrar, Malawi Medical Council

“Returning migrant health workers would bring their expertise from working in a health care system where operations function in a better way. This could lead to support for the Ugandan health care system to develop and grow, to increase capacity and quality of care. They could share experiences and identify the needs to make adjustments to narrow the divide between the UK and Ugandan health care systems. They could support training and human resource issues especially in addressing the high student to teacher ratio which impacts on the quality of training available.”

Dr Ismail Ndifuna, National Programme Officer, UNFPA Uganda

“Good planning is essential using up-to-date information systems. Returning health workers need to feel fully utilised immediately. Returning health care workers should not be focused in clusters but should be well distributed and well placed. All incentives need to be guaranteed to happen. Teaching establishments should also benefit from such placements.”

Dr Bernadette Nalumansi Ssebadduka, International Organisation for Migration

In Malawi, VSO is an implementing partner of the national health Sector Wide Approach (SWAp), supported by the UK’s Department for International Development. VSO doctors and nurses are working in medical training institutions and district hospitals across Malawi to improve the quality of patient care. Over 1,000 health workers are being trained in the colleges where VSO volunteers work and over 600 medical and nursing students and interns are mentored and supervised by volunteers based in district hospitals. VSO is also helping to improve the development of community based health services including building the capacity of village health committees. In addition, VSO has placed volunteers with the Central Ministry of Health to develop a national human resource management information system.

5.3 SUPPORT THE PROFESSIONAL DEVELOPMENT OF MIGRANT HEALTH WORKERS IN THE UK

5.3.1 Review the UK's immigration policies to assess whether they are contributing to 'brain waste'

A number of respondents drew attention to recent changes in the UK's immigration system that may be limiting opportunities for migrant health workers to develop their professional skills. These policies were perceived as potentially leading to the under-utilisation of skilled professionals and migrants either staying longer in the UK or simply migrating elsewhere. The knock-on effect for developing countries is a reduced chance of accruing benefits from migration, as migrant health workers are less likely to return and have fewer new skills to contribute if they do.

"From the standpoint of migrant workers, current policies generate many difficulties. The channeling of the point of entry for many junior staff through training positions often means a degree of deskilling, with doctors with the skills to aspire to registrar-level posts spending long periods on locum contracts as juniors. The goal of up-skilling migrants in preparation for eventual return becomes more protracted, with workers often having to prolong their stay for six or seven years before they acquire new skills. The dependency on employer sponsorship also means that residency rights can be very problematic, with fresh rounds of expensive applications having to be made to the UK Borders Agency whenever the worker changes jobs. Some groups, with senior residential careworkers providing a recent example, are vulnerable to changes in policies which place them outside immigration categories which they

had previously been permitted to enter under. Years of planning and personal investment in employment opportunities in the UK can be badly upset when these changes occur."

Don Flynn, Director, Migrant Rights Network

"Because the immigration rules have changed so much, the opportunities are far more limited [for migrant health workers] now. Access to training was the initial trigger that attracted people to come over here but now their access to training opportunities and further career development is really, really limited because the immigration system has been structured to enable people to access only non-training posts. Previously there had been a permit-free visa available for doctors from outside the EEA who could come here and access training all the way up to consultant level. That ceased to exist in 2006. Although mechanisms such as the Medical Training Initiative have been expanded, that's small numbers and for a time limited period."

Spokesperson, British Medical Association (BMA)

5.3.2 Expand opportunities for migrant health workers to improve their skills, including through programmes such as the Medical Training Initiative

Respondents also felt that the UK Government could do more to help foster return migration and strengthen health systems in developing countries by providing better opportunities for health workers to improve their skills and qualifications while they were in the UK. The Medical Training Initiative (MTI) was suggested by some as a potential model for how the Government could better facilitate the professional development of migrant health workers. Under Tier 5 of the Points Based Immigration System, the MTI enables foreign doctors to work for up to two years in the UK, during which time they are also meant to receive training in skills that will be useful for when they return to their countries of origin. At present, however, the initiative is only available to doctors and in relatively small numbers. For example, just 12 doctors

from sub-Saharan Africa had entered through this scheme between April 2009 and March 2010.²⁶ This type of scheme offers one way for the UK Government to support the training of health workers from sub-Saharan Africa in this country, while also helping to meet labour needs in the NHS. However, some professionals highlighted the need for monitoring of the MTI to ensure that the scheme wasn't open to abuse by employers looking to simply fill gaps or pay below the market rates for particular posts.

"The UK should be offering training and support to overseas doctors. We don't seem to be doing that any more... We must be able to do something for these young doctors so they get a chance to create a reasonable quality service in their home country... Ugandan doctors and higher-level nurses need to come across to the UK to see how we do things; how we treat patients; how health centres can be patient-centred. They need to look at quality, at review..."

Dr Richard Feinmann, VSO volunteer, Uganda

"When African nurses go to the UK we tend to focus on work not education and then we don't progress... You have got to stay for five years to really benefit your family so you can be a long way behind in qualifications that will get you good jobs in Malawi, even if you have had a different experience."

Lorraine, midwife who worked as a registered nurse in a nursing home in the UK for one year before returning to Malawi

"I think allowing Sierra Leonean nurses a chance to learn by working in the UK is a really positive act to re-energise the profession itself to improve standards."

Laura Moffatt, VSO 'PolVol' volunteer, Sierra Leone

5.3.3 Establish bilateral agreements with key sending countries that recognise skills and qualifications gained by migrant health workers in the UK

Throughout this research, numerous health workers told us of the challenges and barriers created by the lack of recognition between countries for their qualifications. Many migrant or aspiring-migrant health workers fed back that if their country of origin recognised the qualifications and experience they had gained in the UK, the incentive to return at some point would be significantly increased. They also felt that this would help reduce some of the bureaucratic re-registration processes that also provide an additional deterrent to return.

"It would be nice if the [Malawi] Government would recognise people when they came back, because at times that is what's not there. People say, 'If I go back, what for? Even if I go back they won't recognise my qualifications that I have done [in the UK]. So you are more likely to come back to the same level position as before you left – and actually that is one of those things that makes people fail to come back."

Annie, Unit Matron in Malawi, worked in a private care home in the UK for five years before returning to Malawi

"Health care workers' qualifications need to be accredited between the two countries."

Dr Ismail Ndifuna, National Programme Officer, UNFPA Uganda

"I have registered and paid for my registration already once, but when I return I will have to go through the process again. It would be better if there was an arrangement so that I can come straight from the UK and slot in without delays and expense."

Health professional considering migration, Malawi

²⁶ Answer to Parliamentary Question, 11 March 2010, House of Lords Debate on the NHS

6. CONCLUSION AND RECOMMENDATIONS TO THE UK GOVERNMENT

6.1 CONCLUSION

“Circular migration is not an option but a necessity in a country where the health care system is in crisis.”

Dr Bernadette Nalumansi Ssebadduka,
International Organisation for Migration

VSO's research has found that the perception of 'one-way only' migration flows from poor to rich countries has little resonance with the real aspirations and plans of many migrant African health workers. The majority of those we interviewed expressed a genuine desire to return to their country of origin and to use their skills to make a difference by working in the health service or sharing the skills they had acquired with others.

There are many aspects of the UK's immigration policy that may not be easily reconciled with the UK's international development goals. However, we believe that increasing the coordination of immigration and development policies to facilitate circular migration for skilled health workers and overcome the barriers for those wanting to return offers a potential 'triple win' scenario.

For the UK, facilitating circular migration offers the ability to continue to meet labour shortages by attracting skilled professionals to work in the health sector for defined periods of time.

For developing countries, it offers the temporary or permanent return of professionals who have acquired new skills and knowledge in the UK. These returning migrants can be deployed to help address staff shortages and improve the quality of Africa's healthcare, including through the training of other health workers.

For aspiring migrant health workers, it provides an opportunity to increase their professional skills and financial resources through legal migration in the knowledge that they will be able to find a job that uses those skills effectively on return. For migrant health workers already in the UK, diaspora volunteering and flexibility in the citizenship pathway presents a chance to make a difference back home on a temporary basis, while also 'testing the water' for a potential permanent return without risking their right to stay in the UK.

We hope these findings will encourage political engagement from the Department for International Development, the Home Office, the Department of Health and No.10 to begin to realise the synergies between migration and development, and to show international leadership by working together in a more coherent way to maximise the potential benefits for global health outcomes and poverty reduction.

6.2 SUMMARY OF RECOMMENDATIONS TO THE UK GOVERNMENT

Get migration working outwards as well as in

- Support organisations that provide information and advice to migrants looking to return to work in the health system in their country of origin
- Allow the suspension of the citizenship journey for migrants returning to do medical work in their country of origin
- Support and promote diaspora volunteering initiatives more widely, and make it easier for migrant health workers to volunteer

Build up African health systems and workforces

- Follow WHO guidelines by ensuring that 50 per cent of health Overseas Development Assistance is spent on health system strengthening, of which at least half should fund emergency health workforce plans
- Scale up the education and training of health workers to address the critical shortages and provide ongoing career development opportunities
- Increase the retention of African health workers by providing financial support to enable governments to increase wages and improve working conditions
- Support British health workers to share skills and knowledge with African colleagues by allowing extended leave of absence schemes from the NHS
- Provide technical support to help African governments effectively utilise and deploy migrant health workers returning to their country of origin

Support the professional development of migrant health workers in the UK

- Review the UK's immigration and health sector recruitment policies to ensure they are not contributing to the deskilling of Africa's health workers
- Expand opportunities for migrant health workers to improve their skills in the UK under Tier 5 of the points based system, including through the Medical Training Initiative
- Establish bilateral agreements with key sending countries that recognises skills and qualifications gained by migrant health workers during their time in the UK

APPENDIX

METHODOLOGY

This paper draws on qualitative research findings commissioned by VSO and undertaken by Plurpol Consulting during 2009. The research involved preliminary focus group discussions involving 43 African health workers in the UK, Malawi, Uganda and South Africa. A series of in-depth semi-structured interviews were then held with a further 22 African health workers who were either working in the UK (10) or had returned to Africa after a period of working in the UK (12). In addition, 24 interviews were conducted with organisations supporting migrant workers, union representatives, Diaspora organisations, academics, NGO staff and government officials across the UK, Malawi and Uganda. This paper is also informed by interviews and reports from numerous VSO health volunteers and programme staff across Africa between 2008-10 to provide a comprehensive briefing.

Excerpts from these focus group discussions and interviews are published throughout the report to illustrate the experiences of Africa's migrant health workers, and VSO's volunteers, as well as the organisations working to understand and address brain drain from Africa's health systems.

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ABOUT VSO

Founded in 1958, VSO is the world's leading independent international development organisation that works through volunteers to fight poverty. VSO currently has 10 dedicated health programmes in **Burkina Faso, Cambodia, Ethiopia, Malawi, Mongolia, Sierra Leone, Sri Lanka, Tajikistan, Tanzania and Uganda**. VSO recruits doctors, nurses, midwives, community health workers, management advisers and other professionals to support the development of stronger, more inclusive and accessible health systems so that the poor and most vulnerable people can realise their right to health. Since 2005, VSO has also supported members of the diaspora to volunteer in their countries of origin through the Diaspora Volunteering Programme. To date, 409 diaspora volunteers have supported 8024 direct beneficiaries through this scheme.

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VALUING HEALTH WORKERS

VSO's international health advocacy strategy 'Valuing Health Workers' advocates for countries to move towards the threshold recommended by the WHO: 2.3 doctors, nurses and midwives per 1000 people. The strategy aims to bring increased attention to the importance of the human resource crisis in developing countries and advocate for increased resources and innovative solutions that will strengthen human resource capacity.





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